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

<table>
<thead>
<tr>
<th>Overall rating for this service</th>
<th>Requires improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are services safe?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services effective?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services caring?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services responsive to people’s needs?</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Requires improvement</td>
</tr>
</tbody>
</table>
We carried out an announced inspection at Department of Community Mental Health – RAF Brize Norton (DCMH) on between 17 and 19 October 2017. Overall, the service is rated as Requires improvement. Our key findings across all the areas we inspected were as follows:

- The team consisted of a full range of mental health disciplines working collaboratively 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 collaborative clinics and group work sessions had improved treatment options for patients and had also addressed waiting list issues.
- Staff acknowledged that major improvements had occurred over the previous 12 months.
- Staff reported that the management team were approachable and supportive of their work. Staff morale had improved and they were proud to work at the service. Staff were very positive about their role in delivering the vision and values of the service.
- Staff showed us that they wanted to provide high quality care. We observed some very positive examples of staff providing practical and emotional support to people. Patients said they were well supported and that staff were kind and enabled them to get better.

The Chief Inspector of Hospitals recommends:

- Governance processes were in place however some issues remained unresolved. In a number of cases the RHQ had not offered sufficient support to the DCMH to address key issues, including staffing, the environment and critical human resources issues.
- Not all risks that we found had been captured within the risk and issues logs or reflected within the common assurance framework.
- Routine referrals were not clinically triaged by the mental health team to determine whether a more urgent response was required or to monitor that patients’ risks had not increased. We were concerned about the lack of oversight of people’s welfare at the point of referral and the subsequent effects this may have on their mental health.
- Not all relevant incidents had been recorded as serious events. Two allegations of inappropriate behaviour by locum staff had been escalated to the Regional Headquarters. However, these had not been reported to the appropriate registration bodies by the Regional Headquarters.
- The DCMH facility was not conducive to a therapeutic environment. Conversations could be heard through walls and the rooms were dated and not comfortable. The Disability Discrimination Act was not being considered. These issues had not been resolved despite the
team escalating these concerns.

- Safety alarms were not working and we were concerned about lone working arrangements.
- Staffing levels hampered the team’s ability to fully develop governance systems. Recruitment had proved challenging and had not been supported by the DMS recruitment team.
- The management system for prescriptions had failed to ensure clear oversight.

Professor Ted Baker
Chief Inspector of Hospitals
## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

The practice is rated as requires improvement for providing safe services.

- Routine referrals were not clinically triaged by the mental health team to determine whether a more urgent response was required or to monitor that patients’ risks had not increased. We were concerned about the lack of oversight of people’s welfare at the point of referral and the subsequent effects this may have on their mental health.

- Not all relevant incidents had been recorded as serious events. Two allegations of inappropriate behaviour by staff had been escalated to the Regional Headquarters. However, these had not been reported to the appropriate registration bodies by the Regional Headquarters.

- There was no clinically based risk assessment of the environment to consider relevant risk factors.

- Safety alarms were not working and we were concerned about lone working arrangements.

- Staffing levels hampered the team’s ability to fully develop governance systems. Recruitment had proved challenging and had not been supported by the DMS recruitment team.

- Staff failed to ensure prescriptions were held securely and accounted for.

- Not all staff had completed necessary mandatory and statutory training.

- Adult safeguarding training was not mandatory and the policy did not reflect the latest legislative guidance.

- Not all relevant incidents had been recorded as serious events.

- Individual patient risk assessments were thorough and proportionate to patients’ risks.

- The team had developed a ‘worries list’ to better support patients in crisis.

---

**Requires improvement**
• Most incidents reported had been appropriately investigated and used to inform practice.
• Training available to staff was of a high quality.

Are services effective?
The practice is rated as good for providing effective services.

• Clinicians were aware of current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Patients were able to access a range of psychological therapies as recommended in NICE guidelines.
• The team used a range of outcome measures throughout and following treatment. These indicated improved outcomes following treatment.
• The team consisted of a full range of mental health disciplines working collaboratively 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.
• Staff received appropriate supervision and were able to access developmental training.
• We were concerned that locum staff did not get timely access to patient records which hampered their ability to begin work with patients.
• Consent was not always clearly documented and could be open to misinterpretation.
• There were no procedures and training for staff regarding the application of the Mental Health Act and the Mental Capacity Act.

