Defence Medical Services

Department of Community Mental Health – Plymouth

Quality Report

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
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 Plymouth between the 18 and 20 February 2020. Overall, we rated the service as Requires Improvement. The Chief Inspector of Hospitals recommends that the DCMH addresses the following:

- During this inspection patients commented that they had waited too long to commence treatment. The team was not always meeting its assessment time targets for routine referrals and there were long waiting times to commence treatment, particularly for high intensity treatment or to see a psychiatrist.
- Staffing was insufficient to meet the demand of the service. Staff reported that staffing levels significantly impacted on their workload and had limited the capacity of the management team to provide clear clinical leadership.
- Not all incidents had been fully investigated. Further work was required to ensure all concerns are captured and learning shared from all adverse events.
- The team's base has insufficient treatment and meeting rooms and was not accessible to anyone with a physical disability. Staff told us they mitigated environmental risks by meeting patients within the reception and escorting them around the building however we were concerned that patients from the base were unaccompanied until they reached the first floor of the building. The team had developed a business case for alternative accommodation however this was yet to be actioned.
- The patient experience survey in December 2019 found that 19% per cent of participants felt their appointment was not at a convenient location. This was supported by the comments made during the inspection.

However, we found areas of good practice:

- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. The team consisted of skilled and experienced staff who worked in partnership with other agencies to manage and assess patient needs and risks.
- Individual patient risk assessments were in place and proportionate to patients' risks. Crisis plans were in place and where a known patient contacted the team in crisis, the team responded swiftly. All referrals were clinically triaged by the mental health team to determine whether a more urgent response was required and to monitor whether patients' risks had increased.
- The service had introduced formal care plans and the multidisciplinary team reviewed these. Patients could access a wide range of psychological therapies and the service had developed a range of therapeutic groups to provide better access to patients who required lower level and more practical interventions.
- Staff showed us that they wanted to provide high quality care. We observed some positive examples of staff providing practical and emotional support to people. Patients stated that they were well supported, and that staff were kind and enabled them to get better.

Are services safe?

Requires Improvement

We rated the DCMH as Requires Improvement for safe because:

- Staffing was insufficient to meet the demand of the service which had resulted in long waiting lists for all forms of treatment.
- Not all incidents had been fully investigated. Further work was required to ensure all concerns are captured and learning shared from all adverse events.
- Should additional staffing be secured, the team's base had insufficient treatment and meeting rooms. The team had developed a business case for alternative accommodation however this was yet to be actioned.
- The team occupied the first and second floor of a shared building. Staff told us they mitigated environmental risks by meeting patients within the reception and escorting them around the building however, we were concerned that patients from the base were unaccompanied until they reached the first floor of the building.
- Overall mandatory training was at 84% compliance however not all staff had undertaken courses in anaphylaxis, safeguarding level 3 and records management.

However:

- 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. Crisis plans were in place and where a known patient contacted the team in crisis, the team responded swiftly.
- We saw good evidence of the team following up on any known risks. All referrals were clinically triaged by the mental health team to determine whether a more urgent response was required and to monitor whether patients' risks had increased.
- The staff had a good awareness of safeguarding procedures and practice.
- Emergency and business continuity plans were in place and effective.

Are services effective?

Good

We rated the DCMH as Good for effective because:

- Formal care plans were in place and were holistic and person centred. Care and treatment plans were reviewed regularly by the multidisciplinary team in weekly team meetings.
- Patients could access a wide range of psychological therapies and therapeutic groups as recommended in NICE guidelines.
- The team used a range of outcome measures throughout and following treatment. These indicated improved outcomes following treatment.
- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. Staff could access developmental training and a range of clinical support.
- The team worked effectively in partnership with other agencies, both inside and outside the military, to manage and assess patient needs and risks. The team offered a peripatetic service to the medical facilities within the catchment area and reported improved working arrangements with primary care, the NHS and third sector.

- The team took an active role in HMNB Devonport's welfare committee. This is a collaborative base wide approach to managing risks and agreeing support to personnel who are struggling to cope with naval life. During the inspection we met with the captain of the base who was highly appreciative of the role the team took to support mental health awareness across the base.
- A consent to treatment form was in place and consent was sought from patients and was clearly documented. Staff had a good awareness of the Mental Capacity Act and mental health legislation.

