CQC's inspection programme of

Defence Medical Services

Annual report for Year 2 (2018/19)

July 2019

Contents

Foreword from the Chief Inspector

I am delighted to present CQC's annual report of the quality of care in Defence Medical Services (DMS) for 2018/19. This report sets out the findings from inspections in Year 2 of this programme.

Everyone in our society, including armed forces personnel and their families, deserve high-quality, accessible care. In view of this, the Surgeon General invited CQC to inspect health care and medical operational capabilities, and we started a programme of inspections in 2017/18.

The aim of our inspections is to highlight notable practice and problems and to make sure that military health services address these for the benefit of both patients and the staff working in them. Where we found concerns in the first year of this programme, we have carried out follow-up visits to ensure that the necessary improvements have been delivered. We found that, in most cases, the services had made improvements.

In rare cases, where we found poor and unsafe practice that put patients at risk, CQC escalated concerns to the DMS Regulator who took regulatory action, with Defence Primary Healthcare providing urgent support to these services.

In our inspection reports, we continue to highlight exemplary practice to encourage other services to learn from it and to adapt what is relevant to use in their own improvement journey. We have identified particular characteristics at the heart of high-quality military healthcare services:

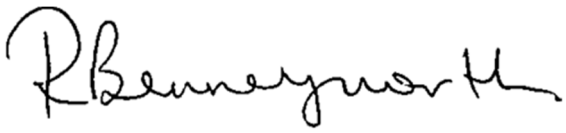
- strong, supportive leadership teams that encourage improvement and innovation
- mature external and internal relationships with key stakeholders
- shared learning across practice teams and the wider health and military communities
- proactive engagement with patients, staff and military command to identify and meet patients' needs
- failsafe systems to underpin safe and effective care and comprehensive training so that staff know how to use them
- flexible use of regional staffing resource to ensure that priority areas are adequately staffed at all times.

We have also found examples of poor care, which we found affected both patients and healthcare professionals in a negative way. In our second year of inspections, we found DMS services where care had fallen short of the quality that people should be able to expect. This poor care was concentrated mainly in medical centres – some of which we were inspecting for the first time, and a small number of others that had not made improvements since our initial inspection. However, we also found a number of medical centres had improved the quality of services where we had issued recommendations in Year 1. The quality of care provided in regional rehabilitation units and departments of defence community mental health facilities that we inspected in Year 2 was generally good. We did not inspect a large number of dental centres in Year 2, but we have re-inspected all centres where we issued recommendations in Year 1. Some of these had been unable to improve the infrastructure of the buildings in which they provide services.

In Year 2, the resource and funding for inspections of dental and medical centres was reduced. Because of this, we have not inspected as many services as we initially intended. It has also been necessary to carry out a number of follow-up inspections where we identified concerns on initial inspection.

I am pleased that the Surgeon General and his team have recognised the value of CQC's inspections and the resulting impact on the care provided to armed forces personnel and their families. I would also like to commend military and civilian personnel for their hard work and commitment to delivering high-quality, safe and effective care.

The Surgeon General, Defence Medical Services Regulator and CQC continue to be committed to ensuring that armed forces personnel and their families have access to the same high-quality care as the rest of society.



Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

The Care Quality Commission (CQC)

CQC's purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

CQC's role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

CQC's values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

Defence Medical Services

The Surgeon General leads the Defence Medical Services (DMS) and sets the standards and rules that all providers of healthcare and medical capability must follow. In partnership with providers, the Surgeon General assures healthcare quality standards set for Defence by national or international authorities.

The DMS provides an occupationally focused primary healthcare service, encompassing primary medical and dental care, occupational health, public health, force preparation, travel medicine, mental health and rehabilitation, and some outsourced services. Secondary healthcare is provided by the NHS, with DMS guiding how NHS services are commissioned and delivered to ensure that they meet specific Defence requirements. The DMS is responsible for developing medical operational capability and generating medically qualified personnel to support operational tasks.

Defence Medical Service Regulator

The DMS Regulator (DMSR) was established as an independent regulator within the Defence Safety Authority in December 2017. DMSR is committed to enhancing the safe delivery of healthcare and medical operational capability, providing independent advice on patient safety, and evidence-based assurance, through regulation where appropriate.

Purpose of Defence Primary Healthcare (DPHC)

Provide and commission safe and effective healthcare, which meets the needs of the patient and the chain of command.

Introduction

The Care Quality Commission (CQC) and its predecessor, the Healthcare Commission, previously inspected DMS military medical facilities* in 2008 and 2011. This followed the recommendations of the Defence Audit Committee (DAC), Joint Forces Command (JFC), the Surgeon General's Non-Executive Director and the then Chair of the Healthcare Commission. The Surgeon General stated that the DMS community should benefit from the same scrutiny of their health service as the rest of the population.

