Defence Medical Services
Defence Mental Health Network South East Region

Quality Report

Defence Mental Health Network South East
Department of Community Mental Health Aldershot
Aldershot Centre for Health
Hospital Hill
Aldershot
GU11 1AY

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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 Defence Mental Health Network South East Region	Good
Are services safe?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall Summary

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

We carried out an announced inspection at the Defence Mental Health Network South East Region between 19 March and 16 April 2024. This inspection spanned the single point of access for defence military care in the region and aspects of the operational delivery of care from the Departments of Community Mental Health (DCMHs) based at Aldershot, Portsmouth and London.

The Network and DCMHs are rated as good overall.

The key questions for this inspection are rated as:

Are the services safe? – Good

Are services responsive? – Good

Are services well-led? – Good

We previously carried out an announced inspection of the Department of Community Mental Health Aldershot in August 2019: the service was rated as good. We inspected DCMH London in November 2021: the service was rated as good overall. We last inspected DCMH Portsmouth in January 2023: the service was rated as good overall however as requires improvement for the responsive domain. This related to delays in assessment and treatment. At this time, the Defence Mental Health Network South East Region was developing to deliver a single point of access and assessment for mental health care to address delays in assessment and treatment.

A copy of the previous reports can be found at:

https://www.cqc.org.uk/sites/default/files/DMS_DCMH_ALDERSHOT.pdf

https://www.cqc.org.uk/sites/default/files/Department_of_Community_Mental_Health_London_good_10_May_2022.pdf

https://www.cqc.org.uk/sites/default/files/2023-04/DMS_DCMH_Portsmouth_London_South_East_good_05_April_2023.pdf

This report describes our judgement of the quality of care at the Defence Mental Health Network South East Region. It is based on a combination of what we found from information provided about the service, onsite inspection at DCMH Aldershot and interviews with staff and others connected with the network. At this inspection we have focused on the domain of responsive however looked at aspects of the safe and well led domains to see what improvement has been made against the recommendations made following the previous inspections.

We found that the Network and DCMHs had addressed all of our previous recommendations and was rated as good for the domains of Safe, Responsive and Well led.

We found the following areas of good practice:

- At this inspection we did not formally look at staffing levels however there had been improvement overall across all parts of the network. When we had inspected DCMH Portsmouth and DCMH London we had observed how staffing levels and service demand had adversely affected morale. At this inspection staff told us that increased staffing and service improvement had greatly improved morale.
- We found that leaders had worked well together to find effective solutions to ensure the safe and effective delivery of care. Staff we met were positive and told us that the team worked well together, and that leaders were approachable and supportive of their work.
- We found that there was clear and accountable leadership across the Network and with the single point of access (SPA) team. Staff had undertaken appropriate supervision and training, and they were positive about their role in delivering the service.
- All areas of concern that we highlighted following our previous inspections had been addressed and the teams were now delivering safe and effective care.
- A range of audit and quality improvement projects had been undertaken and had been used to drive continuous improvement and enhance patient care.
- The Network had developed a clearer operating model and referral pathway and had implemented safe systems and processes. This had ensured effective assessment and allocation of patients and clear clinical risk oversight.
- Throughout the development of the SPA and Network Allocations Meeting (NAM) the team had audited the clinical effectiveness of the service. Areas considered had included the appropriateness of referrals, re-referral rates, times from initial referral to treatment and robustness of initial assessment decisions. Throughout the team had used the information to inform changes to the operational model. As a result, the team had increased relevant training for staff, set up GP access clinics and awareness sessions, amended the assessment tool, and secured specific administration for the team. The team had learnt as part of this process that the treatment offer available required reorganisation and refocus and had addressed this. The team had also increased the appropriateness of referrals, reduced re-referral rates and has significantly reduced times to assessment and treatment.
- Despite an increase in referrals and caseload the team had met the response target for urgent and routine referrals and waiting lists for treatment had reduced.
- 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 were in place to capture governance and performance information. 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.

Are services safe? **Good**

We rated the Network as good for safe because:

- 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.