However:

- While supervision was occurring the recording of this was poor, meaning that the management team could not be assured that staff were appropriately supervised.

Are services caring?

Good

We rated the DCMH as Good for caring because:

- We saw staff that were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them.
- Staff showed us that they wanted to provide high quality care. Staff working extremely hard to meet the wider needs of their patients. We observed some very positive examples of staff providing practical and emotional support to people.
- Patients said they were well supported, and that staff were kind and enabled them to get better.
- Patients stated 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.

Are services responsive to people's needs?

Requires Improvement

We rated the DCMH as Requires Improvement for responsive because:

- During this inspection patients commented that they had waited too long to commence treatment. The team was not always meeting its assessment time targets for routine referrals and there were long waiting times to commence treatment, particularly for high intensity treatment or to see a psychiatrist.
- The team was based within a grade II listed building within the dockyard at HMNB Drake at Plymouth naval base which was not accessible to anyone with a physical disability.
- The patient experience survey in December 2019 found that 19% per cent of participants felt their appointment was not at a convenient location. This was supported by the comments made during the inspection.

However:

- Where a known patient contacted the team in crisis during office hours the team responded promptly.
- The building was comfortable, well decorated and equipped. A waiting area was available for patients. Information was available on display about treatments, local services, patients' rights, and how to complain.

- The team had made arrangements to use alternative facilities where a patient was unable to access the building due to a physical disability.
- The team had a system for handling complaints and concerns. Patients felt that they would be listened to should they need to complain. Learning was captured from complaints.
- The team had begun to operate peripatetic clinics to address long journey times.
- The team had proactively worked with the HMNB Devonport's base commander to allow access through a gate close to the DCMH building so that patients could access the DCMH more easily.

Are services well-led? Good

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

- All staff we spoke with during this inspection were clear regarding the aims of the service and supported the values of the team.
- The team had an overarching governance framework to support the delivery of the service, to consider performance. 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. All risks identified included mitigation and action plans. Risks had been escalated appropriately.
- A range of audit and quality improvement projects were being undertaken. Staff were fully engaged in this process.

However:

- Staffing shortages had limited the capacity of the management team to provide clear clinical leadership. While we could evidence improvement in governance and practice throughout the previous months, we found some areas of practice that required further oversight and improvement.
- Staff reported that morale was good however that staffing levels significantly impacted on their workload.

Our inspection team

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

Background to Department of Community Mental Health – Plymouth

The department of community mental health (DCMH) at Plymouth provides mental health care to a population of over 13500 serving personnel from across all three services of the Armed Forces. The catchment for the service includes all service personnel based at 11 military establishments across the Southwest region covering Devon and Cornwall and a part of Dorset and Somerset, as well as service personnel aboard Plymouth based ships deployed around the world. 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 HMS Drake within HMNB Devonport in Plymouth. The team also operates peripatetic clinics at the Commando Training Centre Royal Marines (CTCRM) Lympstone and HMS Raleigh.

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 240 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. In addition, DCMH Plymouth also offers out of hours support to Royal Navy ships and Medical Facilities on a published rota system with the other two Naval situated DCHM's.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

We carried out an announced inspection between the 18 and 20 February 2020. During the inspection, we:

- looked at the quality of the teams' environment;
- observed how staff were caring for patients;
- spoke with two patients who were using the service;
- spoke with the management team;
- spoke with seven other staff members including doctors, nurses, social worker and administration staff;
- met with the regional clinical director, captain of the base and senior medical officer for Devonport Naval Base;
- reviewed 20 comment cards from patients;
- looked at eight clinical records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- observed the duty worker and the reception staff;
- examined minutes and other supporting documents relating to the governance of the service.

Defence Medical Services

Department of Community Mental Health – Plymouth

Detailed findings

Are services safe?

