Defence Medical Services

Department of Community Mental Health – Bulford

Quality Report

Bulford Healthcare Facility
Kandy Road
Bulford
Salisbury
SP4 9AA

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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?	Outstanding

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 well-led? – Outstanding

We previously carried out an announced comprehensive inspection of the Department of Community Mental Health - Bulford in July 2019 (when the team was based in Tidworth Garrison). The DCMH was rated as requires Improvement overall, with a rating of requires Improvement for the key questions of safe and well-led. The domains of effective, caring and responsive were rated as good. A copy of the report from that comprehensive inspection can be found at:

https://www.cqc.org.uk/sites/default/files/20191002_DMS_DCMH_TIDWORTH.pdf

This report describes our judgement of the quality of care at the Department of Community Mental Health Bulford. 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 27 and 28 July 2021. At this inspection we have focused on the domains of safe and well led to see what improvement has been made against the recommendations made following the previous inspection.

We found the following areas of good practice:

- We found that there was clear and accountable leadership at DCMH Bulford, and staff reported that morale was very good at the team.
- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. Effective systems and processes had been set up to capture governance and performance information. 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 care. The team had implemented safe systems and processes to ensure clear clinical risk oversight of patients.
- The team had developed a clearer operating model and referral pathway. Despite an increase in caseload the team had met the response target for urgent and routine referrals and waiting lists for treatment had reduced.
- Staff had a good awareness of safeguarding procedures and practice. Staff had reported all relevant events and appropriate action had been taken to investigate and learn from these and was used to drive a safety culture.
- A range of quality improvement projects were being undertaken to enhance patient care and the team demonstrated a number of areas of outstanding practice.
- The team had moved to a well-designed single healthcare facility which fully met health and safety standards and was conducive to patient dignity and wellbeing.

- 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 and effectively.

However, the Chief Inspector of Hospitals recommends that the DCMH addresses the following:

- Despite recruitment attempts, there were vacancies for two psychiatrists at the service. The service remained safe through external support however we were concerned about the long-term impact of this deficit.

Professor Edward Baker
Chief Inspector of Hospitals

Are services safe?

Good

We rated the DCMH as good for safe because:

- The team had implemented safe systems and processes to ensure clear clinical risk oversight of patients. All referrals were clinically triaged to determine whether a more urgent response was required and to monitor whether patients' risks had increased. Individual patient risk assessments were thorough and proportionate to patients' risks. The team had developed a process to share concerns about patients in crisis or whose risks had increased. We saw good evidence of the team reviewing risks through the multidisciplinary team and following up on any known risks.
- Overall staffing arrangements were sufficient to meet the needs of patients. Previously a lack of administration staff had significantly impacted on clinicians' workload due to covering reception and completing administrative tasks. This had been fully addressed at this inspection and the team was well resourced in this function. Staff had undertaken all required training.
- Staff had a good awareness of safeguarding procedures and practice. Staff had reported all relevant events and appropriate action had been taken to investigate and learn from these and was used to drive a safety culture.
- The team had moved to a well-designed single healthcare facility which fully met health and safety standards and was conducive to patient dignity and wellbeing.
- 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.

However:

- Despite recruitment attempts, there were vacancies for two psychiatrists at the service. The service remained safe through external support however we were concerned about the long-term impact of this deficit.

Are services well-led?	Outstanding

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

- We found that there was clear and accountable leadership at DCMH Bulford. Leaders were capable and resourceful and worked well together to ensure safe and effective care to patients.
- Staff reported that morale was very good at the team. This had been a positive improvement since our last inspection. Staff reported that they felt supported by their managers and colleagues and stated that the management team were approachable and highly supportive of their work.
- Staff were clear regarding the aims of the service and supported the values of the team. Staff were positive about the improvement at the service and felt this was making a positive difference to the quality of care offered to patients.
- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. Effective systems and processes had been set up to capture governance and performance information and this was used to drive positive change.
- 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 effective care.
- The team had developed a clearer operating model and referral pathway. Despite an increase in caseload the team had met the response target for urgent and routine referrals and waiting lists for treatment had reduced significantly.
- A quality improvement plan was in place and had driven a range of quality improvement projects to enhance patient care. The team demonstrated a number of areas of outstanding practice.

