

Defence Medical Services CQC inspection programme

Annual report for Year 1 (2017/18)



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Foreword from the Chief Inspector

I am delighted to present CQC's report of the quality of care in Defence Medical Services (DMS) for 2017/18. This report has been compiled to inform CQC's Board and the DMS Board of the findings from inspections in Year 1 of this programme. Everyone in our society, including armed forces personnel and their families, deserves high-quality, accessible care. In view of this, the Surgeon General invited CQC to inspect health care and medical operational capabilities. In 2017/18, CQC carried out comprehensive inspections of 35 medical facilities, 24 dentists, two Regional Rehabilitation Units and two Departments of Defence Community Mental Health. This has allowed us to form an initial view of the quality of care provided by the DMS.

We have highlighted some innovative practice in our inspection reports to encourage others to learn from it, to be inspired by it and to adapt what is relevant to use in their own improvement journey. There are particular characteristics at the heart of high-quality military healthcare services: the integrated nature of Defence primary healthcare services means that staff proactively engage with patients and military command to identify local needs; they use this understanding to create a strategy and provide services to respond effectively to meet these needs, sometimes in innovative ways; these services also have strong leadership with a good mix of skills, and good external relationships and partnership working, to share learning with others in the wider health and military communities.

But we also recognise that there are pockets of poor care and that this affects both patients and healthcare professionals in a negative way. In our first year of inspections, we have found practices where care has fallen short of the quality that people should be able to expect. In Year 1, although both the Regional Rehabilitation Units inspected met requirements, 17% of dental centres, 52% of medical facilities and both community mental health facilities inspected were rated as requires improvement or inadequate.

Our inspections are intended to highlight problems and ensure that these are addressed – not only for the benefit of patients, but to help improve and support the healthcare professionals. Where we found concerns, we have commenced a follow-up visit plan to re-inspect and ensure that the necessary improvements have been delivered. In extreme cases, where we found poor and unsafe practice that put patients at risk, the DMS Regulator and Defence Primary Healthcare took action to provide urgent support to the service, and in one case, to close the practice.

Feedback from the majority of the services we have inspected has been positive. Many services told us that their CQC inspection provided valuable feedback and that they valued our acknowledgement of what they are doing well, as well as the insight into where they could improve.

I am pleased that the Surgeon General has extended his invitation, requesting that CQC inspects further medical facilities, departments of community mental health and Regional Rehabilitation Units in 2018/19.

The Surgeon General and CQC are committed to ensuring that armed forces personnel and their families have access to the same high-quality care as the rest of society.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

The Care Quality Commission (CQC)

CQC's purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

CQC's role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

CQC's values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

Defence Medical Services

The Surgeon General leads Defence Medical Services (DMS) and sets the standards and rules to be followed by all providers of healthcare and medical capability to Defence. In partnership with providers, the Surgeon General assures healthcare quality standards set for Defence by National or International authorities.

The DMS provides an occupationally focused primary healthcare service, encompassing Primary Medical and Dental Care, Occupational Health, Public Health, Force Preparation, Travel Medicine, Mental Health and Rehabilitation, and some outsourced services. Secondary healthcare is provided by the NHS with DMS influence on NHS commissioning policy and delivery to ensure that specific Defence requirements are met. The DMS is responsible for the development of medical operational capability and the generation of medically qualified personnel in support of operational tasks.

DMS Mission Statement

DMS seeks to promote, prepare, sustain and restore optimal physical, mental and social well-being of Service Personnel and other entitled personnel in order to maximise fitness for role and contribute to deployed operational capability.

Purpose of Defence Primary Healthcare (DPHC)

To provide a unified, clear focus to the delivery of the primary healthcare element of Force Generation and preparation employing both uniformed and civilian healthcare staff as well as commissioned NHS services. It exploits the synergies inherent in managing the patient pathway for all three Services across general practice, rehabilitation, mental health, occupational health and dentistry.

Introduction

The Care Quality Commission (CQC) and its predecessor, the Healthcare Commission, previously inspected Defence Medical Services (DMS) military treatment facilities in 2008 and 2012. Acting on recommendations made by the Defence Audit Committee (DAC), Joint Forces Command (JFC), the Surgeon General's Non-Executive Director and the then Chair of the Healthcare Commission, the Surgeon General has stated that the DMS community should benefit from the same scrutiny of their health service as the rest of the population.

CQC was therefore invited by the Surgeon General in his role as the Defence Authority to deliver a fully-funded inspection programme for DMS intended to inform the Surgeon General, Defence Medical Services Regulator (DMSR) and those who use DMS services of the standards of care being provided. DMS requires independent, open and transparent judgements from CQC as the healthcare regulator for England.

In April 2017, CQC commenced a programme of inspections for health care and medical operational capability. Defence Medical Services 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, we escalate these concerns swiftly to both the Surgeon General and the DMS Regulator for action to improve or enforce standards.

Approach to DMS inspections

The DMSR delivers a rolling programme of healthcare assurance around the safety and effectiveness of service delivery within DMS. The Common Assurance Framework (CAF) was designed to mitigate for workforce turbulence and support continuity of care, and underpins the Healthcare Governance Assurance Visit (HGAV) approach as a way of recording the real-time compliance of individual services with a suite of indicators. See further information on the [Common Assurance Framework](#) on page 36.

CQC's inspection methodology shares many common aims with the HGAV approach, including:

- seeking assurance that effective governance systems are in place
- ensuring that appropriate policies and guidance are being followed
- ensuring that key performance indicators are being met.

However, CQC’s approach differs as it focuses primarily on the quality of care for the patient, their experience, and whether their needs are being met (see [Appendix A](#) for an example of CQC’s patient-centred approach). The DMS Regulator believes the two approaches are complimentary.

CQC’s quality ratings

CQC’s ratings have been designed to give a clear indication to patients and the public about the quality of services. They also act to encourage improvement, as they enable services rated as requires improvement or inadequate to understand where they need to make improvements and aspire to achieve a higher overall rating.

Ratings are based on a combination of what we find during an inspection, what patients tell us, key performance data and information from the provider itself. Inspectors use all the available evidence and their professional judgement. Following a thorough review process involving a number of checks to ensure quality and consistency, the inspection report is published on CQC’s website.

For all services that CQC regulates, we ask five key questions: are they safe, effective, caring, responsive to people’s needs and well-led? To decide on a rating, the inspection team also asks: does the evidence demonstrate a potential rating of good? If yes, does it exceed the standard of good and could it be outstanding? If it suggests a rating below good, does it reflect the characteristics of requires improvement or inadequate?

We rate each of the five key questions and aggregate them to give an overall rating for a service. Figure 1 shows examples of aggregated ratings.

Figure 1: Examples of overall ratings at service level

Ratings	
Overall rating for this service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people’s needs?	Outstanding ☆
Are services well-led?	Good ●

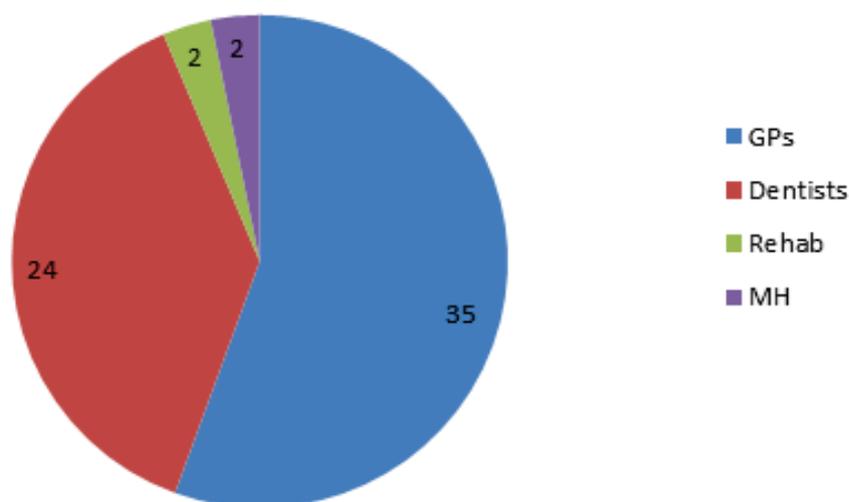
Ratings

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

Overview

We carried out a full year of DMS inspections during 2017/18 (Year 1). Figure 2 shows the total number of inspections undertaken in Year 1. [Appendix A](#) gives a full list of published ratings for all inspections in 2017/18.

