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

Western Sovereign Base and Eastern Sovereign Base Areas, Cyprus

Defence Medical Services inspection report

This report describes our judgement of the quality of Pre-Hospital Emergency Care (referred to throughout the report as PHEC) delivered by British Forces Cyprus (BFC). It is based on a combination of what we found through information provided about the service and through interviews with staff and others connected with the service. We carried out a visit to each of the 3 medical practices from where PHEC is delivered and visited BFC Headquarters to meet with a representative of the regional team, Commander Medical and staff.

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

Contents

Summary

About this inspection

We carried out an announced comprehensive inspection of the PHEC service led by BFC in June 2022. We rated the service as requires improvement overall. The service was rated as inadequate for providing safe services, requires improvement for the effective and well-led key questions. The caring and responsive key questions were rated as good.

We returned in October 2023 to carry out an announced comprehensive follow-up inspection. The service was again rated as requires improvement overall. The service was rated as requires improvement for providing safe services and requires improvement for the well-led key question. The effective, caring and responsive key questions were rated as good. The report for 2023 can be found here:

https://www.cqc.org.uk/dms

We carried out this announced comprehensive follow-up inspection on 7,8, 9 and 10 October 2024. The 3 medical practices at Akrotiri, Dhekelia and Episkopi provide PHEC to anyone in the Sovereign Base Areas (SBAs) including serving personnel and their families, tourists and the local civilian population.

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

The key questions are rated as:

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

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 take appropriate action against CQC's observations and recommendations.

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

At this inspection we found:

- A generally motivated and committed team delivering the PHEC service. However, morale continued to be impacted by a number of continuing and longstanding issues that were outside of their scope to exact change.
- Improvement and significant progress at a tactical level with the onboarding of a PHEC Clinical Director.
- Blurred lines of accountability at a senior leadership level, fragmented lines of accountability and unclear risk escalation pathways continued to pose risks to the safe delivery of the service. We saw examples of risks that had been identified, assessed and actions proposed. However, a lack of clarity around the ownership of these risks hindered progress and resolution. This included risks that had been considered which potentially had a serious impact.
- The 3 sites were now working together and where processes were not yet completely pan-island specific, Sovereign Base Area Ambulance Service (SBAAS) standard operating procedures had been drafted and were awaiting ratification. Learning opportunities from clinical cases and adverse events were now shared at SBAAS monthly meetings and other important updates shared through the 'Team Read'.
- Arrangements were in place for infection prevention and control (IPC). Further improvements to the consistency and the cleaning and checks of the vehicles was highlighted.
- Arrangements were in place for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice.
- Although accepted that the nature of the service meant that feedback from patients would be minimal, particularly from the local Cypriot population, new initiatives to encourage feedback had been implemented.
- Systems were in place to ensure that staff completed the required mandated training and held the appropriate professional registrations. This included staff recruited from the local population. However these systems required expanding to provide reassurance around the suitability of locum paramedics.
- Access to emergency care was in place and the adoption of the model of a paramedic delivered service prevented medical centre staff from having to work excessive hours and ensured the service could be provided at all times.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided.
- Information systems and processes were in place to deliver safe treatment and care. However, staff told us that they continued to experience occasional difficulties when locating addresses and this had caused delays to care.
- The service had established effective lines of communication with the fire service and SBA police. Activities such as major incident planning were done as a collaboration and the issues with scene safety had been addressed. A good relationship with the Republic of Cyprus ambulance service was also reported.
- Formal peer review arrangements were in place for clinical staff and included effective auditing of notes. The exception was long-term locum paramedics who had not been

integrated into any of the arrangements for clinical review. Issues with the assurance of care provided by locums continued.

- Staff understood and adhered to the duty of candour principles.

We found the following areas of notable practice:

The clinical director had identified the need to deliver improvement around the psychological safety of staff at work. They tackled this issue through the newly introduced 'Team Reads' system which aims to communicate urgent messages to all operational crew on a daily basis (and in the absence of effective email access for some staff). Using Team Reads, crews were asked not to discuss and debate previous call-outs in informal spaces and to use only professional forums for formal discussion around shared learning. This was to protect the wellbeing of staff who might have attended difficult scenes and who might be impacted by ill-considered or negative commentary in the staff room from other staff who were not fully informed about what had happened.

The Chief Inspector recommends to the PHEC Cyprus service:

- Ensure the required training is completed for staff using Patient Group Directions.
- Review infection prevention and control processes, in particular, those that related to the cleanliness of the vehicles.
- Create and embed a targeted and achievable business plan which aids succession planning and provides continuity.

The Chief Inspector recommends to the wider organisation:

- There is wide consensus within the PHEC team that 16 paramedics does not suffice to staff the ambulances in place. Whilst locums are used to fill the gaps, the short term nature of these contracts is proving unsustainable in practice due to the constant need to offboard, recruit and onboard locums. Consider alternative and optimal ways to ensure staffing resource for the PHEC service. Abstraction should be taken into account.
- Timely action should be taken to ensure the planned leadership gaps in early 2025 do not adversely impact service delivery.
- The medical equipment requirement for response vehicles must be reviewed to ensure that consideration is given to mitigate the risks of not being able to print 12 lead electrocardiograms (a test that measures the heart's electrical activity) or allow third-party review of cardiac conditions at the scene.
- Implement ways to improve the handover of clinical information to secondary care, for example, printouts from ECGs (electrocardiograms, a test that can be used to check the heart's rhythm).
- Consider the introduction of an integrated monitor/defibrillator system which would improve the performance of teams at cardiac arrests by reducing the number of

separate pieces of equipment required to operated and reduce the risk of items of equipment interfering with one another.

- Ensure that Blue Light drivers have suitable training refreshed at regular intervals.
- Implement ways to improve the speed and accuracy with which PHEC staff locate patients requiring a 112 response.
- Address the requirement for uniform and personal protective equipment for both current and future personnel who deliver the PHEC service.
- Review the number of permanent posts and ensure that recruitment processes support the appointment of staff with the right skills and experience to attend trauma scenes.
- Agree clear lines of accountability and sponsorship at a senior clinical leadership level in order to clarify the ownership of risks escalated and to influence and implement change in the PHEC space.
- Where ambulance response time targets sit outside UK standards, risks to entitled personnel should be mitigated as far as possible and this will be owned by Commander BFC and above. This includes that prior to arriving on island, families and visitors should be informed about the ambulance response time target such that they can consider their personal circumstances and make an informed decision.

Dr Chris Dzikiti

Interim Chief Inspector of Healthcare

Our inspection team

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

Background to PHEC (British Forces Cyprus)

British Forces Cyprus (BFC) provide a PHEC service to a diverse and complex population within the Western and Eastern Sovereign Base Areas (SBAs). The SBAs are British Overseas Territories on the island of Cyprus which include British military bases at Akrotiri, Episkopi, Dhekelia and Ayios Nikolaos, installations and other land retained by the British under the 1960 Treaty of Establishment. The areas serve as a station for signals intelligence and the base at Akrotiri hosts an operational airfield.

The two SBAs are referred to as the Western Sovereign Base Area and include Akrotiri and Episkopi medical centres, and the Eastern Sovereign Base Area includes Dhekelia and Ayios Nikolaos medical centres (Ayios Nikolaos Medical Centre is a satellite of Dhekelia Medical Centre and a fourth station used by the PHEC service).

The medical centres host and resource the emergency ambulance stations and response coordinated by the Unified Control Room run by the SBA police. The Service Delivery Team is responsible for the day-to-day management and delivery of the service. The Service Delivery Team sit in BFC Headquarters and are also responsible for the strategic development of the service. All emergency calls (112, the equivalent to 999 in the UK are received by the Unified Control Room informing which emergency service is required (calls from the SBAs could be diverted to the Republic of Cyprus if received from mobile telephones). A 'METHANE report' is produced for each call (METHANE is an acronym for: Major incident declared, Exact location, Type of incident, Hazards, Access, Number and type of casualties, Emergency services present and required). Requests for an ambulance are then transferred on a dedicated line at Akrotiri in the Western SBA and to Dhekelia in the Eastern SBA for a paramedic-led ambulance dispatch.