The Surgeon General, in his role as the Defence Authority, therefore invited CQC to deliver a fully-funded inspection programme of DMS medical facilities to inform the Surgeon General, Defence Medical Services Regulator (DMSR) and the people who use these services about the quality of care being provided.

CQC started a programme of inspections for health care and medical operational capability in April 2017.

DMS medical facilities are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently, these services are not subject to inspection by CQC and CQC has no powers of enforcement. However, the DMS wished to benchmark its services against those provided for NHS patients, so commissioned CQC to undertake a comprehensive programme of inspections of all military primary and community healthcare services. Where CQC finds shortfalls in the quality of services, we escalate these concerns swiftly to the DMSR so that they can initiate action to improve or enforce standards.

CQC is the independent regulator of health and adult social care in England. However, the service level agreement between CQC, SG and DMSR enables us, at the DMS's request, to inspect military healthcare services in Scotland, Wales, Northern Ireland and overseas.

Approach to DMS inspections

The DMSR delivers a rolling programme of healthcare assurance of the safety of the DMS. The military Common Assurance Framework (CAF) is a Governance and Assurance support tool available to all DMS units. It underpins the Healthcare Governance Assurance Visit (HGAV) approach as a way of recording the real-time compliance of individual services against a set of indicators.

* 'Medical facilities' is the collective term used to describe all medical, dental, rehabilitation and mental health treatment facilities in the DMS.

CQC's inspection methodology shares many common aims with the HGAV approach, including:

- seeking assurance that effective governance systems are in place
- ensuring that appropriate policies and guidance are being followed
- ensuring that key performance indicators are being met.

However, CQC's approach differs as it focuses primarily on the quality of care for the patient, their experience, and whether their needs are being met. The DMSR believes the two approaches are complementary.

CQC's quality ratings

CQC's ratings are designed to give a clear indication to patients and the public about the quality of services. For all services that CQC regulates, we ask five key questions: are they safe, effective, caring, responsive to people's needs and well-led? We give a rating of either: outstanding, good, requires improvement or inadequate. To decide on a rating, the inspection team also asks: does the evidence demonstrate a potential rating of good? If yes, does it exceed the standard of good and could it be outstanding? If it suggests a rating below good, does it reflect the characteristics of requires improvement or inadequate? We rate each of the five key questions and aggregate them to give an overall rating for a service.

The ratings also act to encourage improvement, as they enable services rated as requires improvement or inadequate to understand where they need to make improvements and aspire to achieve a higher overall rating.

Ratings are based on a combination of what we find during an inspection, what patients tell us, key performance data and information from the service provider itself. Inspectors use all the available evidence and their professional judgement to reach a rating. Following a thorough quality assurance process, the inspection report is published on CQC's website.

Overview of inspections in Year 2

In 2018/19, CQC carried out 34 first comprehensive inspections comprising:

- 25 medical centres (including primary care rehabilitation facilities (PCRFs))
- 3 dental centres
- 4 regional rehabilitation units (RRUs)
- 2 military departments of community mental health (DCMH).

In this second year, we also carried out 19 follow-up inspections to ensure that services have resolved the concerns found on initial inspections. We re-inspected:

- 11 medical centres (including PCRFs)
- 5 dental centres
- 1 RRU
- 2 military DCMHs

Following our inspection programme in Year 1, the follow-up inspections have allowed us to continue to form a view of the quality of care provided by the DMS.

The appendix provides a full list of published ratings for all inspections in 2018/19. All CQC's inspection reports for DMS medical facilities are available on CQC's website: www.cqc.org.uk/DMS.

Key findings of inspections in Year 2

Medical centres

All military personnel, some dependants and some civilian staff, are entitled to the services of a military GP practice. Unlike most NHS patients, military staff do not have the right to register with a GP practice of their choice but must register at the location where they are assigned.

In Year 2, CQC continued the programme of inspections of DMS GP services in medical centres. The focus of our approach is the quality and safety of services, based on the things that matter to people. This enables us to get to the heart of people's experiences.

In the first three quarters of 2018/19, CQC's inspection team visited medical centres that DPHC had identified, prioritising inspections of medical centres where there were known risks. In quarter 4, the DMSR took over responsibility for identifying priorities, and continues to ask CQC to inspect services where there is a known risk. This may partly explain why performance across medical centres has not improved since Year 1, when we were invited to inspect a mix of medical centres from those thought to be delivering best practice to those that had known challenges.

