Defence Medical Services

Department of Community Mental Health – Tidworth

Quality Report

DCMH Tidworth
Department of Community Mental Health
The Queen Elizabeth Memorial Centre
St Michaels Avenue
Tidworth
Wiltshire
SP9 7EA

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

Ratings

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

Overall Summary

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

We carried out an announced inspection at the Department of Community Mental Health Tidworth between the 09 and 11 July 2019. Overall, we rated the service as Requires Improvement. The Chief Inspector of Hospitals recommends that the DCMH addresses the following:

- Following concerns raised at the service the Defence Medical Services headquarters commissioned an audit which found that while there were no immediate patient safety concerns there were risks that needed to be addressed. These included the management of the referral pathways, clinical risk management processes, the follow up of patients who did not attend, clinical record keeping and multidisciplinary decision-making, incident reporting and leadership. Work was underway to address these issues, but further improvement was required.
- Not all incidents had been reported appropriately or fully investigated. Further work was required to ensure learning from incidents was shared and used to drive a safety culture.
- A lack of administration staff had significantly impacted on clinicians' workload due to covering reception and completing administrative tasks. At times this had increased patient risk due to poor communication.
- There was not a clear process to manage clinicians' caseloads in their absence. This meant there had been a risk of patients not receiving treatment.
- Managers had recently introduced a number of new procedures to strengthen the governance and administration of the service but these had not been embedded. As a result, the service did not have access to accurate information about performance to support governance and improvement. The risk and issues logs had not captured all risks and the common assurance framework did not reflect a number of important risks.
- Staff reported that morale had been very poor, but this had improved slightly over previous months.
- Recording of clinical and case management supervision was very poor. While staff stated that they had received supervision the records did not demonstrate this.
- The team had a system for handling complaints and concerns but this required further improvement to fully capture patients' concerns.

However, we found areas of good practice:

- Overall staffing arrangements were sufficient to meet the needs of patients. The team consisted of skilled and experienced staff who worked in partnership with other agencies to manage and assess patient needs and risks.
- The service had recently introduced formal care plans and the multidisciplinary team reviewed these. Patients could access a wide range of psychological therapies and the service had developed a range of therapeutic groups to provide more timely access to patients who required lower level and more practical interventions.
- Staff showed us that they wanted to provide high quality care. We observed some positive examples of staff providing practical and emotional support to people. Most patients said they were well supported, and that staff were kind and enabled them to get better.
- Referral pathways had improved. The team was recently meeting the response target for urgent and routine referrals and waiting lists for treatment had reduced over previous months. The team had recently developed a procedure regarding following up patients who did not attend their appointment.

- Staff reported that they felt supported by their immediate colleagues and that individual members of the management team were approachable and supportive of their work. Staff were positive about the recent improvements to the clinical pathway and care delivered, and felt this was beginning to make a positive difference to the quality of care offered to patients.

Professor Edward Baker

Chief Inspector of Hospitals

Are services safe?

Requires Improvement

We rated the DCMH as requires improvement for safe because:

- Following concerns raised at the service the Defence Medical Services headquarters commissioned an audit which found that while there were no immediate patient safety concerns there were risks that needed to be addressed. These included the management of the referral pathways, clinical risk management processes, the follow up of patients who did not attend and incident reporting. Work was underway to address these issues but further improvement was required.
- Staff had not reported all adverse incidents that should have been reported nor had managers fully investigated incidents that had been reported. Further work was required to ensure learning from incidents was shared and used to drive a safety culture.
- A lack of administration staff had significantly impacted on clinicians' workload due to covering reception and completing administrative tasks. At times this had increased patient risk due to poor communication.
- There was not a clear process to manage clinicians' caseloads in their absence. This meant there had been a risk of patients not receiving treatment.

However:

- The mental health team had improved the triage process to ensure that referrals were clinically assessed to determine whether a more urgent response was required and to monitor whether patients' risks had increased.
- Individual patient risk assessments were proportionate to patients' risks. The team had recently developed a process to share concerns about patients in crisis or whose risks had increased. We saw good evidence of the team following up on any known risks.
- 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.
- Overall staffing arrangements were sufficient to meet the needs of patients.
- Staff had undertaken required training.
- Adult safeguarding training had been delivered to the team and the staff had a good awareness of safeguarding procedures and practice.

