Defence Medical Services

Department of Community Mental Health – Donnington

Quality Report

Department of Community Mental Health Donnington
Venning Barracks
DCMH Donnington Building V12
Donnington
Telford
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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

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 (DCMH) Donnington including its satellite services at Hereford, Northern Ireland and Preston between the 26 January and 23 March 2022. Overall, we rated the service as Good.

We found the following areas of good practice:

- Individual patient risk assessments were in place and proportionate to patients' risks. The team had a process in place to share concerns about patients in crisis or whose risks had increased. All referrals were clinically triaged by the mental health team and we saw good evidence of the team reviewing risks through the multidisciplinary team and following up on any known risks.
- Staff had a good awareness of safeguarding procedures and practice. Staff had reported all relevant events and appropriate action had been taken to investigate and learn from these and was used to drive a safety culture.
- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. Overall staffing arrangements were sufficient to meet the needs of patients. Staff could access mandatory and developmental training and a range of clinical support.
- Clinicians were aware of current evidence-based guidance and standards and patients could access a range of psychological therapies as recommended in NICE guidelines. The team used a range of outcome measures throughout and following treatment. Outcomes were reviewed throughout the treatment process and collated and audited to provide an overview of service effectiveness. These indicated improved outcomes following treatment.
- 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.
- Clear referral pathways were in place. Despite a high caseload the team had met the response target for referrals in recent months and waiting lists for treatment were reducing.
- Leaders were capable and resourceful and worked well together to ensure safe and effective care to patients. Staff reported that morale was good, and they felt that the management team were approachable and supportive of their work.
- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning and systems and processes were in place to 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 and included detailed mitigation and action plans and were escalated appropriately.
- Business continuity plans for major incidents had been updated to reflect the risks in relation to the Covid 19 pandemic. Appropriate actions had been taken in response to the pandemic to mitigate the risk of infection to patients and staff and to ensure the service could operate safely.
- The team was undertaking a wide range of clinical audits and quality improvement projects to enhance patient care and was addressing any potential risks as they arose.

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

- Not all facilities that the team operated from were fit for purpose and there was not enough space at some locations if the team returned to mainly face to face treatments.
- While the team had undertaken mandatory training in most areas not all staff had completed basic life support, automated external defibrillator and anaphylaxis management training. This training had not been available during the pandemic and since it was reinstated the team had been struggling to book on to sufficient courses.

Are services safe?

Good

We rated the DCMH as good for safe because:

- The team had implemented safe systems and processes to ensure clear clinical risk oversight of patients. All referrals were clinically triaged to determine whether a more urgent response was required and to monitor whether patients' risks had increased. Individual patient risk assessments were thorough and proportionate to patients' risks. The team had developed a process to share concerns about patients in crisis or whose risks had increased. We saw good evidence of the team reviewing risks through the multidisciplinary team and following up on any known risks.
- Overall staffing arrangements were sufficient to meet the needs of patients.
- Staff had a good awareness of safeguarding procedures and practice. Staff had reported all relevant events and appropriate action had been taken to investigate and learn from these and was used to drive a safety culture.
- Business continuity plans for major incidents had been updated to reflect the risks in relation to the Covid 19 pandemic. Appropriate actions had been taken in response to the pandemic to mitigate the risk of infection to patients and staff and to ensure the service could operate safely.

However:

- Not all facilities that the team operated from were fit for purpose and there was not enough space at some locations if the team returned to mainly face to face treatments.
- While the team had undertaken mandatory training in most areas not all staff had completed basic life support, automated external defibrillator and anaphylaxis management training. This training had not been available during the pandemic and since it was reinstated the team had been struggling to book on to sufficient courses.

Are services effective?

Good

We rated the DCMH as good for effective because:

- Formal care plans were in place for all patients and were holistic and person centred. Care and treatment plans were reviewed regularly in weekly multidisciplinary team meetings. Patients we spoke with confirmed they had been offered copies of their care plans, that these were updated and were useful.

