Defence Medical Services

Department of Community Mental Health – London

Quality Report

Department of Community Mental Health London
Woolwich Station Medical Centre,
Woolwich
Greenhill
London
SE18 4BW

Date of inspection: 9 - 19 November 2021
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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?	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 (DCMH) London between the 9 and 26 November 2022. Overall, we rated the service as Good.

We found the following areas of good practice:

- Individual patient risk assessments were in place and 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 incident reporting and safeguarding procedures and practice. Staff had reported all relevant events and appropriate action had been taken to investigate and learn from these.
- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychologist. 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.
- Staff were kind, caring and compassionate in their response to patients. Patients said they were very well supported, and that staff were kind and enabled them to get better.
- Clear referral pathways were in place. Despite an increase in referrals the team had met the response target for urgent and routine referrals and waiting lists for treatment were minimal.
- 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. Potential risks that we found had been captured within the risk and issues logs and the common assurance framework and included 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 Covid 19 pandemic to mitigate the risk of infection to patients and staff and to ensure the service could operate safely.
- The team was undertaking quality improvement projects to enhance patient care and addressing any potential risks as they arose.

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

- We found gaps in key leadership roles that the regional management team had not fully addressed, while staff acting in to these roles were working hard to lead the team management capacity was having an impact on the delivery of the service.
- Systems were being set up to better capture governance and performance information and local processes had been developed, however these had not yet been fully embedded in the governance process.

- Further work was required to ensure effective risk management and care planning, consent procedures and training compliance.

Professor Edward Baker
Chief Inspector of Hospitals

Are services safe?

Good

We rated the DCMH as good for safe because:

- 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.
- The service was delivered from a safe and accessible building, that was clean and well maintained.
- Staff had a good awareness of incident reporting and 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 Covid 19 pandemic to mitigate the risk of infection to patients and staff and to ensure the service could operate safely.

However:

- Due to delays within the human resources organisation the manager post had not been filled. The service remained safe however we were concerned about the long-term impact of this deficit.
- Overall training compliance averaged 74%, however staff were booked on courses to receive basic life support and AED training which had not been available to staff during the pandemic.
- While we found that an overall risk assessment was in place and known concerns were recorded for all patients, for some patients at increased risk there were no enhanced risk assessment plan in place.
- A consent form had been introduced at the service but was not available in all patient records we reviewed.
- Not all patients we spoke with confirmed they had received copies of their care plans.

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 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.
- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychologist.
- 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.

However:

- A consent form had been introduced at the service but was not available in all patient records we reviewed.

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. Patients told us that staff treated them with respect and communicated 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 heard 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.
- Staff understood confidentiality, and this was maintained at all times.

However:

- Not all patients we spoke with confirmed they had received copies of their care plans.

Are services responsive to people's needs? Good

We rated the DCMH as good for responsive because:

- Clear referral pathways were in place. Despite an increase in referrals the team had met the response target for urgent and routine referrals and waiting lists for treatment were minimal.
- 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 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.
- The team had a procedure regarding following up patients who did not attend their appointment (DNA process). The DNA rate was eight per cent which was in line with 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 had a system for handling complaints and concerns. Staff demonstrated awareness of the complaints process and had worked actively to address any concerns.

Are services well-led? Requires improvement

We rated the DCMH as Requires Improvement for well-led because:

- We found gaps in key leadership roles that the regional management team had not fully addressed, while staff acting in to these roles were working hard to lead the team management capacity was having an impact on the delivery of the service.
- Systems were being set up to better capture governance and performance information and local processes had been developed, however these had not yet been fully embedded in the governance process.
- Further work was required to ensure effective risk management and care planning, consent procedures and training compliance.

However:

- Staff reported that morale was good overall and that they felt supported by their managers and colleagues.
- 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.
- 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.
- The team was undertaking quality improvement projects to enhance patient care and addressing potential risks as they arose.

