Defence Medical Services

Department of Community Mental Health – Plymouth

Quality Report

Department of Community Mental Health Plymouth
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, and information given to us from the provider and patients.

Ratings

Overall rating for this service?	Good

Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall Summary
The five questions we ask about our core services and what we found

The DCMH is rated as good overall.

The key questions for this inspection are rated as:

Are services safe? – Good

Are services responsive? – Good

Are services well led? - Good

We previously carried out an announced inspection of the Department of Community Mental Health - Plymouth in February 2020. The DCMH was rated as requires Improvement overall, with a rating of requires Improvement for the key questions of safe and responsive. The well led domain was rated as good however we had made some recommendations relating to this domain. The domains of effective and caring were rated as good at that inspection. A copy of the report from the February 2020 inspection can be found at:

https://www.cqc.org.uk/sites/default/files/DMS_DCMH_Plymouth_Requires_improvement_26_May_2020.pdf

This report describes our judgement of the quality of care at the Department of Community Mental Health Plymouth. It is based on a combination of what we found from information provided about the service and interviews with staff and others connected with the service. We gathered evidence remotely in line with COVID-19 restrictions and guidance and undertook an announced inspection on the 18 and 19 January 2022. We interviewed additional staff and patients of the service remotely between 20 January and 11 February 2022. At this inspection we have focused on the domains of safe, responsive and well led to see what improvement has been made against the recommendations made following the previous inspection. The ratings of good for the domains of effective and caring remain.

Overall, we rated the service as Good. We found the following areas of good practice:

- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. The team consisted of skilled and experienced staff who worked in partnership with other agencies to manage and assess patient needs and risks. The team was now almost fully staffed and sufficient to meet the needs of patients. Vacancies were being covered by long term agency staff while recruitment was undertaken.
- Mandatory training rates were at 94% and staff had undertaken required supervision.
- Work had been undertaken to ensure appropriate reporting of and capture learning from adverse events and had led to changes in practice. The team had built a positive and open safety culture and there had been minimal negative events.
- Work had been undertaken to improve the safety of the environment and arrangements were in place to meet the needs of patients who had a physical disability.
- The team had improved arrangements to assess patients following referral. Despite an increase in caseload the team had met the response target for urgent and routine referrals and waiting lists for treatment had reduced.

- The team had set up a patient forum and patient experience was very good and had improved since our previous inspection. Patients were positive about the service they had received throughout the pandemic. Most patients felt they had benefited from virtual treatment which they had found more convenient and wished to maintain this approach.
- The management team had developed well and had demonstrated clear and accountable leadership, staff reported that morale was very good and that they felt supported by their colleagues and the management team.
- Governance procedures had been strengthened and had brought about improvement at the service.
- The team undertook audit and a quality improvement plan was in place which had driven a range of quality improvement projects to enhance patient care. Staff were fully engaged in this process.

Are services safe? Good

We rated the DCMH as Good for safe because:

- The team was now almost fully staffed and sufficient to meet the needs of patients. Vacancies were being covered by long term agency staff while recruitment was undertaken.
- Mandatory training rates were at 94% and staff had undertaken required supervision.
- Work had been undertaken to ensure appropriate reporting of and capture learning from adverse events and had led to changes in practice. The team had built a positive and open safety culture and there had been minimal negative events.
- Work had been undertaken to improve the safety of the environment and arrangements were in place to meet the needs of patients who had a physical disability.
- Business continuity plans for major incidents had been updated to reflect the risks in relation to the Covid 19 pandemic. Appropriate actions had been taken in response to the Covid 19 pandemic to mitigate the risk of infection to patients and staff and to ensure the service could operate safely.

Are services responsive to people's needs? Good

We rated the DCMH as Good for responsive because:

- The team had improved arrangements to assess patients following referral. Despite an increase in caseload the team had met the response target for urgent and routine referrals and waiting lists for treatment had reduced.
- The team had set up a patient forum and patient experience was very good and had improved since our previous inspection. Patients were positive about the service they had received throughout the pandemic. Most patients felt they had benefited from virtual treatment which they had found more convenient and wished to maintain this approach.
- The building was comfortable, well decorated and equipped. A waiting area was available for patients. Information was available on display about treatments, local services, patients' rights, and how to complain. The team had made arrangements to use alternative facilities where a patient was unable to access the building due to a physical disability.
- The team had a system for handling complaints and concerns. Patients felt that they would be listened to should they need to complain. Learning was captured from complaints.