Are services effective?

Good

We rated the DCMH as good for effective because:

- Formal care plans had recently been introduced at the team and were in place for all newly admitted patients. Patients who had a care plan told us that these were valued and useful. Care plans were holistic and person centred.
- Care and treatment plans were reviewed regularly by the multidisciplinary team in weekly multidisciplinary team meetings. We were impressed by how well this was managed and that all staff present had been effectively engaged in the decision making.
- Patients could access a wide range of psychological therapies as recommended in NICE guidelines.
- The team offered a range of therapeutic groups to provide more timely access to patients who required lower level and more practical intervention.
- The team used a range of outcome measures throughout and following treatment. These indicated improved outcomes following treatment.
- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. Staff could access developmental training and a range of clinical support.
- The team worked effectively in partnership with other agencies, both inside and outside the military, to manage and assess patient needs and risks. The team offered a peripatetic service to all the medical facilities within the catchment area and reported improved working arrangements with primary care, the NHS and third sector.
- The team participated in unit health committees. This was a highly supportive approach that enhanced the mental health treatment the team was able to offer.
- A consent to treatment form had been introduced and consent was sought from patients and was clearly documented.
- Staff had a good awareness of the Mental Capacity Act and mental health legislation.

However:

- Recording of clinical and case management supervision was very poor. While staff stated that they had received supervision the records did not demonstrate this.

Are services caring?

Good

We rated the DCMH as good for caring because:

- We saw staff that were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them.
- Staff showed us that they wanted to provide high quality care. Staff working extremely hard to meet the wider needs of their patients. 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.
- Patients told us that staff provided clear information to help with making treatment choices. Care records demonstrated the patient's involvement in their care planning.
- We saw staff working with patients to reduce their anxiety and behavioural disturbance.
- Staff understood confidentiality, and this was maintained at all times.
- We were impressed that the acting practice manager has seen a need to support military personnel who were experiencing financial difficulties and had engaged with charities to assist.

Are services responsive to people's needs?

Good

We rated the DCMH as good for responsive because:

- Clearer referral pathways had been developed. The team had begun to meet the response target for urgent and routine referrals and waiting lists for treatment had reduced significantly over the previous year.
- Travelling required by patients for appointments was within an acceptable time allowance at generally less that one hour. Most patients felt their appointment was at a convenient location and at a convenient time.
- The team had improved their procedure regarding following up patients who did not attend their appointment. The non-attendance rate was five per cent which was below the DMS target.
- A comfortable waiting area was available for patients. Information was available on display about treatments, local services, patients' rights, and how to complain. The team's base was accessible to people with a disability and contained sufficient treatment rooms.

However:

- The team was developing a system for handling complaints and concerns but this required further improvement to fully capture and learn from patients' concerns.

Are services well-led?

Requires Improvement

We rated the DCMH as requires improvement for well-led because:

- Following concerns raised at the service the Defence Medical Services headquarters commissioned an audit which found that while there were no immediate patient safety concerns there were risks that needed to be addressed. These included the management of the referral pathways, clinical risk management processes, the follow up of patients who did not attend, clinical record keeping and multidisciplinary decision-making, incident reporting and leadership. Work was underway to address these issues, but further improvement was required.
- Managers had recently introduced a number of new procedures to strengthen the governance and administration of the service but these had not been embedded. As a result, the service did not have access to accurate information about performance to support governance and improvement.
- The risk and issues logs had not captured all risks and the common assurance framework did not reflect a number of important risks.
- Staff reported that morale had been very poor, but this had improved slightly over previous months.

However:

- Staff reported that they felt supported by their immediate colleagues and that individual members of the management team were approachable and supportive of their work.
- Staff were positive and clear about their role in delivering the vision and values of the service.
- Staff were positive about the recent improvements to the clinical pathway and care delivered, and felt this was beginning to make a positive difference to the quality of care offered to patients.

Our inspection team

Our inspection team was led by a CQC Inspection Manager Lyn Critchley. The team included one inspector and a specialist military mental health nursing advisor.