Are services caring?
The practice is rated as good for providing caring services.

• Staff showed us that they wanted to provide high quality care. We observed some very positive examples of staff providing practical and emotional support to people.
• Patients said they were well supported and that staff were kind and enabled them to get better. Patient satisfaction was also demonstrated by positive patient experience survey results and by the minimal level of complaints.
• Staff understood confidentiality and this was maintained at all times.
• Care plans were not routinely given to patients. In practice, plans were in existence but verbally agreed. In complex
cases patients may benefit from a written reminder of the treatment goals.

**Are services responsive?**

The practice is rated as requires improvement for providing responsive services.

- The team was not meeting its targets for urgent and routine referrals. This had improved over previous months since the introduction of the new ways of working.
- The DCMH facility was not conducive to a therapeutic environment. The Disability Discrimination Act was not being considered and dignity and privacy were compromised. These issues had not been resolved despite the team escalating these concerns.
- Staff had developed group work, such as ‘skills and drills’ and anxiety management, in response to previous waiting lists. This work had successfully offered real solutions to patients who needed timely practical intervention.
- The introduction of collaborative clinics had improved treatment options for patients and had also addressed waiting list issues.
- Where a known patient contacted the team in crisis during office hours the team responded positively.
- The team monitored the length of the care pathway. In 82% of cases patients were discharged within nine months of commencing treatment.
- 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?**

The practice is rated as requires improvement for providing well-led services.

- Governance processes were in place however a number of issues remained unresolved. In a number of cases the RHQ had not offered sufficient support to the DCMH to address key issues, including staffing, the environment and critical human resources issues.
- Not all risks that we found had been captured within the risk and issues logs or reflected within the common assurance framework.
- The follow up of some complaints had been poor. Two allegations of inappropriate behaviour by staff had been
escalated to the Regional Headquarters, but had not been reported to the appropriate registration bodies by the Regional Headquarters.

- Staffing levels hampered the team's ability to fully develop governance systems.
- The service had improved its governance and administration procedures over the previous twelve months. Systems were being set up to better capture governance and performance information.
- Staff acknowledged that major improvements had occurred over the previous 12 months.
- Staff were positive and clear about their role in delivering the vision and values of the service.
- Staff reported that the management team were approachable and supportive of their work. Staff morale had improved and they were engaged, enthusiastic and proud to work at the service.
Our inspection team

Our inspection team was led by a CQC Head of Inspection Julie Meikle and Inspection Manager Lyn Critchley. The team included two inspectors and a specialist military mental health nursing advisor.

Background to Department of Community Mental Health – RAF Brize Norton

The department of community mental health (DCMH) at RAF Brize Norton provides mental health care to a population of approximately 15,000 serving personnel from across all three services of the Armed Forces. The catchment area includes bases across Oxfordshire, Wiltshire, Buckinghamshire, Gloucester and South Wales. At the time of the inspection a satellite service based at St Athan in South Wales was providing a minimal service due to staffing needs. At this time staff offered a small number of sessions at St Athan with the majority of patients travelling to Brize Norton to receive their service. At the time of our inspection the DCMH caseload was approximately 450.

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. The service is clinic based with the majority of appointments being held at the clinic at Brize Norton.

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 GPs 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 trusts.

RAF personnel within the team also form part of Tactical Medical Wing. On a duty basis they may be required to perform psychiatric aeromedical evacuation of overseas Armed Forces personnel.

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.

We carried out a comprehensive inspection of this service. The Department of Community Mental Health – RAF Brize Norton was not subject to a CQC inspection as part of the previous inspection programme of DMS facilities.

How we carried out this inspection

Before visiting, we reviewed a range of information 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 17 and 19 October 2017. During the inspection, we:

- looked at the quality of the team’s environment.
- observed how staff were caring for patients.
- spoke with 12 patients who were using the service.
- spoke with the management team and the regional headquarters.
- spoke with 12 other staff members; including doctors, nurses, a psychologist and the social worker.
- visited the onsite pharmacist.
- reviewed five comment cards from patients.
- looked at 10 clinical records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the service.
- observed two collaborative clinics and one group session.
- examined minutes and other supporting documents relating to the governance of the service.