- Patients could access a wide range of psychological therapies as recommended in NICE guidelines. Clinicians were aware of current evidence-based guidance and standards and used this to guide their practice. The team used a range of outcome measures throughout and following treatment. These indicated improved outcomes following treatment.
- We found consideration of capacity in the records we reviewed, and patients told us that they had the need for consent to treatment clearly explained to them.
- 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 and supervision.
- The team worked effectively in partnership with other agencies, both inside and outside the military, to manage and assess patient needs and risks.

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. This included both clinical and administrative staff.
- Staff showed us that they wanted to provide high quality care. Staff worked hard to meet the wider needs of their patients. We observed some positive examples of staff providing practical and emotional support to people.
- Patients said they were very well supported, and that staff were kind and enabled them to get better. Patient survey results were overwhelmingly positive.
- 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.

Are services responsive to people's needs? Good

We rated the DCMH as good for responsive because:

- Clear referral pathways were in place. Despite a high caseload the team had met the response target for referrals in recent months and waiting lists for treatment were reducing.
- The team had offered both virtual and face to face appointments where necessary throughout the pandemic. Patients told us that they had found virtual appointments extremely welcome as this had cut down on travel to appointments and had allowed greater flexibility. The team was increasing their office presence at the time of the inspection to allow greater access to face to face appointments.
- Despite challenges within the environments that the team operated from the team worked hard to protect patient's privacy.
- Information was provided to patients about treatments, local services, patients' rights, and how to complain.
- The team had a system for handling complaints and concerns. Staff demonstrated awareness of the complaints process and had worked actively to address any concerns.

However:

- The team's base was not fully accessible to people with a physical disability however alternate arrangements were in place.

Are services well-led? Good

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

- We found that leaders were capable and resourceful and worked well together to ensure safe and effective care to patients.
- Staff reported that morale was good at the team. Staff reported that they felt supported by their managers and colleagues and stated that the management team were approachable and supportive of their work.
- Staff were clear regarding the aims of the service and supported the values of the team. Staff were engaged in and positive about the improvement at the service and felt this was making a positive difference to the quality of care offered to patients.
- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. Effective systems and processes had been set up to capture governance and performance information and this was used to drive positive change.
- Potential risks that we found had been captured within the risk logs and the common assurance framework. All risks identified included detailed mitigation and action plans and had been escalated appropriately.
- The team was undertaking a wide range of clinical audits and quality improvement projects to enhance patient care and was addressing any potential risks as they arose.

Our inspection team

Our inspection team was led by a CQC Inspection Manager. The team included an additional inspection manager, two inspectors on site, two additional inspectors and an assistant inspector who worked remotely and a specialist military mental health nursing advisor.

Background to Department of Community Mental Health – Donnington

The department of community mental health (DCMH) at Donnington provides mental health care to a population of approximately 18,600 serving personnel from across all three services of the Armed Forces. The catchment for the service includes all service personnel based at military establishments across the West Midlands, North West of England, Northern Ireland and Mid/North Wales. In addition, the team work with those who have returned to the catchment area on home leave. This group of patients accounted for 40% of the team's caseload during 2021. The service operates in a hub and spoke model from a main base at MOD Donnington with spoke mental health teams (MHT's) in Northern Ireland, Preston, Wrexham and Hereford. The team also carries out routine peripatetic clinics at Chester and Kineton medical centres.

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 653 patients.

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

Why we carried out this inspection

The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare Regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare Regulator for the DMS.

