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>Area</th>
<th>Rating</th>
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<tbody>
<tr>
<td>Overall rating for this service</td>
<td>Good</td>
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<tr>
<td>Are services safe?</td>
<td>Good</td>
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<tr>
<td>Are services effective?</td>
<td>Good</td>
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<tr>
<td>Are services caring?</td>
<td>Good</td>
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<tr>
<td>Are services responsive to people’s needs?</td>
<td>Good</td>
</tr>
<tr>
<td>Are services well-led?</td>
<td>Good</td>
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Date of inspection: 02 – 04 April 2019
Date of publication: 24 July 2019
Overall Summary
The five questions we ask about our core services and what we found

Following our previous inspection in October 2017, we rated DCMH Brize Norton as requires improvement for providing safe, responsive and well led services. We had concerns about the environment, that staffing was not sufficient, that staff had not undertaken required training, and that not all patients at risk had been followed up. We carried out this announced inspection at the Department of Community Mental Health – Brize Norton (DCMH) and Mental Health Team St Athan between the 02 and 04 April 2019.

Overall, we rated the service as good.

We found the following areas of good practice:

- Overall staffing arrangements had improved and were sufficient to meet the needs of patients.
- Staff could access mandatory and developmental training and a range of clinical support.
- All referrals were clinically triaged by the mental health team to determine whether a more urgent response was required and to monitor whether patients’ risks had increased. Individual patient risk assessments were thorough and proportionate to patients’ risks.
- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. The team worked in partnership with other agencies to manage and assess patient needs and risks. Clinicians were aware of current evidence based guidance and standards and patients could access a range of psychological therapies as recommended in NICE guidelines.
- Formal care plans and consent to treatment forms had been introduced at the team and were in place for patients following assessment. Care and treatment plans were reviewed regularly by the multidisciplinary team. Patients told us that staff provided clear information to help with making treatment choices.
- Staff were kind, caring and compassionate in their response to patients. 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.
- The team was meeting the response target for urgent and routine referrals and there were no waiting lists for treatment.
- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. Systems and processes had been improved to better capture governance and performance information. All potential risks that we found had been captured within the risk and issues logs and the common assurance framework. All risks identified included mitigation and action plans.
- 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.
The team had addressed all concerns that we raised with them following our October 2017 inspection.

However, we found one area where the DCMH could make improvements. The Chief Inspector of Hospitals recommends that the DCMH addresses the following:

- While the team at Brize Norton did their best to ensure privacy and safety of the environment this remained challenging. Patients with a physical disability did not have easy access to a disability equipped toilet. Soundproofing was not adequate in some areas meaning the team could not use all treatment rooms. However, the team worked hard to ensure alternate arrangements were made to meet people’s needs. The regional management team had raised these concerns with the defence infrastructure team but plans to address these issues had not yet been agreed.

Professor Edward Baker
Chief Inspector of Hospitals

**Are services safe?**

We rated the DCMH as good for safe because:

- Overall staffing arrangements had improved and were sufficient to meet the needs of patients.
- Referrals were clinically triaged to determine whether a more urgent response was required and to monitor whether patients’ risks had increased. Individual patient risk assessments were thorough and proportionate to patients’ risks. The team had developed a process to share concerns about patients in crisis or whose risks had increased.
- Where a known patient contacted the team in crisis, the team responded swiftly. Both staff and patients confirmed easy access to the psychiatrist should a full assessment be required.
- Staff had undertaken all required training.
- Adult safeguarding training had been delivered to the team and the staff had a good awareness of safeguarding procedures and practice.
- Incidents reported had been appropriately investigated and used to inform practice.
- A clinically based risk assessment of the environment had been developed to consider relevant risk factors.
- Staff had addressed previous concerns regarding the management of prescriptions.

However:

- The team’s main base was not fully accessible to people with a disability and contained insufficient treatment rooms due to soundproofing issues. However, the team worked hard to ensure alternate arrangements were made to meet people’s needs. The regional management team had raised these concerns with the defence infrastructure team but plans to address these had not yet been agreed.
- Despite staff undertaking required training nearly all staff we spoke with told us about difficulty in accessing the training system meaning that they were undertaking training off site.
### Are services effective?