Figure 2: First comprehensive DMS inspections in 2017/18 by type



GENERAL PRACTICE

All military personnel, some dependants and civilian staff, are entitled to the services of a military GP practice. Unlike most NHS patients, military staff do not have the right to register with a GP practice of their choice, but must register at the location where they are assigned.

In April 2017, CQC began a programme of DMS general practice inspections. Our inspection teams are led by specialist CQC inspectors, always include a GP, and often include other specialist input from practice nurses, practice managers and pharmacy specialists. We also speak with patients and staff to understand the quality of care from the perspective of people who use the service and staff. Inspections look at the quality of care and treatment across the range of services offered in a practice – for example, from healthcare teams involving doctors, nurses, medics (the work of a military medic has greater scope than that of a healthcare assistant found in NHS GP practices), phlebotomists, pharmacists and physiotherapists. This extends to how practice managers, receptionists and other staff contribute to patient care, and how a practice works with other professionals, such as health visitors, midwives, mental health services, social care services,

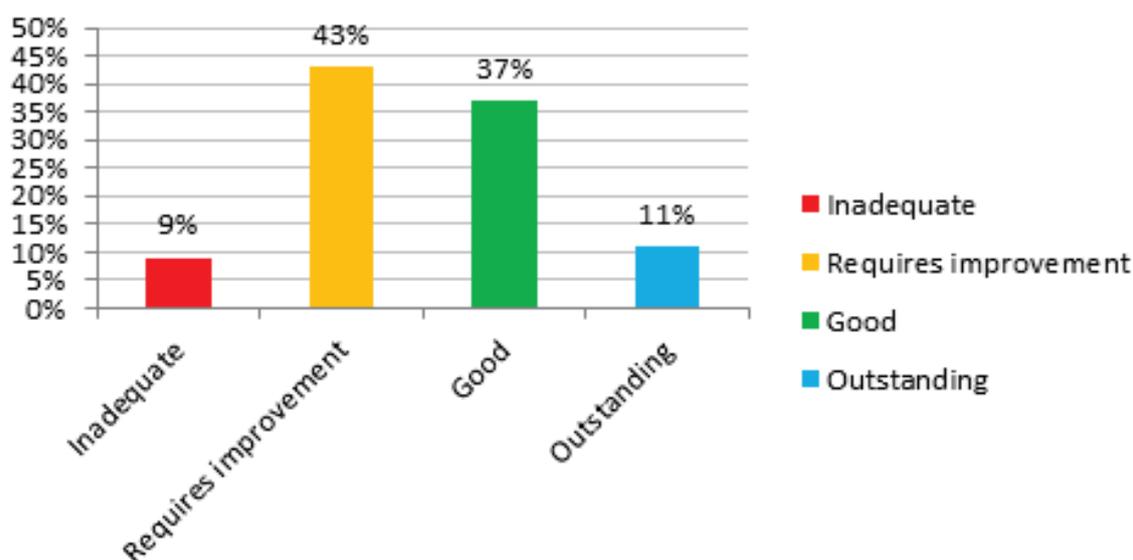
chain of command, welfare and pastoral teams. The focus of our approach is the quality and safety of services, based on the things that matter to people. This enables us to get to the heart of people's experiences.

In the first two quarters of 2017/18, CQC's inspection team visited medical centres nominated by DPHC. In quarter 3, CQC and DPHC worked together to agree a risk-based approach to inform the inspection programme. From that point, inspections included medical centres where there were known risks to quality.

Summary of findings from CQC's inspections in general practice

It is important to remember that this inspection programme is still in its infancy, with only 35 medical centre inspections undertaken in Year 1. It is therefore not appropriate to draw direct comparison with ratings across NHS GP inspections, where the inspection programme is entering its fourth year since ratings started. If we compare the profile at the end of the first programme of NHS inspections, the ratings position has improved as the proportion of practices rated as good or outstanding has increased. Page 22 summarises the follow-up inspection work undertaken in Year 1, which seeks to find assurance that recommendations have been acted on. Very early signs show that the direction of travel is positive and that organisational learning is in place.

Figure 3 : Ratings for medical centres in Year 1

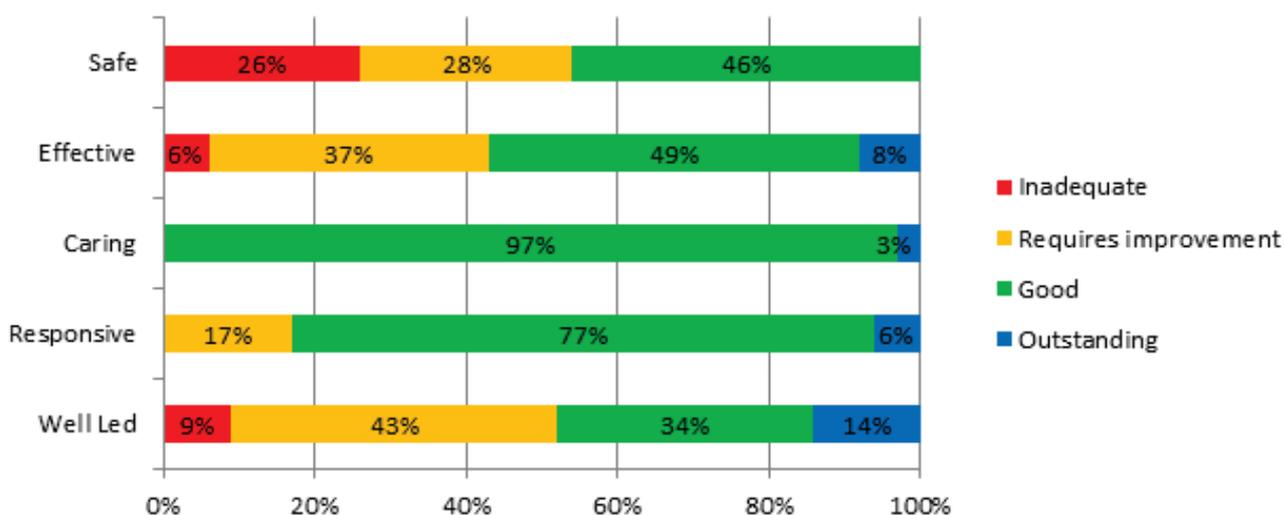


- 9% of medical centres were rated as inadequate
- 43% of medical centres were rated as requires improvement
- 37% were rated as good
- 11% were rated as outstanding.

Ratings by key question for medical centres

The majority of medical centres are caring and responsive. Where we find problems, they are more frequently related to the centre's approach to safety, how effective care is and how well the centre is led and managed. Figure 4 shows medical centres ratings in Year 1 by each key question.

Figure 4: Ratings for medical centres by key question



Safe

Delivering safe care is essential. Patients can be protected from abuse and avoidable harm when a practice has robust systems and processes, creating a strong foundation to enable staff to be proactive about risk, assess and mitigate risk, and see problems before they happen. A safe track record, a willingness to report safety incidents and be actively involved in learning from them to drive improvement – both within and outside the practice – is a key indicator of its safety.

Overall performance for the safe key question is the poorest of all the five key questions, as it shows the largest percentages of ratings of requires improvement and inadequate.

For the safe key question, 46% of medical centres were rated as good, but 28% were rated as requires improvement and 26% rated as inadequate.

Where the rating was good, we found that medical centres encouraged staff to report incidents and errors within a blame-free culture. We saw that significant events were investigated and outcomes discussed at team meetings to prevent them happening again. DPHC has a service-wide system (ASER) for capturing learning from significant events, which supports the local management of issues and also promotes organisational learning. Medical centres that discussed the

learning from other practice areas were able to demonstrate how their outwardly focused vision delivered improvements locally.

In addition, staff were trained (to the appropriate level for their role) to understand their accountabilities around safeguarding vulnerable adults and children. Staff knew how to take action and worked in close partnership with chain of command and welfare and pastoral teams to safeguard personnel and their families. Medical centres rated as good could demonstrate that they had failsafe systems in place to manage and recall patients with long-term conditions and patients taking high-risk drugs.