Background to Department of Community Mental Health – Tidworth

The department of community mental health (DCMH) at Tidworth provides mental health care to a population of approximately 21,000 serving personnel from across all three services of the Armed Forces. At the time of the inspection the overall population was due to increase by approximately 5000 personnel over coming months due to the relocation to the catchment of military personnel being returned from bases in Germany. The catchment for the service includes all service personnel based at 12 military establishments across the South West of England and those who have returned to the catchment area on home leave. The service operates from a main base at Tidworth Garrison. Staff also offer regular peripatetic appointments at other bases including MOD Lyneham, Bovington Camp, Blandford Camp, Warminster Barracks and Larkhill Garrison.

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

At the time of our inspection the DCMH active caseload was approximately 409 patients.

The service operates during office hours. There is no out of hours' service directly available to patients: instead patients must access a crisis service through their medical officers or via local emergency departments. The team participates in a National Armed Forces out of hours' service on a duty basis. This provides gatekeeping and procedural advice regarding access to beds within the DMS independent service provider contract with NHS providers.

Why we carried out this inspection

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

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

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 09 and 11 July 2019. During the inspection, we:

- looked at the quality of the teams' environments;
- observed how staff were caring for patients;
- spoke with six patients who were using the service;
- spoke with the management team, the regional clinical director and regional operations manager;
- spoke with 20 other staff members including doctors, nurses, psychologists, social workers and administration staff;
- reviewed 20 comment cards from patients;
- looked at 10 clinical records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- observed the duty worker, two appointments and two multidisciplinary team meetings;
- attended the business meeting;
- examined minutes and other supporting documents relating to the governance of the service.

Defence Medical Services

Department of Community Mental Health – Tidworth

Detailed findings

Are services safe?

Requires improvement

Our findings

Safe and clean environment

- The team was based at two separate buildings at Tidworth Garrison. The team also had use of other rooms within the regional management teams' quarters at the garrison for meetings and clinical delivery. All buildings used by the team were clean, well decorated and equipped. The team stated that the fragmented facilities could be challenging however during the inspection it was confirmed that the team would move to a single purpose-built facility at Bulford Camp in spring 2020. The team would then be located together and be collocated with a range of other medical services.
- General health and safety and fire safety checks were in place. There was an environmental risk assessment in place supported by local guidance for staff in managing environmental risks. The assessment highlighted the risk factors we observed including the presence of ligature anchor points and other relevant clinical environmental risks. Staff mitigated these risks through meeting patients within the reception and escorting them around the building at all times.
- The buildings were not fitted with a safety alarm however staff had personal alarms to use in the event of an emergency.
- Hand wash facilities and hand gels were available, and staff adhered to infection control principles, including handwashing. Cleaning audits were undertaken regularly, and the buildings were found to be clean throughout. Patients and staff confirmed they found the buildings to be clean and welcoming.
- Equipment logs were in place. Equipment was found to be clean and had been serviced.

Safe staffing

- The clinical team consisted of medical, nursing, psychology and social work staff. At the time of our inspection the clinical team totalled 29 people and was almost fully staffed. This had followed a period of staff shortage that had been largely addressed. There were five vacancies, for a band 7 nurse, two band 6 nurses, a clinical nurse specialist and a part time psychologist. In the interim locum staff covered most of these vacancies. There were four full-time consultant psychiatrists, one of whom was a long term locum. At the time of the inspection one psychiatrist was on leave. The team had recently recruited a deputy manager after a long gap in this role.
- There had been significant shortage of administration staff since 2018 and there was a gap in the practice manager's post. One of the administration team had been acting up in to this post since May 2019. Recruitment was underway to fill these roles. However, staff told us there had been significant

impact on their workload due to manning the reception and undertaking their own administration and at times this had increased patient risk due to poor communication. At the time of the inspection administration staff from the garrison's medical centre were supporting the team and there had been some improvement.

- All new starters whether locum or permanent were provided with induction training and a copy of the induction booklet.
- Up to twenty-five training courses were classed as mandatory dependent on role. We saw that regular locum staff received training similar to permanent staff. At the time of the inspection overall compliance averaged 91%. All courses were above 75% compliance.