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?
Are services safe?

Our findings

Safe and clean environment

- General health and safety and fire safety checks were in place. However, there was no clinically based assessment of the environment to consider relevant risk factors. Risks noted included staff lone working in a building that was shared with another team and had open access to any visitors. There was also no mechanism to make staff aware of potential ligature anchor points that were present in the building.

- Dignity and privacy were also compromised by the shared use of the facility with another RAF function and poor soundproofing in areas. The team’s management had escalated these issues to regional operations, however, they were yet to be resolved.

- The building was fitted with a safety alarm for staff to use in the event of an emergency. However, when tested at the inspection, it did not work.

- There was no clinic room as physical health examinations were undertaken by the GP services and were not carried out at the DCMH base.

- The practice manager told us that there had been problems with cleaning when she came to the service. This had improved following a meeting with the contractors responsible for cleaning and monitored by regular audit. We found that the building was tired and dated in places but was clean.

- The team had an infection prevention and control nurse and staff received infection prevention training. Hand wash facilities and hand gels were available and staff adhered to infection control principles, including handwashing.

- An equipment log was in place. Equipment such as the eye movement desensitization and reprocessing (EMDR) sensors where found to be clean and had been serviced. Portable appliance testing had been undertaken.

Safe staffing

- At the time of our inspection, staffing arrangements at the team were insufficient. There were a number of posts unfilled. Information provided showed that there were six nursing vacancies from the establishment of 17 posts: this equated to 35% vacancies. The establishment required three consultant psychiatrists, however, at the time of the inspection one post was vacant and a further doctor was on long term training and would not return to the team until November 2017. The team also had two social work posts that were vacant.

- The management team explained that following a DMS review in 2015 (DMS 20) a decision was made to employ civilian staff to support military staff to aid consistency within services. However, recruitment to posts had been a challenge and had meant high use of locum staff.
the time of our inspection there were three locum nurses, one locum psychiatrist and one locum social worker. The management team explained that there could be significant delays in the recruitment process. On occasion this had led to the loss of employable candidates. The team was mitigating these high vacancy rates with the use of regular locum staff where possible.

- Managers told us that due to the use of locums and deployment issues there had been more than 50 different staff who had worked at the team over the previous four years.

- At the time of the inspection the team’s caseload was 428. Fifteen people were awaiting allocation to a care coordinator. Ninety-nine patients were attending group activities and did not have a care co-ordinator. All clinical members of the team were assigned a caseload. The average caseload was 22 cases per care co-ordinator but caseloads ranged between four and 31.

- At the time of the inspection a satellite service based at St Athan in South Wales was not operational due to staffing shortage. At the time of the inspection staff offered a small number of sessions at St Athan, with the majority of patients travelling to Brize Norton to receive their service.

- Caseloads were managed and reassessed regularly. Patients and staff told us that there was rapid access to a psychiatrist when required. However, staff explained that this had been achieved through a reorganisation of the care pathway. Staff stated that they were stretched and there were aspects of the service, such as governance and their personal development, that were challenged due to staffing levels.

- The overall average mandatory training rate for staff was 61%. Twenty-two courses were classed as mandatory. We saw that regular locum staff received training similar to permanent staff. The team had recently designated a training lead. He explained that his first role was to collate all training records. He confirmed that this was still in progress and that he believed actual training levels were higher than those recorded. Information provided indicated that training compliance ranged from 100% for Caldecott level 3 to 29% for healthcare governance awareness.

Assessing and managing risk to patients and staff

- Referrals came to the team from medical officers, GPs and other DCMHs. These were indicated as either urgent or routine. Urgent referrals would be considered by the end of the next working day. The target to see patients for a routine referral was 15 days. A duty worker was available each day to review and follow up urgent referrals. However, we had concerns that routine referrals were not clinically triaged by the mental health team to determine whether a more urgent response was required or to monitor that patient’s risks had not increased.

