Defence Medical Services

Department of Community Mental Health – Leeming

Quality Report

Department of Community Mental Health Leeming
Building 20,
The old Medical Centre,
RAF Leeming,
Northallerton,
North Yorkshire,
DL7 9NJ

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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?	Outstanding

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) Leeming between the 5 and 26 October 2021. Overall, we rated the service as Good.

We found the following areas of good practice:

- Individual patient risk assessments were in place and proportionate to patients' risks. The team had a process in place to share concerns about patients in crisis or whose risks had increased. All referrals were clinically triaged by the mental health team and we saw good evidence of the team reviewing risks through the multidisciplinary team and following up on any known risks.
- Staff had a good awareness of safeguarding procedures and practice. Staff had reported all relevant events and appropriate action had been taken to investigate and learn from these and was used to drive a safety culture.
- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant 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. Outcomes were reviewed throughout the treatment process and collated and audited to provide an overview of service effectiveness. These indicated improved outcomes following treatment.
- Staff were kind, caring and compassionate in their response to patients. Patients said they were very well supported, and that staff were kind and enabled them to get better. More than one patient described the service as exceptional and life changing.
- Clear referral pathways were in place. Despite an increase in caseload and referrals the team had met the response target for urgent referrals and waiting lists for treatment had reduced.
- We found that there was clear and accountable leadership at DCMH Leeming. Leaders were capable and resourceful and worked well together to ensure safe and effective care to patients. Staff reported that morale was very good, and they felt that the management team were approachable, highly supportive of their work and went above and beyond to support them.
- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning and systems and processes were in place to capture governance and performance information. All potential risks that we found had been captured within the risk and issues logs and the common assurance framework and included detailed mitigation and action plans and were escalated appropriately.
- Business continuity plans for major incidents had been updated to reflect the risks in relation to the Covid 19 pandemic. Appropriate actions had been taken in response to the 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. The team demonstrated a number of areas of outstanding practice.

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

- The team's base did not fully meet accessibility standards, required maintenance and did not have enough space for the whole team.
- Despite recruitment attempts, there were vacancies for two psychiatrists at the service. The service remained safe however we were concerned about the long-term impact of this deficit.
- Routine referral assessment times had not been met in July 2021 due to a surge in referrals during June and July 2021.

Professor Edward Baker
Chief Inspector of Hospitals

Are services safe? Good

We rated the DCMH as good for safe because:

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

However:

- The team's base required maintenance, such as the roof was leaking in one area, and did not have sufficient space for the whole team.
- Despite recruitment attempts, there were vacancies for two psychiatrists at the service. The service remained safe however we were concerned about the long-term impact of this deficit.

Are services effective? Good

We rated the DCMH as good for effective because:

- Formal care plans were in place for all patients and were holistic and person centred. Care and treatment plans were reviewed regularly in weekly multidisciplinary team meetings. Patients we spoke with confirmed they had received copies of their care plans, that these were updated frequently and were useful.
- Patients could access a wide range of psychological therapies as recommended in NICE guidelines. The team had delivered a therapeutic group to prepare patients for psychological intervention which had proven to be effective, was well received by patients and had cut overall waiting and treatment times.
- Clinicians were aware of current evidence-based guidance and standards and used this to guide their practice. The team used a range of outcome measures throughout and following treatment. These indicated improved outcomes following treatment.
- We found consideration of capacity in all the records we reviewed, and patients told us that they had the need for consent to treatment clearly explained to them.
- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant 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.

Are services caring? Good

We rated the DCMH as good for caring because:

- We saw staff that were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them. This included both clinical and administrative staff.
- Staff showed us that they wanted to provide high quality care. Staff worked extremely hard to meet the wider needs of their patients. We observed some positive examples of staff providing practical and emotional support to people.
- Patients said they were very well supported, and that staff were kind and enabled them to get better. More than one patient described the service as exceptional and life changing. Patient survey results were overwhelmingly positive.
- Patients told us that staff provided clear information to help with making treatment choices. Care records demonstrated the patient's involvement in their care planning.
- We saw staff working with patients to reduce their anxiety and behavioural disturbance.
- Staff understood confidentiality, and this was maintained at all times.