How we carried out this inspection

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 and interviewed patients and staff via video conferencing between the 26 January to 23 March 2022. During the inspection, we visited the team at its bases at MOD Donnington, Northern Ireland, Preston and Hereford and reviewed additional information about the other parts of the service. Specifically we:

- looked at the quality of the teams' environment at MOD Donnington, Northern Ireland, Preston and Hereford;
- observed how staff were caring for patients;
- spoke with twelve patients who were using the service;
- spoke with the regional clinical director;
- spoke with the management team across the service;
- spoke with 20 other staff members including doctors, nurses, psychologists, therapists, social workers and administration staff;
- observed the duty worker and administrative staff at Donnington, Northern Ireland and Preston;
- looked at 30 clinical records of patients;
- joined the multi-disciplinary team meeting;
- joined the management team meeting;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- examined minutes and other supporting documents relating to the governance of the service.

Defence Medical Services

Department of Community Mental Health – Donnington

Detailed findings

Are services safe?

Good

Our findings

Safe and clean environment

- The team's main base was at Venning Barracks at MOD Donnington. There was insufficient space for the whole team within the main building meaning some team members had to work from a second building. The team told us that at present the space at Donnington was adequate however should all the team return to offices in the future there was insufficient treatment rooms. The facilities were clean, and staff reported that maintenance requests would be responded to in a timely way however there were long standing issues with the heating and design of the building.
- The team's facilities at Northern Ireland, Hereford and Preston contained sufficient space for the team and were clean and generally well maintained. Due to the team's building in Wrexham being temporarily occupied by students the team could not presently see patients at their building. The team used medical centre facilities were face to face appointments were necessary.
- Not all treatment rooms were adequately soundproofed at Donnington, Preston and Hereford. However, staff had adopted measures such as playing music in the waiting areas and using alternate rooms to ensure privacy during treatments.
- Comfortable waiting areas were available for patients at the locations visited. Information was available on display about treatments, local services, patients' rights, and how to complain.
- General health and safety and fire safety checks were in place. There was an environmental risk assessment in place for each location supported by local guidance for staff in managing environmental risks. The assessments highlighted the risk factors we observed including the presence of ligature anchor points and other relevant clinical environmental risks. Each location had undertaken an additional risk assessment of potential ligature points. Staff mitigated these risks by meeting patients within the reception areas and escorting them

around the buildings at all times. A request for CCTV had been approved for the building at Donnington so that an additional waiting area could be used in future.
- There were no wired alarm systems in place at any of the locations however staff had been allocated individual panic alarms and guidance in how to respond to these. Lone working practices were in place at all locations including arrangements for logging which staff were in or out of the building.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Hand wash facilities and hand gels were available, and staff adhered to infection control principles, including handwashing. Cleaning and infection prevention audits were undertaken regularly, and the buildings were found to be clean throughout. A risk assessment was in place and appropriate systems based on national guidance had been put into place to manage the risks associated with Covid 19. This included the accessibility and use of personal protective equipment (PPE), Covid testing and safe distancing measures. Patients and visitors were assessed for Covid symptoms prior to entering the buildings.
- Equipment logs were in place. Equipment was found to be clean and had been serviced.

Safe staffing

- The clinical team totalled 39 people across all locations and consisted of medical, nursing, therapy, social work, psychology and administration staff. The team had six additional vacancies, for three band 7 nurses, a military nurse, one social worker and one administrator. Recruitment was ongoing at the time of the inspection and some locum cover was available. The team worked across all locations to ensure that there was access to all disciplines and waiting lists were managed.
- The team benefited from a full-time practice manager and four administrators, one at each main location. The reception areas at each location were always staffed and patients spoke highly about the welcome they received at the service and the responsiveness of administration staff to any queries.
- All new starters, whether locum or permanent, were provided with induction training and a copy of the induction booklet.
- Up to thirty-two 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 75%. However not all staff had received training in basic life support (3%), automated external defibrillator (7%) and anaphylaxis management (26%). This training had not been available during the pandemic and since it was reinstated the team had been struggling to book on to sufficient courses.