- Once a patient was accepted by the team a thorough risk assessment was undertaken and this was reviewed by the multi-disciplinary team. The team operated a ‘worries list’ to share concerns with colleagues about specific patients. Where a known patient contacted the team in crisis the team responded swiftly.

- The team’s social worker acted as the designated safeguarding lead. Adult safeguarding was not part of the DMS’s mandatory training requirements, however, levels 1 to 3 child protection were. Most staff had undertaken levels 1 and 2 child protection training. There had been issues with accessing level 3 safeguarding training. The team’s managers had made a business case to access this training but this had not been approved due to funding. The team had begun to access level 3 training from the nearest local authority. Staff were in the process of undertaking this training with plans for all required staff to complete this by the end of November 2017. This meant that the team had not adequate training in safeguarding adults and gaps in provision
were possible.

- The Ministry of Defence had an up to date policy for child protection. However, we were told that the adult safeguarding policy had not been updated and did not meet the latest guidance in respect of the Care Act 2014. This meant that there were gaps in understanding and action.

- The safeguarding lead had a list of potential safeguarding concerns which he took to the weekly multidisciplinary meetings. However, we had concerns about a vulnerable patient that had been referred to the team. Due to a delay in assessment, as this had been a routine referral, there had been a delay in consideration of potential safeguarding concerns.

- Arrangements were in place for logging which staff were in or out of the building. However, we were concerned that the building and treatments rooms had open access to patients and unknown visitors.

- The DCMH did not dispense medication. Instead, prescriptions were issued for dispensing at the on base pharmacy. DMS had a policy for the storage and logging of prescription numbers, however, this had not been followed. This meant the team could not account for the 134 prescriptions that were missing. Blank prescription forms and pads had not been stored securely. The team conducted an immediate audit and put a system in place to resolve this issue during the inspection.

- All staff received annual basic life support, AED (defibrillator) and anaphylaxis training. The team did not have its own defibrillator available on the premises, however, this was available in another building adjacent to the team's building. However, there was no written procedure for response in a medical emergency other than for staff to call emergency services.

- The team had a business continuity plan for major incidents, such as power failure or building damage. The plan included emergency contact numbers for staff.

**Track record on safety**

- There had been 20 recorded serious events in the 12 months prior to our inspection. These had included one death by suicide of a patient, three confidentiality breaches and three breaches of the urgent referral response time.

- It was noted that two complaints about a locum staff member's inappropriate behaviour had not been recorded as serious events and therefore not investigated as such. However, it was confirmed that these matters had been escalated to the regional headquarters to investigate, although this had not been followed up.

**Reporting incidents and learning from when things go wrong**

- The team used the standardised DMS electronic system to report, investigate and learn from significant events, incidents and near misses. Staff were aware of their role in the reporting and management of incidents.

- The team manager provided examples of significant events reported and improvements made following investigation into the event. For example, following an incident that had occurred when a patient’s worker was unavailable the team had implemented the ‘worries list’ to share concerns with colleagues. We noted from the minutes that significant events were discussed at monthly governance and weekly business meetings, including the outcome and any changes made following a review of the incident.
Are services effective? (for example, treatment is effective)

Our findings

Assessment of needs and planning of care

- Formal assessment was undertaken once a patient's referral was accepted by the team. Following this, a thorough assessment of the patient's needs was undertaken. In practice, clear care and treatment plans were developed and this information was shared verbally with patients. However, formal care plans were not formulated. In complex cases patients benefit from a written record of their treatment goals.

- Information was stored securely. The team had access to an electronic record system which was shared across all DMS healthcare facilities. Paper records were also scanned on to the system to ensure easy access and safe storage. This system facilitated effective information sharing across mental health and GP services. However, we saw evidence of delays in scanning causing delays in information being received. Prior to our inspection the IT operating system had been changed which had caused staff some access issues. However, the managers had arranged for additional training to be delivered to staff in to address this. We were however concerned that locum staff did not get timely access to patient records which would hamper their ability to begin work with patients. This was due to a Ministry of Defence security issue.

Best practice in treatment and care

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. NICE and other guidance was reviewed within team and national governance meetings.