Are services responsive to people's needs? Good

We rated the DCMH as good for responsive because:

- Clear referral pathways were in place. Despite an increase in caseload and referrals the team had met the response target for urgent referrals and waiting lists for treatment had reduced.
- The team had offered both virtual and face to face appointments where necessary throughout the pandemic. Patients told us that they had found virtual appointments

extremely welcome as this had cut down on travel to appointments and had allowed greater flexibility. The team was increasing their office presence at the time of the inspection to allow greater access to face to face appointments.

- The team had a procedure regarding following up patients who did not attend their appointment (DNA process). The DNA rate was ten 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.

However:

- Routine referral assessment times had not been met in July 2021 due to a surge in referrals during June and July 2021.
- The team's base was not fully accessible to people with a physical disability however alternate arrangements were in place.

Are services well-led? Outstanding

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

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

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 a specialist military mental health nursing advisor.

Background to Department of Community Mental Health – Leeming

The department of community mental health (DCMH) at Leeming provides mental health care to a population of up to 17,000 serving personnel from across all three services of the Armed Forces. The catchment for the service includes all service personnel based at eight military establishments across Yorkshire, the Humber and the Northeast. 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 RAF Leeming and peripatetic clinics in York, Dishforth and RHQ Catterick.

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 430 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, RAF personnel within the team also form part of Tactical Medical Wing. On a duty basis they may be required to perform psychiatric aeromedical evacuation of overseas Armed Forces personnel.

Why we carried out this inspection

The 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 between the 5 and 7 October and interviewed patients and staff via video conferencing between 10 and 26 October 2021. During the inspection, we:

- looked at the quality of the teams' environment;
- observed how staff were caring for patients;
- spoke with nine patients who were using the service;
- Spoke with the regional clinical director and regional operations manager;
- spoke with the management team;
- spoke with 15 other staff members including doctors, nurses, psychologists and administration staff;
- looked at 12 clinical records of patients;
- joined the multi-disciplinary team meeting;
- joined the management team meeting;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- 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 – Leeming

Detailed findings

Are services safe?

Good

Our findings

Safe and clean environment

- The team was based within a standalone building within RAF Leeming. The building was generally well maintained however at the time of the inspection there had been a leak in the stairwell of the building. Immediately following the inspection, the maintenance team attended site to evaluate this work. Some treatment rooms were on the ground floor however the building was not fully accessible to anyone with a physical disability. The team had an arrangement in place with the nearby medical centre to use accessible treatment rooms should this be required. The team told us that the space at the facility was adequate at present however should they return fully to office working there is insufficient capacity to meet the team's needs. It was confirmed that the team would move to a purpose-built healthcare facility at Catterick Garrison in 2024.
- 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 by meeting patients within the reception and escorting them 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.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Hand wash facilities and hand gels were available, and staff adhered to infection control principles, including handwashing. Cleaning and infection prevention audits were undertaken regularly, and the 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 25 people and consisted of medical, nursing, social work, psychology, mental health practitioners, and administration staff. The team had five vacancies for a department manager, two psychiatrists, a military nurse and an administrator. One nursing post was covered by a locum staff member. A clinical services manager was being recruited. This was an additional civilian post that would provide overall management to the service. The regional management team had attempted to fill the psychiatry posts without success and recruitment remained open. At the time of the inspection waiting lists were well managed including for psychiatry however we observed this was achieved through the medical team going above there contracted hours and we were concerned about the long-term impact this may have on the service and the medical team.
- 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 thirty-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 89%.