Assessing and managing risk to patients and staff

- In May 2019 an internal defence audit had been commissioned following several Freedom to Speak Up Guardian referrals concerning patient safety. This looked at clinical care and risk management of over one hundred patients who had used the service in the previous six months. This had found that action was required to improve the management of the referral pathways, clinical risk management, clinical record keeping and multidisciplinary decision-making. A third of the patients reviewed required follow up actions to be made however there were no specific immediate patient safety risks identified.
- Referrals came to the team from medical officers and other DCMHs. These were indicated as either urgent or routine. Urgent referrals were considered by the end of the next working day. The target to see patients for a routine referral was 15 days. The team had met the target for assessing new patients in May 2019. This was a recent improvement. A senior nurse or duty worker was available each working day to review all new referrals. This role was ring fenced to ensure adequate response to referrals. Routine referrals were also clinically triaged by the duty nurse to determine whether a more urgent response was required. The team has also recently introduced a duty manager system to ensure a more robust response to referrals. All fresh cases were also taken to the weekly multidisciplinary team meeting to assure an appropriate response.
- Once a patient was accepted by the team a risk assessment was undertaken and this was reviewed by the multi-disciplinary team. In all cases we reviewed we found that risk assessments were in place and addressed all known concerns. We saw good evidence of the team following up on any known patient risks. The team was also in the process of introducing an additional risk management tool for use where a patient was considered at risk of self-harm.
- The team had recently developed a risk pro-forma to record all clinical risk and decisions made at the multidisciplinary team and operated a process to share concerns with colleagues about specific patients whose risks had increased. This included risks due to safeguarding concerns. All at risk cases were discussed at weekly multidisciplinary meetings.
- The team participated in unit health committees where patients had agreed to this. This is a collaborative base wide approach to managing increased risks. During the inspection we saw a very positive response to a patient concern being taken forward through this process.
- 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.
- We were however concerned that there was not a clear process to manage clinician's caseloads in their absence. We raised this concern with the management team at the time of the inspection who addressed this gap in process immediately and checked the caseloads of an absent clinician. They confirmed that all the relevant patients had been followed up by other team members during the absence.
- The team's senior social worker was the designated safeguarding lead. The Ministry of Defence had an up to date policy for child protection however, the adult safeguarding policy was being updated as it did not meet the latest guidance. Child protection training levels one to three were mandatory for DMS staff as appropriate to their role. At the time of the inspection most staff had undertaken levels 1 to 3 training as appropriate to their role. Adult safeguarding was not part of the DMS's mandatory training requirements, however the social worker had recently delivered a training session for staff on safeguarding awareness and had developed a local procedure for reporting adult safeguarding concerns. The team demonstrated an understanding of safeguarding principles and practice.

- Arrangements were in place for logging which staff were in or out of the building at the team's base. Lone working arrangements were in place and we observed staff check on other staff's welfare when working from other bases.
- The DCMH did not dispense medication. On a rare occasion the consultant psychiatrist would prescribe medication but usually this was undertaken via a recommendation to the patient's medical officer who prescribed the medication. Appropriate arrangements were in place for the safe management of prescribing. No delays were reported in patients receiving their medication.
- There were written procedures for response in a medical emergency. Seventy five percent of staff had received annual basic life support, defibrillator and anaphylaxis training. The team had access to emergency equipment in the adjacent dental facility.
- Business continuity plans for major incidents, such as security threat, power failure or building damage were in place. The plans included emergency contact numbers for staff.

Track record on safety

- Between June 2018 and June 2019 there were 34 significant events recorded across the service. This had included two deaths of a patient. Inquests were yet to be heard for these cases however an initial root cause analysis had been undertaken. The incident investigation processes for these cases had been closed. This was not in line with defence policy. However, the interim clinical lead asked for these cases to be reopened during the inspection so additional investigation and learning could be considered. On review of the significant events log an additional concern was found in relation to the reporting process not being followed in the event of a suspected suicide. The team raised this as a significant event during the inspection.
- One moderate concern had been recorded within the significant events log. This related to a lack of response for a local NHS service. All other events had resulted in low or no harm. The majority of these related to gaps in clinical recording that had been noted through the defence audit and poor administration processes.

Reporting incidents and learning from when things go wrong

- The team used the standardised DMS electronic system to report significant events, incidents and near misses. Staff received training at induction regarding the processes to report significant events and had recently received refresher training. Staff were aware of their role in the reporting and management of incidents.
- The management team confirmed that there had been some improvement in sharing learning from significant events and other concerns but acknowledged there was further work to do. Significant events were now discussed at weekly multidisciplinary team meetings including the outcome and any changes made following a review of the incident. Learning and recommendations were noted within the minutes of these meetings. Staff were aware of learning from some previous events but further work was required to embed this.