Requires improvement

Our findings

Safe and clean environment

- The team was based within a grade II listed building within the dockyard at HMS Drake at Devonport naval base. The team told us that space was limited at the building and they were concerned that when additional staff joined the team there would be insufficient office and treatment space. The team had developed a business case for alternative accommodation. The regional clinical director confirmed this was being considered and that in the longer term there were plans for an integrated medical centre at Devonport Naval Base.
- The building was well maintained, and staff confirmed that the maintenance team would generally respond quickly to any maintenance request.
- There was an environmental risk assessment and ligature point audit 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 told us they mitigated these risks by meeting patients within the reception and escorting them around the building at all times. However, we were concerned that patients from the base were unaccompanied until they reached the first floor of the building.
- General health and safety checks were in place. The fire officer had reviewed the building risk assessment in October 2019 but the report for this remained outstanding. However, the team confirmed they had requested this but there were no specific actions required. Staff had undertaken fire safety drills on a regular basis.
- Staff also had access to personal alarms for use in the event of an emergency. Lone working practices were in place including arrangements for logging which staff were in or out of the building.
- Cleaning and infection control audits were undertaken regularly, and the building was found to be clean throughout. Staff had received infection prevention training. Hand wash facilities and hand gels were available, and staff adhered to infection control principles, including handwashing.
- Equipment logs were in place. Equipment was found to be clean and had been serviced. The practice manager told us that she had chased up portable appliance testing for the EMDR

(eye movement desensitisation reprogramming) equipment as this had not been included in the service contract.

Safe staffing

- At the time of the inspection, the clinical team totalled 12 people and consisted of medical, nursing, social work and psychology staff. There had been difficulties in recruiting military and permanent civilian staff and there had been a freeze on using locum staff to fill gaps in posts. At the time of our inspection staffing was at 60% against establishment. The team had five vacancies for military nurses. These would be filled in Autumn 2020 by newly qualified naval nurses. Recruitment was underway to address civilian nursing gaps however there were two further vacancies for band 6 nurses which were unfilled by locum staff. There was only one psychiatrist at the team however an additional civilian psychiatrist had been recruited and was to join the team in April 2020. Staffing was insufficient to meet the demand of the service which had resulted in long waiting lists for all forms of treatment.
- The team benefited from a full-time practice manager and four administrators. The reception was staffed at all times and patients commented positively about the welcome they received at the service.
- All new starters, whether locum or permanent, were provided with induction training and a copy of the induction booklet.
- Up to twenty-seven training courses were classed as mandatory dependent on role. At the time of the inspection overall compliance with training averaged 84%. However, some courses were below 75% compliance: anaphylaxis at 62%; children's safeguarding level 3 at 56%; records management at 67%.

Assessing and managing risk to patients and staff

- 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. This role was ring fenced to ensure adequate response to referrals. Routine referrals were also clinically triaged by the duty nurse to determine whether a more urgent response was required.
- 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 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. All at risk cases were discussed at multidisciplinary meetings. At the time of the inspection six people were considered high risk. Administrators were aware of these individuals and the need to ensure an immediate response where they made contact.
- The Ministry of Defence had an up to date policy for child protection. Child protection training levels one to three were mandatory for DMS staff. At the time of the inspection most staff had undertaken levels one and two training as appropriate to their role however not all staff had completed level 3 training. Adult safeguarding was not part of the DMS's mandatory training requirements, however the team's social worker described good relationships with local authority safeguarding teams and had developed a local procedure for reporting adult safeguarding concerns. The team demonstrated a clear understanding of safeguarding

principles and practice. 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 psychiatrist would prescribe medication, but ongoing prescribing would be undertaken by medical officers 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 had received annual basic life support, defibrillator and anaphylaxis training. The team had recently undertaken an emergency drill: the response time for this had been within resuscitation guidelines.
- Business continuity plans for major incidents, such as security threat, power failure or building damage were in place. At the time of the inspection, a base wide table top exercise was planned for response to a major pandemic.

Track record on safety

- Between January 2019 and February 2020, there were 11 significant events recorded across the service. These had included the death of a patient at HMS Drake in January 2019. The inquest had been heard for this case and a root cause analysis investigation had been undertaken. These had raised concerns about the oversight of vulnerable personnel at the base and alcohol awareness within the team. A base wide action plan had included additional alcohol training for the DCMH staff. The team confirmed that the learning from this had been shared with them following the incident and the investigation.
- In August 2019, a further event occurred where a patient took an overdose in the DCMH building. A root cause analysis investigation had been undertaken due to a significant delay in emergency services attending the patient. Base wide processes for emergency response had been strengthened following this incident. The team had also set in place arrangements to escort patients around the building following this event. However, it was noted that the root cause analysis did not fully investigate all clinical aspects of the incident.
- In February 2020, a records audit found that for one clinician there was missing documentation from some patient's records. An investigation was underway, but it was indicated that this had been due to a technical issue on the records system.
- All other events had resulted in low or no harm. The majority of these related to gaps in clinical recording and poor administration processes.