Assessing and managing risk to patients and staff

- A band 7 therapist and the department manager oversaw all referrals that were made to the DCMH including those for the spoke services. A duty worker was available each working day to review all urgent referrals. Routine referrals were clinically triaged by the duty worker to determine whether a more urgent response was required and allocated to the next available clinician to undertake full assessment. This role was ring fenced to ensure adequate response to referrals.
- Once a patient was accepted by the team a risk assessment was undertaken. In all cases we reviewed we found that risk assessment was in place and addressed all known concerns. Crisis plans were in place and where a known patient contacted the team in crisis, the team

responded swiftly. All patients we spoke with were aware of their crisis plans. Both staff and patients confirmed access to the psychiatrist should a full assessment be required.

- The team had developed a risk pro-forma to record all clinical risk and decisions made at the multidisciplinary team and all fresh cases were taken to the multidisciplinary team meeting to assure an appropriate response. The team recorded 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 and all patients recently discharged from hospital. The team met every morning to discuss any urgent risk issues and all at risk cases were discussed at multidisciplinary meetings.
- The team had introduced a process to ensure that patients on the waiting list were contacted and risk assessed on a regular basis while they awaited treatment.
- The team participated in unit health committees where patients had agreed to this. This is a collaborative base wide approach to managing increased risks.
- Processes were in place to identify, report and manage safeguarding concerns. The Ministry of Defence had introduced policies for safeguarding vulnerable adults and children. The team had developed local procedures to manage safeguarding in the devolved nations where the team operated (Wales and Northern Ireland). Nearly all staff had undertaken required training as appropriate to their role. The team demonstrated an understanding of safeguarding principles and practice and had made a number of safeguarding referrals in the previous year. Safeguarding concerns were discussed at governance and multidisciplinary team meetings.
- Appropriate arrangements were in place for the safe management of medicines. The DCMH did not dispense medication at any locations. Instead the consultant psychiatrists would prescribe medication, but ongoing prescribing would be undertaken by GPs through a shared care agreement. No delays or errors were reported in patients receiving their medication.
- Business continuity plans for major incidents, such as security threat, power failure or building damage were in place and had been updated to reflect the risks in relation to the Covid 19 pandemic. Appropriate actions had been taken in response to the pandemic to mitigate the risk of infection to patients and staff and to ensure the service could operate safely. Where appropriate, staff had worked at home to minimise risk however the team had offered both virtual and face to face appointments where necessary throughout the pandemic.

Reporting incidents and learning from when things go wrong

- Between February 2021 and February 2022, there were 17 significant events recorded across the service. All events had resulted in low or no harm. The majority of these related to administration issues, IT issues and one medical prescribing issue. Root cause analysis investigations had been undertaken where appropriate and were thorough. These provided evidence of learning and had led to improvements in practice.
- 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. Staff were aware of their role in the reporting and management of incidents.
- Staff confirmed significant events were discussed at team and governance 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 previous events.

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. Clear care and treatment plans were developed with patients. Formal care plans were used at the team and were in place for patients we reviewed. Patients we spoke with confirmed they had been offered copies of their care plans and that these were updated. Care plans were holistic and captured all relevant needs and risks. The team had been undertaking regular audits of care plans.
- 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 were scanned on to the system to ensure easy access and safe storage.

Best practice in treatment and care

- Clinicians were aware of relevant 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 reference to NICE guidance. Staff told us of therapeutic practices that met this guidance.
- The team employed psychologists and mental health therapists, 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), alcohol misuse, eating disorder and anxiety. Treatments included the use of cognitive behavioural therapy, cognitive analytical therapy, cognitive processing therapy, eye movement desensitization and reprocessing, psychological therapy and social work intervention.
- At the time of the inspection the team were looking to reinstate a range of therapeutic groups to prepare patients for psychological intervention.
- 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. During the pandemic the team had adjusted this process to ensure patients were able to continue to contribute to these measures. 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 DMS mandated audits such as audits of clinical record keeping, patient experience, supervision levels, significant events trend analysis, security, cleanliness and environmental audits. Additional audits were undertaken of the patient population and referrals process, safeguarding procedures, Covid measures, clinical pathways, the patient of interest list, care plans and job plans. Clinical audits had been undertaken of depression and anxiety outcomes and were underway for treatment outcomes for eating disorders and independent service provider (ISP) admissions.