Are services well-led? Good

We rated the DCMH as Good for well-led because:

- The management team had developed well and had demonstrated clear and accountable leadership, staff reported that morale was very good and that they felt supported by their colleagues and the management team.
- Governance procedures had been strengthened and had brought about improvement at the service.
- Potential risks that we found had been captured within the risk logs and the common assurance framework. All risks identified included detailed mitigation and action plans.
- All areas of concern that we highlighted following our previous inspection had been addressed and the team was now delivering safe and responsive care.
- The team undertook audit and a quality improvement plan was in place which had driven a range of quality improvement projects to enhance patient care. Staff were fully engaged in this process.

Our inspection team

Our inspection team was led by a CQC Inspection Manager. The team included two inspectors who worked remotely and a specialist military mental health nursing advisor.

Background to Department of Community Mental Health – Plymouth

The department of community mental health (DCMH) at Plymouth provides mental health care to a population of over 16000 serving personnel from across all three services of the Armed Forces. The catchment for the service includes all service personnel based at establishments across the Southwest region covering Devon and Cornwall and a part of Dorset and Somerset, as well as service personnel aboard Plymouth based ships deployed around the world. In addition, the team work with those who have returned to the catchment area on home leave. The service operates from a main base at HMS Drake within HMNB Devonport in Plymouth.

The department aims to provide occupational mental health assessment, advice and treatment. The aims are balanced between the needs of the service and the needs of the individual, to promote the well-being and recovery of those individuals in all respects of their occupational role and to maintain the fighting effectiveness of the Armed Services.

At the time of our inspection the DCMH active caseload was approximately 275 patients.

The service operates during office hours. In line with defence policy there is no out of hours' service directly available to patients: instead patients must access a crisis service through their medical officers or via local emergency departments. The team participates in a National Armed Forces out of hours' service on a duty basis. This provides gatekeeping and procedural advice regarding access to beds within the DMS independent service provider contract with NHS providers. In addition, DCMH Plymouth also offers out of hours support to Royal Navy ships and Medical Facilities on a published rota system with the other two Naval situated DCHM's.

Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently, DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Surgeon General's office.

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information the DCMH and the Defence Medical Services had shared with us about the service. This included: risk registers and the common assurance framework, complaints and incident information, clinical and service audits, patient survey results, service literature, staffing details and the service's timetable.

We carried out an announced inspection between the 18 January and 11 February 2022. During the inspection, we:

- looked at the quality of the teams' environment;
- observed how staff were caring for patients;
- spoke with nine patients who were using the service;
- joined the patient experience forum;
- spoke with the management team;
- spoke with seven other staff members including doctors, nurses, social worker and administration staff;
- looked at ten clinical records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- examined minutes and other supporting documents relating to the governance of the service.

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Detailed findings

Are services safe?

Good

Our findings

Following our previous inspection, we rated the DCMH as requires improvement for providing safe services. We had concerns about the safety and capacity of the environment, staffing levels, training compliance and incident management.

When we carried out this follow up inspection, we found that all the above recommendations had been acted on. Following our review of the evidence provided, the DCMH is now rated as good for providing a safe service.

Safe and clean environment

- At the previous inspection the team had told us that their building based within the dockyard at HMS Drake at Devonport naval base had insufficient office and treatment space. Since then the team had been able to use additional rooms within the medical centre at the naval base. In addition, in line with Covid 19 precautions, treatment had predominantly been undertaken virtually to mitigate the risk of infection to patients and staff meaning the team had enough space to meet their needs. As the team was returning to more frequent face to face appointments measures had been put in place to make better use of the space available. The team had also developed a business case for alternative accommodation in the longer term. This was being considered as part of plans for an integrated medical centre at Devonport Naval Base.
- The environmental risk assessment and ligature point audit had been updated in 2021. The assessments highlighted the risk factors we observed including the presence of ligature anchor points and other relevant clinical environmental risks. Staff told us they mitigated these risks by escorting patients into and around the building at all times. In addition, the team had purchased ligature cutters and provided training to staff in their use and local guidance was provided to staff on managing environmental risks.
- The building was well maintained, and staff confirmed that the maintenance team would generally respond quickly to any maintenance request.
- General health and safety checks were in place. The health and safety team had reviewed the building including fire precautions in October 2021 and had confirmed that no specific actions were required. Staff had undertaken fire safety training and drills on a regular basis.

- Staff also had access to personal alarms for use in the event of an emergency. Lone working practices were in place including arrangements for logging which staff were in or out of the building. A policy for managing violence and aggression was in place and had been reinforced with staff following an incident where a patient became verbally aggressive in the waiting area.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Hand wash facilities and hand gels were available, and staff adhered to infection control principles, including handwashing. Cleaning and infection prevention audits were undertaken, and the building was found to be clean throughout. Appropriate systems based on national guidance had been put into place to manage the risks associated with Covid 19. This included the accessibility and use of personal protective equipment (PPE), Covid testing and safe distancing measures. Patients and visitors were assessed for Covid symptoms prior to entering the building.