Are services effective?

Good

Our findings

Assessment of needs and planning of care

- Formal assessment was undertaken once a patient's referral was accepted by the team. Following this, an assessment of the patient's needs was undertaken. Care and treatment plans were developed with patients. Formal care plans had recently been introduced at the team and were in place for all newly admitted patients. Staff were in the process of developing these for all pre-existing patients. Where available care plans were detailed, holistic and captured all relevant needs and risks.
- The team had access to an electronic record system which was shared across all DMS healthcare facilities. This system facilitated effective information sharing across mental health and primary care services. Any paper records, such as outcome measures, were scanned on to the system to ensure

easy access and safe storage. Staff delivering peripatetic clinics at other bases had access to a laptop to view and update records.

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. Clinical records reviewed made some reference to NICE guidance. Staff told us of practices that met this guidance.
- The team employed four psychologists and all nurses were trained in a range of psychological treatments. Patients were therefore able to access a wide 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, cognitive processing therapy, trauma focussed therapy and eye movement desensitization and reprocessing.
- The team offered a range of therapeutic groups to provide more timely access to patients who required lower level, more practical or pre-therapy intervention. These included the military behavioural activation and rehabilitation course (MBARC), anxiety management and the PTSD stabilisation groups. These groups had proven to be effective and had helped to reduce overall waiting and treatment times. The team was also piloting an early intervention group for patients undergoing assessment for temperamental unsuitability.
- Physical healthcare monitoring, including monitoring of the effects of antipsychotic medication, was primarily undertaken by the patient's medical officer. However, staff at the DCMH referenced physical health monitoring they had undertaken.
- Staff described the advice and support they would give to colleagues in primary medical services and the chain of command 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. Outcomes were reviewed throughout the treatment process and collated and audited to provide an overview of service effectiveness. These indicated improved outcomes following treatment.
- A range of audits were undertaken by the team. These included an audit of staff's understanding of incident reporting, the quality of first assessment, staff stress levels, case notes audits, patient experience, cleanliness and environmental audits. Clinical audits were undertaken of patient outcomes including a detailed audit of outcomes across a specific regiment, groupwork outcomes and PTSD treatment outcomes.

Skilled staff to deliver care

- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. These included psychiatrists, nurses, psychologists and social workers.
- New staff, including locums, received a thorough induction. Development training, such as in cognitive behaviour therapy and EMDR, was available to staff. Some nursing staff were undertaking additional academic qualifications financed by the service. The team also hosted GP trainees and student nurses who were training within the Armed Forces.
- Additional bespoke training was delivered to the team at regular weekly professional development sessions. Recent sessions had included learning on adult safeguarding, Mental Capacity Act, incident reporting procedures, temperamental unsuitability assessment and TILS.
- Staff had support through weekly multidisciplinary, caseload management and professional development meetings. Staff were also involved in weekly team meetings.
- Staff had protected time for supervision and professional development. All staff spoken with confirmed that they had received supervision but this was not demonstrated within records provided. Records provided for the six months to June 2019 stated only 50% overall compliance with clinical supervision and just 18% compliance for nursing staff.
- The team stated there had been some difficulties in accessing specialist supervision for EMDR practitioners however this had recently been resolved through access to a telephone supervision service.

- Caseload management was scheduled to occur monthly wherever possible but mandated to occur at least once in every 8 week period. However, records were not available to demonstrate this happened to schedule. Caseload management review compliance rates supplied during the inspection for the six months prior to the inspection were 56%.

Multidisciplinary and inter-agency team work

- Care and treatment plans were reviewed regularly by the multidisciplinary team in weekly multidisciplinary team meetings. Patients at risk were also discussed in these meetings. We attended two multidisciplinary team meetings during the inspection. These were well managed and staff present were effectively engaged in the decision making.
- The team worked in partnership with a range of services both within and outside the military. This included liaison with the NHS providers 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. The team's psychiatrists also worked closely with the NHS team to ensure seamless care. Staff at the DCMH demonstrated effective information sharing and support to the NHS teams in the management of their patients.
- The team participated in unit health committees where patients had agreed to this. This is a collaborative base wide approach to managing risks and agreeing support to service personnel who are struggling to cope with military life. The team confirmed that while this was resource intensive it provided a highly supportive approach that enhanced the mental health treatment they were able to offer.
- As an occupational mental health service, the team's role was to assist patients to retain their occupational status or to leave the armed services. Patients could also use the team during the first six months following discharge from the military. The team worked closely with the Military Welfare Services and the NHS Veterans Mental Health Transition, Intervention & Liaison Service (TILS) and a wide range of third sector organisations to ensure effective support with employment, housing and wider welfare. Several positive examples were given by the team where partnerships had jointly helped patients to remain within the military. Where necessary, when handing care over on discharge of a patient from the services, the team met with the receiving NHS teams.
- The team also offered a peripatetic service to several medical facilities within the catchment area. This included visiting clinics and some bespoke treatment sessions, advice and training for primary health care staff.