Assessing and managing risk to patients and staff

- 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 patients we spoke with were aware of their crisis plans. Both staff and patients confirmed access to the psychiatrist should a full assessment be required.
- The team had developed a risk pro-forma to record all clinical risk and decisions made at the multidisciplinary team and all fresh cases were taken to the multidisciplinary team meeting to assure an appropriate response. The team recorded all clinical risk and decisions made at the multidisciplinary team and operated a process to share concerns with colleagues about specific patients whose risks had increased. This included risks due to safeguarding concerns and all patients recently discharged from hospital. The team met every morning to discuss any urgent risk issues and all at risk cases were discussed at multidisciplinary meetings.
- The team had also implemented a process to ensure that clinician's caseloads where managed and risks taken to the multidisciplinary team in their absence. The team had also introduced a process to ensure that patients on the waiting list were contacted and risk assessed on a regular basis.
- 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 introduced a policy for safeguarding vulnerable adults however adult safeguarding was not yet part of the DMS's mandatory training requirements. 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.

Child protection training levels one to three were mandatory for DMS staff as appropriate to their role. At the time of the inspection all staff had undertaken training as appropriate to their role. The team demonstrated an 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 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 had received annual basic life support, defibrillator and anaphylaxis training. The team had access to emergency equipment, 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 where necessary throughout the pandemic.

Track record on safety

- Between September 2020 and September 2021, there were 12 significant events recorded across the service. This had included one death of a former patient. This was 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, waiting list errors 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. Locum staff however reported that there could be a delay in gaining access to the system. 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. Staff confirmed that they had received support following the death of a former patient and that the clinical lead had led a debrief session.

Are services effective?

Good

Our findings

Assessment of needs and planning of care

- Formal assessment was undertaken once a patient's referral was accepted by the team. Following this, an assessment of the patient's needs was undertaken. Clear care and treatment plans were developed with patients. Formal care plans were used at the team and were in place for all patients we reviewed. Patients we spoke with confirmed they had received copies of their care plans and that these were updated frequently. 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 DMS healthcare facilities. This system facilitated effective information sharing across mental health and primary care services. Any paper records were scanned on to the system to ensure easy access and safe storage.

Best practice in treatment and care

- Clinicians were aware of relevant evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. NICE and other guidance was reviewed within team and governance meetings. Clinical records reviewed made reference to NICE guidance. Staff told us of therapeutic practices that met this guidance.
- The team employed psychologists and mental health therapists, and all nurses were trained in a range of psychological treatments. The team was also working with an outpatient service to provide additional high intensity therapy capacity. 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.
- The team had delivered a therapeutic group to prepare patients for psychological intervention. This group had proven to be effective, was well received by patients and had cut overall waiting and treatment times.
- 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.
- The team monitored the length of the care pathway. This demonstrated that patients received timely and efficient care with 72% of the DCMH's patients having completed their treatment within nine months.
- 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, security, cleanliness and environmental audits, disability access and track and trace compliance. Clinical audits were undertaken of the care pathway, caseload management, care plan completion, treatment outcomes and effectiveness of the outpatient service.

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, psychologists and mental health practitioners.
- New staff, including locums, received a thorough induction. Development training, such as in cognitive behaviour therapy, was available to staff. Three staff were undertaking postgraduate training at the time of the inspection. Staff had undertaken a range of external continued professional development in topics such as trauma, DICES risk management, motivational interviewing and leadership.
- Additional bespoke training was delivered to the team at regular professional development sessions. Recent sessions had included routine use of outcome measures in therapy, drama triangle, social Identity and behavioural activation, domestic abuse and diversity and inclusion.
- The team also hosted GP and psychiatry trainees, and student nurses who were training within the Armed Forces.
- Staff had support through weekly team, daily briefings, 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. Records confirmed good compliance with clinical supervision and caseload management. Psychologists at the team also offered bespoke supervision to staff following complex work and debriefs following any incidents.
- All staff had received appraisals in the previous six months.