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

The SBA population consists of approximately 9,000 military personnel. This includes the families of serving personnel, civil servants and contractors. In addition, there are 20,000 non-military residents who live in the SBA. This population increases in the summer when the tourists and transient population can reach up to 30,000. The military population is also increased by approximately 1,000 to 2,000 service personnel transiting through or temporarily in the SBA for training.

The PHEC is a 24 hour a day, 7 day a week, 365 days a year service.

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

Position	Numbers
Commander Medical BFC and Ambulance Service Chief Executive Officer	1
PHEC Clinical Director	1 (fixed-term post)
Medical and Sovereign Base Area Ambulance Service (SBAAS) Chief Operations Officer	1
Lead Paramedic	1

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

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

Role	Position	Akrotiri	Dhekelia/Ayios Nikolaos	Episkopi
Nursing team	Dispatchers (practice nurses) All nurses now perform dispatch duties as the 2 practices Akrotiri and Episkopi, which have combined to form the WSBA Combined Medical Practice.	3	10	8 with an additional 6 posts that are vacant.
Pharmacy	Pharmacy technicians	2	1	1
Transport	Ambulance Drivers	9	10	5
Practice management	Military practice manager (support the PHEC service in line with the service delivery team)	5 1 dedicated to PHEC management and delivery as 'SBAAS senior paramedic' but also still conducting Level 5 paramedic shifts	2	2 1 conducts SBAAS clinical shifts as level 4 medic
Medical assistant (medics) team *	Combat Medical Technicians (CMTs) / RAF Medics Paramedics	16 5 (4 military, 1 locum)	10 8 (5 locums, 2 military. 1 gapped)	3 (2 gapped filled with intermittent placement medics) 4 (3 are locums)

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

Are services safe?

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

We previously rated the service as requires improvement for providing safe services. This was because we identified areas that needed strengthening including equipment carried on the vehicles to allow third-party review of cardiac conditions at the scene and to interpret electrocardiograms, medicines management arrangements, in particular controlled drugs stored at Akrotiri. The scene of the incident was not always secured resulting in a high risk of potential harm to both staff and patients and at times, staff experienced difficulties in locating the patient following a 112 call.

Safety systems and processes

Each medical centre had safety policies and protocols. British Forces Cyprus (BFC) had their own safeguarding lead who chaired the Specialist Safeguarding Working Group. There were also safeguarding leads for each of the 3 medical centres. The safeguarding pathway for entitled persons was the same for PHEC as for each medical centre. A morning meeting held at each medical centre covered any safeguarding concerns. There was no memorandum of understanding with safeguarding organisations within the Republic of Cyprus so any concerns were relayed to the Sovereign Base Administration (SBA) Police. Social services to BFC personnel were provided by British Forces Social Work Service Cyprus.

Adult and child safeguarding policies were in the form of a standard operating procedure (SOP). The policies were accessible electronically to all staff and outlined clearly who to go to for further guidance including the pathways to social workers via SSAFA (the Armed Forces charity) and there was a reach back service to the UK for additional support. Staff received safeguarding information as part of their induction and training as part of their mandated programme.

The appointed leads for safeguarding had completed level 3 safeguarding training. All staff had completed safeguarding and safety training appropriate to their role and knew how to identify and report concerns. A safeguarding register was held by each practice on DMICP (electronic patient record system) with access limited to appropriate staff members. The PHEC service engaged with this at the monthly primary healthcare team meeting. The deputy safeguarding leads for each medical centre attended the meetings to ensure communication was made to all staff including those working in the PHEC service. Processes had been strengthened with additional prompts added to the patient report form (PRF) to ensure any safeguarding concerns had been actioned appropriately.

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

The PRF was a template that could be used to record a clinical intervention, to audit practice or to use for the handover of patients. This process had previously relied on a photocopy being made at the hospital which delayed the ambulance crews when leaving. A resolution had been found with the introduction of a carbonated paper pad that allowed for a duplicated copy to be left in the accident and emergency department and the original to be retained by the PHEC service. The new forms also allowed a copy to be left at the patient's home following a discharge on scene, facilitating any onward medical care for the patient. The new carbonated PRFs had been procured and were ready to be placed onto the vehicles and the PRF. In addition, 2 further forms were now in use. One was the 'mental capacity assessment and non-conveyance' form (formalised the process of recording capacity in the case of treatment being refused by the patient or transport by the patient against medical advice) and the 'recognition of life extinct' form to standardise recording of a death having occurred.

Staff who acted as chaperones (within the BFC workforce) were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. DBS checks were renewed every 5 years for military staff and 3 years for civilian staff. The PRF form included a prompt to offer the patient a chaperone.

The recruitment for all locally employed civilians was managed by the medical centre managers and they conducted the required checks prior to employment including a 'Basic Personnel Security Standard' check (the equivalent of a DBS check). Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. Staff had crown professional indemnity cover. Professional registrations, DBS and vaccination status were recorded in an electronic folder with restricted access. This document was recorded on the asset register.

New staff were required to complete the Sovereign Base Area Ambulance Service mandated induction which included specific elements for the different roles. There was a checklist which recorded progress and completion of induction. All new staff had commenced their induction and all permanent staff had completed an induction. Locum staff were used to cover staff gaps and there was a specific induction pack which included the appropriate recruitment checks. Locum paramedics were recruited through an agency and were checked to ensure currency. Although familiarisation shifts were provided, an assumption was made that paramedics should be suitable qualified and experienced. However, this was not always found to be the case and some departing paramedic chose not to reapply for a further temporary contract and some had left early with multi-factorial reasons that included the clinical experience required for the role.

The Defence Primary Healthcare (DPHC) infection prevention and control (IPC) leads at Akrotiri, Episkopi and Dhekelia were responsible for IPC for PHEC and had completed role-specific training. With IPC led at a local level, there was no consistency across the 3 sites. There were IPC cleaning registers specific to PHEC but these would benefit from uniformity and clear standards for the teams to follow. Staff were up-to-date with IPC training having attended virtual sessions. Regular audits were undertaken and these included the PHEC service. The IPC audits followed the DPHC mandated monthly rolling programme. A cleaning schedule was in place for vehicles and the cleaning of them was the responsibility of the driver with support from a medic. A quick response (QR) code

system was used to serve as a cleaning schedule and a record of completion. Cleaning took place after each patient and the QR codes were scanned each time a vehicle was cleaned.

Drivers told us that deep cleans were undertaken on an ad hoc basis, for example, when the vehicles were taken off the road for a service. A concern was raised by one of the paramedics that unlike the UK where most ambulances are subject to 'make ready centre' principles or a clear deep clean schedule with vehicles being withdrawn for a deep clean if needed (blood, faeces, suspected infectious diseases). This was not the case with the PHEC vehicles. The draft Sovereign Base Area Ambulance Service (SBAAS) cleaning policy made provision for a weekly internal deep clean but had yet to be ratified and adopted, so at the time of the inspection, there was no evidence of a routine deep clean being conducted. We reviewed the local cleaning procedure at Akrotiri and noted the apparent lack of a scheduled deep clean except following contamination. We noted that, although vehicle cleaning was covered by the QR codes along with equipment checks, there was evidence that in reality, the full checks were not being undertaken. For example, an ASER relating to tyre issues resulted in the vehicle being taken off the road and contributing to a service black status. Service black status was declared when all crews were out responding to calls. In such an event, the ROC ambulance service would be informed and stepped in to provide cover.

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

We highlighted at the previous inspection that medical gases were not always stored in accordance with health and safety regulations. We found that actions had been taken to improve arrangements. At this inspection, we found that the gases were stored in the vehicles and site storage area in a way that was compliant with UK gas guidelines and cylinder storage requirements. The general adherence to PHEC principles had improved at Akrotiri as demonstrated by safe medicines management processes and training records. There was no medical gas policy (could either be added to the draft SBAAS formulary and medicines management document or there could be a stand-alone) to ensure compliant gas storage across the SBAAS.