Safe staffing

- At the time of the inspection, the clinical team totalled 18 people and consisted of medical, nursing, social work and psychology staff. At the last inspection staffing was at 60% against establishment. At this inspection the team had increased and there were only four vacancies. Long term locum staff covered the psychologist and social worker vacancies and recruitment was underway to fill two nursing posts. Staffing was sufficient to meet the demand of the service and as a result, despite increasing demand, waiting lists had reduced for all forms of treatment.
- The team benefited from a full-time practice manager and three administrators. The reception was staffed at all times and patients commented positively about the support they received from the administration team.
- All new starters, whether locum or permanent, were provided with induction training and a copy of the induction booklet.
- Up to thirty-five training courses were classed as mandatory dependent on role. At the time of the inspection overall compliance with training averaged 94%.

Assessing and managing risk to patients and staff

- Referrals came to the team from medical officers and other DCMHs. These were indicated as either urgent or routine. Urgent referrals were considered by the end of the next working day. The target to see patients for a routine referral was 15 days. The team had improved their response to referrals since the last inspection. A band 6 nurse was available each day to triage and determine whether a more urgent response was required for routine referrals. A duty worker was available each working day to respond to all urgent referrals. This role was ring fenced to ensure adequate response to referrals. Routine referrals were also clinically triaged by the duty nurse to determine whether a more urgent response was required.
- All fresh cases were taken to the multidisciplinary team meeting to assure an appropriate response. The team recorded all clinical risk and decisions made at the multidisciplinary team and operated a process to share concerns with colleagues about specific patients whose risks had increased. This included risks due to safeguarding concerns and all patients recently discharged from hospital. All at risk cases were discussed at multidisciplinary meetings. At the time of the inspection 11 people were considered high risk. Administrators were aware of these individuals and the need to ensure an immediate response where they made contact.
- The Ministry of Defence had a policy for safeguarding vulnerable adults however adult safeguarding was not yet part of the DMS's central training delivery. To address this the team had completed training available from the local authority. All staff had completed levels

one to three as required for their role. Child protection training levels one to three were mandatory for DMS staff as appropriate to their role. At the time of the inspection 95% of staff had undertaken training as appropriate to their role. The team demonstrated an understanding of safeguarding principles and practice and had made nine safeguarding referrals in the previous 12 months. Safeguarding concerns were discussed at governance and multidisciplinary team meetings.

- There were written procedures for response in a medical emergency. Staff had received annual basic life support, defibrillator and anaphylaxis training. The team had recently undertaken an emergency drill: the response time for this had been within resuscitation guidelines.
- Business continuity plans for major incidents, such as security threat, power failure or building damage were in place and had been updated to reflect the risks in relation to the Covid 19 pandemic. Appropriate actions had been taken in response to the Covid 19 pandemic to mitigate the risk of infection to patients and staff and to ensure the service could operate safely. Where appropriate, staff had worked at home to minimise risk however the team had offered both virtual and face to face appointments as necessary throughout the pandemic.

Reporting incidents and learning from when things go wrong

- During 2021, there were ten significant events recorded across the service. All events had resulted in low or no harm. The majority of these related to gaps in clinical recording and problems with the attend anywhere consultation system. All had been investigated appropriately and action was noted in response to all the events.
- The team used the standardised defence electronic system to report significant events, incidents and near misses. Staff received training at induction regarding the processes to report significant events. Staff were aware of their role in the reporting and management of significant events, incidents and near misses.
- Staff confirmed significant events were discussed at team and governance meetings including the outcome and any changes made following a review of the incident. Learning and recommendations were noted within the minutes of these meetings. Staff were aware of learning from previous events.

Are services responsive to people's needs?

Good

Our findings

Following our previous inspection, we rated the DCMH as requires improvement for providing responsive services. We had concerns about the team meeting assessment times and there were long waiting lists. In addition, we were concerned that the base that the team operated was not accessible to anyone with a physical disability and not at a convenient location.

When we carried out this follow up inspection, we found that all the above recommendations had been acted on. Following our review of the evidence provided, the DCMH is now rated as good for providing responsive services.