Where centres required improvement, the main issues we found included problems relating to poor systems and processes to manage risk so that incidents are less likely to happen again. These apply to many areas, such as safeguarding, managing serious incidents, management of test results and high-risk medicines and acting on patient safety alerts.

We found that some medical centres were not fulfilling their duties to safeguard vulnerable people, including children. This was often because there was no effective system in place to ensure that all vulnerable patients were known to staff and so patients were not proactively supported and reviewed. We also noted an instance where a patient at risk had moved to a new practice, but these risks had not been communicated to the new service. Children are often registered at a different (NHS) practice to their (military) parent(s) and so timely communication of any risks with key agencies is essential to ensure that protection plans can be instigated.

We also found that some medical centres were not following best practice guidance around infection control and prevention and safe disposal of clinical waste, and there were gaps in medical equipment testing.

Having consistently safe care can be achieved partly by having the proper processes, formal training, and guidance for staff. Being able to easily access and follow up-to-date and relevant policies and guidance enables staff to be confident that they are acting in the right way for patients.

When CQC inspected a number of medical centres in 2012, for example RAF Valley and Leuchars, the recommendations centred on improving poor infrastructure. We note that some work is underway to address these concerns, but we have continued to identify issues with infrastructure across medical centres. Many are not purpose built to deliver primary care and we have identified some common issues: damp, insufficient space, poor ergonomics, lack of sound-proofing and a history of vermin infestations. As a result of these issues, some practices are not able to follow best practice infection control guidance. Practices are unable to address environmental concerns themselves and are mostly reliant on the Station's Health and Safety Team or Regional Headquarters to bid for funding for improvement work.

Example of a medical centre rated as good for the safe key question

Regional Medical Centre RAF Marham, April 2018

An 'issues register' had been implemented to capture and promote learning resulting from not only significant, but also minor events, incidents and near misses. Staff escalated and discussed all events and incidents to decide whether escalation to the ASER (electronic reporting system) was appropriate. One member of staff was responsible for recording and promoting shared learning from all minor and more significant events across the team. Staff provided a number of examples and described how the incidents were managed. They highlighted any changes made as a result of the investigation. For example, a significant event in relation to a sample not being received from the lab had resulted in weekly searches to chase missing samples. We saw a number of issues raised around patient information being incorrectly placed into other patients' records. Mitigating action had been taken, Caldicott principles were referenced and new processes introduced to mitigate future recurrence.

We reviewed safety records and national patient safety alerts, including the minutes of meetings where these were discussed. The pharmacy technician had an overview of the alerts and was the lead for circulating safety alerts for action to the wider staff team. Alerts were discussed at healthcare governance meetings. A register of alerts received at the practice was maintained. When the doctors provided confirmation that an alert had been actioned the register was updated. For example, the practice had ensured that Ventolin Accuhalers had been recalled in line with the February 2018 MHRA alert.

The practice had effective and well-managed systems in place to maintain an accurate and up-to-date register of patients subject to safeguarding arrangements, and patients assessed to be 'at risk'. We were provided with a variety of examples of patients currently deemed vulnerable and at risk. Staff described how concerns were logged on the risk register and discussed with other clinicians at the vulnerable patients meeting held every two weeks. From the examples provided, it was evident the practice 'went the extra mile' to minimise the risk to the patient by providing and/or sourcing relevant support from external stakeholders.

An alert facility within the patient record system, Defence Medical Information Capability Programme (DMICP), ensured any risks showed clearly when the medical record was opened. A vulnerable patient meeting was held every two weeks and any concerns were discussed at these meetings. The child safeguarding pathway protocol was located in all treatment rooms. Safeguarding was a standard agenda item at the HCG meetings.

Paediatric attendance at accident and emergency departments was routinely monitored by the Senior Medical Officer to identify any trends, ensuring that children were protected in line with best practice safeguarding guidelines.

Effective

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. An effective medical centre routinely reviews the effectiveness and appropriateness of its care as part of quality improvement. When care and support is effective, people have their needs assessed and their care and treatment delivered in line with current legislation, standards and evidence-based guidance.

In Year 1, 49% of medical centres were rated as good for the effective key question and 8% were rated as outstanding; 37% were rated as requires improvement and 6% were rated as inadequate.

To support our judgements we look at existing data around patient outcomes including Quality and Outcomes Framework (QOF)* and performance against national screening programmes to monitor outcomes for patients. We also looked at performance against World Health Organisation vaccination targets and the Force Protection Dashboard for service personnel.

Where performance was outstanding, we found:

- a comprehensive and broad cycle of improvement work, relevant to the patient population and delivering demonstrable improved outcomes for patients
- proactive work with external agencies to tackle health inequalities
- examples of staff going the extra mile to meet the needs of vulnerable patients
- proactive and extensive support for staff to develop the skills they need for their role
- a comprehensive approach to supporting patients to achieve a healthy lifestyle, coupled with a targeted programme of health assessments and screening.

Where performance was poor for this question, we found some common themes, as practices had been unable to:

- maximise the functionality of the Defence Medical Information Capability Programme (DMICP) to facilitate clinical searches, assure recall programmes and monitor performance
- ensure adequate staffing levels and skills mix at all times

* QOF is used across many NHS practices as a system to improve the quality of general practice and reward good practice. The Defence Medical Services have a responsibility to deliver the same quality of care as patients expect in the NHS, and QOF provides a useful way for DMS to measure this. Although QOF targets are a good indicator of meeting needs, reaching them all is not in itself an indicator of outstanding care.

- deliver a rolling programme of continuous work focused around improving outcomes for patients
- ensure that all staff had received training relevant to their role
- improve uptake of national screening programmes
- maintain comprehensive childhood immunisation records
- avoid large backlogs of un-summarised notes.

Example of a medical centre rated as outstanding for the effective key question

Leuchars Station Medical Centre, November 2017

The processes to monitor high risk drugs (HRD) and long term conditions (LTC) were aligned so both were reviewed simultaneously. A comprehensive framework of protocols had been developed that brought together NICE (National Institute for Health and Care Excellence), SIGN (The Scottish Intercollegiate Guidelines Network) and QOF so that clinical staff could ensure LTCs and HRDs were managed effectively. A coding system was used on patient records to identify patients prescribed HRDs. An effective recall system was in place for patients with an LTC and for patients taking high risk drugs.

The practice was pro-active in using a quality improvement approach to review its underlying systems of care and identify actions leading to measurable improvements in health care delivery. A comprehensive and wide-reaching active programme of audit was in place that focussed on the needs of the population and demonstrated a commitment to improving outcomes for patients. From September 2016 the spreadsheet showed 35 completed audits (both clinical and administrative). Audits undertaken were relevant to the needs of the patient population, including a rolling programme of audit for long term conditions. There was evidence of up to three cycles for some audits. Examples included antibiotic prescribing, opiate prescribing, consent for cervical smear taking, diabetes, hypertension and sexual health. In addition the practice had undertaken a number of quality improvement projects, triggered by gaps that staff had identified in safety. These included a results handling project, sepsis identification and a proteinuria identification project.

Patients had access to appropriate health assessments and checks. A monthly search was undertaken for all patients aged 50-64 years who were entitled to breast screening. The practice also engaged with all national screening programmes and had a mechanism to ensure that eligible patients were referred into the bowel cancer or abdominal aortic aneurysm (AAA) screening programs. The practice had been successful with its promotion of cervical screening and could demonstrate that there had been an increased uptake of screening since 2015. Data showed that in November 2015 the uptake was 54%, it was 71% in August 2016 and 86.5% in December 2016.

A monthly search was undertaken to monitor the status of childhood immunisations. Childhood immunisation rates were above the DMS average. Staff advised us that the practice bench marks itself against the European Region of the World Health Organisation Target of 95%. Data we looked at showed immunisation rates for the vaccinations given to under two-year-olds was 97% and ranged between 95% and 97% for two to five-year-olds.

Caring

Compassionate care has a lasting impact on people's experience of their medical centre. Practices rated as good knew and understood their patients as individual people and were sensitive to their preferences and requirements.