Appropriate paediatric kit including harnesses was available in each vehicle.

Risks to patients and staff

As at the previous inspection, concerns were raised regarding risks, risk ownership, lack of regular reviews, sharing of insights and learning across the 3 sites. These issues had been addressed effectively at a tactical level. Risks had been separated into issues and risks to remove low level issues from the risk register. The memorandum of understanding (between DPHC and BFC) had been revised since the last inspection and clarified some lines of accountability. However, there was minimal feedback or assurance that these risks were being addressed in a timely manner when escalated. Staff fragility was a significant ongoing risk. Workforce establishments did not make allowance for abstraction (time

whereby staff are unable to fulfil front-line duties including annual leave, sickness, continued professional development (CPD) and training including clinical currency for paramedics). In the UK, the NHS England target for most healthcare services is approximately 30% abstraction when calculating staffing time requirements. There was no validated abstraction level for the PHEC team in Cyprus, and so additional training time that military personnel are allowed and time for induction had not been factored in. Discussion had taken place around the potential for dual crewing (instead of having 3 people in each ambulance) but this would require significant training of the drivers to absorb the medic function. The PHEC team strived to deliver a responsive ambulance service with 16 paramedics. However, this was barely sufficient to cover 4 ambulances 24/7. There was a heavy reliance on agency paramedics working 60 hours a week, and with the turnover of agency paramedics, this introduced considerable risk. The Clinical Director for PHEC (CD PHEC) and Lead Paramedic reported that they regularly had to cover gaps on the rotas themselves.

Although working hours were still exceeded at times, the paramedics were not required to deliver the primary care service during the day (unlike the doctors that we previously saw at past inspections delivering PHEC). Civilian locum paramedics worked 60 + 5 hours per week duty periods (5 hours are for travel if needed between WSBA and ESBA), usually split into 24 hours on, 24 hours off pattern (they had signed European Working Time Directive waivers which were popular due to renumeration for locum staff. All attempts were made to limit military paramedics to 48 hour working weeks. Paramedics reported that the low number of call outs during a shift allowed for adequate rest periods and sleeping during shifts. When questioned, paramedics did not flag that fatigue had ever (in their opinion) compromised clinical decision making. However, an isolated concern had been raised prior to the inspection. Staff confirmed that ongoing monitoring of working patterns was planned to determine the need to commission a time/motion study and engage a subject matter expert to confirm and comment further.

The reliance on locum paramedics created some risks to the service. Funding was only assured until March 2025 with a request for extension submitted. There were fewer confirmed permanent posts (known as PIDs) than paramedics working in the service. This resulted in it not being possible to recruit permanent team members. In addition, some locum paramedics who had been in post for more than 12 months, had not taken part in any appraisal as they were not line-managed by permanent team members. This was a continuing problem although locums were supported in refreshing skills and maintaining currency. Although qualifications were appropriate, the assurance process to assure the currency and competency of locums was reliant on the individual paramedic's honesty and ability to self-reflect on their individual educational needs or currency gaps. An incident which had been captured in an ASER (system for recording and acting on significant events) compromised the paramedic, their crew colleagues and the care the patient should have received.

The appointment of a clinical director holding 'Fellowship in Immediate Medical Care' and with extensive PHEC experience had been a notable positive development. In conjunction with the Lead Paramedic, tangible, accessible on-island leadership had significantly progressed governance and safety in a short period of time. There were now regular clinical meetings, a set of draft SOPs were being developed and the 'Team Read' alerts process. Continued improvements in clinical safety and the development of the service were dependent on continuity planning which risked stalling or reversing the progress. This

was because the CD PHEC was due to leave in March 2025 and the succession had yet to be decided so any recruitment could not be commenced.

Scene safety had improved although there were still times when it was a reported problem with the lack of road closures to secure a scene. Notable progress had been made with SBA police scene safety training and the ability for crews on scene to contact the duty superintendent if concerned. However, safety at road traffic collision sites was not helped by an acknowledged lack of compliance with the use of personal protective equipment, most notably, high visibility jackets. Risks were reviewed weekly at BFC Headquarters by the Service Delivery Team. Some ASERs linked to risks were still awaiting a report from the Operational/Clinical leads after more than 200 days.

The vehicles were equipped with emergency kit, including an automatic external defibrillator (can administer a shock but not indicate the heart rhythm), oxygen with masks and emergency medicines were kept in each ambulance. Equipment and medicines were checked daily and after any emergency call out. Despite being raised prior to the initial inspection, ambulances still did not have printing capability (the printing of electrocardiograms or ECGs is an important tool in diagnosing cardiac conditions and allows better liaison with receiving units). The Defence Consultant Advisor PHEC had supported the capability for printing and funding had been applied for (an initial business case was submitted in 2022 to procure appropriate additional equipment for cardiac monitoring had been submitted to DPHC but there had been no tangible progress). Paramedics felt uncomfortable that they were still using the same equipment.

The prioritisation and purchase of items deemed essential for the safe and effective delivery of PHEC care should be undertaken. Equipment scaling should reflect a local needs assessment for a centralised service and should be supported by a scope of practice (still in development). Other PHEC systems have equipment and drugs committees to consider such concerns. Most manual defibrillators carried in UK ambulances can also be used in an automated external defibrillator (AED) mode where they analyse the ECG and recommend delivery of a shock when appropriate. There are advantages and disadvantages of each mode. Although AED mode may improve the time to first shock, manual mode may reduce pre-shock pauses and increase chest compression fraction which is associated with increased return of spontaneous circulation (ROSC). Therefore, although manual defibrillation should be the preferred option for appropriately trained paramedics, it should be recognised that solo responders are potentially in a stressful environment and are attempting to manage multiple complex factors. The option of equipping the ambulances with a combined monitor and defibrillator with a manual defibrillator option has merit, giving responders the option of using equipment with which they are most familiar.

A total of 8 ASERs had been raised since February 2024 around the need for appropriate cardiac equipment. Crews had been advised to stop raising ASERs on such issues as the system, was flooded with a known issue. Crews felt there was a lack of response and resolution to this ongoing issue. As the PHEC team did not have access to the final outcome after a patient had been taken to hospital, their ability to secure improvements was limited. Resuscitation Council UK and National Institute for Health and Care Excellence guidelines on the management of patients requiring ROSC (the resumption of a sustained heart rhythm after cardiac arrest) could not be met without the appropriate cardiac equipment. As crews were unable to print 12 lead ECGs, patients who could

potentially be discharged at the scene were unnecessarily transported to hospital to exclude acute cardiac syndrome. This impacted the availability of the service for subsequent calls and led to unnecessary hospital attendance.

A PHEC induction course was in place. However, the delivery of this was variable and there was no evidence of benchmarking, audit or review of this training across the 3 sites to ensure consistency. Work was underway to standardise the process across SBAAS where possible with inclusion of any site specific variation. With the high turnover of staff, including locums and placement medics, induction courses were fluid, lasted approximately 2 weeks with familiarisations, moulages (scenario based training), supernumerary shifts and a sign off schedule. As part of their induction, staff had to complete a suite of training that included safeguarding, basic life support, instruction on how to use the automated external defibrillator (known as an AED) and anaphylaxis (severe allergic reaction). The programme was run approximately every 6 weeks to cater for the large number of short term placement medics. Medics and paramedics had been able to return to the UK to attend the BATLS/MPHEC (Battlefield Trauma Life Support and Military Pre-hospital Emergency Care) when their courses required renewal. Medics completed basic life support training but were not required to complete advanced life support (ALS) training as every ambulance had a paramedic on board (every paramedic should be proficient in ALS as part of their registration and continued professional development requirements).