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, therapists and social workers.
- New staff, including locums, received a thorough induction. Development training, such as in cognitive behaviour therapy, was available to staff. Staff received a weekly continued professional development session which had included topics such as NICE guidelines for eating disorders, neurological conditions, post-natal care, autism and chronic pain, management of violence and aggression, caseload studies, treatment outcomes, risk management and the future operating model.
- Staff had support through daily briefings, weekly team, multidisciplinary and professional development meetings. Staff were also involved in monthly governance meetings and took lead roles on the governance agenda.
- Staff confirmed that they had protected time for supervision and professional development and received regular supervision and caseload management. Records confirmed good compliance with clinical supervision and caseload management. Psychologists at the team also offered bespoke supervision to staff following complex work and debriefs following any incidents.
- All staff had received appraisals in the previous six months.

Multidisciplinary and inter-agency team work

- Care and treatment plans were reviewed regularly in multidisciplinary team meetings. Patients at risk and all newly referred patients were discussed in these meetings. We observed that multidisciplinary team meetings were well managed and staff present were engaged in the decision making. The team also met every morning to discuss any urgent risk issues and allocate new patients.
- 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 nurse 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.
- 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. Where necessary, when handing care over on discharge of a patient from the service, the team met with the receiving NHS teams.
- The team had developed good working relationships with the defence primary care teams across the catchment area and operated from a range of medical centres where required. 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 primary medical team at Hereford were very positive about the DCMH team and stated that the were an integral part of their work. The team was actively involved in the unit health committees to

ensure effective support to their patients. The team had also provided specialist advice and training for primary health care staff and military units to raise mental health awareness.

Adherence to mental health legislation

- The Mental Health Act was used very infrequently at the service. Should a Mental Health Act assessment be required the team 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.
- Staff did not receive formal training in the Mental Health Act and Code of Practice however information was available to staff and the team's social workers acted as leads regarding the Act.

Good practice in assessing capacity and consent

- There was not a specific policy on the Mental Capacity 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 consideration of capacity in all the records we reviewed. In line with the principles of the Act, staff assumed capacity unless there was evidence to suggest otherwise.
- 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 treatment and share information.

Are services caring?

Good

Our findings

Kindness, dignity, respect and support

- 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. This included both clinical and administrative staff. Patients we spoke with told us that staff were kind and supportive, and that they were treated with respect. We received several positive comments from patients about the treatment that they had received.
- Staff showed us that they wanted to provide high quality care. We observed staff working hard to meet the wider needs of their patients. Patients told us that staff would help them to access all possible support that they could.
- 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 were used at the team and were in place for patients. Care plans demonstrated the patient's involvement in their care. Records confirmed a copy of the care plan had been offered to the patient and patients we spoke with confirmed they had been offered copies of their care plans, that these were updated and were useful.
- 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 provided access to a range of information regarding the service delivered and 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 November 2021, 39 people had participated in the survey. All participants stated they would recommend the service to friends and family should they need to use it and where happy with their care. All participants felt staff would listen to their concerns.
- The team had adopted a 'you said, we did' approach to patient feedback. In response to feedback that the waiting area at Donnington was dull the team had applied for a welfare grant and used this to update the area and install a fish tank.
- Several patients confirmed their families had been involved appropriately within their care. Staff also confirmed times when they had offered support and advice to family members.