As well as observing how staff interact with patients, we base our judgements on patient feedback from comment cards, interviews with patients and data from the practice's own patient surveys.

We found that all 35 medical centres inspected in Year 1 provided caring services to their patients, with caring being the best performing key question. All staff working in medical centres were found to treat their patients with compassion, kindness, dignity and respect. An example of this is respect for patients' privacy both in reception areas and in consulting rooms. Similarly, taking time to explain to patients what their care involves and what choices are available to them. Interpretation services were available for patients who do not have English as a first language. We saw good support for patients who may have family or dependants that could become isolated. There were also examples of how staff used their links with military welfare staff to ensure sufficient support mechanisms were in place for those family members and dependants affected by a patient's deployment.

One area where there was scope for some medical centres to improve was in proactively identifying and supporting patients who are carers. For example, providing links with carers' organisations and ensuring that the carer's emotional and healthcare needs are met.

Example of a medical centre rated as good for the caring key question

HMS Drake, February 2018

All the CQC comment cards filled out by patients described their care and treatment in a highly positive way. They said that they felt involved in decision making about the care and treatment they received. They commented that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. They said staff were kind and respectful.

Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. The practice offered patients the services of either a female or a male GP.

The practice proactively identified patients who were also carers, during discussions in consultations and information was available in the waiting room. There was one carer registered at the time of the inspection. There were systems in place for patients to identify themselves as carers; a code was added to their records in order to make them identifiable and so that extra support or healthcare could be offered as required. The PMO (Principal Medical Officer) attended monthly welfare meetings with other health professionals to discuss where extra support and care were needed.

Responsive

Good quality care is organised so that it responds to, and meets, the needs of the practice's local population. This includes access to appointments and services, choice and continuity of care and meeting the needs of different people, including those in vulnerable circumstances. As well as face-to-face consultations, a responsive medical centre will carry out consultations by telephone and offer tailored appointment lengths, home visits and extended opening hours.

In Year 1, 6% of medical centres were rated as outstanding for providing a responsive service, 77% were rated as good, 17% rated as requires improvement and none were rated as inadequate.

Where we judged care to be good, we often found that medical centres had gathered feedback from patients and staff and used this knowledge to ensure that care was as convenient and accessible as it could be. We found that medical centres offered longer appointments to patients who required them and that both staff and patients were clear about when home visits were appropriate.

Patients told us that online services for requesting repeat prescriptions, a dedicated line for obtaining test results and arranged transport for patients to hospital appointments were helpful. Responsive medical centres worked in close partnership with PCRFs (Primary Care Rehabilitation Facilities) to facilitate timely access to physiotherapy and exercise rehabilitation.

Example of a medical centre rated as outstanding for the responsive key question

RAF Coningsby, December 2017

During the recent national NHS crisis involving a computer hacking incident, the medical centre contacted the NHS GP practice in their local community and offered their support. As a result of this, seven patients were seen during the week of the incident by clinicians from the military medical centre.

The practice recognised the importance of providing holistic patient support. There were numerous examples of patients requiring the sort of support that is difficult to obtain when taken away from family and friends by military service. For example, a patient suffered an accident and became immobile. They did not live on the base. The practice arranged for them to have ground floor accommodation on the base, ensured they had the appropriate equipment to maintain independence, arranged physiotherapist appointments to suit their availability, some transport was arranged on occasion, food delivered to their room and arrangements made for their relative to have passes to visit them on camp.

The standard distance from base that the practice would usually register dependants was within five miles. In some instances they had registered children outside of this where both parents were serving in the military. In many of these cases, the children were registered at a different practice to their parents. The practice recognised this carried significant clinical risk in terms of safeguarding, family health, maternal mental health and providing holistic care as the practice had no insight into the wider family dynamic. The practice identified this risk and worked to mitigate by prioritising the registration of those children and actively invited them to register even though they were outside of the usual catchment area. The practice were increasing their dependant registrations but were limited to 20 per month, however if a family wanted to register they would be given priority.

Where improvements were required for responsiveness, we identified two common themes: Shoulder Cover (access to a GP once the medical centre has closed and before the out-of-hours service is available) was lacking at some practices. Although written complaints were generally dealt with in line with DPHC policy, there was scope to ensure that verbal complaints were reported, investigated and learned from in the same way. Staff and patients were not always clear what the policy was on home visits.

Well-led

In Year 1, 14% of medical centres were rated as outstanding for the well-led key question and 34% of practices were rated as good; a further 43% were rated as requires improvement and 9% were rated as inadequate.

During the first year of GP inspections, we have found examples of outstanding leadership in five medical centres. Key to their success was a strong governance framework and visible leadership, coupled with a collaborative team approach to promote learning and innovation. We met with staff who were committed to the vision and values of DPHC and who were supported to make improvements to the way they delivered patient care. Those medical centres rated as outstanding in leadership fostered a culture where challenge and transparency allowed teams to abide by their duty of candour.

Example of a medical centre rated as outstanding for the well-led key question

Army Training Centre, Pirbright (December 2017)

Practice staff had embraced their own local mission statement – “Doing the right thing on a difficult day.”

Policies were implemented and were available to all staff. These were updated and reviewed regularly. A significant finding of our inspection was that governance processes were truly embedded at the practice and fully understood by staff. The effect of this was significant, in that when key staff were posted to other duties, good governance was maintained. This contributed to the safe and effective running of this busy practice.

There was a clear leadership structure and staff felt supported by management. Staff told us the practice leaders were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run and develop the practice. We particularly noted the ‘learning atmosphere’ in the practice, which was promoted by leaders. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.

Leaders and staff at the practice recognised they would not achieve the highest standards of clinical care for their patients alone. We saw several examples of local partnership working that brought real benefits to patients and to the wider community. For example, work with the specialist TB nurse at a local hospital to reduce the possible spread of disease and doctors providing an extended on-call service to patients who phoned the practice outside of normal opening times. We also noted strong working links with external agencies, such as a local Young Carers Association and Independent Living Council, which brought both financial and practical help for carers, in turn contributing to the overall health and well-being of these patients. Doctors and nurses spent a considerable amount of time supporting patients at risk of isolation, for example, young mothers whose partners were away on military exercise.

Although CQC has undertaken only 35 medical centres inspections in Year 1, we have noted a number of common themes where centres are judged to require improvement or to be inadequate in the quality of their leadership.

Workforce gaps are a significant challenge for the Surgeon General in delivering safe and effective care. Medical centres with lower ratings tend to have larger numbers of vacancies and posts that have not been covered (where staff are deployed, on long-term sick or on maternity leave – called ‘soft gapping’). In addition, requests for staff to support operational and Navy/Army/RAF tasks, and lack of available civilian and locum staff mean that some practices struggle to deliver continuity of service.

We can draw a direct link between poorer ratings and deployment of the Regimental Medical Officer (RMO), whose key role is to support personnel at home and on deployment, resulting in a lack of clinical leadership at the medical centre. There are a number of instances where medical centre management at best requires improvement because of the ‘soft gapping’ of key management positions. As the Surgeon General does not own the military personnel assigned to DPHC, he has limited flexibility within workforce management and, at times, lines of accountability are unclear. Consequently, he is unable to ensure that the right Suitable, Qualified and Experienced Personnel (SQEP) are in the right posts at the appropriate time.

Governance systems are not always effective and do not support the delivery of consistently high-quality services. Common gaps identified include health and safety governance, systematic review of patient notes and coding, large backlogs of un-summarised notes, systems to capture and proactively support vulnerable patients and failsafe systems to manage test results.

We found that staff were not always clear who was accountable for safety and quality, such as safeguarding and infection control leads. Lack of clear accountability was a particular issue in practices where NHS locums were invited to deliver care on a contractual basis and where clinical leaders were absent due to deployment.

Communication across practice teams was sometimes ineffective, particularly where a key staff member (particularly the Senior Medical Officer) had been deployed. Practice and clinical meetings did not always take place regularly and standing agenda items, recent NICE guidance and the risk register were therefore not discussed and actions were overlooked.