A suitably qualified and experienced paramedic/medic had responded to all 112 calls since August 2023. There was no longer a requirement for medics to respond on their own, and inconsistencies in the skill and experience levels of medic responders was mitigated. The CD PHEC planned to develop the PHEC SharePoint to include the daily moulage training mock scenarios that included febrile convulsions, unstable angina, etc. This was also to include the clinical topic of the day; an example was the treatment of heat illness. In addition, there was ‘drug of the day’; these included indications, contra-indications and administration based on the Joint Royal College Ambulance Liaison Committee or ‘JRCALC’ recommendations. JRCALC combines expert advice with practical guidance to help paramedics in their challenging roles and supports them in providing patient care covering issues, such as medicines and clinical guidelines used by the paramedics.

Multi-casualty training scenarios were held as station-wide events in coordination with the SBA police and fire service. There were robust major incident plans detailed in station protocols, of which SBAAS response was a major component. These were rehearsed annually with additional exercises to look at specific major incidents (migrants, airfield incidents) more frequently. Notable call outs for SBAAS included a major incident response to a 31 person migrant boat and multi-vehicle road traffic collisions. There was a combined response between station, SBAAS, customs and SBA Police. The incident was handled well and all migrants were appropriately cared for and medically assessed. There was a clearly defined plan in place for processing of the migrants over to the processing centre in Dhekelia.

There was no formal agreement with host nation emergency services but there was a mutual understanding at an operational level of mutual support both ways in the event of a major incident. This was demonstrated on a weekly level with host nation support when the PHEC went into ‘service black’ (capacity breached), with host nation ambulances responding within the SBA. However, there was no co-ordinated plan around dealing with

a mass casualty or disaster-level incident (crowd crush incident, earthquake or explosion would be possible scenarios) within the catchment area. A plan and regular rehearsal would likely reduce the number of casualties in such a potential incident but would be resource intensive to achieve. This significant risk to life should be understood and held at a high level within the Chain of Command.

In October 2024, BFC Headquarters ran a simulated event around a terrorist attack as part of an annual programme of scenario testing. The PHEC service was invited and participated. It was concluded that as a combined effort, the scenario was effectively dealt with. Although there was no formal policy or SOP, there was a clear understanding that such an incident would be supported by all available staff. There was a reliance on the host nation for an enhanced response due to the small scale of the PHEC service.

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

The vehicles had an air conditioning system throughout and ambulances were fitted with temperature probes. Temperature checks were now routinely being carried out and when there were high temperatures within the vehicles, medicines and equipment were moved into a temperature controlled area or a cooler room within the medical centre. Data loggers that recorded the temperature were present in the vehicles as well as in the fridges within the medical centres used to store medicines.

Across DPHC, including the PHEC service in Cyprus, there was a lack evidence-based guidance to demonstrate risks around efficacy and denaturing of medicines were being suitably mitigated when being stored at temperatures over 25˚C. There was a workaround to formally write off and destroy all oral medicines after 6 months, and all liquids for injections after 1 month. Although there was clear guidance for this decision to mitigate risk, accountability had been taken by the senior clinician for this intervention. The workaround adopted was pragmatic and had merit but needed formalising into a Cyprus PHEC owned SOP with the input of pharmacist expert advice.

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

A number of the paramedics had previously raised a concern about the lack of clarity with regards to court and legal processes, which made them feel vulnerable about their rights and what they could/could not do when treating a mentally unwell patient. At this inspection, staff reported they had received improved training related to mental health

issues and better clarity/guidance about where to escalate/manage mental health incidents, for example, the ‘mental capacity assessment’ form.

Information to deliver safe care and treatment

The practices ran on a clinical system known as ‘DMICP deployed’ (DMICP is the system used throughput DPHC and ‘deployed’ means it runs off a local server). Following each case, a record was scanned onto DMICP by way of a PRF. A Cypriot resident would have a DMICP account set up and be registered as a non-entitled patient so records could be scanned and then archived (not deleted so records would be retrievable) after 3 months. A policy was in place to detail the process. In this way, the PHEC system had an effective process for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Each morning a meeting was held to discuss any new cases and any ongoing issues with patients within the PHEC service. Each month, a joined up pan-island clinical meeting was held.

A PRF audit against Health and Care Professional Council standards had recently been conducted at Dhekelia and learning outcomes shared widely with all teams during the pan-island PHEC clinical meeting. Paramedics and medics understood the importance of worsening advice (informing the patient on what to do if symptoms had not improved), especially in the context of discharge on scene. We were assured that this was an integral part of PHEC practice.

Seriously unwell mental health patients requiring immediate treatment would be conveyed to a dedicated safe area within the emergency department and would be cared for in the host nation system which could involve admission to a hospital in Nicosia where in patient mental health patients were cared for. The Defence mental health team had expressed concern over the quality and safety of this treatment but this was outside of the scope of this inspection. If the patient was serving/entitled family member, PHEC staff would discuss with the duty mental health team who may offer additional intervention, temporisation, and emergency aeromedical evacuation from Cyprus to the UK. There was still no official designated ‘safe place’ but there had not been any patients with serious mental health needs treated by the PHEC team since the last inspection.

Limitations of DMICP did not allow mobile teams to access the electronic health records when mobile or attending patients in the community. The workaround was for the dispatch nurse to access DMICP and pass relevant details to the PHEC team (this would only work for service personnel with a DMICP record, and not for civilians). We observed 2 ambulance dispatches but there was no DMICP access seen as part of this process. In the NHS, the National Patient Spine overcomes some of these difficulties in the UK but is not practical in Cyprus and therefore presents a risk. This risk was low given the volume of activity and the lack of a fully integrated health care system on the island. As the new dispatchers are trained, it was planned for them to work from algorithms (a web-based triage system that uses a series of questions to assess symptoms and provide clinical advice) that would not require access to patient records (UK dispatchers and call handlers do not routinely access medical records).

Safe and appropriate use of medicines

Improvements had been made to the PHEC medicines management processes since the last inspection. There was now a uniform drug formulary (albeit in draft form) with clear guidance from the service's clinical lead and input from the Chief Pharmacist. There were clear and safe processes across all 3 medical centres for the management (including storage, replenishment and destruction) of PHEC medication. The service was moving towards a SBAAS medicines management SOP to ensure consistency and resilience across the 3 sites. Commander Medical was the accountable officer for controlled drugs (CDs). The Medicine Provisioning Point (MPP) received deliveries, flown in from the UK, and then distributed to each medical centre (the MPP was out of scope for this inspection so was not visited).

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

Appropriate arrangements were established for the safety of CDs, including destruction of unused items. These arrangements were supported by a local working procedure. A small number of CDs were held in stock. Monitoring and storage arrangements were in accordance with guidelines and policy. The gaps in the administration and storage of CDs at Akrotiri had been effectively actioned, monthly checks for the fentanyl lozenges (held as part of the PHEC modules) were now completed and there was evidence of monthly CD checks for the CDs held in the PHEC paramedic bags. CD destruction was now done in line with policy.

SOPs were in place to support safe dispensing practice. Staff who were prescribers had signed the SOPs applicable to them. Patient Group Directions were signed and authorised to enable paramedics to facilitate the safe supply of appropriate medication.

Although the Patient Group Directions were up-to-date (apart from one), the actual compliance in terms of the required training and understanding was yet to be completed.

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

Track record on safety

The CD PHEC provided a detailed response to risks and actioned whenever it was possible. Some risks that had been escalated to a strategic level lacked any meaningful progress and conclusive response. For example, staff reported that they had stopped raising significant events for cardiac equipment because feedback had been minimal and there was a lack of assurance that these risks were being addressed in a timely manner. Another example was the lack of clarity around blue light driver training. Staff felt that this was putting both staff and patients at risk. Despite Defence Consultant Advisor PHEC approval from the UK and persistent follow up, the CD PHEC was yet to gain assurance that this risk would be mitigated or held as 'tolerated' at a senior level.