Are services responsive to people's needs? **Good**

We rated the Network as good for responsive because:

- The Network had developed a clearer operating model and referral pathway and had implemented safe systems and processes. This had ensured effective assessment and allocation of patients and clear clinical risk oversight.
- Throughout the development of the SPA and Network Allocations Meeting (NAM) the team had audited the clinical effectiveness of the service. Areas considered had included the appropriateness of referrals, re-referral rates, times from initial referral to treatment and robustness of initial assessment decisions. Throughout the team had used the information to inform changes to the operational model. As a result, the team had increased relevant training for staff, set up GP access clinics and awareness sessions, amended the assessment tool, and secured specific administration for the team. The team had learnt as part of this process that the treatment offer available required reorganisation and refocus and had addressed this. The team had also increased the appropriateness of referrals, reduced re-referral rates and has significantly reduced times to assessment and treatment.
- Despite an increase in referrals and caseload the team had met the response target for urgent and routine referrals and waiting lists for treatment had reduced.

Are services well-led? **Good**

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

- We found that there was clear and accountable leadership across the Network and with the single point of access (SPA) team. Staff had undertaken appropriate supervision and training and reported that morale was good, and they were positive about their role in delivering the service.
- All areas of concern that we highlighted following our previous inspections had been addressed and the teams were now delivering safe and effective care.
- 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 were in place to capture governance and performance information. 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.
- A range of audit and quality improvement projects had been undertaken and had been used to drive continuous improvement and enhance patient care.

Our inspection team

Our inspection team was led by Lyn Critchley. The team included two specialist military mental health nursing advisors.

Background to Defence Mental Health Network South East Region

Defence Mental Health Network South East Region is comprised of three departments of community mental health (DCMHs): Aldershot, Portsmouth and London. Since September 2021, the three services have increasingly worked together as a single point of access (SPA) to respond to initial referral requests, to assess patients and to offer treatment across the teams.

The Network provides mental health care to a population of approximately 32,000 serving personnel from across all three services of the Armed Forces. The catchment for the service also includes all service personnel on Royal Navy ships based at HM Naval Base Portsmouth which can significantly increase the population when ships are in port. In addition, the team also work with those who have returned to the catchment area on home leave. At the time of our inspection the active caseload of the Network was approximately 774 patients.

During this inspection we looked at the quality and safety of assessment and access to treatment provided by the Network and have rated this. However, we also considered how the three teams in the region had come together, the leadership and oversight of this and what action had been taken against any previous recommendations made to the individual DCMHs.

The departments aim 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.

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting the team, we reviewed a range of information the Defence Mental Health Network South East Region had shared with us about the network and individual DCMHs. This included: network policies and procedures, 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 onsite inspection on 19 and 20 March 2024. During this review, we visited the team at Aldershot, met virtually with staff working at home and key staff from DCMH Portsmouth and DCMH London, and reviewed additional information about the other parts of the service. Specifically, we undertook the following:

- observed how staff were caring for patients;
- observed the SPA duty worker and administrative staff;
- spoke with the regional manager;
- spoke with the SPA and DCMHs management team;
- spoke with seven other staff members including doctors, nurses, psychologists, therapists, and administration staff;
- spoke with the regional clinical director;
- joined the network allocations meeting;
- joined the multi-disciplinary team meeting;
- joined the nursing cadre's team meeting:
- looked at clinical records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service;
- examined minutes and other supporting documents relating to the governance of the service.

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Detailed findings

Are services safe?

Good

Our findings

Assessing and managing risk to patients and staff

- All initial referrals were clinically triaged by the single point of access duty workers to ensure that sufficient information was received to conduct assessment. This included a check to determine whether a more urgent response was required to routine referrals. The team then undertook a full assessment including risk assessment.
- Following this all assessments were taken to the network allocation meeting (NAM) for multidisciplinary assessment and to decide on appropriate treatment. If further clinical decision making was required staff could return the case to the NAM for additional consideration.
- Once the treatment pathway was decided, the patient was informed of the decision and allocated to the most appropriate DCMH who would then allocate to the most appropriate clinician to undertake treatment.
- The NAM kept oversight of all referrals, assessments and waiting lists to ensure equitable and effective response to referrals.
- Allocated 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 weekly to discuss any urgent risk issues and all at risk cases were discussed at multidisciplinary meetings.
- The team had a process to ensure that patients with higher risks on the waiting list were contacted and risk assessed on a regular basis while they awaited treatment.
- In all cases we reviewed we found that record keeping was of a good standard, assessments were thorough and that risk assessments were in place and addressed known concerns. Crisis plans were in place and where a known patient contacted the team in crisis, the team responded swiftly.
- We observed both the NAM and multidisciplinary team meetings to be well managed and consider all relevant risk issues at an appropriate level of detail.

