Pre-Hospital Emergency Care (PHEC) Service, Cyprus

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 Service, Cyprus (referred to throughout the report as PHEC) delivered by British Forces Cyprus (BFC), transferred to Defence Primary Healthcare (DPHC) during the inspection process. The report 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 centres from where PHEC is delivered, met with a representative of the DPHC overseas regional team, spoke remotely with the clinical lead and visited BFC Headquarters.

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

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Summary

About this inspection

We carried out our first 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 followed up on the initial inspection in October 2023. 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.

We returned in October 2024 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 the safe, effective and well-led key questions. The caring and responsive key questions were rated as good.

The previous report from October 2024 can be found here:

www.cqc.org.uk/dms

We carried out this announced comprehensive follow-up inspection on 9, 10 and 11 December 2025.

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

The key questions are rated as:

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

The Care Quality Commission (CQC) does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the observations and recommendations within this report.

This inspection is one of a programme of inspections 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:

- The 3 sites were now working together under a lead paramedic. Sovereign Base Area Ambulance Service (SBAAS) standard operating procedures and local working practices had been implemented
- Lines of accountability at a senior leadership level had been addressed by way of a memorandum of understanding (MOU) that clearly defined Defence Primary Healthcare as responsible for the PHEC service. Learning opportunities from clinical cases and adverse events were now shared at SBAAS meetings and with other overseas military PHEC providers. Case discussion was supported by representatives from a UK ambulance service.
- 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. An effective relationship with the Republic of Cyprus ambulance service was also reported.
- Operational support was provided on island and clinical support through reach back to a Clinical Advisor in the UK who acted as clinical lead for the service.
- Arrangements were established and used for managing medicines, including obtaining, prescribing, recording, handling and disposal in the practice.
- Access to emergency care was through a paramedic led service. This model mostly enabled medical centre staff from having to work excessive hours to support service delivery.
- All blue light drivers had received suitable training and refresher sessions were planned at regular intervals.
- Systems ensured that staff completed the required mandated training and held the appropriate professional registrations. This included staff recruited from the local population. These systems had been strengthened to provide assurance around the suitability of locum paramedics.
- Staff understood the Mental Capacity Act (2005) and how it applied in the context of the service they provided. A new mental health patient care pathway had been implemented.
- Formal peer review arrangements were for established clinical staff included effective auditing of clinical notes.
- Staff understood and adhered to the duty of candour principles.
- Although accepted that the nature of the service meant that feedback from patients would be minimal, particularly from the local Cypriot population, initiatives to encourage feedback had been implemented.
- To assist the handover of clinical information to secondary care, the integrated monitor/defibrillator system had been delivered and printers were on order with delivery pending at the time of inspection.
- Systems ensured that staff completed the required mandated training and held the appropriate professional registrations. This included staff recruited from the local

population. These systems had been strengthened to provide reassurance around the suitability of locum paramedics.

- Prior to arriving on island, entitled personnel and their families were now informed about the ambulance response time target such that they can consider their personal circumstances and make an informed decision.
- Identified risks had been assessed, progressed and actions proposed. However, the time required to establish the MOU had hindered progress and resolution. It was too early to see the positive impact of solutions such as for the dispatch function and printing capabilities on vehicles.
- Infection prevention and control (IPC) improvements in systems and processes for the consistency and cleaning checks of vehicles had been implemented. However, were yet to be fully established.
- A newly established team of paramedics leading the PHEC service. However, service delivery had not adapted to the continued reliance on locum paramedics which impacted the capacity of those in leadership roles.
- At Episkopi, the low number of medics resulted in working patterns that exceeded levels detailed in the Defence Instruction and Notice, equivalent to the EU working time directive.
- Staff told us that they continued to experience difficulties when locating addresses and this had caused delays to dispatch and therefore timely safe care and treatment.
- The arrangements for support and integration for exception continued to be long-term locum paramedics who had not been integrated into any of the arrangements for them to be included in performance and clinical review of the service.