Our inspection team

Our inspection team was led by a CQC Inspection Manager Lyn Critchley. The team included two inspectors and an assistant inspector who worked remotely and two specialist military mental health nursing advisors.

Background to Department of Community Mental Health – London

The department of community mental health (DCMH) London provides mental health care to a population of up to 5,800 serving personnel from across all three services of the Armed Forces. The catchment for the service includes all service personnel based at nine military establishments across London and the south east. In addition, the team work with those who have returned to the catchment area on home leave. The service operates from a main base at Woolwich Station Medical Centre.

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 187 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 on 9 and 11 November 2021 and interviewed patients and staff via video conferencing between 11 and 26 November 2021. During the inspection, we:

- looked at the quality of the teams' environment;
- observed how staff were caring for patients;
- spoke with 12 patients who were using the service;
- spoke with the regional clinical director;
- spoke with the management team;
- spoke with nine other staff members including doctors, nurses, social workers, psychologists and administration staff;
- looked at 16 clinical records of patients;
- joined the multi-disciplinary team meeting;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- observed the duty worker;
- examined minutes and other supporting documents relating to the governance of the service.

Defence Medical Services

Department of Community Mental Health – London

Detailed findings

Are services safe?

Good

Our findings

Safe and clean environment

- The team was based with other primary care services within Woolwich Station Medical Centre. The medical centre was located outside of the military base and was easily accessible to all patients. The team occupied the first floor of the building. There was a lift available to access the first floor and the building was accessible to people with a physical disability. The building was well maintained, and the team confirmed that any required maintenance was managed in a timely way.
- 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 assessments highlighted the risk factors we observed including the presence of ligature anchor points and other relevant clinical environmental risks. Staff mitigated these risks through an intercom door entry system meaning reception staff could manage entry to the building. The waiting area could be observed by reception staff and staff escorted patients around the building at all times.
- Lone working practices were in place including arrangements for logging which staff were in or out of the building. Staff had access to personal protection alarms should this be required. A risk assessment was in place regarding lone working and managing aggressive behaviour.
- 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, and the building was found to be clean throughout. 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 building.
- Equipment logs were in place. Equipment was found to be clean and had been serviced.

Safe staffing

- The clinical team totalled 18 people and consisted of medical, nursing, social work, psychology and administration staff. The team had five vacancies for a department manager, a psychiatrist and three community mental health nurses. The nursing posts were being covered by locum staff members. The regional management team had decided to recruit a band 7 nurse manager to replace the military department manager role. This was yet to be advertised at the time of the inspection due to delays within the human resources organisation. A principal psychologist had recently joined the team following a gap in this post.
- The team benefited from a full-time practice manager and two administrators. The reception was staffed at all times and patients spoke very 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 twenty-one 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 74%. At this time staff were booked on courses to receive basic life support and AED training: these had not been available to staff during the pandemic.

Assessing and managing risk to patients and staff

- A duty worker was available each working day to review all new referrals. Routine referrals were clinically triaged by the duty nurse to determine whether a more urgent response was required.
- Once a patient was accepted by the team a risk assessment was undertaken. In all cases we reviewed we found that an overall risk assessment was in place and known concerns were recorded however for some patients at increased risk there were no enhanced risk assessment plan in place. 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 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 also met every morning to discuss any urgent risk issues and all at risk cases were discussed at 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.
- The Ministry of Defence had a policy for safeguarding vulnerable adults however adult safeguarding was not yet part of the DMS's central training delivery. To address this the team had completed training available from the local authority. The social worker had also developed a local procedure for reporting adult safeguarding concerns and had recently delivered a training session to staff about procedures. Child protection training levels one to three were mandatory for DMS staff as appropriate to their role. At the time of the inspection staff had undertaken training as appropriate to their role. The team demonstrated an understanding of safeguarding principles and practice and had made 12 safeguarding referrals in the previous 12 months. 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. 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.
- There were written procedures for response in a medical emergency. Staff were booked to receive updated basic life support, defibrillator and anaphylaxis training. The team had access to emergency equipment within the medical centre, and this had been checked regularly.
- 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 Covid 19 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 as necessary throughout the pandemic.