Our inspection team

Our inspection team was led by a CQC Inspection Manager Lyn Critchley. The team included two inspectors and an assistant inspector who conducted remote interviews with staff. A defence specialist advisor was also available remotely to support the team where required.

Background to Department of Community Mental Health – Bulford

The Department of Community Mental Health (DCMH) at Bulford provides mental health care to a population of approximately 26,000 serving personnel from across all three services of the Armed Forces. Since our previous inspection of the service in July 2019 the overall population served had increase by approximately 8000 personnel due to the relocation to the catchment of military personnel who had returned from bases in Germany. The catchment for the service includes all service personnel based at 12 military establishments across the South West of England and those who have returned to the catchment area on home leave. The service had previously been based at Tidworth Garrison but had moved to a main base at Bulford Camp Healthcare facility in August 2020.

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 518 patients. This had increased by over 100 patients since our last inspection of the service.

The service operates during office hours. 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.

Why we carried out this inspection

The 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 CQC's observations and recommendations. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare Regulator for the DMS.

How we carried out this inspection

As this was a follow-up inspection, we focused on the two key questions where improvements were required. The key questions for this inspection were:

• Are services safe?
• Are services 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 27 and 28 July 2021 and interviewed staff between the 27 and 30 July 2021. During the inspection, we:

- looked at the quality of the teams' environment;
- observed how staff were caring for patients;
- spoke with the clinical lead, management team and the regional director;
- spoke with 14 other staff members including doctors, nurses, psychologists, social workers and administration staff;
- joined the multi-disciplinary team meeting;
- joined the management team meeting;
- looked at six 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.

Defence Medical Services

Department of Community Mental Health – Bulford

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 staff capacity, clinical risk management, whether all patients at risk had been followed up appropriately and the management of and learning from significant events.

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 safe services.

Safe and clean environment

- The team had moved from its previous premises at Tidworth Garrison to a purpose-built healthcare facility at Bulford Camp in August 2020. This had brought the team together under one roof with a range of other primary care services. The building was close to, but outside the main perimeter of Bulford Camp making it easily accessible to all patients. The building had been built to NHS standards and was well decorated and equipped, and fully accessible to anyone with a physical disability.
- General health and safety and fire safety checks were in place. There was an environmental risk assessment in place supported by local guidance for staff in managing environmental risks. The DCMH team had undertaken a detailed ligature anchor point audit and action plan on behalf of the facility. Staff mitigated potential ligature risks through meeting patients within the reception and escorting them around the building at all times.
- 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 regularly, 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) and Covid testing.

Safe staffing

- The clinical team consisted of medical, nursing, psychology and social work staff. At the time of our inspection the team totalled 27 people. There were seven vacancies, including two military nurses, a social worker and two part time psychologists. In the interim locum staff covered nursing and social work vacancies and recruitment was underway for the psychologist posts. Two additional band 7 nursing posts had recently been filled. There were two full-time consultant psychiatrists, one who was also the clinical lead however the service had vacancies for a further two psychiatrist posts. The regional management team had attempted to fill these posts and recruitment remained open. To mitigate this risk additional support had been provided through remote appointments with an external psychiatrist and the regional management team was exploring options to employ specialty registrars at the time of the inspection. However, we were concerned about the long-term impact this may have on the service and the medical team.
- When we previously inspected there had been a significant shortage of administration staff and there was a gap in the practice manager's post. This had significant impact on clinical staff's workload due to manning the reception and undertaking their own administration. Since the move to the new healthcare facility in August 2020 the administrative function had been reorganised. The facility employed a senior practice manager and the team had its own office manager. The facility employed a shared administrative and reception team and was well resourced in this function.
- All new starters whether locum or permanent were provided with induction training and a copy of the induction booklet.
- At the time of the inspection overall mandatory training compliance averaged 84%. We saw that regular locum staff received training similar to permanent staff.