The Chief Inspector recommends to the PHEC Cyprus service:

- Continue to develop IPC processes, including the implementation of deep cleans for vehicles.
- Introduce processes to maintain clinical oversight of long-term locum paramedics.
- Ensure the recently produced business plan is implemented, with specific attention to providing protected time for paramedics who hold leadership responsibilities.
- Ensure Episkopi staff do not work in excess of the Defence Instruction and Notice equivalent to the EU Working Time Directive
- Continue to strengthen the 112 PHEC response by improving dispatch processes, ensuring effective prioritisation, and enhancing the accuracy of patient location.

Professor Bola Owolabi

Chief Inspector of Primary and Community Services.

Our inspection team

This inspection was undertaken by a CQC inspector. 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. A second CQC inspector was in attendance together with a representative from DMSR.

Background to PHEC 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 2 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. However, during the inspection, this responsibility was being transferred to the Defence Primary Healthcare (DPHC) overseas team through a memorandum of understanding (MOU) confirming that DPHC had overall responsibility for the service. This clearly defined a paramedic-led service supported at a strategic level operationally and support from an SBA Consultant Advisor (Pre-Hospital Emergency Medicine Consultant based in the UK). The Senior Medical Officers at each medical centre on the island provided clinical support as required and this was detailed in the MOU.

All 112 emergency calls (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 outgoing as responsibilities are transferred to the DPHC overseas team PHEC lead
Clinical Advisor	1 based in the UK working 1 day a week in the PHEC
Medical and Sovereign Base Area Ambulance Service (SBAAS) Chief Operations Officer	1
Lead Paramedic for the SBAAS Team lead paramedic for the Western SBA Team lead paramedic for the Eastern SBA	1 1 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	Eastern SBA	Western SBA
Dispatchers	All practice nurses perform dispatch duties on a rota	14 (4 vacant)	20 (4 vacant)
Transport	Ambulance drivers	10	15 (1 vacant)

Medical assistant (medics) team *	Combat Medical Technicians (CMTs) / RAF Medics Paramedics	9 8 (1 military, 1 full-time reservist, 6 locums)	19 (1 vacant) 8 (2 military, 6 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 the cleaning of the ambulances and the need to communicate what level of response is available to serving personnel and their families including those visiting. We made recommendations to carry equipment on the vehicles to allow third-party review of cardiac conditions at the scene and to interpret electrocardiograms, improve medicines management arrangements, securing the safety of staff at the scene and issues in locating the patient following a 112 call.

We continued to rate the service as requires improvement. Although recommendations had been considered and actions planned or completed, it was too early to evidence the positive impact. Of note, the key risk of workforce remained due to fragility from a reliance on temporary healthcare workers and reliance on using medics from the medical centres; in particular at Episkopi. Despite clear efforts and improvements having been made, the systems and process to ensure deep cleaning of vehicles had yet to be fully established.

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 safeguarding leads for each of the 3 medical centres and a morning meeting held at each covered any safeguarding concerns. The safeguarding pathway for entitled persons was the same for pre-hospital emergency care (PHEC) as for each medical centre. There was no memorandum of understanding (MOU) 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 medical centre 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 population of 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. Carbonated paper pads 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 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. Paramedics used the 'mental capacity assessment and non-conveyance' form to formalise the process of recording capacity in the case of treatment being refused by the patient or transport by the patient against medical advice. The 'recognition of life extinct' form was used to standardise the recording of a death having occurred.

Staff who acted as chaperones 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. The professional registration, DBS and vaccination status of staff was recorded in an electronic folder with restricted access. This document was recorded on the asset register.

Medics arrived on island with suitable training and completed a 2-week induction programme with a paramedic mentor. One week of the induction programme was primary healthcare and the other PHEC. All new staff had commenced their induction and all permanent staff had completed an induction. Major incident medical management and support training was not a requirement for military paramedics. Staff mentioned this as a consideration given the fragility of the major incident response and reliance on locum paramedics already working 60 hour weeks to ensure service delivery.

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. Employment history and qualifications was provided by the agency and reviewed by the PHEC lead paramedics to determine suitability for working in the SBAAS. Familiarisation shifts were provided as part of the induction.