- The team employed two psychologists and nurses were also trained in a range of psychological treatments. Patients were able to access a range of psychological therapies as recommended in NICE guidelines for depression, post traumatic stress disorder (PTSD) and anxiety. Treatments included the use of cognitive behavioural therapy, motivational interviewing, cognitive analytical therapy, solution focussed brief therapy and eye movement desensitization and reprocessing.

- As an occupational mental health service the team's role was to assist patients to retain their occupational status or to leave the armed services. Patients could also use the team during the first six months following discharge from the military. The team worked closely with the Veterans Welfare Agency and the NHS England led Armed Forces Transition Service to ensure effective support with employment, housing and wider welfare.

- The team had introduced therapeutic groups to offer more timely access to patients who required lower level and more practical intervention. The first 'skills and drills' group had concluded and evaluation was being undertaken at the time of our inspection. An anxiety
management group was delivered during the inspection and patients were positive about this intervention.

- Physical healthcare monitoring, including monitoring of the effects of antipsychotic medication, was undertaken by the DMS GP practices. Staff described the advice and support they would give to colleagues in GP services around specialist mental health monitoring.

- The team used a range of outcome measures throughout and following treatment. These included work and social adjustment scale, patient health questionnaire, generalised anxiety disorder scale, the PTSD checklist and the alcohol use disorders identification test.

- The management team confirmed that there was no audit schedule but this was being developed. However, clinical staff had participated in some clinical audit. These included case notes audits, caseload analysis and care pathway evaluation, as well as the aviators audit and ‘the medical occupational outcomes of patients assessed in Defence MH Services’ which both considered the effectiveness of treatment outcomes.

**Skilled staff to deliver care**

- The team consisted of a full range of mental health disciplines working collaboratively under the clinical leadership of a consultant psychiatrist. These included nurses, psychologists and social workers.

- The team consisted of skilled and experienced staff who worked in partnership to manage and assess patient needs and risks. Where new staff joined the team, including locums, they received a thorough induction. Staff were well qualified and able to offer a variety of treatments. Development training, such as in cognitive behaviour therapy and EMDR, was also available to staff. Some nursing staff were undertaking additional academic qualifications financed by the service. The team also hosted student nurses training within the Armed Forces.

- Staff had support through weekly multidisciplinary, caseload management and business meetings. Staff were also involved in monthly governance meetings. Staff we spoke with confirmed that they had protected time for supervision and professional development. Staff were positive about their supervision and felt well supported through the team structure.

**Multidisciplinary and inter-agency team work**

- Care and treatment plans were reviewed regularly by the multi-disciplinary team in weekly team meetings.

- Following a review of the care pathway the team had reorganised the outpatient clinics to be more efficient and provide patients with easier access to the psychiatrist. The ‘collaborative clinic’ had begun in August 2017 and was proving successful by the time of our inspection. Patient feedback was positive about the clinics.

- The team worked in partnership with a range of services both within and outside the military. These included liaison with the NHS trusts who are independent service providers of psychiatric beds. The team had a liaison officer and deputy liaison officer whose role it was to work with the NHS team to ensure effective care and discharge from the service.

- As an occupational health service the team worked closely with a range of agencies to support military personnel to leave the Armed Forces. This role included access to employment, housing and welfare organisations including the Defence Medical Welfare Service and Armed Forces Transition Service. Where necessary, when handing care over on discharge of a patient from the services, the team would meet with the receiving NHS teams.
Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Staff did not receive training in the Mental Health Act and Code of Practice. However, we found that they were knowledgeable about the principles of the Act.

- The Mental Health Act was used very infrequently at the service. There was not a specific procedure for staff about how to manage assessment under the Mental Health Act. Should a Mental Health Act assessment be required the provider worked with local NHS trusts to access this through civilian services. Staff explained that this could prove challenging due to patients living and working in areas away from the base. The team gave an example of a case that had occurred in previous weeks and how they had ensured timely access through crisis teams.

Good practice in applying the Mental Capacity Act

- Staff did not receive specialist training in the Mental Capacity Act. There was not a specific policy on the Mental Capacity Act that staff were aware of and could refer to. However, all staff spoken with had an awareness of the principles of the Act and the need to ensure capacity and consent.