We rated the DCMH as good for effective because:

- 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 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.
- Formal care plans and consent to treatment forms had been introduced at the team and were in place for patients following assessment. Care and treatment plans were reviewed regularly by the multidisciplinary team. Patients told us that staff provided clear information to help with making treatment choices.
- The team had developed an operating procedure to assist staff about how to manage assessment under the Mental Health Act.

### Are services caring?

We rated the DCMH as good for caring because:

- 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.

### Are services responsive to people’s needs?

We rated the DCMH as good for responsive because:

- Clear referral pathways were in place. Urgent referrals were considered by the end of the next working day and the target to see patients for a routine referral was 15 days. The team was meeting the response target for urgent and routine referrals and there were no waiting lists for treatment. All patients had a care co-ordinator.
- Where a known patient contacted the team in crisis during office hours the team responded positively. This included rapid access to a psychiatrist.
- The collaborative clinics and group work sessions had improved treatment options for patients and had also addressed waiting list issues.
- The team had a procedure regarding following up patients who did not attend their appointment (DNA process). The DNA rate was six per cent which was below the DMS target.
- 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.
However:

- Travelling required by patients for appointments was generally less than one and half hours. Most patients felt their appointment was at a convenient location and at a convenient time however in the patient experience survey between September 2018 and March 2019 18% of St Athan patients stated their appointment was not at a convenient location.

Are services well-led?

We rated the DCMH as good for well-led services because:

- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. Systems and processes had improved and better captured governance and performance information.
- Potential risks that we found had been captured within the risk and issues logs and the common assurance framework. All risks identified included mitigation and action plans.
- 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.
- The team had addressed or escalated all concerns that we raised with them following our October 2017 inspection.
- A range of audit and quality improvement projects were being undertaken.

Our inspection team

Our inspection team was led by a CQC Inspection Manager Lyn Critchley. The team included one inspector and a specialist mental health nursing and social work advisor. The Senior National Professional Advisor for GP services also joined the inspection.

Background to Department of Community Mental Health – RAF Brize Norton

The department of community mental health (DCMH) at Brize Norton provides mental health care to a population of approximately 16,720 serving personnel from across all three services of the Armed Forces. The catchment area includes bases across Oxfordshire, Wiltshire, Buckinghamshire, Gloucester and South Wales. The team also provide care to service personnel who are sick at home in the surrounding area. The team operates from a main base at RAF Brize Norton and a satellite service based at MOD St Athan in South Wales. At the time of our inspection the DCMH caseload was approximately 465.

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 most of appointments being held at the team’s bases at Brize Norton and St Athan.
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 DCMH Brize Norton in October 2017. The service was rated as Requires Improvement overall and Requires Improvement for the safe, responsive and well led domains. At that time, the satellite service at St Athan was not fully operational due to staffing needs so was not inspected.

The report for this inspection can be found here: LINK TO BE ADDED PRE PUBLICATION

We carried out this announced follow up inspection between 2 and 4 April 2019. During this inspection we focused on the safe, responsive and well led domains at Brize Norton to consider what improvement had occurred. This report covers our findings in relation to the recommendations made and any additional improvements made since our last inspection. At St Athan we looked at all five of the key questions and our findings are included in this report.

How we carried out this inspection

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

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

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

We carried out an announced inspection between 02 and 04 April 2019. During the inspection, we:

- looked at the quality of the team’s environments;
- observed how staff were caring for patients;
- attended three collaborative clinics and an initial assessment;
- spoke with eight patients who were using the service;
- spoke with the management team;
- met with the regional clinical director;
- met with the senior medical officer for Brize Norton;
- spoke with ten other staff members; including doctors, nurses, a psychologist and a social worker;
- reviewed 32 comment cards from patients;
- looked at 16 clinical records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- examined minutes and other supporting documents relating to the governance of the service.
Are services safe?