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.
- At the time of the inspection, three 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 had a dedicated liaison worker who attended the ward round and met with the patient on a regular basis when DCMH patients were admitted as inpatients. Where a patient was placed a significant distance from the team, the local DCMH performed this role with the patient.
- Clear referral pathways were in place. 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. A band 7 therapist and the department manager oversaw all referrals that were made to the DCMH including those for the spoke services. A duty worker was available each working day to review all urgent referrals. Routine referrals were clinically triaged by the duty worker to determine whether a more urgent response was required and allocated to the next available clinician to undertake full assessment.

- The management team told us that referrals had been increasing in previous years and they had seen a significant rise in the numbers of patients who were sick at home. These individuals accounted for over 40% of the DCMHs caseload during 2021. Many patients in this group had complex care needs and required lengthy treatment. At the time of the inspection the team's active caseload was 653. There had been 269 referrals in the six months to February 2022. The team confirmed that the DCMH manager and clinical lead closely monitored the referral data to ensure that risks were managed and to alleviate any blockages by deploying "surge" assessment capacity at times of high numbers of referrals, were the team would divert from additional activities to manage assessment within timeframe.
- Since December 2021, the DCMH had met the target for assessment of patients following all urgent referrals. The team stated that they always had same day assessment appointments for 'emergency referrals'.
- The DMS performance target for assessing patients within 15 days of routine referral was set at 95%. Since January 2022, the DCMH had assessed all patients within 15 days following routine referrals however the team had missed the target in November 2021 (at 93%) and December 2021 (at 94%). The management team confirmed that they had investigated all cases that were indicated as missing the target, on investigation in all instances the patient had been seen within the required time however the assessment dates had been incorrectly recorded on the electronic recording system. The department manager was working with staff to address this issue.
- 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.
- The management told us that the service was very busy and there were waiting lists for treatment. This had reduced slightly following the pandemic however at the time of the inspection 40 people were waiting for step 2 – low intensity therapy, the longest length of wait was 21 weeks. 67 people were waiting for step 3 - high intensity therapy, the longest length of wait was 35 weeks. 14 people were waiting for psychology, the longest length of wait was 10 weeks however there were no people waiting for psychiatry. The waiting list was reviewed weekly by the clinical lead and the waiting list manager to ensure that all clinical risks were appropriately managed. The team were looking to introduce group work and additional clinics at the time of the inspection to further address the waiting lists.
- Throughout the pandemic staff had mainly worked at home to minimise risk however the team had offered both virtual and face to face appointments where necessary. Patients told us that they had found virtual appointments extremely welcome as this had cut down on travel to appointments which could take significant time for some patients and had allowed greater flexibility. The team was increasing their office presence at all bases at the time of the inspection to allow greater access to face to face appointments.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients we spoke with confirmed that they were able to access the team's respective bases easily.
- Treatment rooms were on the ground floor at MOD Donnington and Preston. At Hereford and Northern Ireland, the team was based on the first floor however the team had arrangements

in place with the nearby medical centres to use accessible treatment rooms should this be required.
- The team told us that at present the space at most facilities was adequate to meet the team's needs. However, should all the team return to offices in the future, there was insufficient treatment rooms at Donnington. In addition, due to the team's building in Wrexham being temporarily occupied by students the team could not presently see patients at their building. The team used medical centre facilities were face to face appointments were necessary. The team used medical centre facilities were face to face appointments were necessary.
- Comfortable waiting areas were available for patients at the locations visited. Information was available on display about treatments, local services, patients' rights, and how to complain.
- Not all treatment rooms were adequately soundproofed at Donnington and Preston. However, staff had adopted measures such as playing music in the waiting areas and using alternate rooms to ensure privacy during treatments.
- Prior to the lockdown, in line with Covid-19 guidance the team had offered peripatetic clinics at Chester and Kineton medical centres. At the time of the inspection the team was beginning to re-establish these services.