Reporting incidents and learning from when things go wrong

- The team used the standardised defence electronic system to report significant events, incidents and near misses. Staff received training at induction regarding the processes to report significant events. The team undertook an audit of staff's awareness of incident recording processes in July 2019, which led to additional awareness training for staff. Staff were aware of their role in the reporting and management of significant events, incidents and near misses.
- 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 in place for all patients we reviewed. Care plans were holistic and captured all relevant needs and risks.
- The team had access to an electronic record system which was shared across all defence 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. Staff told us of therapeutic practices that met this guidance.
- The team employed two psychologists and all nurses were trained in a range of psychological treatments. The team was also working with the NHS to provide additional high intensity therapy capacity. Despite delays, 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 and anxiety. Treatments included the use of cognitive behavioural therapy, cognitive processing therapy and eye movement desensitization and reprocessing, alcohol work, motivational interviewing, supportive counselling and social work intervention.
- The team had introduced therapeutic groups to provide more timely access to patients who required lower level, more practical or pre-therapy intervention. These included the military behavioural activation and rehabilitation course (MBARC) and the depression and anxiety management course. These groups had proven to be effective and were well received by patients.
- 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. The team also audited patient outcomes following each groupwork course. 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 patient experience, complaints management, clinical record keeping, supervision levels, staff awareness of incident procedures, security, cleanliness and environmental audits. Clinical audits were undertaken of caseload management, care plan completion, group work effectiveness and treatment outcomes.

Skilled staff to deliver care

- The team consisted of a range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. These included nurses, social workers and psychologists.
- New staff received a thorough induction. Development training, such as in cognitive processing therapy, was available to staff. Some staff were undertaking additional academic qualifications financed by the service. The team also hosted GP and psychiatry trainees and student nurses who were training within the Armed Forces.
- Additional bespoke training was delivered to the team at regular professional development sessions. Recent sessions had included the step one pilot study, incident process awareness, ligature audit findings and risk management, and safeguarding awareness.
- Staff had support through weekly multidisciplinary and professional development meetings. Staff were also involved in monthly governance meetings.
- Staff confirmed that they had protected time for supervision and professional development and received regular supervision and caseload management. An audit of supervision in January 2020 found that all staff were receiving appropriate and regular supervision and case management support however record keeping for this required improvement. Psychologists at the team also offered bespoke supervision to staff following complex work and debriefs following any incidents.

Multidisciplinary and inter-agency team work

- Care and treatment plans were reviewed regularly in multidisciplinary team meetings. Patients at risk were also discussed in these meetings. Staff told us that multidisciplinary team meetings were well managed and staff present were engaged in the decision making.
- The team worked in partnership with a range of services both within and outside the military. This included liaison with the NHS providers who are independent service providers of psychiatric beds. The team had a liaison officer whose role it was to work with the NHS team to ensure effective care and discharge from the service. 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 provided specialist advice and training for primary health care staff and offered a peripatetic service to several medical facilities within the catchment area. The team had also provided mental health awareness training to over 300 team managers across the region.
- The team took an active role in HMNB Devonport's welfare committee. This is a collaborative base wide approach to managing risks and agreeing support to personnel who are struggling to cope with naval life. The team confirmed that while this was resource intensive it provided a highly supportive approach that enhanced the mental health treatment they were able to offer. During the inspection we met with the captain of the base for HMNB Devonport who was highly appreciative of the role the team took to support mental health awareness across the base.

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 worker acted as a lead 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 the records we reviewed. In line with the principles of the Act, staff assumed capacity unless there was evidence to suggest otherwise.
- 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

- Staff demonstrated that they wanted to provide high quality care. We heard some positive examples of staff providing practical and emotional support to people. We observed staff working extremely hard to meet the wider needs of their patients.
- Staff were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them. The patients we spoke with told us that staff were kind and supportive, and that they were treated with respect. Some patients commented that the support offered was exemplary.
- 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. 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. Information was stored securely, both in paper and electronic format.