Track record on safety

- Between October 2020 and November 2021, there were 14 significant events recorded across the service. This had included two deaths of former patients. Both cases were under investigation at the time of the inspection. All other events had resulted in low or no harm. The majority of these related to administration issues and breaches of confidentiality and one clinical 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.

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. Additional training had been delivered to staff to support reporting. 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. Following the death of a former patient and the clinical lead had led a debrief session and further sessions were planned to support staff's learning.

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. Formal care plans were used at the team and were in place for all patients we reviewed. Care plans were holistic and captured all relevant needs and risks. However, some patients we spoke with stated that while they discussed their care needs with staff, they had not received actual copies of their 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 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 processing therapy and eye movement desensitization and reprocessing, addictions therapy, motivational interviewing and group work.
- 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 that was being undertaken for their patients.
- 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 clinical record keeping, patient experience, supervision levels, significant events trend analysis, infection prevention and control, cleanliness and environmental audits. Clinical audits were undertaken of the care pathway, caseload management, shared care agreements, treatment outcomes and medication recommendations.

Skilled staff to deliver care

- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychologist. These included psychiatrists, nurses, social workers and psychologists.
- New staff, including locums, received a thorough induction. Development training, such as in cognitive behaviour therapy, was available to staff.
- Additional bespoke training was delivered to the team at professional development sessions. Recent sessions had included safeguarding procedures, ECAF completion and governance. Staff had requested training in Naval occupational procedures as they had been supporting a Naval DCMH for a few months, the management team were looking in to sourcing this at the time of the inspection.

- The team also hosted student nurses who were training within the Armed Forces and a student social worker.
- Staff had support through daily briefings, weekly team and multidisciplinary and professional development meetings and monthly business and governance meetings.
- 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. The acting department manager had recently taken over the caseload management to bring about improvement in clinical records completion.
- Psychologists at the team also offered bespoke supervision to staff following complex work and debriefs following any incidents.
- All employed staff had received appraisals in the previous six months.

Multidisciplinary and inter-agency team work

- Care and treatment plans were reviewed in multidisciplinary team meetings. Patients at risk and all newly referred patients were discussed in these meetings. The acting manager had introduced a new pro forma and recording process to the meetings to ensure efficiency and accurate recording. 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 team. 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 was actively involved in the unit health committees to ensure effective support to their patients. The team had also provided specialist advice 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 should this be required.

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 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 explained to them however we did not find records of consent in all records we reviewed. The management team told us that they had recently introduced a single page consent form that was emailed to all new patients along with further guidance about the ongoing need for consent.

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. Patients told us that staff treated them with respect and communicated effectively with them. This included both clinical and administrative staff. We received several extremely positive comments from patients about the treatment that they had received. This was supported by very positive findings within the patient experience survey.
- 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. 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 all patients. Care plans reviewed did include the views of patients however, some patients we spoke with stated that while they discussed their care needs with staff, they had not received actual copies of their care plans.
- 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 introduced an informative introduction email and leaflets explaining the service that was delivered and regarding the need for consent. The team also provided access to a range of information 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 October 2021, 15 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.
- At the time of the inspection the team was undertaking additional research to gather patients views regarding the effectiveness of virtual appointments and their preference regarding appointment delivery methods.
- 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. Patients confirmed that they were given advice about how to access out of hours support. 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.
- 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 regular basis when DCMH patients were admitted as inpatients. Where a patient was 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 duty worker was available each working day to review all new referrals. Routine referrals were clinically triaged by the nurse to determine whether a more urgent response was required.
- The management team told us that referrals had increased during 2021. The team was also supporting patients from the catchment bases for another DCMH within the region. At the time of the inspection the team's active caseload was 187. There had been 146 referrals in the 6 months to November 2021.