Adherence to the Mental Health legislation

- Two of the team's psychiatrist were section 12 approved doctors and the team's social worker was a registered approved mental health professional. Together they supported staff's knowledge of the Mental Health Act. Staff were knowledgeable about relevant mental health legislation.
- The Mental Health Act was used very infrequently at the service. Should a Mental Health Act assessment be required the provider worked with the local NHS provider to access this through civilian services. Staff told us that there were positive relationships between the DCMH and the local NHS inpatient service provider which facilitated timely access to a bed.

Good practice in assessing capacity 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 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 all records we reviewed we found records of consent to share information. A consent to treatment form had been introduced and we found records of consent to treatment in most records.

Are services caring?

Good

Our findings

Kindness, dignity, respect and support

- Staff showed us that they wanted to provide high quality care. We observed some very positive examples of staff providing practical and emotional support to people. We observed staff working extremely hard to meet the wider needs of their patients. This included active involvement in unit health committees that considered the wider support needs of people who were struggling to cope with military life. We were impressed that the acting practice manager has seen a need to support military personnel who were experiencing financial difficulties and had engaged with charities to assist. This scheme had been adopted by the team and had provided food and baby product vouchers for a number of patients. We also noted some occasions when staff had found creative ways to meet individual patient's needs.
- We saw staff that were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them. Almost all of the patients we spoke with told us that staff were kind and supportive, and that they were treated with respect.
- Staff demonstrated that they were knowledgeable about the history, possible risks and support needs of the people they cared for. We saw staff working with patients to reduce their anxiety and behavioural disturbance.
- Confidentiality was understood by staff and maintained at all times. Staff maintained privacy with people, who were asked if they would like their information shared with their relatives, within the chain of command and other bodies, including CQC. Information was stored securely, both in paper and electronic format.

The involvement of people in the care they receive

- Formal care plans had been introduced at the team and were in place for all newly admitted patients. Staff were in the process of developing these for pre-existing patients. Where available care plans demonstrated the patient's involvement in their care. Patients we interviewed and feedback reviewed suggested staff provided clear information to help with making treatment choices.
- Relatives' needs were noted to be considered within patients notes. We also examples of where the team had raised specific concerns regarding patients' dependents.
- Information was available at the service about a range of organisations that would provide advice and support to serving and former Armed Forces personnel. Staff told us about many positive relationships with support organisations.
- The team had leaflets explaining the service that was delivered and access to a range of booklets regarding clinical conditions and treatments available to support the conditions. These were shared with patients routinely. Patients reported positively regarding these.
- The team undertook patient experience surveys on an ongoing basis. In June 2019, 12 people had participated in a survey. All participants stated their appointment was at a convenient location and their appointment was at a convenient time. Ten said they felt involved in decisions about their care. Ten stated they would recommend the service to friends and family should they need to use it.

Are services responsive to people's needs?