The involvement of people in the care they receive

- Formal care plans were in place for all patients. Care plans demonstrated the patient's involvement in their care. The feedback we received suggested staff provided clear information to help with making treatment choices.

- 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 an informative leaflet explaining the service that was delivered. This included links to a number of useful online applications. The team also provided access to a range of booklets and information regarding clinical conditions and treatments available to support the conditions. These were shared with patients routinely.
- The team undertook patient experience surveys on an ongoing basis. In December 2019, 53 people had participated in the survey. Ninety-one per cent of participants said that they felt involved in their care and 93% stated they would recommend the service to friends and family should they need to use it. Eighty-five per cent knew how to complain and felt listened to.
- The team also asked participants about whether the waiting time to commence therapy was too long. Fifty-five per cent of patients agreed the wait was too long from assessment to treatment. This was supported by the comments we received during this inspection. Six of 20 people commented that they had waited too long to commence treatment.
- The team had recently introduced a 'you said we did' board at the team base to indicate action taken as a result of surveys and comments.

Are services responsive to people's needs?

Requires improvement

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. In addition, DCMH Plymouth also offered out of hours support to Royal Navy ships and medical facilities on a published rota system with the other two Naval situated DCHM's.
- Where a known patient contacted the team in crisis during office hours the team responded promptly. The team confirmed this included rapid access to a psychiatrist.
- At the time of the inspection, six patients were in a bed within the NHS. Staff told us that there were positive relationships between the DCMH and the NHS inpatient service providers which facilitated timely access to a bed. The team attended the ward round and met with the patient on a weekly basis when DCMH patients were admitted as inpatients. 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, GPs 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 senior nurse or 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. All fresh cases were also taken to the multidisciplinary team meeting to ensure an appropriate response.
- At the time of the inspection the team's active caseload was 240. There had been 63 referrals in the three months to January 2020.
- Since October 2019, the DCMH had met the target for assessment following all urgent referrals. The team stated that they always had same day appointments for emergency referrals. The team had seen eight patients in an emergency since October 2019.
- Information provided ahead of the inspection showed that since October 2019 the DCMH had met the target for assessment following routine referrals in only 91% of cases. On further analysis by the team three of the five missed targets related to recording errors rather than delayed assessments. One appointment had been delayed due to patient availability. One appointment was delayed due to clinician availability.
- During this inspection six of 20 people commented that they had waited too long to commence treatment. At the time of the inspection there was a waiting list of 41 patients waiting to commence step 2: the longest wait was 27 weeks. Twenty-five patients were waiting for step 3 - high intensity therapy: the longest wait was 17 weeks. Three patients were awaiting specialist psychology treatment: the longest wait was 9 weeks. There were 44 patients waiting for psychiatrist appointments: the longest wait was 16 weeks. It was confirmed that all of those awaiting therapy were allocated to a care co-ordinator and in some cases involved in group work.
- Within the Armed Forces, personnel can be ordered to attend for a medical appointment. However, personnel do not have to accept treatment. The team had a procedure regarding following up patients who did not attend their appointment (DNA process). The team confirmed that usually only patients who had been deployed to other duties at short notice did not attend. The team was undertaken analysis to better understand people's reasons for not attending appointments and had improved appointment systems as a result. The DNA rate in December 2019 was 9%. This was within the DMS target of 10%.

The facilities promote recovery, comfort, dignity and confidentiality

- The building was comfortable, well decorated and equipped. A waiting area was available for patients. Information was available on display about treatments, local services, patients' rights, and how to complain.
- Treatment rooms were adequately soundproofed to ensure privacy during treatments.
- The team was based within a grade II listed building within the dockyard at HMS Drake at Devonport naval base. The team occupied the top two floors of the building meaning the treatment and meeting rooms were not accessible to anyone with a physical disability. Where required the team could use rooms within the offices of the occupational health team who occupied the ground floor of the building. Alternatively, the team had used facilities within the naval service recovery centre building at the dockyard which had full disability access.
- The team told us that space was limited at the building and they were concerned that when additional staff joined the team there would be insufficient office and treatment space. The team had developed a business case for alternative accommodation. The regional clinical director confirmed this was being considered and that in the longer term there were plans for an integrated medical centre at Devonport Naval Base.