- In all of the records we reviewed we did not find any evidence of capacity assessments. However, in line with the principles of the Mental Capacity Act, staff assumed capacity unless there was evidence to suggest otherwise.

- We observed staff discussing consent to treatment with patients however this was not always clearly documented and so could be open to misinterpretation. In most cases we found records of consent to share information. However, we did not find records of consent to treatment. In one record we found reference to the patient being judged to have given implied consent as they attended the appointment. Staff told us that GPs were responsible for gaining consent. It is the individual healthcare professional's responsibility to assure capacity and gain consent and this should be considered on an ongoing basis.
Are services caring?

Our findings

Kindness, dignity, respect and support

- Staff showed us that they wanted to provide high quality care. We observed some very positive examples of staff providing practical and emotional support to people.

- We saw staff that were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them. All of the patients we spoke with told us that staff were kind and supportive, and that they were treated with respect.

- Staff demonstrated that they were knowledgeable about the history, possible risks and support needs of the people they cared for. We saw staff working with patients to reduce their anxiety and behavioural disturbance.

- Confidentiality was understood by staff and maintained at all times. Staff maintained privacy with people, who were asked if they would like their information shared with their relatives, within the chain of command and other bodies, including CQC. Information was stored securely, both in paper and electronic format.

The involvement of people in the care they receive

- Care plans were not routinely given to patients. However, in practice, plans were verbally agreed with patients. Patient feedback suggested staff provided clear information to help with making treatment choices. In complex cases patients benefit from a written record.

- The majority of patients we spoke with did not want involvement of their families and carers. However, two patients confirmed their families had been involved.

- Information was available at the service about a range of organisations that would provide advice and support to serving and former Armed Forces personnel.

- The DCMH undertook a patient experience survey on an ongoing basis. This was collated and analysed on a quarterly basis. In the preceding nine months 124 people had participated in the survey. This showed a high and increasing level of satisfaction. In September 2017 100% of patients would recommend the service to friends and family; 96% felt they would be listened to if they complained and felt involved in decisions regarding their care; 98% felt the appointment was at a convenient time and 92% agreed their appointment was at a convenient location.
Are services responsive to people’s needs?

Our findings

Access and discharge

- The service operated during office hours. There was no out of hours’ service directly available to patients: instead patients had to access a crisis service through their GPs or via local emergency departments. Where a known patient contacted the team in crisis during office hours the team responded promptly.

- The team participated in a National Armed Forces out of hours’ services on a duty basis. This provided gatekeeping and procedural advice regarding access to beds within the DMS independent service provider contract with NHS trusts.

- At the time of the inspection a satellite service based at St Athan in South Wales was not operational due to staffing needs. Staff offered a small number of sessions at St Athan with the majority of patients travelling to receive their service.

- At the time of the inspection the team’s caseload was 428. Fifteen people were awaiting allocation to a care coordinator. Ninety-nine patients were attending group activities and did not have a care co-ordinator. All clinical members of the team were assigned a caseload. The average caseload was 22 cases per care co-ordinator but caseloads ranged between four and 31.

- Referrals came to the team from medical officers, GPs and other DCMHs. These were indicated as either urgent or routine. Urgent referrals would be considered by the end of the next working day. The target to see patients for a routine referral was 15 days. A duty worker was available each day to review and follow up urgent referrals. However, we had concerns that routine referrals were not clinically triaged by the mental health team to determine whether a more urgent response was required.

- Information provided showed that in September 2017 the team had received eight urgent referrals. This had met the target for response to the referral in 75% of cases. The team stated that the two cases that had not met the target had been triaged to become routine referrals following receipt, however, had not been amended on the database. The managers explained that there had been an improvement in performance on previous months. Between June and August 2017 the team had met the target for 71% of cases.

- The information showed that the team had received 48 routine referrals during September 2017. The team had met the response time to these in 65% of cases. This was an improvement on previous months. Between June and August 2017 the team had met the target for 51% of cases. The team explained that they had developed therapeutic groups to offer more timely access to patients who required lower level and more practical intervention. The first ‘skills and drills’ group had concluded and evaluation was being undertaken at the time of our inspection. An anxiety management group was delivered during the visit and patients were positive about this intervention.
• The team monitored the length of the care pathway. In 82% of cases the patients were discharged within nine months of commencing treatment. More than half of patients were discharged within six months of commencing treatment.