Our findings

**Safe and clean environment**
- At St Athan the team shared their facility with the base’s general medical practice. The mental health team’s area was distinct from the GP team and was found to be well decorated and clean.
- Staff at St Athan had access to hand wash facilities and hand gels were available. The team had received infection prevention training and staff adhered to infection control principles, including handwashing.
- General health and safety and fire safety checks were in place at both team bases.
- At the last inspection, we had been concerned about the clinical risks within the environment at Brize Norton. Since, the team had developed a comprehensive clinically based risk assessment of the environment for both bases. This included reference to risks presented by potential ligature anchor points and lone working. Actions undertaken to mitigate the concerns included guidance for staff to raise their awareness of environmental risks and by escorting patients around the building.
- While the team at Brize Norton did their best to ensure privacy and safety of the environment this remained challenging. We had also been concerned that dignity and privacy were compromised by poor soundproofing in areas at Brize Norton. The team’s management had escalated these issues to regional operations. The regional team told us a business case had been developed to install soundproofing and had raised this with the central command. Until the work is undertaken the team managed this through the careful allocation of rooms for treatment sessions.
- Previously we had been concerned that dignity and privacy were compromised at Brize Norton by the shared use of the facility with another RAF function. Since the team have locked the connecting door and ensured that both teams use their distinct access to the building.
- The building at Brize Norton had limited access to people with a disability. Patients with a physical disability did not have easy access to a disability equipped toilet. The team had escalated these concerns to the regional management team. The regional management team had raised these concerns with the defence infrastructure team but plans to address these issues had not yet been agreed. In the interim, the team had made alternate
arrangements to meet patients with a disability at the base’s GP practice and a disabled access toilet could also be accessed in the adjacent building.

- The building at Brize Norton was fitted with a safety alarm for staff to use in the event of an emergency however when tested at the previous inspection it had not fully worked. This had been addressed and staff only saw patients in rooms where the alarm was fitted. Staff at St Athan had access to personal alarms. Arrangements were in place for logging which staff were in or out of the building at both bases.

**Safe staffing**

- At the time of the previous inspection, there were a number of posts unfilled and staffing arrangements were insufficient. Not all patients had been allocated a care coordinator. Staff had told us 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. Staff shortage had also led to the satellite service based at St Athan not being fully operational. Instead staff had offered a small number of sessions at St Athan, with the majority of patients travelling to Brize Norton to receive their service.

- Since, defence had undertaken recruitment and staffing was sufficient to ensure that there was a full team at St Athan. The team consisted of an assistant department manager supported by three band 7 mental health practitioners, two nurses, a social worker and administrator. A psychiatrist and the lead psychologist from Brize Norton visited the clinic on a regular basis.

- At Brize Norton there were vacancies for two military and one civilian nurse, a social worker, a psychologist and for the practice manager and one administrator. This equated to 32% vacancies across all posts. Gaps in provision were mainly covered by locum staff. Locum staff were regular and received training and development in line with substantive staff. The gap in social work provision was managed through the social worker at St Athan with the support of a nurse from the Brize Norton team. The team had been without a practice manager for six months. At the time of the inspection a replacement had been recruited and was about to take up post. There was an additional gap in administration due to sickness. In the interim this role was being covered by administrative staff from the base’s medical centre.

- The regional director confirmed that recruitment was underway to address all gaps. He and the team confirmed that there had been improvement in the recruitment process which was undertaken by a central defence service.

- At the time of the inspection the overall team’s caseload was 465. The team was meeting targets for assessment of routine and urgent referrals. There were no waiting lists for treatment. The average waiting time from referral to treatment was 24 days. All patients had an allocated care coordinator. All clinical members of the team were assigned a caseload. The average caseload at St Athan was 10 cases per care co-ordinator but caseloads ranged between five and 17.

- Caseloads were managed and reassessed regularly. Patients and staff told us that there was rapid access to a psychiatrist when required. Staff stated that they were busy but caseloads were manageable. Staff told us that there was time to be involved in governance and their personal development.

- The overall average mandatory training rate for staff was 90% across the defence medical services key training requirements. Ten courses were classed as mandatory. We saw that regular locum staff received training similar to permanent staff. The team had a designated a training lead who ensured that training records were up to date and reminded staff of training requirements. Information provided indicated that training compliance ranged from 100% for child protection and infection control to 85% for healthcare governance awareness. Despite
staff undertaking required training nearly all staff we spoke with told us about difficulty in accessing the training system meaning that they were undertaking training off site. Managers confirmed that staff were given time to complete this.