The Defence Primary Healthcare (DPHC) infection prevention and control (IPC) leads at Akrotiri, Episkopi and Dhekelia medical centres continued to be responsible for IPC within the PHEC service. It was planned for SBAAS to have a responsible individual for the service once more permanent paramedic posts were filled. Staff were up-to-date with IPC

training and regular audits undertaken included use of personal protective equipment and compliance with the bare below the elbows policy.

Quick response or QR codes were used for a daily cleaning check of the ambulance fleet and served as both a cleaning schedule and a record of completion. Cleaning was the responsibility of the driver with support from a medic and paramedics who would clean touch points inside the vehicle. Cleaning took place after each patient and the QR codes were scanned each time a vehicle was cleaned. In addition, a more in depth internal clean of the ambulances was completed on a rolling monthly rota. This consisted of each compartment being emptied, cleaned and the contents checked for expiry dates. A contract had been tendered for deep cleaning the vehicles at 6 month intervals but a provider was yet to be found. In the interim, deep cleans were undertaken on an ad hoc basis, for example, when the vehicles were taken off the road for a service. Spill kits were available in each vehicle for cleaning bodily fluids.

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.

Medical gases were stored in the vehicles and site storage area in a way that was compliant with UK gas guidelines and cylinder storage requirements.

Appropriate paediatric kit including harnesses was available in each vehicle.

Risks to patients and staff

Issues and risks were separated to remove low level issues from the risk register. We reviewed the risk register to find that actions had been taken, were part way towards completion or were evidentially being planned. The MOU between DPHC and BFC was signed off soon after the inspection. A copy reviewed after the inspection detailed ownership of risk.

Staff fragility was a significant ongoing risk and had been identified at previous inspections. Workforce establishments now made allowance for abstraction, time whereby staff are unable to fulfil front-line duties including annual leave, sickness, continued professional development and training (the NHS England target for most healthcare services is approximately 30% abstraction when calculating staffing time requirements). At this inspection we found that the required paramedic hours had increased to the equivalent of 23 full time equivalent. However, we identified that the lead paramedics did not have protected time after December 2025 so would be on the rota to crew the vehicles. In addition, medics from Episkopi were working hours that were in excess of those detailed in the Defence Instruction and Notice equivalent to the EU working time directive.

Although working hours were still exceeded at times, the paramedics were not required to deliver the primary care service during the day. 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.

Responders reported a marked improvement in scene management since the last inspection. Although still described as occasionally an issue with road and scene control not at UK levels, SBA police were said to be more aware and responded well to concerns of ambulance teams working at the 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. Staff reported improved compliance with the use of personal protective equipment, most notably, high visibility jackets.

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. The implementation of software to address the issue and was pending at the time of inspection.

The vehicles were equipped with emergency kit, including an automatic external defibrillator (AED) that could 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. Ambulances were to have a patient monitor incorporating a manual defibrillator that could administer a shock and monitor the heart rhythm together with printers for the printing of electrocardiograms (ECGs), an important tool in diagnosing cardiac conditions The hardware was on order awaiting delivery and once available, would allow patients to be potentially discharged at the scene avoiding being transported unnecessarily to hospital to exclude acute cardiac syndrome. Manual defibrillators allowed Advanced Life Support (ALS) trained paramedics to operate to their full scope of practice. The printers would facilitate better liaison with receiving units.

Ambulances were now equipped with a combined monitor and defibrillator with a manual defibrillator option. 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 an increased chance of spontaneous circulation (ROSC, the resumption of a sustained heart rhythm after cardiac arrest). Manual defibrillation should be the preferred option for appropriately trained paramedics. This equipment could now be used to analyse the ECG and recommend delivery of a shock when appropriate. Resuscitation Council UK and National Institute for Health and Care Excellence guidelines on the management of patients requiring ROSC could now be met with the additional cardiac equipment.

A new SBA PHEC induction course had been implemented since the last inspection. We reviewed this and found it to be thorough with role specific elements. Induction courses

lasted approximately 2 weeks with familiarisations, moulages (scenario based training), supernumerary shifts and a sign off schedule. Each new staff member was allocated an experienced colleague to provide mentorship. Initial shifts included familiarisation with the local geography including family quarters and hospitals.