- Since April 2021, the DCMH had met the target for assessment following all urgent referrals. The team stated that they always had same day assessment appointments for 'emergency referrals'.
- In the three months prior to the inspection, the DCMH had met the target for response to routine referrals in 95% of cases. This is in line with the defence target and above the national average. The management team confirmed that were the target was missed it was due to date recording errors or patient availability. The team told us that they would usually see new patients who had been referred as routine within a week and this was confirmed by patients that we spoke with.
- 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 clinical lead told us that she monitors the referral and waiting list information on a weekly basis to ensure risks are managed and to alleviate any blockages.
- At the time of the inspection the longest length of wait for treatment was 28 days. Waiting lists were minimal with no people waiting for step 2 – low intensity therapy, six people waiting for psychology and 10 people for psychiatry.
- 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 throughout the pandemic. Patients told us that they had found virtual appointments useful 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. The team was beginning a survey to gather patients views regarding the effectiveness of virtual appointments and their preference regarding appointment delivery methods.
- 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 team confirmed that usually only patients who had been deployed to other duties at short notice did not attend. The DNA rate at September 2021 was eight per cent which was within the DMS target.

The facilities promote recovery, comfort, dignity and confidentiality

- The team was based with other primary care services within Woolwich Station Medical Centre. Patients we spoke with confirmed that they were able to access the team base easily as it was outside of Woolwich Barracks.
- The team occupied the first floor of the building however there was a lift available to access the first floor and the building was accessible to people with a physical disability.
- There were sufficient treatment rooms at the building, and these were welcoming and conducive to patient dignity and wellbeing. Treatment rooms were adequately soundproofed to ensure privacy during treatments.
- A comfortable waiting area was available for patients. Information was available on display about treatments, local services, patients' rights, and how to complain. However, we noted that some information was out of date. The team removed and updated this during the inspection.
- Prior to the lockdown, the team had offered peripatetic clinics at several locations including Chatham, Hyde Park Barracks, Maidstone and Northwood HQ. These had ceased in 2020 in line with Covid-19 guidance however at the time of the inspection the team was looking 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 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.
- 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 October 2021 found that all patients knew how to make a complaint. Patients spoken with during the inspection understood how to make a complaint and all felt they would be listened to if they complained.
- In the 12 months prior to our inspection, there had been one formal complaint. This had related to a poorly managed transfer of care. The practice manager confirmed that they had fully investigated this complaint and it had been resolved.
- During 2021, the team had received 29 compliments about the service. During this inspection we received feedback from patients and heard very positive comments about the staff, and the service patients had received.
- 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 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"

- Staff were positive and clear about their own 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 continuous learning. The team had a monthly governance meeting which staff attended. The meeting considered good practice guidelines, policy development, risk issues, learning from complaints and adverse events, team learning and service development. Minutes for this meeting showed the service had improved its governance and administration procedures over the previous months.

- Systems were being set up to better 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 information about performance against targets and outcomes however this had not yet been fully embedded in the governance process.
- The common assurance framework (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 had recently been allocated lead roles on areas of the CAF and had begun to meet to update assurance information. We found that this document was in the process of being updated however 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 team were working through the action plan to address all identified risks.
- The acting 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: the manager and clinical lead gaps, environmental risks, Covid management, and capacity and support being provided to another DCMH. All risks included detailed mitigation and action plans. Potential risks that we found had been captured within the risk and issues logs and the common assurance framework action plan and escalated appropriately.
- There had been a number of positive developments and improvements to care outcomes at the DCMH. These included:
    - Despite increasing referrals to the service, the team had better than the National average performance for waiting times and meeting referral targets.
    - The clinical lead monitored the referral and waiting list information on a weekly basis to ensure risks were managed and to alleviate any blockages in capacity.
    - Patient experience was very good and patients we spoke with during the inspection described the service as excellent. The patient survey in October 2021 had received overwhelmingly positive responses to all questions. The team was undertaking further work to capture patients views of virtual working.
    - Record keeping overall was of a very good standard.
- However, there are areas of work that require further improvement including:
    - Not all patients had received a copy of their care plan.
    - For some patients at increased risk there were no formal enhanced risk assessment plan in place. This had been acknowledged by the management team.
    - While consent forms had been put in place these could not be located in patient files.
    - At the time of the inspection overall training compliance averaged 74%, however it is acknowledged that staff were booked on key courses that had not been available to staff during the pandemic.