The risk register was not an agenda item on the monthly clinical meeting as it sat in the management rather than clinical sphere. However it was discussed at weekly meetings. Nevertheless, risks were well understood and articulated on the island by the service delivery team. It was unclear where some risks to life were owned, for instance tolerating a 20 minute response time for all categories of calls and operating with Blue Light drivers with lapsed training. A 'tolerate' to these risks to life needed to be held at a strategic level. Families and visitors have a right to be briefed about the level of emergency response service in place before they make a decision to come onto the island.

Lessons learned and improvements made

At all 3 medical centres, every call out was discussed at the morning brief and if there were any learning events, these were the raised as an ASER. Processes had been developed so that learning was communicated and actioned across island. Effective dissemination of urgent communication was made via 'Team Reads' and group discussion took place at the monthly PHEC governance meeting. However, as previously noted, there were areas where reporting fatigue had set in. Staff had become disillusioned by a lack of resolution following reporting their concerns, particularly around emergency response equipment.

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

Are services effective?

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

At the last inspection, the effective key question was rated as good. However, the continuation of issues highlighted at the last inspection combined with new issues highlighted through improved governance has resulted in the service being rated as requires improvement for providing effective services. Continuing issues included the lack of suitable personal protective equipment, the dispatch process and training for dispatchers.

Effective needs assessment, care and treatment

There had been tangible progress in the development of standard operating procedures (SOPs) and a Sovereign Base Area Ambulance Service (SBAAS) workbook. This had been facilitated and expedited with the appointment of a PHEC clinical director (CD PHEC). There was recognition of areas requiring external approval or action that had led to delays in further progress. The Joint Royal Colleges Ambulance Liaison Committee guidelines were used by clinicians. A notes audit of the patient report form (PRF) included a qualitative check of established guidelines being followed. Audits of the PRF forms at Dhekelia had been identified as good practice and the process was to be rolled out across island. The Blue Light Forum meetings included clinical guidelines as a standard agenda item.

The PHEC service did not use a formal triage assessment tool as part of its service and ‘ambulance quality indicators’ as adopted by NHS England for ambulance services in the UK did not apply in Cyprus. The operating model was intended to generate an ambulance dispatch for every 112 contact and there was no differentiation with regards to categories of ambulance response times and no formalised triage tool. This did mean that there was no formal process to differentiate and prioritise care and there was a reliance on the decision of the dispatcher. The Resuscitation Council UK data suggests that where a patient experiences a cardiac event, the chance of return of spontaneous circulation decreases by circa 10% for every minute beyond the UK category 1 target response time of 7 minutes. Given that the PHEC was using a self-imposed, non-evidence based target of a 20 minute response time, there was a systemic risk to the most seriously ill patients who are unconscious or not breathing. This did not factor in that they are not able to include the lag time in the 112 call reaching the dispatcher, due to the call being handled initially by the unified control room (where all 112 calls were received initially). Furthermore, the limitations of the response target time had not been highlighted to personnel, their families and any visitors such that they could make an informed choice before coming onto the island.

When the ambulance was dispatched, no secondary contact number was being taken. Although there had been no reported incidents or concerns logged for this, it is best practice to capture a second contact number to ensure the ambulance dispatches to the right location, or in case the patient deteriorates at the scene. There was no Global Positioning System nor automated process in the ambulances to assist finding the correct

location. We were told of cases where the dispatcher and crew were unable to identify the correct patient location.

The cardiac monitoring equipment (Tempus Pro device) did not have a 'shock box' (built in defibrillator). This meant that some advanced life support interventions (synchronised direct current shock and external pacing) were unavailable to advanced life support qualified team members. In addition it was necessary to attach a separate AED to the patient when managing a cardiac arrest, increasing the complexity of managing these cases. This was a recommendation in the last report and the CD PHEC had continued to request (without success) these capabilities supported by the Defence Consultant Advisor for PHEC. The Defence solution for PHEC L5 is Tempus Pro monitor with separate AED to manage a cardiac arrest.

Monitoring care and treatment

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

There were several examples of best practice and audit being undertaken across all 3 sites. The CD PHEC had fostered a culture of continuous improvement of which audit formed a large part. Regular audits included:

- The use of quick response codes for the cleaning of vehicles.
- The process for recording, replenishment and destruction of controlled drugs (CDs) as part of the improved approach to medicines management with a clear audit trail for CD reconciliation and oversight.
- A review of daily checks which identified some improvement needed in the completeness that had been addressed and shared.
- PRF content against Health and Care Professional Council standards.

Since the last inspection, there had been progress made against benchmarking or measuring the effectiveness of the service. However, this was compounded by the way that information was captured. Every metric was recorded manually, and this introduced human error. It did not recognise the inevitable 'lag time' for calls to be passed to the dispatcher from the Republic of Cyprus (ROC) and its police telephony system. The PHEC service aimed to have an ambulance on scene within 20 minutes. There was no stratification or prioritisation of the risk of calls, so the PHEC service did not provide differentiated care to its patients. Data had been captured for the time period April 2023 to March 2024. There had been 707 incidents, serving 767 patients that resulted in an ambulance call out; the average response time was 10 minutes. The data set broke down

the reason for each call out with 439 categorised as medical; these included 5 cardiac arrests and 5 drownings. Trauma comprised of 261 call outs, 83 of which were for road traffic collisions. Call outs were also broken down by month with March having the fewest (45) and September the most (74).

Effective staffing

There was no formal training needs analysis document in place for the PHEC service. At a local level, the Lead Paramedic reviewed the training skills and needs of their team. However, there continued to be some inconsistency between the training undertaken by locum staff, employed paramedics and medics. We noted that some of the training staff had received whilst working in the UK was either out-of-date or needed further validation to ensure that it was relevant for the PHEC service. There was no requirement for Defence Primary Healthcare to onboard, recruit or offboard agency staff. In the absence of any clear responsibility for this, issues highlighted included the induction process and the suitability of employed staff.

The reliance on locums presented a governance risk to provide assurance of skills as well as burdening the Lead Paramedic with induction work and training. There was a reliance on placement medics. The use of reservist paramedics had been explored but was on home-commitment (a type of full-time reserve service commitment, no accommodation, no families) and rates of pay were lower than the average pay when working in the UK. There was discussion ongoing to improve the offer to full commitment. There was also the aspiration to reach a position of having 8 regular military and 8 reservist military paramedics.

There was a significant variance in terms of continued professional development allowance for substantive staff and locums. Staff we spoke with (nurse dispatchers, medics, drivers, and paramedics) at all 3 sites stated that they had never asked nor were expected to act outside of their scope of practice or capability. There was reach-back for support from a suitably skilled GP or senior clinician available and no concerns were raised about reach-back by any staff interviewed. There was no effective mechanism for ensuring those who came out to Cyprus to take up locum positions had the skills, currency and experience to do the job.

Uniform and appropriate kit remained an issue, with most uniform procured personally by the staff themselves in the absence of some essential items. The uniform issue was being addressed but the personal protective equipment was not always fit for purpose and this had resulted in staff not always being compliant in wearing it. For example, the high visibility jackets were fleece lined so not ideal for the hot climate.

The improved governance had highlighted that blue light driver refresher training was not being completed. In some cases, this had not been done for 10 years (in the UK, this is a 2 day refresher course required every 3 years). The CD PHEC had been told to refer to Defence Land Safety Regulations but it was not clear if these only applied to the UK. Commander Medical had asked for the service to be based on UK acceptable standards and these were not being met in relation to driver training. The Blue Light training available

focussed more on new drivers rather than creating a clear refresher cycle for established drivers.

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

Most medics working in the PHEC service had the required Battlefield Advanced Trauma Life Support and Military PHEC training. Courses were available on-island; previously staff had to travel back to the UK. Paediatric Immediate Life Support training for medics was not always completed but there was always a suitably trained paramedic in attendance. In addition, the reach-back access to doctors was robust.