Are services responsive to people's needs?

Good

Our findings

Following our previous inspections of the DCMHs within the Network, we rated DCMH Portsmouth as requires improvement for providing responsive services. We had concerns about the team meeting assessment times and there were long waiting lists. This was also impacting on the responsiveness of DCMH Aldershot and DCMH London.

When we carried out this follow up inspection of the Network, we found that all the above recommendations had been acted on. Following our review of the evidence provided, the Network and DCMHs are now rated as good for providing responsive services.

Access and discharge

- Clear referral pathways were in place. Due to capacity concerns impacting access to the service across the three DCMHs in the South region in 2021, a single point of access had been developed for the region. DCMH Aldershot became the access point for all referrals in the region and undertook initial triage of all newly referred patients. Since, the team has worked hard to develop the network approach to maximise capability, enhance resilience, and improve patient access. The Single Point of Access (SPA) has been formalised and enhanced to include all assessment activity and treatment oversight. A dedicated SPA team has been set up with its own team leader and psychiatry input. A single contact number has been put in place and the team has been raising awareness about the referral process with all primary care staff. Shared policies and procedures have been developed and staff have received detailed competency based training to ensure effectiveness and consistency of assessment procedures. This has also provided equitable access to all referred persons regardless of their location.
- Since June 2023, the network allocation meeting (NAM) has formed to meet weekly to agree the treatment pathway of each referred person. The NAM includes all relevant clinicians, the senior clinical team and dedicated administration. We found the NAM to be a very effective process to ensure the most appropriate treatment pathway of each referred person.
- Within the single point of access, duty workers and a senior clinician are available each day to undertake the liaison with referrers, initial triage and assessment. Where a known patient contacted the DCMHs in crisis during office hours the teams responded promptly. Each DCMH also had a duty worker whose role it was to deal with any urgent concerns regarding patients who were allocated to treatment. The teams confirmed this included rapid access to a psychiatrist.
- Referrals came to the SPA from medical officers and other DCMHs. These were indicated as either urgent or routine. Urgent referrals are to be considered by the end of the next working day. The target to see patients for assessment following a routine referral is 15 days. The DMS performance target for assessing patients within 15 days of routine referral is set at 95%. Since December 2023, the SPA team had fully met the target for responding to urgent cases and for routine referrals in 98% of cases. Since the SPA team and NAM team has been in place, the majority of patients have been assessed within one day of referral. This took approximately 17 days at the time of our last inspection. During the same period, the time from assessment to treatment decision had reduced from 25 to 2.3 days and the time from referral to treatment decision had more than halved from 22.5 to 9 days.

- At the time of the inspection the teams across the Network's active caseload was 774. There had been 415 new referrals between June 2023 and January 2024. This had been increasing at each DCMH throughout the period. Of these 84% of people had been accepted for treatment by the teams. The SPA team had been auditing the appropriateness of referrals since June 2023 when acceptance levels were at 76%. There had also been a reduction in re-referrals following rejection by the SPA from 10% to 7% during the same period. During this time, the team had worked hard to support GPs in their initial clinical decision making. Initiatives had included awareness raising sessions for GPs and easy access to psychiatry and SPA advice ahead of referral.
- The management team told us that the DCMHs were very busy and there were waiting lists for treatment however these had improved greatly at all services since our last inspection of the Network. At the time of this inspection across the network 59 people were waiting for therapy groups, the longest length of wait was 153 days however most had been waiting less than 70 days. Groups were planned to commence to address this need. Nine people were waiting for core therapy, the longest wait for this was 125 days. Thirty people were waiting for enhanced therapy, the longest length of wait was 186 days. Thirteen people were waiting for psychology, the longest length of wait was 174 days. Twenty-one people were waiting for psychiatry.