Access and discharge

- In line with DMS requirements the service operated during office hours only. There was no out of hours' service directly available to patients: instead patients had to access a crisis service through their medical officers or via local emergency departments.
- Clear referral pathways were in place. Referrals came to the team from medical officers, GPs and other DCMHs. These were indicated as either urgent or routine. Urgent referrals were considered by the end of the next working day. The target to see patients for a routine referral was 15 days. A band 6 nurse and duty worker were available each working day to review all new referrals. Routine referrals were clinically triaged by the nurse to determine whether a more urgent response was required. All fresh cases were also taken to the multidisciplinary team meeting to ensure an appropriate response.
- At the time of the inspection the team's active caseload was 275. There had been 137 referrals over the period September to November 2021. This was significant increase in referrals since the previous inspection. The team had made improvement to the referrals process to reduce the number of inappropriate referrals. This included clearer information for primary care staff and timelier and more consistent triage of referrals through the appointment of a referrals co-ordinator.
- Since January 2021, the DCMH had met the target for assessment following all urgent referrals. The team stated that they always had same day appointments for emergency referrals.
- The DMS performance target for assessment within 15 days following routine referral is 95%. Since May 2021 the team had met the target in 100% of cases in all months bar October 2021 when the team meet the target in 97% of cases. On further analysis by the team the missed targets related to recording errors rather than delayed assessments.
- To address waiting lists, the team audited a number of episodes of care which showed that staff capacity wasn't being fully used. Following this a tool was developed to monitor capacity with a goal of making the team more effective in reducing waiting list times and improving access to timely care.
- At the previous inspection patients commented that they had waited too long to commence treatment. At this inspection waiting lists had reduced and overall waiting times had decreased: twenty-five patients were waiting to commence step 2: the longest wait was 32 days. Nineteen patients were waiting for step 3 - high intensity therapy: the longest wait was 123 days. Three patients were awaiting specialist psychology treatment: the longest wait was 39 days. There were 29 patients waiting for psychiatrist appointments: the longest wait was 81 days. It was confirmed that all of those awaiting therapy were allocated to a care co-ordinator.

The facilities promote recovery, comfort, dignity and confidentiality

- The building was comfortable, well decorated and equipped. A waiting area was available for patients. Information was available on display about treatments, local services, patients' rights, and how to complain.
- Treatment rooms were adequately soundproofed to ensure privacy during treatments.
- The team was based within a grade II listed building within the dockyard at HMS Drake at Devonport naval base. The team occupied the top two floors of the building meaning the treatment and meeting rooms were not accessible to anyone with a physical disability. Where required the team used facilities within the medical centre at the dockyard which had full disability access.

Meeting the needs of all people who use the service

- The team could offer flexible appointment times during office hours. Patients confirmed that they were given time off to attend appointments and the chain of command was supportive of this.
- At the previous inspection some patients told us that the teams base was not at a convenient location due to travelling times and difficulty for them in accessing the base due to its security status. The team had proactively worked with the base commander to allow access through a gate close to the DCMH building. Patients confirmed that they were now able to access the dockyard easily. In addition, in line with Covid 19 precautions, treatment had predominantly been undertaken virtually to mitigate the risk of infection to patients and staff. Overall, patients had welcomed this and most stated that they wanted to continue this approach as it had cut down on travel to appointments and had allowed greater flexibility.
- Throughout the pandemic where required the team had maintained face to face appointments. The team was increasing their office presence at the time of the inspection to allow greater access to face to face appointments. The team undertook a patient experience audit in September 2021 which indicated that patients were happy with the level of access to the service. Patients we spoke with very positive about the service they had received throughout the pandemic.

Listening to and learning from concerns and complaints

- The team had a system for handling complaints and concerns. The practice manager was the designated person responsible for managing all complaints. A policy was in place and information was available to staff. Staff demonstrated awareness of the complaints process and had supported patients to raise concerns.
- Patient waiting areas had posters and leaflets explaining the complaints process. Patients spoken with during the inspection understood how to make a complaint and all felt they would be listened to if they complained.
- In the 12 months prior to our inspection, there had been one formal complaint which when investigated was reclassified as a service complaint. The team supported the patient with this process.
- During 2021, the team had received 10 written compliments about the service. During this inspection we received feedback from nine patients: throughout we heard very positive comments about the staff, and the service patients had received.
- Staff received feedback on complaints and investigation findings during business and team meetings. We saw evidence of information sharing in meeting minutes.

Are services well-led?

Good

Our findings

At the previous inspection we rated well led as good however recommended that the DCMH make improvement in some areas. We had asked the team to address the following issues:

- Staffing shortages had limited the capacity of the management team to provide clear clinical leadership.
- We had found some areas of practice that required further oversight and improvement.

- Staff reported that morale was good however that staffing levels significantly had impacted on their workload.
- While supervision was occurring the recording of this was poor, meaning that the management team could not be assured that staff were appropriately supervised.