Multidisciplinary and inter-agency team work

- Care and treatment plans were reviewed regularly in multidisciplinary team meetings. Patients at risk and all newly referred patients were discussed in these meetings. We observed that multidisciplinary team meetings were well managed and staff present were engaged in the decision making. The team also met every morning to discuss any urgent risk issues and allocate new patients.
- The team worked in partnership with a range of services both within and outside the military. This included liaison with the NHS providers who are independent service providers of psychiatric beds. The team had a liaison nurse whose role it was to work with the NHS team to ensure effective care and discharge from the service. The team's psychiatrists also worked closely with the NHS team to ensure seamless care. Staff at the DCMH demonstrated effective information sharing and support to the NHS teams in the management of their patients.
- As an occupational mental health service, the team's role was to assist patients to retain their occupational status or to leave the armed services. Patients could also use the team during the first six months following discharge from the military. The team worked closely with the Military Welfare Services and the NHS Veterans Mental Health Transition, Intervention & Liaison Service (TILS) and a wide range of third sector organisations to ensure effective support with employment, housing and wider welfare. Where necessary, when handing care over on discharge of a patient from the service, the team met with the receiving NHS teams.
- The team had worked proactively with the defence occupational health team who had been experiencing delays to ensure more timely support to their patients. Since the DCMH team had met regularly with the occupational health team to ensure collaborative working.

- 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 and training for primary health care staff and military units to raise mental health awareness.

Adherence to mental health legislation

- The Mental Health Act was used very infrequently at the service. Should a Mental Health Act assessment be required the team worked with the local NHS provider to access this through civilian services. Staff told us that there were positive relationships between the DCMH and the local NHS inpatient service provider which facilitated timely access to a bed.
- Staff did not receive formal training in the Mental Health Act and Code of Practice however information was available to staff and the team's social workers acted as leads regarding the Act.

Good practice in assessing capacity and consent

- There was not a specific policy on the Act within defence services, but information was available to staff and all had awareness of the principles of the Act and the need to ensure capacity and consent.
- It is the individual healthcare professional's responsibility to assure capacity and gain consent and this should be considered on an ongoing basis. We found consideration of capacity in all the records we reviewed. In line with the principles of the Act, staff assumed capacity unless there was evidence to suggest otherwise.
- Patients told us that they had the need for consent to treatment clearly explained to them. In all records we reviewed we found records of consent to treatment and share information.

Are services caring?

Good

Our findings

Kindness, dignity, respect and support

- We saw staff that were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them. This included both clinical and administrative staff. All the patients we spoke with told us that staff were kind and supportive, and that they were treated with respect. We received several extremely positive comments from patients about the treatment that they had received. More than one patient described the service as exceptional and life changing.
- Staff showed us that they wanted to provide high quality care. We observed staff working extremely hard to meet the wider needs of their patients. Patients told us that staff would help them to access all possible support that they could.

- Staff demonstrated that they were knowledgeable about the history, possible risks and support needs of the people they cared for. We saw staff working with patients to reduce their anxiety and behavioural disturbance.
- Confidentiality was understood by staff and maintained at all times. Staff maintained privacy with people, who were asked if they would like their information shared with their relatives, within the chain of command and other bodies, including CQC. Information was stored securely, both in paper and electronic format.