Assessing and managing risk to patients and staff

• All referrals were managed by staff at Brize Norton. Referrals went to the team from medical officers, GPs and other DCMHs and 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. Routine referrals were 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. This had not always been the case when we inspected previously.

• Once a patient was accepted by the team a thorough risk assessment was undertaken and this was reviewed by the multi-disciplinary team. Where a known patient contacted the team in crisis the team responded swiftly.

• The team’s lead social worker based at St Athan acted as the designated safeguarding lead across the service. Due to a gap in social worker provision at Brize Norton, a nurse within that team acted as safeguarding champion and was supported by the regional social work lead.

• Adult safeguarding was not part of the DMS’s mandatory training requirements, however, levels 1 to 3 child protection were. Staff had undertaken required levels of child protection training. In addition, staff had received some bespoke training in adult safeguarding from the local safeguarding board and the team’s lead social worker. The regional clinical director confirmed that he was about to commission formal external adult safeguarding training for all staff.

• The Ministry of Defence had an up to date policy for child protection. However, we were told that the adult safeguarding policy had not yet been updated and did not meet the latest guidance in respect of the Care Act 2014. Local referral procedures had been developed to support staff’s understanding of safeguarding practice.

• The safeguarding lead had a list of potential safeguarding concerns which she took to the weekly multidisciplinary meetings. The team operated a ‘worries list’ to share concerns with colleagues about specific patients.

• The DCMH did not dispense medication at either base. Instead, prescriptions were issued for dispensing at the on base pharmacy. Since our last inspection, a local procedure had been put in place for the storage and logging of prescription numbers.

• Ninety per cent of staff had received annual basic life support, AED (defibrillator) and anaphylaxis training. At St Athan the team shared the facility with the medical centre and had access to a defibrillator. At Brize Norton 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. There was a written procedure for response in a medical emergency.

• 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

• Across the service there had been nine recorded significant events in the 12 months prior to our inspection. These had included one case where a safeguarding referral had not been made, one case were a patient who did not attend had not been followed up, three concerns regarding communication with other services, two documentation issues and one breach of the urgent referral response time.

• We did not find any other concerns that should have been recorded as a serious event.
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 where a safeguarding referral had not been made a full team discussion and learning session had been carried out. 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?

Our findings

Assessment of needs and planning of care

- All referrals and initial assessment was managed by staff at Brize Norton. Following this, a thorough assessment of the patient’s needs was undertaken by the allocated clinician. Clear care and treatment plans were developed and this information was shared with patients.
- Since our previous inspection formal care plans had been developed across the service and were being rolled out to all patients as part of a patient information wallet. These were reviewed every two months with the patient. Where patients had received these, they were considered to be helpful and address their needs.
- 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 the team and with GP and other mental health services. Locum staff now received timely access to patient records. This had been an issue at the previous inspection.

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 governance meetings.
- The team at St Athan had access to a psychologist and the nurses were also trained in a range of psychological treatments. Patients could 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.
- 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 an audit schedule and plan had been developed. Clinical staff had participated in monitoring and clinical audit including: case notes’ quality, caseload analysis, referral rates, environment and ligature audit, ASER (significant event reporting) compliance, supervision rates, group work outcome and patient experience.

Skilled staff to deliver care

The team consisted of skilled and experienced staff who worked in partnership to manage and assess patient needs and risks. The team at St Athan consisted of nurses and social workers but had access and clinical leadership from a consultant psychiatrist and clinical psychologist.

Where new staff joined the team, 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.

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 and at bi-monthly reviews.

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 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 the Veteran Transition Intervention and Liaison Service (TILS). Where necessary, when handing care over on discharge of a patient from the services, the team would meet with the receiving NHS teams.

The team had developed a GP liaison role and had delivered several sessions to GPs and primary care staff regarding ‘step one’. This is a defence initiative to ensure timely access to primary mental health intervention.

Mental Health legislation

The Mental Health Act was used very infrequently at the service. Staff did not receive formal training in the Mental Health Act and Code of Practice however informal training had been delivered by team members on aspects of the Act.