As part of their induction, staff had to complete a suite of training that included safeguarding, basic life support (BLS), instruction on how to use the defibrillator and anaphylaxis (severe allergic reaction). The programme was refreshed annually as a minimum, most staff completed it at 6 month intervals. Medics and paramedics had returned 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. Paramedics proficiency in ALS formed part of their registration and continued professional development requirements.

A suitably qualified and experienced paramedic/medic responded to all 112 calls. The SharePoint site was being developed to include a training register that outlined moulage training, mock scenarios and training conducted within the medical centres, such as ejector seat training. A business case was in progress for all paramedics to have the Joint Royal College Ambulance Liaison Committee or 'JRCALC' application on their tablets and duty phones. 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 major incident plans detailed in station protocols, of which SBAAS response was a significant 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 multi vehicle road traffic collisions and crews had been put on standby to respond to wildfires that had been declared a major incident.

There was no formal agreement with the host nation emergency services but there was a mutual understanding, at an operational level, of mutual support in the event of a major incident. This was demonstrated on a weekly level when the PHEC went into 'service black' (capacity breached), with the host nation ambulances responding within the SBA. It was confirmed that Commander Med would take control of all medical assets from DPHC in the event of a major incident being declared. A capability training event for a mass casualty event had been scheduled for 2 days in March 2026 together with the Republic of Cyprus Ambulance Service.

In October 2025, BFC Headquarters ran a simulated event around an earthquake as part of an annual programme of scenario testing. Each medical centre carried out major incident scenario training annually and the PHEC service was invited and participated in each. A counter-terrorism simulation exercise was carried out in 2024. 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.

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 Directorate together with relevant subject matter experts and key 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. Doctors at each medical centre would follow up any cases that been referred in from the PHEC clinicians. Children under the age of 5 were identified and passed to the children’s nurse. A 6 weekly joined up pan-island clinical meeting was held.

Regular PRF audits against Health and Care Professional Council standards were conducted and learning outcomes shared widely with all teams during the pan-island PHEC clinical meeting. Twenty PRFs were examined and found to be complete. Data

included timings, presenting conditions, evidence of accident and emergency assessment sets of patient observations, clear descriptions of interventions, including medicines administered and disposal decisions. The formal audit that had originated in the ESBA had been rolled out into the WSBA and PRF audits were planned at 6 monthly intervals.

Mental health patients deemed at risk to themselves or others, requiring immediate treatment would be conveyed to a dedicated safe area within the emergency department and they 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 were available for service personnel and their families. However, there was no reach back for non-entitled patients. If the patient was a 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. A mental health patient care pathway had been implemented and laid out the roles and responsibilities of key stakeholders, the principles to be adhered to, on-scene response, transfer and admission to a mental health facility. The identification of a safe space was a key consideration documented in the pathway. Although there had not been any patients with serious mental health needs treated by the PHEC team since the last inspection, there was still no officially designated ‘safe place’.

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). In the NHS, the National Patient Spine overcomes some of these difficulties in the UK but is not practical in Cyprus with the lack of a fully integrated health care system on the island. To mitigate some risks, it was planned for dispatchers to work from algorithms (a 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

Medicines management processes for the PHEC service were in place. There was a uniform drug formulary and safe processes for the management including storage, replenishment and destruction of PHEC medication. The service now had an 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.

Across DPHC, including the PHEC service in Cyprus, it was normal practice to formally write off and destroy all oral medicines after 6 months, and all liquids for injections after 1 month.

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.

Patient Group Directions were up-to-date with one exception, Penthrox (pain-relieving vapour), which had not been signed as it was awaiting an update for children under 5. We were sent confirmation that this had been completed soon after the inspection.

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

Risks were well understood and articulated on the island by the service delivery team. The MOU provided clarity on where risks were owned. Families and visitors had recently started to be briefed about the level of emergency response service in place before they make a decision to come onto the island. A dedicated ASER and risk register meeting formed part of the 6 weekly rolling programme.

Lessons learned and improvements made

At all 3 medical centres, every call out for the PHEC service was discussed at the morning brief and if there were any learning events, these were then 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.