The involvement of people in the care they receive

- Formal care plans were used at the team and were in place for all patients. Care plans demonstrated the patient's involvement in their care. Records confirmed a copy of the care plan had been offered to the patient and patients we spoke with confirmed they had received copies of their care plans, that these were updated frequently and were useful.
- Information was available at the service about a range of organisations that would provide advice and support to serving and former Armed Forces personnel. Staff told us about many positive relationships with support organisations.
- The team had introduced an informative introduction email and leaflets explaining the service that was delivered. 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 July 2021, 21 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 planning an additional survey 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. The team participated in a National Armed Forces out of hours' services on a duty basis. This provided gatekeeping and procedural advice regarding access to beds within the DMS independent service provider contract with NHS providers.
- At the time of the inspection, two 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 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 been increasing significantly. At the time of the inspection the team's active caseload was 430. There had been 309 referrals in the 6 months to September 2021.
- Since April 2021, the DCMH had met the target for assessment of patients following all urgent referrals. The team stated that they always had same day assessment appointments for 'emergency referrals'.
- The DMS performance target for assessing patients within 15 days of routine referral was set at 95%. Since August 2021, the DCMH had assessed all patients within 15 days following routine referrals however the team had missed the target in July 2021 (at 92%). The management team confirmed that this had been due to a surge in demand as there had been 122 new patient referrals during June and July 2021 and in some cases, this 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 team told us that there had previously been significant waiting lists at the service, but they had worked hard to address these. The team was working with an outpatient service to provide additional high intensity therapy capacity. The team had also delivered a therapeutic group to prepare patients for psychological intervention. This group had proven to be effective, was well received by patients and had cut overall waiting and treatment times.
- The clinical lead told us that she monitors the waiting list information on a weekly basis to ensure risks are managed and to alleviate any blockages by deploying "surge" assessment capacity. This involved staff in diverting from their non-essential work to focus on assessments.
- At the time of the inspection the average length of wait was 42 days. Waiting lists had reduced to 34 people for step 2 – low intensity therapy, 16 people for step 3 - high intensity therapy, 6 people for psychology and 8 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 extremely welcome as this had cut down on travel to appointments and had allowed greater flexibility. The team was increasing their office presence at the time of the inspection to allow greater access to face to face appointments. 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 ten per cent which was in line with the DMS target.

The facilities promote recovery, comfort, dignity and confidentiality

- The team was based at a standalone facility at RAF Leeming. Patients we spoke with confirmed that they were able to access the base easily.
- Some treatment rooms were on the ground floor however the building was not fully accessible to anyone with a physical disability. The team had an arrangement in place with the nearby medical centre to use accessible treatment rooms should this be required.
- The team told us that the space at the facility was adequate at present due to some staff home working however should they return fully to office working there is insufficient capacity to meet the team's needs. It was confirmed that the team would move to a purpose-built healthcare facility at Catterick Garrison in 2024.
- A comfortable 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.
- Prior to the lockdown, in line with Covid-19 guidance the team had offered peripatetic clinics at a number of locations including York, Dishforth and RHQ Catterick. At the time of the inspection the team was beginning to re-establish these services. In the interim the team had worked with medical centres to ensure patients received mental health support when required.

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 eight military establishments across Yorkshire, the Humber and the Northeast. Travelling required by patients for appointments could be lengthy at up to two hours.
- 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 July 2021 found that 100% 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 complaints. This had related to the response to an external clinician's query. The practice manager confirmed that they had fully investigated this complaint and it had been resolved.
- During 2021, the team had received 38 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?

Outstanding

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 governance meeting which all staff attended and took an active role in. The meeting considered good practice guidelines, policy development, risk issues, learning from complaints and adverse events, team learning and service development. In addition, daily briefings, weekly business meetings and multidisciplinary meetings considered areas of governance and practice. Minutes for these meetings showed the service had effective governance and administration procedures in place.
- Effective systems and processes were in place to capture governance and performance information. Local processes had been developed, including complaints procedures, training and supervision logs and local procedures for managing referrals, waiting lists, risk and safeguarding. The management team had access to detailed information about performance against targets and outcomes.
- The common assurance framework (CAF), is a DMS structured self-assessment internal quality assurance process, which forms the basis for monitoring the quality of the service. All members of the team were allocated lead roles on areas of the CAF and would meet regularly to update assurance information. 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 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: psychiatry vacancies, environmental risks and lack of accessibility, meeting regulation requirements, Covid management and capacity. 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, length of patient care pathway and patient satisfaction. The team stated that they always had same day assessment appointments for 'emergency referrals'. This was above the target for urgent referrals.
- the clinical lead monitored the waiting list information on a weekly basis to ensure risks were managed and to alleviate any blockages by deploying "surge" assessment capacity. This involved staff in diverting from their non-essential work to focus on assessments.
- the team actively engaged with stakeholders to gather feedback about the service and make necessary improvements and partnership working with other parts of the defence medical services, NHS and voluntary groups was very effective. The team was actively involved in the unit health committees to ensure effective support to their patients and had actively engaged with the medical officers and the regional occupational health team to improve patients access and outcomes.
- the team had delivered a therapeutic group to prepare patients for psychological intervention. This group had proven to be effective, was well received by patients and had cut overall waiting and treatment times. Plans were in place to increase the range of groupwork available.
- formal care plans were used at the team and were in place for all patients. Care plans viewed were of a very high standard. Patients we spoke with confirmed they had received copies of their care plans, that these were updated frequently and were useful.
- patient experience was very good and patients we spoke with during the inspection described the service as exceptional and life changing. The patient survey in July 2021 had received overwhelmingly positive responses to all questions.