Assessing and managing risk to patients and staff

- When we had previously inspected the service, we had been concerned about clinical risk management, whether all patients at risk had been followed up appropriately and there was not a clear process to manage clinicians' caseloads in their absence. This meant there had been a risk of patients not receiving treatment. At this inspection we found that team had addressed these concerns and had implemented safe systems and processes to ensure clear clinical risk oversight of patients.
- The team had reviewed its operating model and referral pathway which had led to the development of a separate team to enable a timelier response to assessment of new patients. Referrals came to the team from medical officers and 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 met the target for assessing new patients in the six months to June 2021.
- Once a patient was accepted by the team a risk assessment was undertaken. The team had undertaken significant training in clinical risk management and had introduced additional risk management tools for use where a patient was considered at risk of self-harm. In all cases we reviewed we found that risk assessments were in place and addressed all known concerns. We saw good evidence of the team following up on any known patient risks.
- All fresh cases were also taken to the weekly multidisciplinary team meeting to assure an appropriate response. The team had developed a risk pro-forma to record 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. All at risk cases were discussed at weekly multidisciplinary meetings. The team had undertaken a multidisciplinary team and risk proforma audit in May 2021 which showed that 100% of all proformas were completed appropriately.

- The team had also implemented a process to ensure that clinician's caseloads where managed and risks taken to the multidisciplinary team in their absence. The primary health care team had also introduced a process to ensure that patients on the waiting list were contacted and risk assessed on a regular basis.
- The team participated in unit health committees where patients had agreed to this. This is a collaborative base wide approach to managing increased risks. The team had attended 95% of unit health committees in the previous 12 months and was able to demonstrate positive comments from base commanders as a result of this work.
- Where a known patient contacted the team in crisis, the team responded swiftly. Staff confirmed easy access to a psychiatrist should a full assessment be required.
- The Ministry of Defence had introduced a policy for safeguarding vulnerable adults however adult safeguarding was not yet part of the DMS's mandatory training requirements. To address this the social worker had delivered a training session for staff on safeguarding awareness and arrangements were also being made for staff to complete training available from the local authority. The social worker had also developed a local procedure for reporting adult safeguarding concerns. Child protection training levels one to three were mandatory for DMS staff as appropriate to their role. At the time of the inspection staff had undertaken training as appropriate to their role. The team demonstrated an understanding of safeguarding principles and practice.
- Lone working arrangements were in place and arrangements were in place for logging which staff were in or out of the building at the team's base.
- The DCMH did not dispense medication. On a rare occasion the consultant psychiatrist would prescribe medication but usually this was undertaken via a recommendation to the patient's medical officer who prescribed the medication. Appropriate arrangements were in place for the safe management of prescribing. No delays were reported in patients receiving their medication. The team planned to undertake an audit of prescription management.
- There were written procedures for response in a medical emergency. Staff had received annual basic life support, defibrillator and anaphylaxis training. An automatic external defibrillator (AED) and emergency medication were available and accessible in the event of a medical emergency.
- 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 where necessary throughout the pandemic.
- At the time of the inspection the service experienced a major IT issue which had meant that the business continuity plan had been put in to action. The staff had worked from home and various other medical facilities and had maintained planned appointments throughout.

Track record on safety

- At our previous inspection we had been concerned about the reporting and management of significant events. At this inspection we found that staff had reported all relevant events and that appropriate action had been taken to investigate and learn from these. Between January and June 2021 there were 31 significant events recorded across the service. This was an increase on the previous year however the management team confirmed that they had encouraged a positive reporting culture and that the threshold for reporting was lower than previously.