The nurse dispatchers had not received any formal training with regards to the dispatch function and process so an ambulance was sent to each call without any prioritisation process. The ambulance dispatch process also relied on the quality of the information passed from the ROC police contact centre, which the PHEC team had no control nor influence over. Once the call arrived via 112, it was managed by a nurse. The nurse used METHANE report to capture the salient information and then passed this onto the ambulance team. There were single points of failure with this process; everything was captured manually, including the location of the patient. The nurse dispatcher did not remain on the line with either the caller (every 112 call is third party) nor the ambulance crew itself, nor did they retain open channels in case the crew needed to contact them. There were plans to develop a single response centre for the island that used a system to pinpoint the location and prioritise calls based on clinical need. However, this was still in the discussion stage and a funding request had been submitted.

There was utilisation of learning-needs based moulage training at all sites delivered by the paramedics. There was a clinical moulage log resource on the SharePoint with links to evidence and discussion points applicable locally. This was referenced by teams for daily moulages. The ‘after action reviews’ (AARs) following fatal incidents were a positive demonstration of an appropriate review having been carried out. Training in the management of traumatic cardiac arrest had been provided following the identification of this as a learning need. All sites conducted regular moulage training. These were paramedic led and based on the perceived training needs of the team. This training formed a key part of competence/currency maintenance of the service and mitigated against potential skill fade caused by the low number of presentations. The development of a skills matrix detailing when each critical skill has been simulated in training (or performed in real life) would help team members stay current. In particular with the lack of training needs analysis and screening of locum paramedics before they started. Recently a bus crash scenario had been exercised by the Blue Light Working Group members as an opportunity to learn in a practical environment. There has been a focus on paediatric care requirements in such an accident.

Doctors involved in supporting the PHEC service were advanced life support (ALS) trained, and ALS was now specified on assignment orders (requirements issued in advance of staff taking up their new post). Doctors reported no difficulty in accessing ALS training and military paramedics also had access but had to return to the UK for this training. Locums were required to fund and arrange their own courses.

Although there was no formal clinical reach back available for crews, this should not be necessary given each ambulance had a registered healthcare professional on board. However, in practice informal discussion with a colleague is a useful means of sense checking decisions in complex pre-hospital scenarios. Crews reported no difficulty in obtaining advice from CD PHEC when available. At other times the duty doctor (available 24/7) was used most frequently and there was no difficulties reported in accessing them. None of the ambulance staff commented that they felt unsupported. A clinical supervision SOP would be helpful to formalise processes.

Coordinating care and treatment

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

British Forces Cyprus (BFC) Headquarters enabled the establishment of links with ROC state secondary care services and BFC contracted secondary care hospitals. These included connecting and conducting visits with the ROC hospitals used by the PHEC service. Defence consultant advisors visited regularly to look at the ROC hospitals and made recommendations to both the provider and to Commander Medical BFC. At the last inspection, there was no formalised route by which concerns with respect to secondary care could be raised by PHEC and there was a general lack of confidence that these concerns would be addressed. At this inspection, the ASER management system provided a suitable platform to raise concerns which were progressed by CD PHEC with support from Commander Medical. The standards and practise at host nation hospitals was out of scope for this inspection.

Major incident training was co-ordinated to include the SBA police and fire service. The ROC ambulance service had now engaged and was to be included in future training. The Blue Light Forum had been re-established and provided an opportunity for the emergency services to meet together for discussion. We previously highlighted the risks around major incidents as the PHEC service would not have the numbers to provide a surge response. Mitigation would require co-ordination with ROC civil authorities and ambulance service and a regular joint exercise of a scenario would be required to provide assurance and training. Although a mass casualty response had not been formalised or enacted, there had a been a coordinated scenario-based training exercise based on a terrorist attack and involving a multi-casualty and multi-service response.

How the service encourages primary prevention measures

Primary prevention recommendations had included improvement of the road surface, signage to warn drivers of a bend in the road and a reduction in taxi fares to discourage

drink driving. The ‘Blue Light Forum’ provided a platform for formal discussion to be held between the emergency services. There was evidence of sharing of the learning outcomes from AARs beyond the medical centre. Liaison with the SBA police and administration had led to considerable progress on scene safety including better training for the SBA police and establishment of a mechanism to raise live concerns about scene safety to the duty police superintendent.

PHEC staff participated in the ‘SBA Police Road Safety Awareness Week’ campaign to improve road safety and reduce road traffic collision related incidents. An educational leaflet advised the population (both the military and local) what the service provided and what was not included in the service. The health fayres on the military bases were supported by the PHEC team with stands and ambulances in attendance. A route had been developed to prevent unnecessary transportation to hospital by referring patients directly into primary care services and directing to other appropriate services. For example, on call midwifery, GP out-of-hours service, mental health services (for entitled patients).

Consent to care and treatment

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

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

At this inspection we found 2 new forms had been introduced to support clinicians in recording that capacity had been assessed and for when they had to confirm life extinct. There was also clear lines of communication to the PHEC Clinical Director for advice and guidance.

Are services caring?

We rated the service as good for providing caring services.

Kindness, respect and compassion

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

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

With the consent of the patient, PHEC staff offered relatives transport to the hospital or ensured they were kept informed of the situation. When the patient did not consent to treatment or transport, this was now recorded on a templated form carried by all ambulance crews.

Involvement in decisions about care and treatment

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

Privacy and dignity

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

In the unusual event of a patient wishing to see a same gender clinician, this could be facilitated as the PHEC team included both male and female clinicians. However, with the service being an emergency response, no such requests had been made.

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

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

A translation service was available if needed. However, this service was not appropriate for ambulance dispatch due to the length of time taken to access a translator. Although there were no reported incidents of when language barrier had been an issue, the service continued to rely on drivers when dealing with patients who could only speak Greek. There was a potential problem should a visitor be treated, who could not speak English or Greek. There was an increased possibility of this with the movement of migrants through the Sovereign Base Areas (SBAs), in particular around Dhekelia. However, no incidents of concern had been reported. The ambulance crews did not have access to hearing induction loops in the vehicles but they were available at each medical centre and ambulance station.

Whilst no formal health needs assessment had been undertaken to explore the service required for non-entitled patients (non-military personnel and their families), staff had considered the potential needs of patients they might be called upon to provide a service for. The Defence Science and Technology Laboratory at Porton Down had been approved to do some modelling on how the SBA will look in the future so that the ambulance service reviewed and developed accordingly. There was the opportunity to undertake further analysis using data and patient demographics to shape the future evolution of the service based around patients' needs.

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

In accordance with the Defence Medical Services Regulator Regulatory Instruction, DMS staff including PHEC staff were required to complete autism and learning disability training.

Timely access to care and treatment

The PHEC service was targeted to attend the scene within 20 minutes of receiving a call. This had been achieved for over 90% of call outs with an average response time of 10 minutes. We noted that the timings started from the ambulance being dispatched, not from

when the call was received (UK standards are measured from when the call is answered) and so the assertion that 90% of calls had been reached within 10 minutes was not accurate. The nearest A&E department for the Western SBA was at Limassol General Hospital and for the Eastern SBA was at Larnaca General Hospital or Nicosia General Hospital. Travel distances were approximately 20 minutes dependent on where the incident was within the SBA. In addition, the PHEC service provided a patient transport service to the private hospital contracted in Nicosia. Patients were sent to the nearest state hospital appropriate for emergency admissions. Private providers on island met the need for those patients that had mobility needs and needed urgent but not emergency care.

Listening and learning from concerns and complaints

The PHEC service took complaints and concerns seriously and responded to them appropriately to improve the quality of care. The complaints procedure was integrated into the process at each medical centre with the respective leads designated as the responsible person who initially received any complaints that related to the PHEC service and then forwarded it onto the PHEC clinical director (CD PHEC). The medical centres had a process to manage complaints in accordance with the Defence Primary Healthcare complaints policy and procedure.

There was scope for non-military personnel to feedback on the PHEC service through a process within secondary healthcare providers. The medical centres provided an opportunity for military personnel and their families to give feedback. Responding to feedback on the PHEC service was integrated so would be communicated through the practice meetings and healthcare governance meetings. However, the CD PHEC had implemented feedback methods so that data specific to PHEC could be collated.

Are services well-led?