The culture that leaders create within a medical centre is important: where we saw high-quality general practice there was a more inclusive approach and a culture that valued the input of staff, with a balanced team that respected and valued all professionals with mutual respect and connection. However, some medical centres issued directives and did not always listen to their staff teams. We have interviewed a number of civilian (locum and permanent) staff across our inspections who highlight the importance of an inclusive working environment that values the input of the whole team.

Civilian staff often provide stability and continuity of care within a medical centre and they may provide many years of care at the same place under the steer of many different military staff. A good practice will acknowledge and make good use of the acquired knowledge and advice that civilian staff can bring to their work. In return, the practice will benefit where civilian staff quickly engage with, guide and support new military staff who often move to new practices every two years.

Feedback did not always drive improvement. Although most medical centres used surveys to collect feedback from patients, only a few proactively sought formal feedback from their staff. This meant that opportunities to drive improvement and innovation were lost and staff did not always feel empowered to drive change at their practice.

Follow-up inspections of general practice

Towards the end of Year 1, we have undertaken five follow-up inspections at five medical centres to see whether required improvements had been delivered. A follow-up inspection focuses on the particular key question where improvement is needed, and does not always look at all key questions. This included a medical centre that was rated as inadequate overall in May 2017. Figure 5 shows that all five practices had addressed the recommendations made at their first inspection and demonstrates that DMS is a learning organisation.

Figure 5: Ratings for first and follow-up inspections of key questions for medical centres

	Safe		Effective		Well led		Overall	
	1st	2nd	1st	2nd	1st	2nd	1st	2nd
RAF Scampton	I	G	RI	G	I	G	I	G
HMS Neptune	RI	G	G	G	RI	G	RI	G
RAF Cosford	G	G	G	G	RI	G	G	G
Abbey Wood	G	G	RI	G	RI	G	RI	G
Army Foundation College (Harrogate)	G	G	RI	G	G	G	G	G

I Inadequate
 RI Requires improvement
 G Good

Example of improvement: [RAF Scampton Medical Centre](#)

Rated overall as inadequate August 2017

Rated overall as good April 2018

We interviewed key staff at Scampton Medical Centre to understand the improvement journey from their perspective.

RAF Scampton Medical Centre supports operations at RAF Scampton, providing primary medical services and emergency care to a practice population of approximately 400 personnel, drawn from all three services in the UK Armed Forces.

CQC first inspected the medical centre in May 2017, leading to a report and rating of inadequate in August 2017. A follow up inspection in February 2018 led to a rating of good.

Priorities for improvement

Senior Medical Officer Squadron Leader Adrian Dawson joined the practice just as the first report was published. He'd had a full briefing from his senior officer based at regional HQ. "I felt things could be fixed", he says. "Some of the concerns were down to lack of awareness of process – things were being done but not in a way that could be demonstrated sufficiently to give CQC assurance. "But we did need external support from the region. We couldn't fix the fact that we were a single-handed practice." He says a big challenge was to build up the morale of staff: "I needed to be clear that this was a system failure not a personal failure."

For Practice Manager Sergeant Lorraine Barclay, the key things to address were infection control and getting the right frameworks and policies in place. "The first thing I did was re-visit the Defence Medical Services Infection Control policy. Then I met with the contracts monitoring team and we created check lists for cleaners and for medics. I set up a recording system and arranged a deep clean of the medical centre."

Recording and reporting

CQC's original report noted that there was a system in place for recording and reporting significant events. However, this appeared to be on an individual basis and events were not routinely discussed and analysed, with findings shared within the practice and more widely. "We already had the correct policies and procedures, so this was about following them and doing things right" says the Practice Manager. The Senior Medical Officer says there were two aspects to putting this right. The first part of this was to develop a change in culture by "continually making the practice team aware that significant event and complaints information is important and emphasising learning and sharing – rather than looking at events in a punitive way."

The second part was to formalise an approach to recording and reporting. "Each month there's a slot on our healthcare governance meeting where events are discussed. Staff are also encouraged to discuss issues among themselves."

Roles, responsibilities and communication

Being clear about roles and responsibilities was another area that needed prompt attention. "We identified 18 areas for which there was no clear lead", says the Senior Medical Officer. "We now have a list showing designated leads and deputies, recognising that, in the military, personnel can often be moved around the organisation or onto other tasks for a while." Previously, staff had been unaware, for example, who the lead was on managing medicines, or who would deputise for the practice manager.

According to the Senior Medical Officer, in the past "staff had felt a little in the dark", so improving communications and, importantly, giving staff the assurance that they were being listened to were priorities.

Meetings are now held more regularly, with monthly practice and monthly governance meetings. “It is a small unit”, says the Practice Manager, “so everyone is involved in the meetings, whatever their rank.”

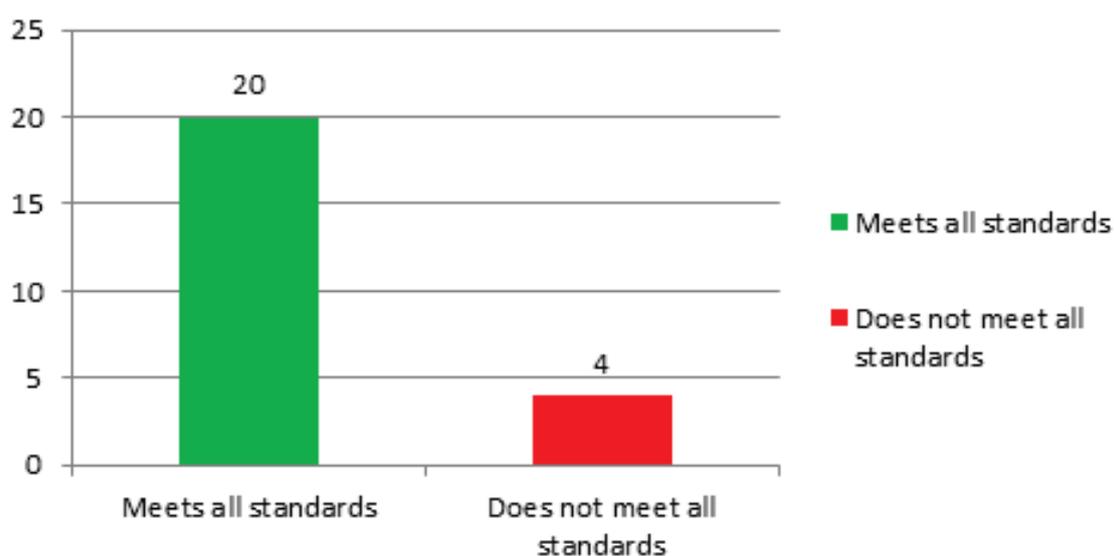
Staff told CQC inspectors that the leadership of the service had improved and that they now felt engaged, supported and valued by management.

CQC’s inspection methodology is still relatively new for military services and, although follow-up work has started recently, the majority of our follow-up work will take place in Year 2. We will continue to follow up recommendations made during Year 1 to ensure that improvements for patients continue to be implemented.

DENTAL SERVICES

CQC inspects only 10% of high street dental services each year, and does not formally rate these providers. The same approach is echoed in the DMS inspections – although there is no rating, recommendations are stated within the report.

Figure 6: Outcomes of DMS dental service inspections in Year 1



Since April 2017, CQC has undertaken inspections at 24 DMS dental services at the request of the Surgeon General (figure 6). Our inspection teams are led by specialist CQC inspectors, and always include a dental professional acting as a specialist advisor. We also speak with patients and staff to understand what the quality of care in a practice is truly like. Inspections look at the quality of care and treatment as well as a range of preventative measures.

Summary of findings from CQC's inspections in dental services

Safe

Overall, our inspections identified that:

- Staff had a clear understanding of the requirements of the DMS-wide Automated Significant Event Reporting (ASER) system.
- There was a high level of understanding of safeguarding responsibilities.
- Services followed relevant safety law when using needles and other sharp dental items.
- Dentists used rubber dams when providing root canal treatment in line with national guidance.
- Staff had been trained in how to deal with medical emergencies and refresher training was provided every six months.
- All relevant staff were registered with the General Dental Council (GDC) and had appropriate indemnity cover in place.
- Organisation-wide health and safety policy and protocols were in place to support with managing potential risk.
- As a result of poorly-maintained buildings, some practices were unable to achieve 'best practice' as detailed in guidelines issued by the Department of Health and Social Care – Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance'.
- Other services were unable to demonstrate how they effectively assessed levels of risk around health and safety as they were unable to obtain the outcomes of assessments, audits and routine safety checks regarding the dental centre from external contractors.
- Practices had suitable arrangements to ensure the safety of the X-ray equipment. A Radiation Protection Advisor and Radiation Protection Supervisor were identified for all practices.