• Within the Armed Forces, personnel can be ordered to attend for a medical appointment. However, personnel do not have to accept treatment. The team had a procedure regarding following up patients who did not attend their appointment. The team confirmed that very few patients did not attend appointments: usually this only occurred when patients had been deployed to other duties at short notice.

The facilities promote recovery, comfort, dignity and confidentiality

• The DCMH facility was not conducive to a therapeutic environment. The Disability Discrimination Act was not being considered and the building limited access to people with a disability. At the time of the inspection one patient who was a wheelchair user attended the base. The patient was unable to use toilet facilities at the building.

• There were sufficient treatment rooms at the time of the inspection. However, the team expressed concern about space should the additional staff be recruited. The managers had arranged for the continuous improvement team to visit the facility in November 2017 to consider how to make better use of the available space.

• Dignity and privacy were compromised by the shared use of the facility with another armed forces function and poor soundproofing in treatment rooms.

• The team’s management had escalated all of the facilities issues to regional operations however they were yet to be resolved due to funding.

• Information was available in public areas on treatments, local services, patients’ rights, and how to complain.

Meeting the needs of all people who use the service

• The team was able to offer flexible appointment times during office hours. Patients confirmed that they were given time to attend appointments and the chain of command was supportive of this. The DCMH undertook a patient experience survey on an ongoing basis. In September 2017, 98% felt the appointment was at a convenient time.

• The DCMH serves a population located across five counties and South Wales. The team could be as far as four hours from the patient’s home base. Some patients told us that their appointment meant considerable travel. In the patient experience survey 8% of patients stated their appointment was not at a convenient location.

Listening to and learning from concerns and complaints

• The team had a system for handling complaints and concerns. A policy was in place and information was available to staff. The practice manager was the designated person responsible for managing all complaints.

• Patient waiting areas had posters and leaflets explaining the complaints process. Patients spoken with understood how to make a complaint. Most felt they would be listened to if they complained. The patient experience survey in September 2017 found that 96% of patients felt they would be listened to if they complained.
• In the 12 months prior to our inspection there had been nine complaints; five related to inconsistency in treatment and three related to when a patient was unhappy with the level of care provided. All complaints, whether written or verbal, where recorded in the complaints log. The practice manager confirmed that she had fully investigated five of the complaints and was investigating the others. One complaint had been made to the Armed Forces Ombudsman.

• Staff demonstrated awareness of the complaints process and had supported patients to raise concerns. Staff received feedback on complaints and investigation findings in business and governance meetings. We saw evidence of information sharing in meeting minutes. Actions taken as a result of complaints included a review of locum caseloads and care pathways to deliver a more consistent model.
Are services well-led?
(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Requires improvement

Our findings

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 statement was:
  - 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.

- Staff were positive and clear about their role in delivering the vision and values of the service.

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 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. Minutes for this meeting showed the service had improved its governance and administration procedures over the previous 12 months. Systems were being set up to better capture governance and performance information.

- The common assurance framework (CAF), a structured self-assessment internal quality assurance process, formed the basis for monitoring the quality of the service. The department manager, in conjunction with the management team, kept it under review and updated it when necessary. An update in the form of a progress report on the CAF and associated action plan was submitted to Regional Headquarters (RHQ) each quarter.

- The department manager was the nominated risk manager. Risk and issues were reviewed monthly or as identified and logged on the Regional Headquarters risk and issues registers. These were overseen by the regional operations manager. The risk and issues logs included: recruitment and staffing levels, staff well-being, lack of level 3 child protection training, the IT transfer process and the inability to offer a service at St Athan.

- There had been a number of positive developments and improvements to care outcomes in the previous 12 months. These included the development of the collaborative clinics and therapeutic group-work. These had improved treatment options for patients and had also addressed waiting list issues. Patient experience had improved. Local procedures had been developed, including the development of the training and supervision logs, an improved induction pack and guidance on completion of healthcare records. Systems had been put in place to capture performance information. Work had been undertaken to capture learning from
adverse events and had led to changes in practice.