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

Are services effective?

We rated the service as good for providing effective services.

We previously rated the service as requires improvement for providing effective services. This was because we identified areas that needed strengthening including the provision of suitable personal protective equipment, not having cardiac monitoring equipment, staff training, the dispatch process and training for dispatchers.

At this inspection, we found that sufficient action had been taken to improve the rating to good.

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 by the PHEC clinical director. The lead paramedic was continuing with the work and there was a task to collate a formulary of SOPs and local working practices. SOPs had been drafted and were awaiting review and implementation.

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 had now been rolled out across island having previously been identified as good practice at Dhekelia. PHEC Staff were able to join a call held every 2 months attended by all overseas bases who provided PHEC. This provided a forum for clinical review with cases being presented for discussion.

As highlighted at previous inspections, 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 continued 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. We again found 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. Plans to address this were in the final stages and the dispatch function was to be moved to a Unified Control Room (UCR) where trained dispatchers would prioritise responses when needed. However, there was still recruitment and training required to make this fully operational. Data had started to be captured to allow a review of response times from initial call to arrival at the scene.

Since the last inspection, the limitations of the response target time had been highlighted to personnel, their families and any visitors such that they could make an informed choice before coming onto the island. An initial communication followed up by a briefing was provided to all personnel and families arriving in Cyprus. Implementation of this had been made soon before the inspection so we were unable to speak with anyone new on island

who had completed the process. A review of the presentation provided assurance that essential information was provided to allow informed decisions to be made.

The cardiac monitoring equipment (Tempus Pro device) now had a ‘shock box’ (built in defibrillator). This meant that some advanced life support (ALS) interventions (synchronised direct current shock and external pacing) were now available to ALS qualified team members.

Monitoring care and treatment

The care provided to patients was monitored every morning during a group call at Akrotiri and Episkopi. Dhekelia had their own meeting for the Eastern SBA. Discussion took place about all new and ongoing call outs and any follow on requirement. These meetings were attended by doctors and the PHEC staff on duty at the time, incoming and outgoing crews attended as part of the daily handover. Individuals requiring an appointment were booked in from that day.

There were several examples of best practice and audit being undertaken across all 3 sites. The Clinical Director PHEC had fostered a culture of continuous improvement of which audit formed a large part. The lead paramedics had continued this work and regular audits included:

- The use of quick response (QR) codes for the daily cleaning of vehicles. Each cupboard had its own QR code and was cleaned on a monthly cycle.
- 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.
- PRF content against Health and Care Professional Council standards.

Progress had been made against measuring the operational effectiveness of the service with the introduction in May 2024 of a mechanism to capture data. This data had been collated by the Clinical Advisor when looking to gain an understanding of what the service was delivering operationally and to determine requirements going forward. Each metric continued to be recorded manually but this would be automated with the pending introduction of computer aided dispatch.

Data was now captured on the mobilisation time from the call being received to the crew starting to mobilise to the scene. This provided visibility of any delay but 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. A dispatch mechanism direct from the UCR to the live ambulance crews was close to implementation with plans for a system to be in place in early 2026. Times to mobilise were commonly between 3 and 4 minutes, this could be delayed when an interpreter, often the driver, was required to clarify the incident address of location.

The PHEC service aimed to have an ambulance on scene within 20 minutes. With the information from the SBA Police being limited and the call outs so, approximately 2 per

day combined across the Eastern SBA and Western SBA, there had historically been no stratification or prioritisation of the risk of calls. An ambulance continued to be dispatched in response to each call but to allow the PHEC service to provide differentiated care to its patients. Work was well underway to categorise calls through the UCR with trained dispatchers able to prioritise in the event of simultaneous incidents.

SBAAS staff reached approximately half of incidents within 7 minutes of being tasked, and the vast majority of cases were reached within 18 minutes. Improved triage and dispatch mechanisms were imminent and would allow for a more tailored response to individual incidents. The Memorandum of Understanding included a 7 minute response time to areas classed as ‘urban’ and 18 minutes for areas classed as ‘rural’. Further work was required to agree the geographical split.