The team had developed an operating procedure to assist staff about how to manage assessment under the Mental Health Act. Should a Mental Health Act assessment be required the provider worked with the local NHS provider to access this through civilian services.

Good practice in applying the MCA and consent

Staff had received bespoke training in the Mental Capacity Act. There was not a specific policy on the Act within defence services but information was available to staff and all had awareness of the principles of the Act and the need to ensure capacity and consent.

It is the individual healthcare professional’s responsibility to assure capacity and gain consent and this should be considered on an ongoing basis. We found some evidence of
capacity assessments in the records we reviewed. In line with the principles of the Act, staff assumed capacity unless there was evidence to suggest otherwise.

- We observed staff discussing consent to treatment with patients. Patients told us that they had the need for consent to treatment clearly explained to them. In records we reviewed we found records of consent to share information. Consent to treatment forms had recently been introduced for each therapy across the DCMH and we found records of consent to treatment in most cases.

Are services caring?

Our findings

Kindness, dignity, respect and support

- Staff at St Athan showed us that they wanted to provide high quality care. We heard about some very positive examples of staff providing practical and emotional support to people.
- We received 29 comment cards from patients at St Athan. These unanimously stated that staff were kind, caring and compassionate in their response to patients. The patients we spoke with told us that staff were supportive and that they were treated with respect. We observed staff treating patients with respect and communicating effectively with them.
- Staff demonstrated that they were knowledgeable about the history, possible risks and support needs of the people they cared for. Staff worked with patients to reduce their anxiety and behavioural disturbance.
- Confidentiality was understood 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 agreed with patients and a copy offered to them. Patient feedback suggested staff provided clear information to help with making treatment choices.
- Most patients we spoke with did not want involvement of their families and carers. However, one patient confirmed their family had been involved and well supported by the team.
- 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 six months to March 2019, 33 people at St Athan had participated in the survey. This showed a high level of satisfaction. Ninety-one per cent of patients would recommend the service to friends and family; 91% felt they would be listened to if they complained and felt involved in decisions regarding their care; 97% felt the appointment was at a convenient time however 82% 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 in defence: 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 our previous inspection the satellite service based at St Athan in South Wales was not operational due to staffing needs. Staff from Brize Norton had offered a small number of sessions at St Athan with most patients travelling to Brize Norton to receive their service. Patients had not been happy about having to travel a considerable distance to receive their treatment. Since 2018 the team had been re-established at St Athan to better meet the needs of patients from South Wales.
- At the time of this inspection the overall DCMH’s caseload was 465. Thirty-five of these were receiving treatment from St Athan: 430 at Brize Norton. All patients had an allocated care coordinator. All clinical members of the team were assigned a caseload. The average caseload was 10 cases per care co-ordinator but caseloads ranged between five and 17.
- All referrals were managed by staff at Brize Norton. Referrals went to the team from medical officers, GPs and other DCMHs and 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. Routine referrals were 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. This had not always been the case when we inspected previously.
- Information provided showed that between December 2018 and February 2019 the DCMH had received 15 urgent referrals. The team had met the target for response to the referral in all cases. This had been an improvement in performance on previous months.
- The information provided showed that the DCMH had received 137 routine referrals during the same period. The performance data (KPI) suggested that the team had only met the response time in 64% of cases. Following this, the manager undertook a full caseload audit to better understand response to referrals. This established that during January 2019 just one referral had not been assessed within the 15-day limit. This had been due to the patient’s availability for the assessment. During the month the response date had been recorded wrong in 20 cases. Since the manager has worked with staff to address recording errors on the electronic referral form. In March 2019, the KPI was missed in just one case.
- Following assessment there were no waiting lists for treatment. The average waiting time from referral to treatment was 24 days.
- Within the Armed Forces, personnel can be ordered to attend for a medical appointment. However, personnel do not have to accept treatment. The DCMH had a procedure regarding following up patients who did not attend their appointment (DNA process). The team confirmed that usually only patients who had been deployed to other duties at short notice did not attend. The DNA rate at March 2019 was 6%. This was within the DMS target of 10%.
The facilities promote recovery, comfort, dignity and confidentiality