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 11 military establishments across the South West of England. Travelling required by patients for appointments was within an acceptable time allowance at less than one and half hours. The team undertook patient experience surveys on an ongoing basis. In December 2019, 53 people had participated in the survey. All participants felt that their appointment was at a convenient time however only 81% per cent of participants stated their appointment was at a convenient location. The team also operates peripatetic clinics at the Commando Training Centre Royal Marines (CTCRM) Lympstone and HMS Raleigh however the team was looking at expanding the peripatetic clinics to additional bases to address this.
- The team told us that there had been difficulty for patients in accessing the base due to its security status. Since then the team had proactively worked with the base commander to allow access through a gate close to the DCMH building. Patients confirmed that they were now able to access the dockyard easily.
- 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. The patient experience survey in December 2019 found that 85% 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 six formal complaints. One complaint had related to multiple changes in clinician. All other complaints related to poor communication and clerical errors. The practice manager confirmed that they had fully investigated all of the complaints. None of the complaints had resulted in an armed service complaint or had been referred to the Armed Forces Ombudsman.
- Since January 2019, the team had received 30 written compliments about the service. During this inspection we received feedback from over 20 patients: throughout we 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?

Good

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 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 team and governance meeting which all staff attended. The meeting considered good practice guidelines, policy development, risk issues, learning from complaints and adverse events, team learning and service development. In addition, weekly business meetings and multidisciplinary meetings considered areas of governance and practice.
- Systems and processes were in place to capture governance and performance information. Local processes had been developed, including incident and complaints procedures, training and supervision logs and local procedures for managing referrals, risk and safeguarding. The management team had access to information about performance against targets and outcomes. However, governance process had not yet fully led to improvement in all areas.
- 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. We found that this document was up to date 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 reviewed where 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 lack of clinical space, manning including a lack of a second consultant psychiatrist, waiting lists, environmental risks due to ligature points and fire risks. All risks included detailed mitigation and action plans. The manning risk had been appropriately escalated to senior command which had resulted in the employment of a second consultant from April 2020. Potential risks that we found had been captured within the risk and issues logs and the common assurance framework and escalated appropriately.
- Overall, we found that the DCMH had made improvements and was moving in the right direction. We could evidence improvement in governance and practice throughout the previous twelve months however we found some areas of practice that required further focus. These included:
    - Staffing was insufficient to meet the demand of the service which had resulted in long waiting lists for all forms of treatment.
    - That not all incidents had been fully investigated. Further work was required to ensure all concerns are captured and learning shared from all adverse events.
    - While supervision was occurring the recording of this was poor, meaning that the management team could not be assured that staff were appropriately supervised.
    - Should staffing be secured the team's base has insufficient treatment and meeting rooms. The team had developed a business case for alternative accommodation however this was yet to be actioned by the regional team.

Leadership, morale and staff engagement

- The management team consisted of a clinical lead, a department manager, a deputy department manager, a practice manager and a lead psychologist. The clinical lead had

joined the team in October 2018. Since November 2018 she had been the only consultant psychiatrist at the team. The department manager had joined the team in November 2018 and the deputy department manager in January 2020.

- All staff attended team meetings and monthly governance meetings. Staff told us that new developments were discussed at these meetings and they were offered the opportunity to give feedback on the service.
- Staff reported that morale was generally good and there had been no bullying at the team. Staff confirmed that they felt supported by their colleagues and the management team. However, staff told us that staffing levels significantly impacted on their workload and at times limited the capacity of the management team to provide clear clinical leadership.
- A whistleblowing process was in place that allowed staff to go outside of the chain of command. Staff knew about the whistleblowing process and said they would feel confident to use this. There had been no formal reported cases of whistleblowing or bullying at the team and no referrals to the Freedom to Speak Up Guardian in previous months.

Commitment to quality improvement and innovation

- A range of audits were undertaken by the team. These included an audit of patient experience, complaints management, clinical record keeping, supervision levels, staff awareness of incident procedures, security, cleanliness and environmental audits. Clinical audits were undertaken of caseload management, care plan completion, group work effectiveness and treatment outcomes.

- The team had developed an informative leaflet explaining the service that was delivered. This included links to a number of useful online applications. These were shared with patients routinely and valued by patients.
- The team had developed peripatetic clinics and proactively worked with the base commander to allow access through a gate close to the DCMH building so that patients could access the DCMH more easily.