- However, governance was not yet fully embedded at the team. A number of issues remained unresolved. In a number of cases the RHQ had not offered sufficient support to the DCMH to address key issues including staffing, the environment and critical human resources issues. Not all risks that we found had been captured within the risk and issues logs or reflected within the CAF. We were concerned that:
  
  o Staffing levels hampered the team’s ability to fully develop governance systems. Recruitment had proved challenging and had not been supported by the DMS recruitment team.
  
  o The follow up of some complaints had been poor. Two allegations of inappropriate behaviour by staff had been escalated to the RHQ, however, had not been reported to the appropriate registration bodies by the Regional Headquarters.
  
  o The management system for prescriptions had failed to ensure clear oversight.
  
  o Consent was not always clearly documented and so could be seen to be open to misinterpretation.
  
  o The DCMH facility was not conducive to a therapeutic environment. The Disability Discrimination Act was not being considered. There was no clinically based risk assessment of the environment. Dignity and privacy were compromised by the shared use of the facility. Safety alarms were not working and we were concerned about lone working arrangements.
  
  o Routine referrals were not clinically triaged by the mental health team to determine whether a more urgent response was required or to monitor that patients’ risks had not increased. We were concerned about the lack of oversight of people’s welfare at the point of referral and the subsequent effects this may have on their mental health.
  
  o The overall average mandatory training rate for staff had improved but was at 61%.
  
  o Response times to referrals had improved but the performance targets were not yet being met.

Overall we found that the DCMH had been unable to evidence governance or meet key performance targets in the past. However, they had made improvements and were moving in the right direction at an appropriate pace. We could evidence improvement in governance and practice throughout the previous 12 months.

**Leadership, morale and staff engagement**

- The management team consisted of a clinical lead, a department manager and a practice manager. All post holders had joined the team in the previous 18 months. The clinical lead explained that the team had been underperforming when she joined. Staffing was low and the team had lacked motivation. Waiting lists had been high and the level of care delivered was poor. The management team had worked hard to motivate the team and bring in systems and processes to deliver safe and effective care in a timely manner.

- Staff reported that the management team was approachable and supportive of their work. Staff morale had improved and staff were clear regarding managers and their own roles and responsibilities. Staff stated that they were part of a cohesive team and felt supported by their managers and colleagues. Staff were positive about the introduction of the collaborative clinics and group work and felt this was making a positive difference to the quality of care offered to patients.
• Sickness and absence rates at the team were minimal.

• A whistleblowing process was in place that allowed staff to go outside of the chain of command. Staff knew about the whistleblowing process and most would feel confident to use this. There had been no reported cases of whistleblowing or bullying at the team.

• All staff attended team meetings and monthly governance meetings. Staff told us that new developments were discussed at these meetings and they were offered the opportunity to give feedback on the service and input into service development.

• Recently staff had been given the opportunity to take on leadership roles. Staff were positive about this and demonstrated their passion to improve the services offered.

Commitment to quality improvement and innovation

• The management team consisted of a clinical lead, a department manager and a practice manager. All post holders had joined the team in the previous 18 months. The clinical lead explained that the team had been underperforming when she joined. Staffing was low and the team had lacked motivation. Waiting lists had been high and the level of care delivered was poor. The management team had worked hard to motivate the team and bring in systems and processes to deliver safe and effective care in a timely manner.

• Staff reported that the management team was approachable and supportive of their work. Staff morale had improved and staff were clear regarding managers and their own roles and responsibilities. Staff stated that they were part of a cohesive team and felt supported by their managers and colleagues. Staff were positive about the introduction of the collaborative clinics and group work and felt this was making a positive difference to the quality of care offered to patients.

• Sickness and absence rates at the team were minimal.

• A whistleblowing process was in place that allowed staff to go outside of the chain of command. Staff knew about the whistleblowing process and most would feel confident to use this. There had been no reported cases of whistleblowing or bullying at the team.

• All staff attended team meetings and monthly governance meetings. Staff told us that new developments were discussed at these meetings and they were offered the opportunity to give feedback on the service and input into service development.

• Recently staff had been given the opportunity to take on leadership roles. Staff were positive about this and demonstrated their passion to improve the services offered.