When we carried out this follow up inspection, we found there had been improvement regarding all our recommendations. Following our review of the evidence provided, the DCMH has retained the rating of good for providing well-led services.

Good governance

- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. The team had a monthly business and governance meeting which all staff attended. In addition, weekly business meetings and multidisciplinary meetings considered areas of governance and practice. Minutes for these meetings showed the service had improved its governance and administration procedures since our previous inspection.
- Effective systems and processes had been set up to capture governance and performance information. Local processes had been developed, including incident and complaints procedures, training and supervision logs and local procedures for managing referrals and safeguarding. The management team had access to detailed information about performance against targets and outcomes.
- The common assurance framework (ECAF), is a DMS structured self-assessment internal quality assurance process, which should form the basis for monitoring the quality of the service. We found that this document was up to date and all issues and risks relevant to service had been incorporated in the document. An update in the form of a progress report on the ECAF and associated action plan was submitted to the regional headquarters on a regular basis.
- Risk and issues were reviewed monthly or as identified and logged on the regional headquarters and local risk and issues registers. The risk and issues logs included key concerns such as infrastructure and environmental risk, fire risk, staffing, Covid working arrangements and information management issues. All risks included detailed mitigation and action plans. All potential risks that we found had been captured within the risk and issues logs and the common assurance framework.
- We found that the DCMH had made positive improvements since our previous inspection and had addressed all areas of previous concern. Improvements included:

    - The team was now almost fully staffed and sufficient to meet the needs of patients. Vacancies were being covered by long term agency staff while recruitment was undertaken.
    - Mandatory training rates were at 94% and staff had undertaken required supervision.
    - Work had been undertaken to ensure appropriate reporting of and capture learning from adverse events and had led to changes in practice. The team had built a positive and open safety culture and there had been minimal negative events.
    - Work had been undertaken to improve the safety of the environment and arrangements were in place to meet the needs of patients who had a physical disability.
    - The team had improved arrangements to assess patients following referral. Despite a significantly increased caseload the team had met the response target for urgent and routine referrals and waiting lists for treatment had reduced.

- Patient experience was very good and had improved since our previous inspection. Patients were positive about the service they had received throughout the pandemic. Most patients felt they had benefited from virtual treatment which they had found more convenient and wished to maintain this approach.

Leadership, morale and staff engagement

- The management team consisted of a clinical lead, a department manager, a deputy department manager, a practice manager and a lead psychologist. The clinical lead and the practice manager had joined the team in 2021. The management team had developed well and had demonstrated clear and accountable leadership, staff reported that morale was very good and that they felt supported by their colleagues and the management team. Staff told us that the management team provided clear clinical leadership.
- All staff attended team meetings and monthly governance meetings. Staff undertook key governance lead roles and told us that new developments were discussed at these meetings and they were offered the opportunity to give feedback on the service.
- Staff reported that there had been no bullying at the team. A whistleblowing process was in place that allowed staff to go outside of the chain of command. Staff knew about the whistleblowing process and said they would feel confident to use this. There had been no formal reported cases of whistleblowing or bullying at the team and no referrals to the Freedom to Speak Up Guardian in the previous six months.

Commitment to quality improvement and innovation

- The team undertook a wide range of audits including patient satisfaction, caseload management and notes audits, safeguarding, supervision, infection prevention and control and Covid management, patient pathways and access to the service, health and safety and ligature audits. Audit results and learning were shared with staff and presented to the governance committee and used to manage change.
- To address waiting lists, the team audited a number of episodes of care which showed that staff capacity wasn't being fully used. Following this a tool was developed to monitor capacity with a goal of making the team more effective in reducing waiting list times and improving access to timely care.
- Following an audit of patient pathways conducted in May 21, the team had reorganised the administration so that consultants had dedicated support from a named administration team member, who manage and reviewed their caseloads, patient taskings and booking of appointments, thus reducing delays to the patient care pathways.
- The team had improved their response to referrals through allocating a dedicated band 6 nurse to triage routine referrals and a duty worker available each day to respond to all urgent referrals. In addition, the team had worked with medical officers to ensure that referrals where appropriate and that early interventions (step 1) were made available within primary care. Since there had been a 30% reduction in inappropriate referrals.
- The team had developed a local supervision policy and recording system. Training was provided to staff to introduce the policy and recording template. This had provided the management team with assurance that supervision was being undertaken and supervision levels had increased.
- The team had set up a patient forum in September 2021. We attended a meeting during our inspection and found that patients valued this opportunity to feedback on the service and felt listened to.