- There were sufficient treatment rooms at St Athans. The environment was comfortable, had a well-equipped waiting area and was accessible to people with a disability.
- 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 December 2018, 90% felt the appointment was at a convenient time.
- The DCMH serves a population located across five counties and South Wales. At the previous inspection some patients told us that their appointment meant considerable travel: this was particularly patients located in South Wales whose home base could be as far as four hours from Brize Norton. At this inspection most patients we spoke with or received comments from were happy with the location of their appointment however some patients in wales remained concerned regarding the length of travel to the team in St Athan. In the patient experience survey between September 2018 and March 2019 18% of St Athan 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 department 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 December 2018 found that 98% of patients felt they would be listened to if they complained.
- In the 12 months prior to our inspection there had been six complaints; two related to inconsistency in treatment, two related to a delay in treatment, one to a cancellation of appointment and one where when a patient was unhappy with the care provided. All complaints, whether written or verbal, where recorded in the complaints log. The department manager confirmed that she had fully investigated all of the complaints. No complaints 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.

Are services well-led?

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 teams mission statement was:
“To deliver a safe and effective mental healthcare service for Defence in order to enhance and sustain the operational effectiveness of the three services”.

- Staff were positive and clear about 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 since the last inspection in October 2017.
- Systems had been improved to better capture governance and performance information. Local processes included incident and complaints procedures, training and supervision logs and local procedures for managing referrals and safeguarding.
- The management team had access to detailed information about performance against targets and outcomes. The team was meeting targets for assessment and treatment and had addressed previous waiting lists.
- 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 each quarter. The CAF addressed all areas of concern that we had found at the inspection of October 2017.
- 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 practice manager and social worker, lack of adult safeguarding training and suitability of clinical space. We did not find any other issues that had not been captured in the risk register.
- Following our previous inspection, we rated DCMH Brize Norton as requires improvement for providing safe services, responsiveness and leadership. We had concerns about the environment, that staffing was not sufficient, that staff had not undertaken required training, and that not all patients at risk had been followed up. The team had not been meeting targets. When we carried out this follow up inspection we found that all the above recommendations had been acted on or escalated appropriately by the team at Brize Norton. However, firm plans were not yet in place to address all of the environmental concerns.
- At the time of the previous inspection, staffing arrangements were insufficient which had led to the satellite service based at St Athan not being fully operational. Instead staff had offered a small number of sessions at St Athan, with the majority of patients travelling to Brize Norton to receive their service. Since the team had undertaken recruitment and staffing was sufficient to ensure that there was a full team at St Athan. The had addressed many patients concerns about travelling long distances to receive treatment. Patients were extremely positive about this service.
- While the environment at Brize Norton remains challenging the team had worked hard to ensure privacy and safety. Environmental risk assessments have been put in place and include all relevant risks. Staff awareness of safety within the building had improved. While a solution to soundproofing is found, staff worked hard to ensure patients were not overheard while in treatment.
Leadership, morale and staff engagement

- The management team consisted of a clinical lead, a department manager and a deputy department manager who was lead at St Athan. The practice manager post had been unfilled for six months however a new practice manager was about to begin at the time of the inspection.
- 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 their work and felt this was making a positive difference to the quality of care offered to patients.
- 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. While there remained gaps in some roles staff management had looked to creative ways to cover these responsibilities. Staff were busy but motivated to deliver the service.
- 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.
- 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

- Clinical staff had participated in monitoring and clinical audit including: case notes’ quality, caseload analysis, referral rates, environment and ligature audit, ASER (significant event reporting) compliance, supervision rates, group work outcome and patient experience.
- Prior to our previous inspection the collaborative clinic and therapeutic group work had been developed to offer more timely access to patients who required lower level and more practical intervention. The team audited this approach during 2018. This audit demonstrated high levels of patient satisfaction.
- Formal care plans had been introduced at the team in 2018 and were in place for newly accepted patients. Where available care plans were detailed and captured all relevant needs and risks. Patients who had a care plan told us that these were valued and useful.
- Consent to treatment forms had been introduced for all therapies. We found records of consent to treatment in most records. We observed staff discussing consent to treatment with patients. Patients told us that they had the need for consent to treatment clearly explained to them. In all records we reviewed we found records of consent to share information.