Meeting the needs of all people who use the service

- The teams across the network could offer flexible appointment times during office hours. The teams offered both virtual and face to face appointments from the relevant bases where necessary. At the time of the inspection there were plans to extend the availability of groupwork to all main bases.

Are services well-led?

Good

Our findings

When we carried out this inspection, we found there had been improvement in regard to all our recommendations made following previous inspections at DCMH Portsmouth and DCMH London.

Good governance

- The network had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. The team had monthly governance and business meetings 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, patient experience, team learning, quality improvement (QI) and service development. In addition, weekly team meetings, cadre meetings, continuous professional development sessions and multidisciplinary meetings considered areas of governance and practice. Minutes for these meetings showed the service had effective governance and administration procedures in place.

- The Network had a lead for governance processes and members of the team were allocated lead roles on areas of the common assurance framework (E-HAF) and governance agenda and would meet regularly to update assurance information.
- Effective systems and processes were in place to capture governance and performance information. Local processes and a dashboard had been developed, including information about complaints, training, supervision and key performance indicators, and local procedures for managing referrals, waiting lists, risk and safeguarding where in place. The management team had access to detailed information about performance against targets and outcomes.
- Risk and issues were identified and logged on the headquarters and local risk and issues registers. The risks included detailed mitigation and action plans and had been escalated to headquarters appropriately. Potential risks that we found had been captured within the risk and issues logs and the common assurance framework action plan.
- We found that the Network had made improvement since our previous inspections at DCMH Portsmouth and DCMH London and had addressed all areas of previous concern.

Leadership, morale and staff engagement

- The leadership team for the Network consisted of a regional manager supported by team managers and clinical leads for each DCMH and the SPA. The Network also had a lead for governance. Managers told us that they had worked hard to form the senior management team and to effect positive change.
- At this inspection we did not formally look at staffing levels however there had been improvement overall across all parts of the network. When we had inspected DCMH Portsmouth and DCMH London we had observed how staffing levels and service demand had adversely affected morale. At this inspection staff told us that increased staffing and service improvement had greatly improved morale. We found that leaders had worked well together to find effective solutions to ensure the safe and effective delivery of care. Staff we met were positive and told us that the team worked well together, and that leaders were approachable and supportive of their work.
- Staff were clear regarding their own roles and responsibilities. Job plans, objectives and expectations were in place for the team. Staff had benefited from additional training, clearer operating procedures and job plans.
- Staff had access to regular professional development, clinical supervision and caseload management appropriate to their role. The team regularly audited attendance and the quality of clinical supervision. All staff had undertaken an appraisal in the previous six months.
- All staff attended team meetings, governance meetings and multidisciplinary meetings. Staff told us that service developments were discussed at these meetings, and they were offered the opportunity to give feedback on the service and input into service development. Staff took lead roles in supporting the improvement agenda.

Commitment to quality improvement and innovation

- An annual audit programme was in place and staff were involved in conducting and identifying audit topics. Topics included audits such as for clinical record keeping, patient experience, supervision levels, significant events trend analysis, complaints process, cleanliness and environmental audits. Audits were used to inform changes to practice. Feedback and changes as a result of the audits were taken to the governance meetings and used to plan future development and the ongoing audit programme.
- Throughout the development of the SPA and NAM the team had audited the clinical effectiveness of the service. Areas considered had included the appropriateness of referrals, re-referral rates, times from initial referral to treatment and robustness of initial assessment

decisions. Throughout the team had used the information to inform changes to the operational model. As a result, the team had increased relevant training for staff, set up GP access clinics and awareness sessions, amended the assessment tool, and secured specific administration for the team. The team had learnt as part of this process that the treatment offer available required reorganisation and refocus and had addressed this. The team had also increased the appropriateness of referrals, reduced re-referral rates and has significantly reduced times to assessment and treatment.

- In line with the development of the SPA and NAM amendments had also been made to the multidisciplinary team process. Through audit the team had demonstrated a significant reduction in the clinical team spent within multidisciplinary team meetings and more effective decision making.