Good

Our findings

Access and discharge

- In line with DMS requirements the service operated during office hours only. There was no out of hours' service directly available to patients: instead patients had to access a crisis service through their medical officers or via local emergency departments. 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 providers.
- Where a known patient contacted the team in crisis during office hours the team responded promptly. The team confirmed this included rapid access to a psychiatrist.
- At the time of the inspection six patients were in a bed within the NHS. Staff told us that there were positive relationships between the DCMH and the NHS inpatient service providers which facilitated timely access to a bed. The team attended the ward round and met with the patient on a weekly basis when DCMH patients were admitted as inpatients. Two patients were a significant distance from the team, in these cases the local DCMH performed this role with the patients. In both cases the team at Tidworth were fully engaged in this process.
- Referral pathways were in place and had improved in recent months. Referrals came to the team from medical officers, GPs and other DCMHs. These were indicated as either urgent or routine. Urgent referrals were considered by the end of the next working day. A senior nurse or duty worker was available each working day to review all new referrals. This role was ring fenced to ensure adequate response to referrals. Routine referrals were also clinically triaged by the duty nurse to determine whether a more urgent response was required. The team has also recently introduced a duty manager system to ensure a more robust response to referrals. All fresh cases were also taken to the weekly multidisciplinary team meeting to assure an appropriate response.
- At the time of the inspection the team's active caseload was 409. There had been 216 referrals in the first five months of 2019. This had been a slight decrease on the previous year. The team explained that a new care pathway, step one, had been introduced to the region by DMS in 2018 meaning that primary care now offered first line treatment to patients with lower levels needs, rather than immediately refer to the DCMH.
- The team offered peripatetic clinics at a number of the medical facilities, part of this role was to support primary health workers' knowledge about managing common mental health issues.
- Information provided showed that during May 2019 the DCMH had met the target for assessment following all urgent referrals. This was recent improvement.
- The management team stated that there had been significant waiting lists and delays in treatment since the beginning of 2018. This had been due to staffing shortages. The overall waiting lists had been approximately 200 patients in September 2018. By June 2019 there was a waiting list of 24 patients for low intensity therapy and 56 patients for high intensity therapy. It was confirmed that all of those awaiting therapy were allocated to a care co-ordinator and in most cases involved in group work.
- Within the Armed Forces, personnel can be ordered to attend for a medical appointment. However, personnel do not have to accept treatment. The team had a procedure regarding following up patients who did not attend their appointment (DNA process). The defence audit undertaken in May 2019 had recommended a more robust process for following up people who did not attend. The team was undertaking an audit at the time of the inspection to better understand people's reasons for not attending appointments. The DNA rate at May 2019 was 5%. This was within the DMS target of 10%.

The facilities promote recovery, comfort, dignity and confidentiality

- The team worked across four buildings at Tidworth Garrison. The team stated that the fragmented facilities could be challenging to work in however there were sufficient rooms to offer treatment. During the inspection it was confirmed that the team would move to a single purpose-built facility at Bulford Camp in spring 2020. The team would then be located together and be collocated with a range of other medical services.
- The main building had a garden area that was available for use by both patients and staff.

- The team's facilities at Tidworth Garrison were accessible to patients with a physical disability. Both main buildings had access to disabled toilet facilities.
- A comfortable waiting area was available for patients. Information was available on display about treatments, local services, patients' rights, and how to complain.
- Most treatment rooms were adequately soundproofed to ensure privacy during treatments. In one area where this was not the case however the team used alternate rooms to ensure consultations were not overheard.

Meeting the needs of all people who use the service

- The team could offer flexible appointment times during office hours. Patients confirmed that they were given time off to attend appointments and the chain of command was supportive of this.
- The DCMH serves patients from twelve military establishments across the South West of England, and those who have returned to the catchment area on home leave. Travelling required by patients for appointments was within an acceptable time allowance at generally less that one hour. The team undertook a patient experience survey on an ongoing basis. In June 2019, the survey found that all participants felt their appointment was at a convenient location and at a convenient time.
- The team confirmed that they had access to interpreters should this be required.

Listening to and learning from concerns and complaints

- The team had a system for handling complaints and concerns. The department manager was the designated person responsible for managing all complaints. A policy was in place and information was available to staff. Staff demonstrated awareness of the complaints process and had supported patients to raise concerns. The department manager acknowledged that while there was a process in place the system to record complaints and capture learning required improvement. In addition, there was not a formal process to capture informal complaints.
- Patient waiting areas had posters and leaflets explaining the complaints process. The patient experience survey in June 2019 found that all bar one patient knew how to make a complaint. Patients spoken with during the inspection understood how to make a complaint and all, but one felt they would be listened to if they complained.
- Since January 2019 there had been two formal complaints. These had related to a delay in treatment and poor communication. The department manager confirmed that she had fully investigated the complaints. None of the complaints had resulted in an armed service complaint or had been referred to the Armed Forces Ombudsman.
- Staff received feedback on complaints and investigation findings during business and team meetings. We saw evidence of information sharing in meeting minutes.