- All events recorded had resulted in low or no harm, a number of which were downgraded from the automated significant event reporting process (ASER) as they fell below the threshold for reporting following initial triage. The majority of these related to gaps in clinical recording that had been noted through audit and to poor administration processes.
- During the inspection there were two significant events in relation to former DCMH patients. These events were subject to investigation through the DMS ASER process managed through primary care services. The team had worked hard to ensure the timely availability of relevant information in relation to these matters.

Reporting incidents and learning from when things go wrong

- The team used the standardised DMS electronic system to report significant events, incidents and near misses. Staff received training at induction regarding the process to report significant events and had received refresher training. Staff were aware of their role in the reporting and management of incidents.
- Findings from ASERs were reported at management team meetings and to staff at governance and team meetings. The team had implemented a process where two staff worked together on all investigations. This was to widen learning and to ensure rigour in investigation. Staff confirmed that there had been improvement in shared learning from significant events and that these were discussed at meetings including the outcome and any changes made following a review of the event. Learning and recommendations were noted within the minutes of these meetings. Staff were aware of learning from previous events and what actions had been taken to address the risks.
- The team provided an example of positive action following a significant event which had resulted in the clinical lead offered training to medics working across primary care practices regarding the application of the Mental Health Act and the management of patients during a crisis.

Are services well-led?

Outstanding

Our findings

Following our previous inspection, we rated the DCMH as requires improvement for being well-led. We had concerns about leadership and poor morale at the service. Governance procedures had not fully captured risks or brought about a safe service.

When we carried out this follow up inspection, we found there had been clear and sustained improvement in regard to the above recommendations. Following our review of the evidence provided, the DCMH is now rated as outstanding for providing well-led services.

Vision and values

- The DCMH leadership team told us of their commitment to deliver quality care and promote good outcomes for patients. The team's mission was:

  "To deliver a safe and effective mental healthcare service for Defence in order to enhance and sustain the operational effectiveness of the three Services".

- Staff were positive and clear about the team's purpose and their individual role in delivering the vision and values of the service. Since our previous inspection, the team had changed the operating model and separated in to the assessment and treatment teams. Staff were clearer about their roles in delivering the care pathway and this had promoted a more efficient response to patients.

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. The meeting considered good practice guidelines, policy development, risk issues, learning from complaints and adverse events, team learning and service development. 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 (CAF), 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 CAF and associated action plan was submitted to the regional headquarters on a regular basis.
- The department manager was the nominated risk manager. 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 psychiatrist vacancies, Covid working arrangements and IT infrastructure 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 significant improvement since our previous inspection and had addressed all areas of previous concern. Improvements included:
    - The management team had developed well and had demonstrated clear and accountable leadership, staff reported that morale was very good at the team.
    - The team had developed a clearer operating model and referral pathway. Despite an increase in caseload the team had met the response target for urgent and routine referrals and waiting lists for treatment had reduced significantly.
    - When we had previously inspected the service, we had been concerned about clinical risk management, whether all patients at risk had been followed up appropriately and there was not a clear process to manage clinicians' caseloads in their absence. At this inspection we found that team had addressed these concerns and had implemented safe systems and processes to ensure clear clinical risk oversight of patients.
    - At our previous inspection we had been concerned about the reporting and management of significant events. At this inspection we found that work had been undertaken to capture learning from adverse events and had led to changes in practice and the team had built a positive and open safety culture
    - Previously a lack of administration staff had significantly impacted on clinicians' workload due to covering reception and completing administrative tasks. This had

been fully addressed at this inspection and the team was well resourced in this function.
    - Patient experience was very good and improved since our previous inspection.
    - The team had moved to a well-designed single healthcare facility which fully met health and safety standards and was conducive to patient dignity and wellbeing.
    - Complaint processes had not been well managed at our previous inspection. This had been fully addressed and the team had received just one complaint during 2021. The team had received a significant number of compliments during the same period.
- Partnership working with other parts of the defence medical services, NHS and voluntary groups was very effective. The team was actively involved in the unit health committees to ensure effective support to their patients. The team actively engaged with stakeholders to gather feedback about the service and make necessary improvements.