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

Whilst progress had been made to address concerns around staff capacity to provide pre-hospital emergency care (PHEC), the ownership and mitigation of risk at a strategic level was not always clear. A credible governance system had recently been introduced to better integrate processes across all 3 sites.

Leadership, capacity and capability

A clinical director for the PHEC (CD PHEC) service came into post in February 2024. They arrived with frontline experience in anaesthesia and pre-hospital emergency medicine delivery and Helicopter Emergency Medical Services qualifications. The post holder confirmed they were well supported by the Defence Consultant Advisor for PHEC (DCA PHEC). The PHEC service across the island was therefore now a paramedic response service lead by a PHEC specialist clinician. In their initial 7 months in post, the CD PHEC worked extensively on implementing clinical governance systems, on establishing better team cohesion and a pan-island approach to PHEC delivery, alongside a commitment to filling gaps in clinical shifts. The role was funded by the Defence Deanery and line management arrangements spanned Commander Medical British Forces Cyprus (BFC) (operational) and DCA PHEC (clinical). The CD PHEC role was exclusively protected for the development and delivery of the PHEC service and this had afforded the post holder the capacity to make significant progress with introducing improvements in the leadership and delivery of the PHEC service.

Key delivery successes since the CD PHEC had been in post included:

- the establishment of a ‘Team Reads’ system to embed island wide learning
- the re-design of the patient report form (to meet UK standards)
- the introduction of a ‘Recognition of Life Extinct Form’ (to meet UK standards), the introduction of a form to assess the mental capacity of patients, to formalise the recording of non-conveyance of a patient, to record input from parents and guardians and to record any consent for decisions.
- The establishment of pan island monthly PHEC meetings incorporating sound clinical governance elements.
- Development of a series of pan-island clinical and non-clinical SOPs (not yet ratified or operational).
- Driving forward service design and improving clinical standards.
- Provision of visible, credible and experienced clinical leadership presence for the Sovereign Base Area Ambulance Service on island.
- Expert advice to Commander Medical to enable improved understanding and support of the service in BFC Headquarters.

The current CD PHEC was due to remain in post until March 2025 and succession planning required prompt exploration if a smooth transition and ongoing improvement was to be achieved.

Issues around staffing capacity had been addressed further since the last inspection and there were now 16 paramedics in post (including 5 military and 1 full time reserve service). It had been recognised that this establishment was insufficient to resource the 4 ambulances and so 10 locums had been employed on short-term (mainly 3 month) contracts. However, the short-term nature of these contracts was proving unsustainable in practice due to the constant need to offboard, recruit and onboard locums. The permanent paramedics were suitably qualified to deliver a level 5 service but the locum paramedics were not always suitably experienced. At this inspection we met with a paramedic response team led by a clinical director with qualifications in and experience of pre-hospital emergency medicine delivery and oversight. This leadership arrangement was having a positive impact based on the feedback from the staff team and the outcomes for patients.

There was a new role of ‘Lead Paramedic’ for PHEC, based in Akrotiri, although this role constituted 1 of the 16 paramedic roles which impacted their capacity to fully undertake their duties. There was variance across the 3 sites in terms of service delivery. However, this was based more around the variance in staff profiles (variable proportions of locum paramedics or medics/nurses). The Lead Paramedic did visit and liaise with paramedic colleagues across the other 2 sites and worked closely with the CD PHEC with collaborative work on operational processes and standard operating procedures (SOPs). There was no job description for the CD PHEC although they had started to develop their own. Written job descriptions and terms of reference were not in place for the Lead Paramedic and for the drivers.

Accountability for this service sat with the Director Overseas Bases as the 2 star owner. A memorandum of understanding (MOU) set out responsibilities for the delivery of the Sovereign Base Areas Ambulance Service (SBAAS). Defence Primary Healthcare (DPHC) continued to be responsible for overall resourcing and this created a barrier for sustainable improvement and prevented the paramedic team from having up-to-date equipment, suitable training and personal protective equipment. Whilst we have seen operational improvements, based on the previous inspections, ownership and accountability issues remained and this was a risk to sustainability.

Vision and strategy

The CD PHEC alongside the British Forces Cyprus (BFC) team and PHEC staff articulated a clear vision and aspiration for a PHEC service with an enduring corporate identity, clear accountability for resourcing and embedded SOPs, working practices and guidelines. There was scope to formalise and consolidate these shared aims and how they would be achieved in a targeted and achievable business plan.

The PHEC team stated that they were currently some way along the pathway to achieving this vision and aspiration but they were clear to confirm that additional work was required in order to fully consolidate the improvement journey. As at the last inspection, we once

again found that the vision will only be delivered with the appropriate buy-in and resource commitment of all key stakeholders. This would include available and accessible funding for standard kit items and essential training. For example, blue light refresher training for all DPHC drivers and the need for electrocardiogram (ECG) printing capacity to avoid patients unnecessarily being taken to hospital. The lack of ECG printing facilities alongside the requirement for manual defibrillators disabled the effective post return of spontaneous circulation management (ROSC) in accordance with National Institute of Clinical Excellence and Resuscitation Council UK guidelines.

The CD PHEC acknowledged that the current resource was insufficient to aspire to meet UK standards for 'category 1' patients situated outside of the military bases (NHS England target response time is currently a mean average time of 7 minutes and a minimum of 90% of call outs to people with immediately life-threatening and time critical injuries and illnesses are attended inside 15 minutes). The risk to a patient with a life-threatening concern in more remote areas remained. The MOU had been updated to mirror the 20 minute response time provided by the ROC ambulance service and outlined adapted timelines according to challenging geography. The key performance indicator for SBAAS response time was 20 minutes for 90% of dispatches. Unlike the UK, the time started from when the call was received by the responding crew. The PHEC team stated that no patient had experienced harm within the last 7 months as a result of a prolonged response time. A functioning 'Community First Responder' scheme was being explored as a possible way to reduce time to initial shock when responding to a cardiac arrest.

At our last inspection, we identified the need to clarify lines of accountability to ensure the delivery of a PHEC service achieves the best possible outcomes for patients. Since then, a MOU had been created and ratified which outlined the responsibilities of the Deputy Commander Chief of Staff BFC and accountabilities of Commander DPHC. Nevertheless some areas of accountability remained unclear. For example, the line management responsibility for blue light drivers and the need to ensure their refresher training. Although we were told that drivers were DPHC assets, the Lead Paramedic was taking some ownership in the absence of any day-to-day progress.

Culture

Discussion with staff revealed a 'no blame' culture at all ranks and grades. Staff we spoke with were aware of the whistle-blowing policy and freedom to speak up champion. Work was well underway to re-design the service to be delivered on a pan-island basis, allowing more efficient sharing of resource and island-wide ownership of and shared learning from significant events and near misses. Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff were aware of and had systems to ensure compliance with the requirements of the duty of candour. There was information displayed to advise staff on the freedom to speak up process and this included signposting to a confidential helpline to support those who wished to raise a concern in confidence.

At our last inspection, staff raised concerns around ASERs being reported to DPHC, meaning that subsequent sharing had been lost to those delivering the PHEC service. Since then, a new identity and reporting line for PHEC related ASERs had been

implemented resulting in appropriate ownership, swifter resolution of investigations and improved pan-island discussion around subsequent learning from reported events. The newly established pan-island PHEC meetings provided a much improved forum for shared learning with all paramedics and dispatch nurses invited to attend. The CD PHEC and paramedics also attended quarterly permanent joint overseas bases clinical governance meetings where learning was discussed with a wider audience.

The CD PHEC had identified the need to deliver improvement around the psychological safety of staff at work. They addressed this issue through the newly introduced 'Team Reads' system which aimed to communicate urgent messages to all operational crew on a daily basis (and in the absence of effective email access for some staff). Using 'Team Reads', crews were asked not to discuss and debate previous call-outs in informal spaces and to use only professional forums for formal discussion around shared learning. This was to protect the wellbeing of staff who might have attended difficult scenes and who might be impacted by ill-considered or negative commentary in the staff room from other staff not fully informed about what had happened.