Effective

Overall, our inspections identified that:

- Dental care records were detailed; containing comprehensive information about the patient's current dental needs, past treatment, medical history and treatment options.
- Patients' treatment needs were assessed by the dentist in line with recognised guidance.
- Prevention was put at the heart of each practice's approach in order to avoid oral health care issues whilst on deployment.
- Staff were well-trained and supported with their professional development required for registration with the GDC.
- Practices had referral arrangements with local NHS trusts if oral surgery was required.
- Even though the staff had a good awareness of the Mental Capacity Act (2005) and how it applied in their setting, some inspections identified a need for formal training.

Caring

Overall, our inspections identified that:

- All our inspections identified that staff were aware of their responsibility to respect people's diversity and human rights.
- Emerging themes suggested staff were professional, respectful and provided an honest and understandable explanation of each stage of their treatment plan.

Responsive

Overall, our inspections identified that:

- All our inspections found a high level of satisfaction regarding the responsiveness of the practice, including access to a dentist for an urgent assessment and emergencies out of normal hours.
- All staff had received training in complaints, so were familiar with the policy and their responsibilities. Processes were in place for documenting and managing complaints.

Well-led

Overall, our inspections identified that:

- Overall our inspections of dental services found a high standard of clinical care, underpinned by high standards of governance.
- A framework of organisation-wide policies, procedures and protocols was in place. In addition, there were dental-specific protocols and standard operating procedures that took account of current legislation and national guidance.
- The lines of communication within practices and with the base chains of command were structured, robust and of value to all parties and at all organisational levels.
- Dental fitness targets were reviewed along with failed attendance at appointments (FTA). Relevant outcomes from these meetings were shared with staff at the practice meetings.

Notable practice

When we inspect primary care high street dental practices, we aim to capture aspects of the delivery of care that are worthy of sharing with the wider profession to:

- promote good ideas and learning between providers
- develop insight about initiatives that enhance the patient experience and help to improve care
- reflect back to providers about their contribution to the wider health and social care agenda.

During our inspections in the dental services division of DMS, we found examples of high-quality care that are useful to share with dental teams across the DMS.

[Example 1 – Carver Barracks, July 2017](#)

The practice was undertaking an oral health audit involving the completion of a structured questionnaire with each patient. The audit looked in detail at each patient's history and current oral hygiene habits. Not only did the audit support with the identification of themes in relation to oral health need at the population level, it also provided each patient with bespoke advice on how to improve their oral hygiene. Feedback from patients suggested they valued the advice provided about oral hygiene.

The dental centre had developed good and effective relationships with the co-located medical centre. Where appropriate, the dental team referred patients to the medical centre for health promotion support, including smoking cessation and advice about alcohol use. An arrangement was in place for doctors to check a patient's dental record when they attended for an appointment. If the patient was out-of-date for a dental check-up they were advised to call across to the dental centre to make an appointment. This had a positive impact on ensuring patients were receiving a dental assessment in a timely way and meant the dental centre was consistently meeting dental targets. In addition, both practice managers shared attendance at unit committee and quarter master meetings, and raised agenda items on behalf of each other, which demonstrated effective and efficient use of resources.

Example 2 – RAF Cosford, October 2017

Leadership of the practice was inspiring and focused on change. A whole team approach was embedded at the practice as staff continually sought to improve and develop the service for patients. The following evidence supports this.

Staff were proactive in seeking patient feedback about the service and this was evident in the exceptional amount of patient feedback. The practice had a number of ways in which they sought feedback. Patients were informed about what happened with their feedback through a display in the waiting area titled 'What have we done with your suggestions'. Not only was it evident the practice acted on patient feedback, it was clear the practice valued the input of patients by informing them how their feedback had been used to improve the patient experience.

The lead member of staff for infection prevention and control (IPC) had developed specific checks for the surgeries to ensure they complied with national guidance on IPC. They included a 'weekly surgery checklist' and a 'material expiry dates' checklist used to routinely monitor that all dental materials were in-date. These checks were having the desired outcome as we found all instruments and materials were within their expiry date.

Monitoring outcomes for patients was based on the military dental targets. The way in which the targets were monitored, particularly for the MOL(AIR) project, allowed for performance to be compared on a month by month basis. Identifying variances and reasons for a dip in performance led to the team exploring ways in which improvements could be made.

The senior dental officer had developed 'clinical efficiency audit' methodology and conducted the audit between December 2016 and May 2017. The aim was to establish the effectiveness and efficiency of dental appointment times; were they sufficient or whether extra time was needed and could the team work more efficiently.

REGIONAL REHABILITATION UNITS

During the first year of the DMS inspection programme, CQC's regional rehabilitation team carried out two inspections of Regional Rehabilitation Units (RRUs).

These were at RRU Cosford and RRU Portsmouth during quarter 3 and quarter 4 respectively. The inspections were delivered through a bespoke inspection framework using the skills of inspectors with a physiotherapy or occupational therapy background. We included rehabilitation specialist advisors working within DMS on each inspection.

We did not give ratings for these inspections as CQC does not have the powers to rate comparable type services (for example, community rehabilitation). However, both services inspected were high performing with demonstrably good leadership. Only minor issues were identified at these locations, with no breaches of regulations. For example, at RRU Cosford some single-use items were found to have exceeded their 'use by' date, and at RRU Portsmouth the nature of the premises meant that it was difficult to maintain patient confidentiality at all times, though staff were conscious of this and checked with patients when carrying out assessments.

As we only carried out two inspections, no themes have emerged as yet. Looking ahead, we will carry out four further inspections during 2018/2019, including in countries outside England. We will also introduce ratings during the summer of 2018 as CQC gains powers to rate the comparable type services.

Summary of findings from CQC's inspections of RRUs

Safe

Across both RRUs, there was a good safety culture among staff. Staff were aware of their responsibilities and understood how to report incidents. There were few reportable incidents at either unit, but there was evidence that practice changed as a result of learning.

At both units where there were incidents relating to individual patients, there was some concern that patients were not always kept fully informed of the incident and its outcome.

All staff had received appropriate training. This included safeguarding training at the level appropriate for the unit. Systems were in place to ensure that the necessary risk assessments had taken place, including infection prevention.

Effective

Patients had their clinical needs assessed in line with national clinical standards. Care was planned with each patient individually. The assessment was carried out by a multidisciplinary team of medical, physiotherapy staff and Exercise Rehabilitation Instructors, and included podiatry staff where necessary.

Multidisciplinary team working was seen to be particularly effective and embedded in both the units inspected.

Both units used outcome measures to assess the effectiveness of treatment. There was also structured formal course assessment, which involved patients. Staffing levels at the times of inspection were acceptable, although there were a number of locum staff at both units. Staff changes were frequent – in part due to the rotation of staff though different military units. However, all staff were flexible and between the two main groups (physiotherapists and exercise rehabilitation instructors) courses were well-run.

Patient records were electronic, and used the defence medical information capability programme, which allowed staff to access patient information from any location.

Caring

All interactions that we observed between staff and patients were appropriate and staff demonstrated empathy towards the patient. They took appropriate steps to maintain patients' privacy and dignity, including chaperone where necessary.

Patient satisfaction was generally very high. There were a number of formal and informal opportunities for patients to feed back, and this was actively sought by unit staff.

Responsive

The services provided at RRUs are bespoke. Their purpose is an occupational one, to support injured service personnel to achieve optimal functional fitness.

Services such as podiatry were generally available, but there were some challenges with access to patients, depending on staff availability and size of the area covered by individual RRUs.

The greatest challenge faced by the RRUs was with regard to facilities. The units were situated on different bases, so staff on the unit were limited both in their ability to improve the facilities, but also dependent on the requirements of the host base. For example, one RRU had to relocate on a number of occasions during a year as the host base used the main gym hall to host other events.