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 over twenty military establishments across the West Midlands, North West of England, Northern Ireland and Mid/North Wales. In addition, a significant number of patients at the service are sick at home. Therefore, travelling required by some patients for appointments could be lengthy at up to three hours. Virtual appointments had been welcomed by most patients as an alternative to long travelling times.
- 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 practice 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 about other services.
- Patient waiting areas had posters and leaflets explaining the complaints process and information about how to complain was shared with patients at the commencement of their treatment. The patient experience survey in November 2021 found that all patients knew how to make a complaint. Patients spoken with during the inspection understood how to make a complaint and felt they would be listened to if they complained.
- In the 12 months prior to our inspection, there had been no formal complaints at the service.
- Since March 2021, the team had received 12 compliments about the service. During this inspection we received feedback from patients and heard positive comments about the staff, and the service patients had received.

Are services well-led?

Good

Our findings

Vision and values

- The team's mission was:
  "To deliver a safe and effective mental healthcare service for Defence in order to enhance and sustain the operational effectiveness of the three Services"

- The DCMH leadership team told us of their commitment to deliver quality care and promote good outcomes for patients. Staff were positive and clear about their role in delivering the vision and values of the service. Staff felt positive about the team and their own work and that this was making a positive difference to the quality of life of patients.

Good governance

- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. The team had a monthly governance meeting which all staff attended and took an active role in. The meeting considered good practice guidelines, policy development, risk issues, learning from complaints and adverse events, team learning and service development. In addition, daily briefings, weekly team meetings and continuous professional development sessions and multidisciplinary meetings considered areas of governance and practice. Minutes for these meetings showed the service had effective governance and administration procedures in place.
- Effective systems and processes were in place to capture governance and performance information. Local processes had been developed, including complaints procedures, training and supervision logs and local procedures for managing referrals, waiting lists, risk and safeguarding. The management team had access to detailed information about performance against targets and outcomes.
- The common assurance framework (E-CAF), is a DMS structured self-assessment internal quality assurance process, which forms the basis for monitoring the quality of the service. All members of the team were allocated lead roles on areas of the CAF and governance agenda and would meet regularly to update assurance information. We found that this document was up to date, was detailed and all issues and risks relevant to the service had been incorporated in the document. An update in the form of a progress report on the CAF and associated action plan was submitted to the regional headquarters (RHQ) on a regular basis.
- The department manager was the nominated risk manager. Risk and issues were 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: staff vacancies including remote psychiatry cover, waiting lists, environmental risks including ligature points and lack of centralised alarms, lone working, training access and Covid management. All risks included detailed mitigation and action plans and had been escalated to regional headquarters appropriately. Potential risks that we found had been captured within the risk and issues logs and the common assurance framework action plan.
- We found a number of positive aspects at the DCMH. These included:
  - The management team was well formed and demonstrated clear and accountable leadership. Despite the team delivering the service from multiple locations across three nations staff reported that morale was good and they felt part of a cohesive team.

- Despite a high caseload the team had met the response target for urgent and routine referrals in recent months and waiting lists for treatment were reducing.
- Multidisciplinary team processes were working well. A standardised recording system was operating, and all new referrals were discussed at the multidisciplinary team.
- All referrals and the waiting lists were overseen by the management team. The team had introduced a process to ensure that patients on the waiting list were contacted and risk assessed on a regular basis while they awaited treatment.
- The team was almost fully staffed, and most vacancies were being covered by long term agency staff while recruitment was undertaken.
- Staff had access to all necessary supervision and a wide range of continuous professional development.
- Patient experience was good. Patients we spoke with during the inspection were positive about the service and the patient survey in November 2021 had received overwhelmingly positive responses to all questions.
- The team had developed good working relationships with the defence primary care teams across the catchment area and operated from a range of medical centres where required. The primary care team at Hereford spoke very highly about the support they received from the DCMH team.