Effective staffing

The Lead Paramedic reviewed the training skills and needs of their team and had collated a matrix to monitor currency. The induction programme and recruitment of agency staff had been strengthened to improve the suitability of employed staff. This had resolved previous issues with high turnover of agency staff caused by them not being suitably experienced.

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 was now supported with the offer of full commitment which included the provision of accommodation and more competitive rates of pay. There was also the long-term aspiration to reach a position of having more regular 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 been 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. At the last inspection we identified that there was no effective mechanism for ensuring those who came out to Cyprus to take up locum paramedic positions had the skills, currency and experience to do the job. Improvements had been made with a vetting process that involved a review of skills and experience to ensure suitability.

Uniform and appropriate kit had previously been highlighted as an issue with most uniform procured personally by the staff themselves in the absence of some essential items. A pool of kit scaled per person was purchased following approval of funding. The pool was being increased to build resilience by having a stock of all sizes. Items included high visibility vests for use in summer, waterproof jackets for use in winter, SBAAS epaulettes for drivers and SBAAS branded clothing for medics and paramedics that identified respective roles.

The last inspection highlighted that blue light driver refresher training was not being completed. In some cases, this had not been done for 10 years. At this inspection we

found that training needs had been addressed and all drivers had been trained to a UK standard for blue light driving. Drivers repeated a full assessment every 3 years and familiarisation annually which included both day and night driving. Two lead drivers had been trained as trainers so the annual familiarisation training could be delivered on Island. The 3 yearly assessments were carried out by an external assessor who travelled out from the UK.

Training for drivers was in-date and the lead was planning to implement a system to monitor the time individual drivers spent driving with blue lights to increase the frequency of familiarisation sessions where fewer hours experience had been gained.

Paramedics were now leading and delivering the PHEC service with support from medics, nurses and a clinical advisor. 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. When paramedics returned to the UK for their NHS experience, the backfill was now considered resulting so workforce gaps were covered.

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 accessible.

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 the 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. This was due to change in early 2026 with trained dispatchers working from a UCR using a support system. In the interim, the Clinical Advisor for PHEC provided categorisation details to the nurses to advise category 1 calls. Details were displayed on the wall for reference.

There was utilisation of learning-needs based moulage training delivered by the paramedics. There was a clinical moulage log resource on the SharePoint with links to evidence and discussion points applicable locally. The ‘after action reviews’ (AARs) following fatal incidents were a positive demonstration of an appropriate review having been carried out. Moulage training was 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 was underway with each critical skill simulated in training or performed in real life to help team members stay current.

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).

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 the duty doctor when available. At other times the duty doctor (available 24/7) was used most frequently and there were no difficulties reported in accessing them. None of the ambulance staff commented that they felt unsupported.

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 had established 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. The ASER management system provided a suitable platform for PHEC staff to raise concerns. The standards and practice 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 an earthquake involving a multi-casualty and multi-service response. There had also been a real life response to wildfires in 2025 which was supported by the service although not in the SBA.

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 in the Eastern SBA. In the Western SBA, information went through the Chief Operations Officer. Liaison with the SBA police and administration had continued and paramedics reported progress on scene safety. There was a mechanism to raise live concerns about scene safety to the duty police superintendent.

PHEC staff participated in the annual '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 for entitled personnel 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 patient report form.

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.

Forms were used to support clinicians in recording that capacity had been assessed and for when they had to confirm life extinct. There were also clear lines of communication to the Clinical Advisor for PHEC, Senior Medical Officers at each medical centre and the Chief Operations Officer 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 had not consented 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.

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. The timings continued to start from the ambulance being dispatched, not from when the call was received (UK standards are measured from when the call is answered). However, data was now being captured for the time from the call being received to the ambulance crew being mobilised. 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 lead paramedic. The process to manage complaints were 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. Responding to feedback on the PHEC service could be communicated through the practice meetings and healthcare governance meetings. However, and for autonomy and independence, the PHEC had feedback methods so that data specific to PHEC could be collated and managed within the service. Complaints and compliments were a standing agenda item at the 'general' meeting held every 6 weeks.

Are services well-led?