Both units inspected had challenges meeting access targets, for example, timely access to the MIAC (multidisciplinary injury assessment clinic), or timely access to certain types of course. There wasn't a clear pattern as to reasons, although it was often linked to staff availability.

Well-led

Both units had exemplary leadership and staff were engaged in the development and leadership of the units. Staff groups were cohesive and worked well together to provide a high quality service. Leaders were visible, and all staff were encouraged to share their views and take part in service development.

Governance arrangements were in place with clear lines of accountability and reporting. There were appropriate meetings (for example, risk), which were minuted and staff were aware of outcomes.

Quality improvements were encouraged, both from feedback from patients as well as audit outcomes.

MENTAL HEALTH SERVICES

During the first year of inspection activity as part of the Defence Medical Services programme, CQC's mental health team carried out two inspections of services from the Department of Community Mental Health (DCMH).

These were at DCMH Brize Norton and DCMH Scotland during quarter 3 and quarter 4 respectively. The inspections were delivered through a bespoke inspection framework using the skills of inspectors with a mental health background. The inspection team was supported by a specialist military mental health nursing advisor.

Summary of findings from CQC's inspections of mental health services

Safe

Safe community mental health services ensure that people are protected by a strong comprehensive safety system, with a focus on openness, transparency and learning when things go wrong.

We found that the infrastructure at some bases was poor and presented risks to patients. At Brize Norton there was no clinically-based risk assessment of the environment to consider relevant risk factors. At Kinloss, the open access to clinic rooms, bathrooms and kitchen areas created multiple risks to both patients and staff.

Staffing levels were insufficient to meet targets and relied on the use of a number of locum staff. Not all teams were meeting their targets for routine referrals and, at Faslane, there were long waits, particularly for high-intensity treatment. Recruitment had proved challenging and staff reported that support from DBS (Defence Business Services) could be improved.

At Brize Norton not all relevant incidents had been recorded as serious events or investigated appropriately. Adult safeguarding training is not mandatory within DMCH and the policy did not reflect the latest legislative guidance. In some services, staff had limited awareness of their adult safeguarding responsibilities.

We found that at Brize Norton, 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 also concerned that patients had not always been followed up appropriately when they failed to attend an appointment. However, once patients were using a service, individual patient risk assessments were thorough and proportionate to risks. Teams had developed processes to share concerns about known patients in crisis or whose risks had increased.

Effective

Effective community mental health services ensure that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

In all 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, although there were delays at some services.

The teams included skilled and experienced staff who worked in partnership with other agencies to manage and assess patient needs and risks. Staff received appropriate supervision and appraisal, and were able to access developmental training.

Treatment plans were agreed with patients and consent was sought. However, this was not always clearly documented.

Example of effective good care

DCMH Brize Norton, October 2017

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 focused brief therapy and eye movement desensitization and reprocessing.

At the time of our inspection, the team had not been meeting its targets for urgent and routine referrals. However, this had improved over previous months following the introduction of new ways of working. 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 effectiveness of the clinics.

The team had also 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 very positive about this intervention.

Caring

Caring community mental health services ensure that people are supported, treated with dignity and respect, and are involved as partners in their care.

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 the feedback we received.

Patients told us that staff provided clear information to help with making treatment choices. The care records reviewed demonstrated that patients were involved in their care planning.

Responsive

Responsive community mental health services ensure that services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.

Not all teams were meeting their targets for routine referrals. At Faslane, there were long waits, particularly for high-intensity treatment. At Brize Norton, the team had developed clinics and group work to improve treatment options for patients and to begin to address waiting list issues.

The DCMH facilities were not conducive to a therapeutic environment. The Disability Discrimination Act was not being considered at Brize Norton, and dignity and privacy were compromised at other services. The location at Faslane made access difficult and stressful for both patients and staff. For example, patients undertook therapy within hearing of the firing range. Low staffing levels also meant that patients had to travel a significant distance to access appointments at main bases.

Teams monitored the length of the care pathway. In over 80% of cases, patients were discharged within nine months of starting treatment.

There was a system for handling complaints and concerns and patients felt that they would be listened to if they needed to complain. Although learning was captured from complaints, we found that not all complaints had been fully investigated.

Well-led

Well-led community mental health services have strong leadership, management and governance, to ensure the delivery of high-quality and person-centred care, to support learning and innovation, and to promote an open and fair culture.

There was a governance structure in both inspected services. However, this had not always led to improvement or learning. A number of known issues, such as staffing, the environment and critical human resources issues remained unresolved at services. Not all risks that we found on inspections had been captured within the risk and issues logs or reflected within the common assurance framework.

At both services, staff wanted to do a good job and were positive and clear about their own role in delivering the vision and values of the service. However, we found a mixed picture of leadership and differing levels of morale. Teams at Brize Norton and Kinloss reported that their management team was approachable and supportive of their work. Staff morale was good and they were engaged, enthusiastic and proud to work at the service. However, the management structure was not being adhered to at Faslane so that leadership roles were unclear. Morale was poor and some staff were displaying dysfunctional interpersonal relationships within the management and staff team. This was undermining performance and was not managed at any level.

Response of Defence Primary Healthcare to recommendations

Defence Primary Healthcare (DPHC) has monitored the judgements and recommendations published by CQC, and has used this to inform quality improvement work at a regional and national level.

Development and sharing lessons and recommendations

CQC identified gaps in the processes for monitoring patients on high-risk medicines (HRM). In response, an HRM Working Group was formed to share regional practice and introduce common practice. The group has collated a concise list of drugs with agreed associated coding, and distributed the NHS document *Suggestions for Drug Monitoring in Adults in Primary Care* 'Oct 17 to assist practices with appropriate drug monitoring.

CQC's inspection work around leadership prompted the Royal Navy Leadership Academy to facilitate a 'Leadership & Team Working Day'. This aims to deliver an understanding of what good leadership looks like and how instrumental it is for underpinning the delivery of safe and high-quality care. The initiative is being scoped for wider use.

CQC found that a number of medical facilities do not maintain a carers register. In response, DPHC has issued advice to all medical centres around ensuring that carers have access to flexible appointments, their health needs are monitored and that they are offered flu vaccinations. DPHC has requested the use of appropriate clinical codes and alerts so that staff can better offer support to patients who have a caring role.

CQC recognises that feedback from patients is a key lever for improvements in health care. Medical centres continue to develop innovative ways to collect patient experience data. One medical centre reported a lower response rate from its patients, the lack of qualitative data being a major limitation. They have trialled different ways to encourage patients to provide more feedback. A number of regions have started forming patient participation groups to gather additional input from patients. Another medical centre has implemented the 'Happy Helmet', which was welcomed by patients and encourages helpful feedback from across the patient population. This uses a picture representation of an MK7 combat helmet, which invites patients to write comments, both positive and negative, on leaf-like post-it notes and to stick these on the helmet.

A medical centre in North Region has been trialling an iPad to record patient feedback, which has prompted increased feedback. The patient population is prohibited from using mobile phones during the day so previously feedback was

poor. The success of this pilot is informing a wider DPHC initiative to change the way strategic patient experience data is gathered.

CQC identified a need to implement comprehensive service level agreements (SLAs), where NHS GPs are contracted to provide services on behalf of Defence Medical Services. SLAs are a key tool for setting out clear lines of responsibility and support, so that contractors can be fairly guided in their work, and held to account. DPHC has triggered an external 'Defence Healthcare Optimisation Study' which, as well as answering other questions, will seek to find better ways to deliver contracted services.

Updated Electronic Common Assurance Framework for the DMS

The electronic Common Assurance Framework or eCAF is a web-based version of the DMS Common Assurance Framework, which is accessible to all DMS personnel. It provides tailored variations of the assurance tool that are specific to DMS medical capabilities, allowing for bespoke qualitative reporting that enables the Chain of Command to consider recent evidence, evaluate site-specific healthcare processes, identify risks, and provide evidence to drive quality improvement. Following the inspection programme, the associated review of the eCAF has included amendments to the questions that are directly influenced by CQC's keys lines of enquiry and their outcomes.