Are services well-led?

Requires Improvement

Our findings

Vision and values

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

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

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

Good governance

- Following concerns raised at the service the Defence Medical Services headquarters commissioned an audit which found that while there were no immediate patient safety concerns there were risks that needed to be addressed. These included the management of the referral pathways, clinical risk management processes, the follow up of patients who did not attend, clinical record keeping and multidisciplinary decision-making, incident reporting and leadership. Work was underway to address these issues, but further improvement was required.
- The team had an overarching governance framework to support the delivery of the service, to consider performance and continuous learning. The team had a monthly governance meeting which staff attended. The meeting agenda had been strengthened recently and considered good practice guidelines, policy development, risk issues, learning from complaints and adverse events, team learning and service development. Minutes for this meeting showed the service had improved its governance and administration procedures over the previous months.
- Systems were being set up to better capture governance and performance information however these had not yet been fully embedded in the governance process. Further work was needed to ensure learning from all adverse events and concerns and to build a positive safety culture.
- 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 the regional headquarters (RHQ) on a regular basis. Generally, this included all areas for development but did not fully record and address the findings of the headquarters commissioned audit in May 2019.
- The department manager was the nominated risk manager. Risk and issues were reviewed monthly or as identified and logged on the regional headquarters and local risk and issues registers. These were overseen by the regional operations manager. The risk and issues logs included: manning, environmental safety including ligature points, safeguarding, staff stress and Caldecott issues. All risks included detailed mitigation and action plans. Most potential risks that we found had been captured within the risk and issues logs. However, we noted that it did not fully reflect the findings on the defence commissioned audit in May 2019 including inadequate recording of clinical records.
- Following the defence commissioned audit there had been a number of positive developments and improvements to care outcomes in the previous months. Waiting lists had reduced. Patient experience was generally positive and improving. Risk management had improved. The duty system had been strengthened and the team was now responding appropriately to referrals and had begun to meet key performance indicators. Multidisciplinary team decision making had improved. Environmental risk assessments were in place and included all relevant risks. Partnership working with a range of services had improved and brought about effective treatment for patients.
- Overall, we found that the DCMH had made improvements and was moving in the right direction at an appropriate pace. We could evidence improvement in governance and practice throughout the previous six months however we found some areas of practice that required further improvement. These included:
  - That not all incidents had been reported appropriately or fully investigated. Further work was required to ensure all concerns are captured and learning from all adverse events.
  - A lack of administration staff had significantly impacted on clinician's workload and at times this had increased patient risk due to poor communication.

- There was not a clear process to manage clinician's caseloads in their absence.
- Supervision recording was poor, meaning that the management team could not be assured that staff were appropriately supervised.
- The recording and management of complaints required some improvement.
- The CAF and risk registers needed further work to reflect all potential risks and challenges.

Leadership, morale and staff engagement

- The management team consisted of a clinical lead, a department manager, a deputy department manager, a practice manager and a lead psychologist. The clinical lead was absent from the service, so an interim clinical lead had been in place for two months. There was also an interim practice manager in post. The deputy department manager had joined the team very recently following a long gap in this post.
- 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. Some staff told us that this had been a recent development.
- 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 said they would feel confident to use this. However, there had been several referrals in previous months to the Freedom to Speak Up Guardian regarding patient safety concerns. These concerns led to a defence commissioned audit of the service. The audit identified clinical risks that needed to be addressed and poor leadership. While all concerns were being worked on some staff remained concerned that processe required further improvement and that the service was not yet fully safe.
- Staff reported that morale had been very poor and there had been some bullying at the team. However, staff confirmed that they felt supported by their immediate colleagues, the department manager and interim clinical lead and that morale had improved in recent months.
- Sickness and absence rates at the team were minimal.
- Staff felt positive about their own work and that this was making a positive difference to the quality of life of patients.

Commitment to quality improvement and innovation

- Formal care plans had recently been introduced at the team and were in place for newly admitted patients. Staff were in the process of developing these for all pre-existing 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.
- A consent to treatment form had been introduced and 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.
- We were impressed that the acting practice manager has seen a need to support military personnel who were experiencing financial difficulties and had engaged with charities to assist. This scheme had been adopted by the team and had provided food and baby product vouchers for a number of patients. We also noted some occasions when staff had found creative ways to meet individual patient's needs.