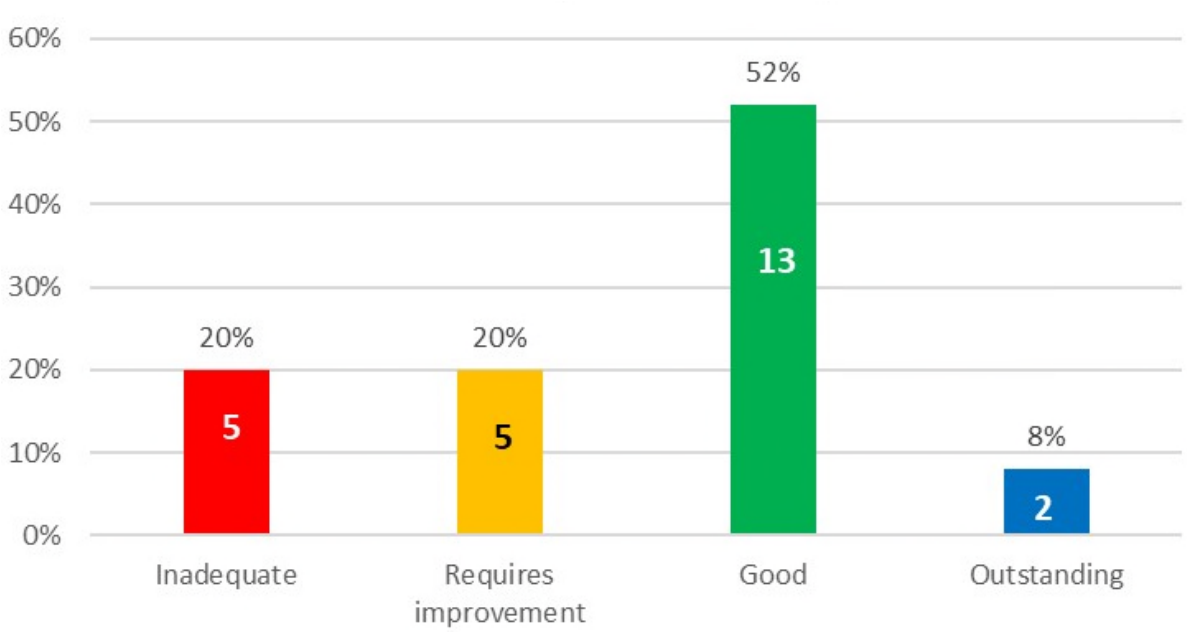
Summary of findings

It is important to remember that, although we have completed Year 2 of this inspection programme, we have only inspected a total of 59 medical centres. It is therefore not appropriate to draw direct comparison with ratings across NHS GP inspections, where we have been rating GP providers for six years and have an established baseline of quality, with around 8,000 NHS GP practices having been rated at least once. Military general practice and NHS general practice are different in a number of ways: practice populations are much smaller in DMS practices than NHS practices, providing services for families is far less common, and there is a greater focus on occupational health delivery throughout the DMS. The epidemiology is also different for military medical centres, where staff see significantly higher numbers of patients with muscular skeletal injuries and fewer patients with chronic conditions.

The follow-up inspections carried out in Year 2 sought to confirm that CQC's recommendations have been acted on. This work, although still ongoing, shows a generally positive shift and that there has been some organisational learning where we previously identified concerns.

Figure 1 shows the overall ratings for medical centres, which we determine by aggregating ratings for the five key questions.