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

We previously rated the service as requires improvement for providing well-led services. This was because we identified areas that needed strengthening including the concerns around staff capacity and a lack of clarity with the ownership and mitigation of risk at strategic level.

At this inspection, we found that sufficient action had been taken to improve the rating to good.

Leadership, capacity and capability

Ownership and accountability issues for this service highlighted at previous inspections had been clarified through a memorandum of understanding (MOU) that 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. The MOU was signed soon after the inspection visit and paved the way for operational improvements.

The clinical director for the pre-hospital emergency care (PHEC) service had been replaced by a Lead Paramedic with 1 day a week remote clinical advice support from the Clinical Advisor for PHEC to the SBAAS. The Clinical Advisor was an accident and emergency consultant with frontline experience in pre-hospital emergency medicine delivery and Helicopter Emergency Medical Services qualifications.

The PHEC service across the island was now a paramedic-led service. Up until March 2025, a Clinical Director PHEC had been in post and worked extensively on implementing clinical governance systems to establish better team cohesion and a pan-island approach to PHEC delivery. A meeting cycle had been drafted into a proposed calendar which showed an aspiration for regular pan-island SBAAS meetings. These included a general meeting with the first having been conducted in November 2025. The meeting had been used to nominate roles within the service for feeding back at quarterly intervals. The nomination of roles included:

- fleet manager
- training lead to include clinical updates
- audit lead
- significant events
- health assurance framework
- medicines management to include equipment care.

Terms of reference (ToRs) were being developed as the SBAAS Lead Paramedic had only been in post for 3 weeks. Minutes of the November 2025 meeting showed that they had been discussed with development of these roles and ToRs planned as part of an effective governance framework.

There remained a short-term risk to sustainability due to the reliance on locum paramedics to deliver the service. There was 4 military paramedics tasked with the leadership but were also required to deliver the service both through being on the crew rotas and as the resilience in the system to cover any gaps as well as provide support to complex cases.

Key delivery successes since the last inspection included:

- the establishment of a blue light training programme for drivers
- establishment of pan island PHEC meetings incorporating sound clinical governance elements
- the development of a series of pan-island clinical local working practices
- uniforms and personal protective equipment to all staff
- new shock boxes for each vehicle and the pending delivery of hardware to provide printing capabilities on each vehicle.

Issues around staffing capacity had been addressed further since the last inspection and there was now the equivalent of 24 whole time equivalent paramedics in post. The increase from 16 had been achieved by using locum paramedics working 60 hour weeks.

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 based 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 all sites and worked closely with the Clinical Advisor and Chief Operations Officer. Written job descriptions and terms of reference were being updated following the accountability and responsibility moving to DPHC.

Vision and strategy

The DPHC overseas team and Chief Operations Officer articulated a clear vision and aspiration for a PHEC service although no formal plan was in place. During the inspection, a written document was produced by the Overseas PHEC Lead that detailed the strategic plan up until 2035. This detailed:

- recruitment for all paramedic posts from military paramedics to remove the requirements for locum staff
- transfer of the dispatch service from the out-of-hours nursing team to the unified control room
- a health needs analysis to provide evidence for any required increase in workforce
- enhanced role for drivers to allow them to provide medical support to paramedics

- training of infection, prevention and control leads within the PHEC service and implementation of a contract for deep cleaning the vehicles.

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.

The PHEC service 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 Memorandum of Understanding (MOU) mirrored 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 there had been no known instances in the last 12 months when a patient had experienced harm as a result of a prolonged response time.

A functioning 'Community First Responder' scheme continued to be explored as a possible way to reduce time to initial shock when responding to a cardiac arrest. The planned introduction of software could allow the potential for mapping out defibrillators and utilisation of a responder scheme if put in place.

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.

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 paramedic-led and delivered on a pan-island basis, allowing more efficient sharing of resource and island-wide ownership of 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.

The 'Team Reads' system communicated 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 callouts 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 previous inspections, staff highlighted the limitations faced when waiting for strategic decisions to be reached. This had impacted their confidence and morale. At this inspection we found progress had been made, most notably with electrocardiogram (ECG) printing capabilities that were due to be in place once printers had been delivered. The MOU had removed the blurred lines of accountability that were hindering progress.