At the last inspection, staff highlighted the limitations faced when waiting for strategic decisions to be reached. This had impacted their confidence and morale, most notably for those who attended the scene of a road traffic accident and were still having to deliver care in an unsafe environment. At this inspection, the feedback was positive in interviews across all 3 sites when discussing scene safety. Direct links had been set up between the crews and duty superintendent so concerns could be relayed from the scene. However, the lack of progress with ECG printing capabilities highlighted that confidence and morale continued to be impacted by long standing issues that could not be resolved at an operational level.

Processes were in place to support permanent staff with professional development. This included appraisal and peer review. Staff were scheduled to receive annual appraisals and were supported to meet the requirements of professional revalidation where necessary. As we found at our last inspection, long-term locum paramedics had not taken part in any appraisal or continuing professional development as they were not line-managed by permanent team members. There was a difference in the skillset and perception of locum paramedics and substantive military paramedics, and this needed to be addressed at a more senior level. Staff told us that the 'locum badge' impacted identity and self-esteem.

Governance arrangements

Since the last inspection, monthly pan-island PHEC clinical governance meetings had been established to which all paramedics, dispatch nurses and BFC representatives were invited. This was a significant step forward, bringing pan-island crews together regularly to discuss learning, governance and new policy. Staff confirmed plans were in place to invite pharmacy staff in future. The CD PHEC had established standing agenda items which included:

- SBAAS operational updates
- Introduction of new team member

- Clinical cases of note
- SBAAS governance update (including the introduction of new SOPs)
- Service improvement work (including quality improvement projects)
- Hot clinical topics (examples included the management of emergency tracheostomy and heat illness)
- ASER shared learning
- Open staff forum.

The meetings generally took the form of a presentation and it had not always been possible to maintain formal minutes due to capacity constraints. The team recognised that maintaining minutes or action points would be a best practice opportunity, particularly as a reference for staff who could not attend the meeting.

At the last inspection, BFC staff outlined their plans to create a new governance approach for the PHEC service based on CQC key lines of enquiry and health assurance framework. There had been progress and there was now a credible PHEC governance system in place. Work was underway to support this with an overarching clinical governance policy to demonstrate the SOPs and how they fitted into the overall framework. With the exception of input from a pharmacy technician, there was now a pan-island model for the sharing of information, best practice, audit, risks and learning across all 3 sites.

There was a theme of moving towards a pan-island approach to provide consistency, including progress with the development of SOPs. For example, the SBAAS workbook developed by the SBAAS team now that the CD PHEC was in post. However, although the SOPs had been written, they were delayed in the ratification process. There were 13 SOPs, 3 had been published and 10 were in draft format awaiting ratification.

The ‘Ambulance Working Group’ and ‘Blue Light Forum’ had been replaced with a quarterly Blue Light Working Group. Police and fire representatives were in attendance, alongside the CD PHEC and representatives from BFC. BFC set the agenda for the meeting which generally included issues and risks, blue light drivers, dispatch, scene safety, TRIM (trauma risk management), tri-sector, local events with security implications, major incident planning and response. Interagency interaction had taken place between the CD PHEC and the lead for the Republic of Cyprus (ROC) ambulance service.

Quarterly regional governance meetings were held with the Regional Clinical Director for overseas. Representatives from each practice were invited to routinely submit their top 3 risks.

The PHEC team had worked hard to tackle the consolidation of consistent and pan-island SOPs. This work was ongoing at the time of the inspection. An approach to how each SOP would be ratified had been formally laid out, ensuring that subject matter experts and key stakeholders were engaged in this important process.

Managing risks, issues and performance

CQC escalated concerns around the delivery of PHEC following inspection of the medical centres in Cyprus in 2019. A letter was sent to Defence Medical Services Regulator (DMSR) in December 2019 outlining concerns around staff training, competency and confidence, potential risks to patients and impact on staff morale and wellbeing. As a result we were invited to inspect the PHEC service in Cyprus in 2019. Following this first inspection, an Urgent Improvement Notice (UIN) was issued by the DMSR to the Director Overseas Bases that outlined 9 areas for improvement. We re-inspected the PHEC service in October 2023 and following this inspection, the UIN was revised down to an improvement notice with the 3 areas of focus being staffing requirements, scene safety and the governance around risk ownership and accountability. Seven corrective action notices were served and these included a review of the requirements for medical equipment carried in the vehicles, completion of monthly controlled drug checks, improvements in the speed and accuracy of locating patients, address the requirements for personal protective equipment and implement ways to handover patient information to secondary care. In October 2024 we find that these risks lack ownership and so resolution has not been forthcoming.

There is a continued lack of clarity around who owns risk at a senior level. Risks have continued to be recorded and escalated appropriately at service level but these have not subsequently been owned and responded to by senior leadership. The tendency to ‘tolerate risk’ had continued and there was a lack of mitigation of known risk. Some significant issues, for example, printing facilities for ECGs, continued to be held at an inappropriately low level and staff had not been able to influence change effectively. This had impacted their morale.

Each medical centre owned a business continuity plan which was comprehensive and it was a requirement for it to be read by all staff including PHEC teams based there.

Appropriate and accurate information

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

Currently, patient records for the PHEC service were paper based. Each medical centre had their own server so could not see one another’s records. It was planned for the new dispatchers to be trained to work from algorithms and would therefore not require access to patient records (UK dispatchers and call handlers do not routinely access medical records). Improvements had been made to the patient report form (PRF) and the sharing of information was now better facilitated with the introduction of carbon based triplicate paper. This supported the sharing of information when transferring the care of a patient, most commonly into secondary care at a hospital.

Engagement with patients, the public, staff and external partners

The PHEC Team had processes in place to involve as many patients, staff and external partners to support sustainable services. Due to the nature of the service, patient feedback was minimal. It was normal for feedback to be channelled through one of the military medical centres. Registered patients who had used the 112 service could leave feedback anonymously via a suggestion box positioned in each of the waiting rooms in the 3 medical centres. Notice boards in the waiting areas provided a summary of the complaint process and duty of candour principles.

CD PHEC had reviewed methods for capturing feedback and was implementing a quick response (QR) code feedback system for patients. There were business cards on each ambulance with useful telephone numbers too. These included the hospital liaison officer, military welfare services and the numbers for the medical centres. Letter of thanks from patients and outgoing staff were shared with PHEC colleagues. These business cards included the QR code and invited patients to scan and submit feedback on the care received. The cards could also be used to provide a short, handwritten response.

Good and effective links with internal and external organisations were established, including with the welfare team, the mental health team based at Akrotiri, Chain of Command, ROC emergency services, DPHC Headquarters and host nation healthcare providers. Of note, good links had been forged with the SBA emergency services with the PHEC clinical director having established a coordinated review and response with the respective heads of each service. This had driven improvement most notably through the ASER review process and paramedics reported significant improvements in the management of scene safety by the SBA police.

Continuous improvement and innovation

The ‘Team Reads’ system had been introduced as a way to provide daily updates on any urgent issues to pan-island crews. This provided a swift and uniform way for all PHEC staff to consistently access information pertinent to their role. Topics were determined by feedback generated from significant event reviews, clinical updates and any other information seen as requiring urgent communication. Topics issued to date included:

- Assessment and treatment plans for diving casualties
- Guidance around safe attachment of Marshall adult bag-valve-mask oxygen tubing
- Checks to ensure the compatibility of Tempus Pro ECG electrodes (following supply of incompatible electrodes) with other ECG recording devices such as the AEDs,
- An outline of the correct protocol for communication between dispatch staff and SBAAS crews
- Incompatible laryngoscope blades and handles.
- Use of helicopter transfers.
- Medicines management heat mitigation.

In addition, further areas of improvement included:

- The extension of the PRF audit across all sites.
- The elevation in standards and more robust processes for medicines management that included a draft single drug formulary for the PHEC. All medicines had been reviewed by a multidisciplinary team and were fit for purpose.