Leadership, morale and staff engagement

- At the previous inspection we had found that leadership arrangements were not effective, and that roles and accountabilities were unclear. Since then, the management team had changed. An experienced department manager had joined the team and the clinical lead had been confirmed in post. The team was supported by a permanent practice manager and a deputy department manager. At this inspection, we found a clear and effective management structure in place. Leaders worked well together and demonstrated high levels of experience, capability and resourcefulness to deliver safe and effective care to patients.
- The management team had established clearer roles and responsibilities. Staff were clearer regarding their manager's and their own roles and responsibilities. Management lines had been reviewed to ensure clearer accountability. Clearer job plans, objectives and expectations had been set for the team.
- Morale had significantly improved at the service. At the previous inspection staff had reported poor morale that had not been appropriately addressed. All the staff we spoke with during this inspection stated that they now felt part of a cohesive team and that they were engaged in the development of the service. Staff were positive about the leadership team, confirming leaders were approachable, highly supportive of their work and went above and beyond to support them. Staff stated a high level of satisfaction with their work and the functioning of the team. Staff told us that they were passionate about their work and proud to work in the team. A number of military staff had requested to continue their role at the team when they were due to be rotated to other services.
- The management team had undertaken the Health and Safety Executive (HSE) Management Standards Indictor Tool to gauge staff satisfaction since 2019. This was repeated every six months and has shown increasingly improving levels of staff satisfaction since 2019.
- Staff confirmed that there had been clear and supportive working arrangements throughout the Covid pandemic. The team had developed and updated risk assessments and business continuity plans for the management of Covid-19 throughout the pandemic and had ensured that the staff had access to IT to enable homeworking, PPE and access to Covid testing. The team had worked effectively and safely through rotational office working meaning they could offer both virtual and face to face appointments where necessary.
- Staff had access to regular professional development and clinical supervision. In July 2021 all staff had received clinical supervision appropriate to their role. All staff attended team meetings, governance meetings and weekly multidisciplinary meetings. Staff told us that service developments were discussed at these meetings and they were offered the opportunity to give feedback on the service and input into service development. Staff valued being part of working groups and took lead roles in supporting the improvement agenda.

- A whistleblowing process was in place that allowed staff to go outside of the chain of command. Staff also had access to a Freedom to Speak Up Guardian (FTSU). Staff knew about the whistleblowing and FTSU processes and all stated they would feel confident to use these should they need to. There had been no formal reported cases of whistleblowing or bullying at the team in the previous year.
- During this inspection, we met with the acting regional director. She acknowledged the significant improvement at the service and confirmed high level support to the team to address emerging risks and aid development. The DCMH leadership team confirmed that the regional leadership team was supportive of their work.

Commitment to quality improvement and innovation

- The team had a detailed quality improvement plan in place and could evidence that there had been significant improvement at the service since the last inspection. There was evidence of improvement to the clinical pathway, clinical risk management processes, multidisciplinary working and to the governance structure. The team was also undertaking quality improvement projects and addressing any potential risks as they arose. The following is a summary of additional improvements and good practice we identified:
  - The team worked with a wide range of partner organisations to support patients and supported units via Military Unit Health Committees. The team had attended over 90% of meetings in 2021 and a team member received a General Officer Commanding's Commendation for outstanding work in supporting Unit Health Committees.
  - Following an incident that was reported through the ASER system the clinical lead offered training to medics working across primary care practices regarding the application of the Mental Health Act and the management of patients during a crisis. This session was extremely well attended and received positive feedback. As a result, the clinical lead will deliver a second session during the autumn.
  - One of the team was awarded the Burroughs Cup in June 2021, this award is given to the Army's registered nurse who has contributed most in the field of mental health nursing to enhance patient care.
  - Two team members were released to support an operation in Estonia to work with army units who were experiencing a spike in mental health presentation.
  - 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, patients with emergency health needs access to prompt care, access to services, 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.