However, some areas required further work including:

- Mandatory training rates were at 75% however not all staff had undertaken required training in basic life support, automated external defibrillator and anaphylaxis management. This training had not been available during the pandemic and since it was reinstated the team had been struggling to book on to sufficient courses.
- Not all facilities that the team operated from were fit for purpose. Soundproofing was poor at Donnington and Preston, to manage privacy this limited the available clinical space at the services. In addition, the heating system at Donnington needed addressing.

Leadership, morale and staff engagement

- The management team consisted of a clinical lead who was a civilian consultant psychiatrist, a military department manager, a military deputy department manager and senior officer for the Northern Ireland team, and a practice manager.
- Staff were clear regarding their manager's and their own roles and responsibilities. Clear job plans, objectives and expectations were in place for the team. At this inspection, we found a clear and effective management structure in place. Leaders worked well together and demonstrated high levels of experience, capability and resourcefulness to deliver safe and effective care to patients.
- Morale was good at the service. Staff we spoke with during this inspection stated that they felt part of a cohesive team and that they were engaged in the development of the service. Staff were positive about the leadership team, confirming leaders were approachable and supportive of their work. Staff stated a good level of satisfaction with their work and the functioning of the team.
- The team was almost fully staffed. The few gaps in the team were mainly filled by long term locum staff. Sickness and absence rates at the team were minimal.
- Staff confirmed that there had been supportive working arrangements throughout the Covid pandemic. The team had developed and updated risk assessments and business continuity plans for the management of Covid-19 and had ensured that the staff had access to IT to enable homeworking, PPE and access to Covid testing. The team had worked effectively

and safely through virtual and rotational office working meaning they could offer both virtual and face to face appointments where necessary.

- A whistleblowing process was in place that allowed staff to go outside of the chain of command. Staff also had access to a Freedom to Speak Up Guardian (FTSU). Staff knew about the whistleblowing and FTSU processes and stated they would feel confident to use these should they need to. There had been no formal reported cases of whistleblowing or bullying at the team in the previous year. Where required staff performance issues had been managed appropriately.
- Staff had access to regular professional development, clinical supervision and caseload management appropriate to their role. The team regularly audited attendance and the quality of clinical supervision. All staff had undertaken an appraisal in the previous six months.
- All staff attended team meetings, governance meetings and weekly multidisciplinary meetings. Staff told us that service developments were discussed at these meetings and they were offered the opportunity to give feedback on the service and input into service development. Staff valued being part of working groups and took lead roles in supporting the improvement agenda.

Commitment to quality improvement and innovation

- An annual audit programme was in place and all staff were involved in conducting and identifying audit topics. Topics included DMS mandated audits such as audits of clinical record keeping, patient experience, supervision levels, significant events trend analysis, security, cleanliness and environmental audits. Additional audits were undertaken of the patient population and referrals process, safeguarding procedures, Covid measures, clinical pathways, the patient of interest list, care plans and job plans. Clinical audits had been undertaken of depression and anxiety outcomes and were underway for treatment outcomes for eating disorders and independent service provider (ISP) admissions. Audits were used to inform changes to practice. Feedback and changes as a result of the audits were taken to the governance meetings and used to plan future development and the ongoing audit programme.
- The team was undertaking quality improvement projects and addressing any potential risks as they arose. These included:
    - During the pandemic the team had set up daily morning meetings for all staff to discuss clinical risk and to ensure staff's welfare.
    - The team had adopted a 'you said, we did' approach to patient feedback. In response to feedback that the waiting area at Donnington was dull the team had applied for a welfare grant and used this to update the area and install a fish tank. The management team were in the process of adopting the same approach with staff at the time of the inspection.
    - To address waiting lists the team were in the process of setting up collaborative clinics and reinstating groupwork at the time of the inspection. An audit was underway looking at staff's job plans to see if there was further efficiency measures that they could take.
    - To address the levels of inappropriate referrals the management team was discussing service boundaries with senior managers and primary care leaders to ensure referrals were appropriate. The team was also developing a resource pack for people with mental health needs including details of local services and literature to signpost to more appropriate support.