Leadership, morale and staff engagement

- The management team consisted of a clinical lead who was a consultant psychologist, an acting department manager, a lead for healthcare governance, a band 7 team leader and a practice manager. The clinical lead had taken on this role in 2015 due to a gap in the military psychiatrist role. The acting department manager had joined the team in January 2020 as the second in command however had stepped in to the manager role in March 2020 due the departure of the previous manager. The other management team members had been at the service for a number of years.
- The management team told us that they had worked hard to form a cohesive management team and had established clearer roles and responsibilities while ensuring effective management cover available to staff at all times. Staff were clear regarding their manager's and their own roles and responsibilities. Clear job plans, objectives and expectations were in place for the team. At this inspection, we found a clear and effective management structure in place. Leaders worked very well together and demonstrated high levels of experience, capability and resourcefulness to deliver safe and effective care to patients.
- The management team had undertaken a range of initiatives to support and engage staff. This had included a daily briefing meeting to check on staff welfare and to share risk. A mentor system had been put in place for all new staff: the team confirmed that while this was a voluntary system for the experienced staff, everyone had offered their mentorship. The team has set up an awards schemes and team members were regularly nominated for national awards. Whitespace had been put in place during the Covid pandemic to provide staff with up to two hours per month to undertake activity to promote their health and

wellbeing. Sat the time of the inspection the team was planning to undertake the Health and Safety Executive (HSE) Management Standards Indictor Tool to gauge staff satisfaction.

- Morale was very good at the service. All the staff we spoke with during this inspection stated that they felt part of a cohesive team and that they were engaged in the development of the service. Staff were positive about the leadership team, confirming all leaders were approachable, highly supportive of their work and went above and beyond to support them. Staff stated a high level of satisfaction with their work and the functioning of the team. Staff told us that they were passionate about their work and proud to work in the team. Several military staff told us that the team was the best place they had worked, and they wished to continue their role at the team rather than be rotated to other services.
- Staff confirmed that there had been clear and 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 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 required training and had access to regular professional development and clinical supervision. All 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 been given the opportunity to take on leadership roles. Staff were positive about this and demonstrated their passion to improve the services offered.
- During this inspection, we met with the regional clinical director and regional operations manager. They acknowledged the team was performing well and confirmed high level support to the team to address any emerging risks and aid development. The DCMH leadership team confirmed that the regional leadership team were supportive of their work.

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, security, cleanliness and environmental audits, disability access and track and trace compliance. Detailed clinical audits were undertaken and had been used to inform changes to practice. These included audits of the care pathway, caseload management, care plan completion, treatment outcomes, reasons for re-referrals and effectiveness of the outpatient service. Feedback and changes as a result of the audits were taken to the governance meetings and used to plan future development and the ongoing audit programme.
- The team was undertaking quality improvement projects and addressing any potential risks as they arose.
- The following is a summary of additional improvements and good practice we identified:
  - The team had volunteered to lead an outpatient service pilot project working with two other DCMHs to improve access to the service and treatment. This had led to decreased waiting lists for psychology across the services.

- To improve communication between medical centres and the DCMH the management team had set up monthly engagement meeting with all senior medical officers which had facilitated easier patient referral and improved working relationships.
- Due to capacity issues for the regional occupational health team the DCMH management team had set up monthly engagement meetings to share patient information and facilitate a smoother and faster discharge for patients who were leaving the military.