The system contains a self-assessment tool, local governance management tool, an integrated management action plan, and a site-specific dashboard function that displays management information and status, as well as underpinning the formal assurance reporting process. It allows free text serial descriptions and management actions to be documented and interrogated, providing a system-wide 'data rich' thematic analysis. The DMSR will continue to evolve the eCAF in line with issues identified from all the available assurance tools, including CQC inspections of the DMS.

The eCAF is currently being rolled out across Defence Primary Healthcare and it is hoped that all primary healthcare assets are on the system by late summer 2018.

Conclusion

At the end of the first year of our inspections, we can conclude that the quality of care is mixed across the different services provided by DMS. Given the small number of inspections carried out so far, we are cautious about drawing firm conclusions, as a baseline of quality has yet to be established. However, early findings indicate that dental centres and Regional Rehabilitation Units are delivering good quality care. A number of medical facilities are providing good care, but we have identified that there are pockets of poor practice. CQC has made recommendations so that care can improve for the benefit of patients and the profession. We have only inspected two Departments of Community Mental Health and early indications are that effective, compassionate care is being delivered. However, work is needed to ensure that services are delivered safely and that patients can access care in a timely manner.

We want to continue to work with and support Defence Medical Services so that all military personnel and their dependants receive good high-quality care. We will continue to inspect military healthcare services to extend our view of quality and to provide a valuable baseline. We will also follow up the recommendations we have made. Our inspections have found a number of internal factors that contribute to high-quality care, and factors that may inhibit it. We recognise the need for clearer lines of accountability around the shortfall in the workforce, along with broader sharing of best practice and innovation.

Going forward

As a learning organisation, CQC recognises the aspects of our first year of inspections that have worked, and those that we need to improve. Moving forward into Year 2, we have committed to inspect primary care rehabilitation facilities, alongside medical facilities. In Year 2, our inspection work will be targeted at the areas of higher risk, which are considered to be general practice and mental health.

Commitment from Defence Medical Services Regulator

The Defence Medical Services is a progressive and learning organisation that welcomes external assurance by CQC. The DMS is determined to address identified shortfalls in care. In response to early CQC reports, the Surgeon General directed work to identify key factors influencing Defence Primary Healthcare performance. Areas of concern are being addressed by Short Term Implementation Measures, while a Defence Healthcare Delivery Optimisation study is considering options for the future model of healthcare delivery across Defence. The Surgeon General is committed to continuing the CQC inspection programme, which is driving quality improvement, informing the DHDO study, and promoting confidence in the delivery of healthcare across the Armed Forces community.

Head Defence Medical Services Regulator and Inspector General

Appendix A: CQC's person-centred approach

These slides are taken from a presentation delivered at the DMS Annual Review Meeting and show an example of how CQC focuses its work.

Our Focus :Scenario



- Emma Brown has just joined the Army Foundation College.
- She is 16 years of age
- She does not currently have access to her mobile phone.
- Emma cannot leave the base or move buildings without an escort.
- Prior to joining, Emma was in care. She has no family support.
- Some days Emma feels depressed and alone. She told the nurse that she sometimes has suicidal thoughts.
- Emma has developed mild asthma. Emma struggles with reading and cannot read the guidance with her inhaler.
- She has been involved in a couple of fights and she was sent to the GP practice for wounds to her hands.

Safe, effective and compassionate primary care for Emma



Arrangements in place to safeguard and care for Emma:

- A Safeguarding Register which is instantly accessible and flags Emma's vulnerability
- Named GP who communicates proactively with Emma.
- Longer appointment times required. DNAs followed up as priority.
- Proactive partnership working with chain of command, social services and pastoral teams.
- Prompt referral to mental health team as necessary.
- GP Practice staff are involved in supporting Emma during periods of leave, ensuring she can access NHS services.
- Pharmacy Support to read and understand the inhaler guidance

5

CQC's key lines of enquiry (KLOEs) focus around Emma as a person, and whether the medical centre is able to proactively meet her individual needs and keep her safe. This involves ensuring that safeguarding policies are in place and that staff are trained to take action if they need to. The inspection team would look to ensure that staff (including locums) can quickly identify that Emma is vulnerable and so requires rapid access to see a GP. They would seek to ensure that Emma can access longer appointments to discuss her concerns and that, if she does not attend an appointment, this is followed up straight away.

Inspectors would also look for evidence of strong partnership working with Chain of Command, SAFFA (The Armed Forces Charity), pastoral teams, social services and the mental health team, to ensure that all available resources are accessible to support Emma. We would also look to see that a timely referral had been made into the mental health team and that Emma had been supported to attend the appointment. When Emma leaves her Unit during leave, a responsive and caring practice would ensure that she knows how to access help through NHS services if she needs it.

Appendix B: Inspection ratings 2017/18

Service	Overall rating
Medical facilities	
Abbey Wood Medical Treatment Facility	Requires improvement
Abingdon Station Medical Centre	Requires improvement
Aldershot Garrison	Good
Army Foundation College	Good
ATC Pirbright	Outstanding
Bovington Medical Centre	Requires improvement
Brawdy Medical Centre	Inadequate
Chatham Medical Centre	Good
Chester Medical Facility	Requires improvement
Chicksands Station Medical Centre	Good
DMS Stafford	Good
Fort George Medical Centre	Inadequate
HMS Drake Medical Centre	Good
HMS Excellent Medical Centre	Good
HMS Neptune Medical Centre	Requires improvement
HMS Raleigh Medical Centre	Good
HMS Sultan Medical Centre	Good
Hounslow	Requires improvement
Leuchars Station Medical Centre	Outstanding
MRS Aldergrove	
MRS Royal Military Academy Sandhurst Medical Centre	Requires improvement
Northwood HQ	Requires improvement
RAF Boulmer Medical Centre	Requires improvement
RAF Conningsby Medical Centre	Outstanding
RAF Cosford Medical Centre	Good
RAF Lossiemouth Medical Centre	Outstanding
RAF Marham Regional Medical Centre	Good
RAF Scampton Medical Centre	Inadequate
RAF Valley Medical Facility	Good
Shorncliffe Medical Centre	Requires improvement
Shrivenham Medical Centre	Requires improvement
St Athan Medical Treatment Facility	Requires improvement
Warminster Primary Healthcare Centre	Requires improvement
Woolwich Medical Centre	Requires improvement
York Garrison Medical Treatment Facility	Good

Service	Overall rating/outcome
Dental facilities	
Carver Barracks Dental Centre	Meets all key questions
Catterick Dental Centre	Does not meet all key questions
Centre for Restorative Dentistry	Meets all key questions
Chicksands Dental Centre	Meets all key questions
Deepcut Dental Centre	Meets all key questions
Dental Centre Minley	Meets all key questions
Dental Centre RAF Linton On Ouse	Meets all key questions
Dental Centre Tidworth	Does not meet all key questions
DPHC Dental Centre Bickleigh	Meets all key questions
DPHC Dental Centre Chatham	Meets all key questions
HMS Drake Dental Centre	Does not meet all key questions
HMS Neptune Dental Centre	Meets all key questions
Innsworth Dental Centre	Meets all key questions
Leuchars Dental Centre	Meets all key questions
Lyneham Dental Centre	Meets all key questions
RAF Brize Norton Dental Centre	Meets all key questions
RAF Cosford Dental Centre	Meets all key questions
RAF Leeming Dental Centre	Does not meet all key questions
Shrivenham Dental Centre	Meets all key questions
Stafford Dental Centre	Meets all key questions
St Athan Dental Centre	Meets all key questions
Topcliffe Dental Centre	Meets all key questions
Windsor Dental Centre	Meets all key questions
Woolwich Dental Centre	Meets all key questions
Mental health services	
Department of Community Mental Health – Scotland	Inadequate
Department of Community Mental Health – RAF Brize Norton	Requires improvement
Regional rehabilitation unit services	
Cosford Regional Rehabilitation Unit	Meets all key questions
Portsmouth Regional Rehabilitation Unit	Meets all key questions
Follow-ups	
Abbey Wood Medical Treatment Facility	Good
Army Foundation College	Good
HMS Neptune Medical Centre	Good
RAF Cosford Medical Centre	Good
RAF Scampton Medical Centre	Good

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