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. Long-term locum paramedics had still not taken part in any appraisal or continuing professional development as they were not line-managed by permanent team members. This had been highlighted at the previous 2 inspections. There was a difference in the skillset and perception of locum paramedics and substantive military paramedics, and this was a continuing issue from previous inspections. An improved vetting process for locum paramedics was now in place that checked staff were suitably experienced and a long-term plan to have more substantive posts filled with military paramedics to reduce the reliance on locum staff.

Governance arrangements

Since the last inspection, a rolling 6 weekly programme of pan-island PHEC clinical governance meetings had been established to which as a minimum, all paramedics, medics, support, operations officer and the clinical advisor were invited to. Additional staff were invited or included in the circulation of minutes where appropriate. For example the regional lead for ASERs attended the ASER meetings and the Senior Medical Officers were sent the minutes of meetings for awareness. This was a significant step forward, bringing pan-island crews together regularly to discuss learning, governance and new policy.

British Forces Cyprus (BFC) and the SBAA are the Intelligent Customer for their population at risk within Cyprus and had monthly meetings with DPHC and the SBAAS to discuss healthcare delivery, which included a quarterly meeting schedule for the Intelligent Customer Steering Group. This provides a multilayered approach to governance and helps structure the tactical to strategic space to respond to any risks and issues. In addition, there was a quarterly meeting with all overseas PHEC providers to present clinical cases for shared learning. Monthly operational meetings were held to feed into the quarterly working group. A quarterly meeting was held between the overseas territories and a UK ambulance service to discuss challenges faced and share learning and good practice.

ASERs were now used routinely and discussed in the newly established general meetings. Sharing of learning now occurred through the global PHEC virtual meetings. In addition, there was informal peer-to-peer support and a positive and professional culture towards learning and service improvement.

The Clinical Advisor's first report to the Defence Consultant Advisor for PHEC included initial response data to inform care, positioning of ambulances and areas where the service required change.

There was continuing progress towards a pan-island approach to provide consistency, including progress with the development of a SharePoint site. The service had encountered delays in the ratification process for standard operating procedures (SOPs) once written. Local working practices (LWPs) were now being used as a more dynamic solution as they did not require ratification. SOPs remained and had been reviewed but LWPs were found to be easier to implement and faster to become operational.

The 'Ambulance Working Group' and 'Blue Light Forum' had been replaced with an 'Areas Resilience Forum' chaired by the Police Constable for the SBA. Police and fire representatives were in attendance, alongside representatives from the PHEC team. The agenda for the meeting 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.

Quarterly regional governance meetings were held with the RCD for overseas. Representatives from each practice were invited to routinely submit their top 3 risks in advance.

The PHEC team continued to work on the consolidation of consistent and pan-island SOPs. This work was ongoing at the time of the inspection due to the changes in personnel and the new MOU.

A meeting schedule had recently been implemented with a rolling 6 week programme that consisted of dedicated time for:

- clinical
- clinical case studies
- Joint Royal Colleges Ambulance Liaison Committee clinical guidelines
- audit/patient group directions
- significant events and risk register
- general to include workforce, fleet of vehicle, compliments and complaints

All meetings had written terms of reference.

Managing risks, issues and performance

In October 2024 we reported that risks lacked ownership and so resolution has not been forthcoming. At this inspection we found that a new MOU was in place awaiting final sign off. This document served to clarify ownership and responsibility for risks to the service delivery and staff.

Workforce fragility was identified as the key risk. 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. There was a long-term strategy to directly employ paramedics and funding had been secured to have position identified posts (referred to as PIDs) to allow recruitment to happen with funding already secured.

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 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. The patient report form was on carbon based triplicate paper to aid 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 as possible, 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. The PHEC service were encouraging feedback direct by way of QR codes and Sharepoint areas to be more independent of the medical centres.

The Clinical Advisor for 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. Good links had been forged with the SBA emergency services with the PHEC service 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 was used 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:

- standardisation of vehicles to make them uniform across island with layout of the equipment and response bags.
- 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.
- screening of locum paramedic applicants was now permitted by the locum agency.