Leadership, morale and staff engagement

- At this inspection, we found gaps in leadership roles. Staff acting in to these roles were working hard to lead the team however management capacity was having an impact on the delivery of the service. The management team consisted of a clinical lead who was a consultant psychologist, an acting department manager and a practice manager. The clinical lead had taken on this role very recently due to a gap in the military psychiatrist role. The acting department manager had joined the team in July 2021 as the second in command however had immediately stepped in to the manager role due the departure of the previous manager. The Practice manager had joined the team in March 2021. The regional

management team had decided to recruit a band 7 nurse manager to replace the military department manager role. This was yet to be advertised at the time of the inspection due to delays within the human resources organisation. The regional team also confirmed that there was no plan to recruit to the military psychiatrist clinical leadership role.

- The management team told us that they were working hard to form a cohesive management team and had established clearer roles and responsibilities while ensuring effective management cover available to staff. The management team were developing job plans, objectives and expectations for the team, but further work was needed to establish these.
- The management team had undertaken initiatives to support and engage staff. This had included a daily briefing meeting to check on staff welfare and to share risk. Staff we spoke with during this inspection were passionate about their work and proud to work in the team. They stated they were also positive about the management team's attempts to support them but that the absence of a substantive manager and clinical lead had impacted the DCMH.
- The team had been supporting patients from the catchment bases for another DCMH within the region since August 2021. Staff told us that while they were happy to support this work, they did not feel fully equipped to deliver this and were concerned about a lack of standardised pathways and processes. Staff had requested training in Naval occupational procedures however this was yet to be delivered.
- 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 throughout the pandemic 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 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 mostly knew about the whistleblowing and FTSU processes and all 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.
- Sickness and absence rates at the team were minimal.
- Staff had undertaken most required training and had access to regular professional development and clinical supervision. All employed staff had undertaken an appraisal in the previous six months. All staff attended team meetings, daily briefings, weekly multidisciplinary and governance meetings. Staff told us that new developments were discussed at these meetings and they were offered the opportunity to give feedback on the service and input into service development. Staff had recently been given the opportunity to take on leadership roles.
- During this inspection, we met with the regional clinical director. They acknowledged that the gaps in key posts had impacted on the team and confirmed arrangements to recruit to the manager post.

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 an audit of clinical record keeping, patient experience, supervision levels, significant events trend analysis, infection prevention and control, cleanliness and environmental audits. Detailed clinical audits were undertaken and had been used to inform changes to practice. These included audits of the care pathway, caseload management, shared care agreements, treatment outcomes and medication recommendations. 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 several quality improvement projects including:
  - The introduction of a multidisciplinary team pro forma and process to ensure efficiency and make improvement to the multidisciplinary team meetings and oversite of patient risk
  - The development of a 'single page staff management system' which aims to offer a single reference point for the staff member, other staff, and the managers to briefly see the management administration of the team.
  - The development of a single page letter which is sent to a patient by email at referral informing them what can be expected from the team. This letter includes information about consent, complaints, safety netting, polices, if they require interpreters, have special requirements due to disabilities, how to access attend anywhere and a leaflet out lining the core team information such as hours and function.
  - Introduction of weekly senior management team meetings to review all adverse service information and performance data in a timely way.
  - The allocation of lead roles on areas of the CAF to all staff members to re-engage the team after months of silo working during the pandemic.