Figure 1 : Overall ratings for medical centres in Year 2

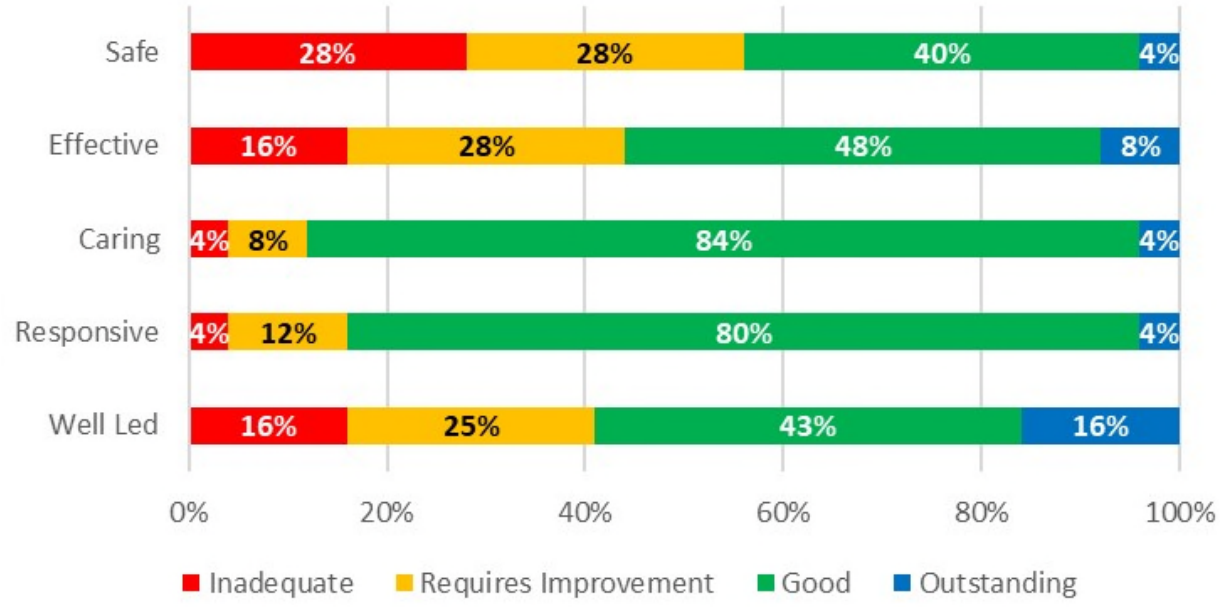


- 20% (5) were rated overall as inadequate
- 20% (5) were rated overall as requires improvement
- 52% (13) were rated overall as good
- 8% (2) were rated overall as outstanding

Ratings by key question for medical centres

As in Year 1, we found the majority of medical centres to be caring and responsive. Where we find problems, they are more frequently related to the centre's approach to safety, the effectiveness of care and treatment, and how well the centre is led and managed. Figure 2 shows ratings for medical centres in Year 2 by each key question.

Figure 2: Ratings for medical centres by key question in Year 2



Safe

Delivering safe care is essential. Patients can be protected from abuse and avoidable harm when a practice has robust systems and processes, creating a strong foundation to enable staff to be proactive about risk, assess and mitigate risk, and see problems before they happen. As well as having a safe track record, a willingness to report safety incidents and be actively involved in learning from them to drive improvement – both within and outside the medical centre – is a key indicator of its safety.

As in Year 1, overall performance for the safe key question in Year 2 is the poorest of all the five key questions, as it shows the largest percentages of ratings of requires improvement and inadequate. Many of the issues in the recommendations that we made in Year 1 of this inspection programme have continued to be raised through Year 2. This calls into question the capacity of Defence Medical Services to acknowledge and implement organisational learning relating to the safe key question.

In Year 2, 44% of medical centres inspected for the first time were rated as good or outstanding for the safe key question, but 28% were rated as requires improvement and 28% rated as inadequate for safety. There is a clear link between a lower rating for leadership and a lower rating for safety.

In 2017/18, inspections of medical centres raised concerns around:

- managing test results safely
- applying rigorous root cause analysis and shared learning from serious incidents and significant events to prevent them happening again
- lack of robust systems to promptly identify vulnerable patients and patients taking high-risk drugs that require monitoring, and following related guidance (including shared care agreements)
- enabling staff to raise an alarm to call for help
- providing adequate levels of staff and skills mix to deliver safe care
- backlogs in summarisation of newly registered patient notes
- providing appropriate training for staff responsible for infection prevention and control, environmental cleaning and waste management arrangements
- lack of assurance that buildings and infrastructure were fit to deliver health care, and that staff followed guidance on infection prevention and control to meet standards.

In March 2019, we continued to raise many of the same concerns.

Safeguarding

In Year 1, we found that some medical centres were not fulfilling their duties to safeguard vulnerable people, including children. Often, this was because there was no effective system to ensure that all vulnerable patients were known to staff and so patients were not proactively supported and reviewed. In Year 2, we have continued to issue recommendations to some practices to address this. We noted that one practice was not using alerts from the Defence Medical Information Capability Programme (the military patient records system (DMICP)) to instantly identify patients who were vulnerable, including patients with mental health concerns. As a result, when the Senior Medical Officer (SMO) was deployed elsewhere, practice staff and locums were not aware of the needs of the vulnerable patients at their practice. In the absence of the SMO, patients with mental health needs had not been recalled or reviewed and no clinical representative had attended health and welfare meetings with the Chain of Command and pastoral teams, potentially leaving vulnerable patients with unmet needs.

High-risk medication management

As in Year 1, we inspected medical centres that had no safe systems to manage patients who are prescribed high-risk drugs, with no shared care protocols in place. This has meant that some patients have not received the monitoring required to maintain their health and wellbeing. CQC notes that funding for 'Dispensing for Doctors' training, which previously informed prescribers about these areas of prescribing, has been withdrawn for the DMS.

Central Alerting System

In Year 1 we identified the need for some medical centres to implement a safe system to ensure that they acted on alerts from the Central Alerting System (CAS) at patient level. This included ensuring that alerts and updates from the Medicines and Healthcare products Regulatory Agency (MHRA) were received, disseminated and appropriately actioned for each patient. In Year 2, we continued to find that some medical centres needed to take action in these areas. On inspection, we saw some patients had been prescribed contra-indicated medicines, which risks safety.

Infrastructure

Practices are unable to address environmental concerns themselves and rely on the station's health and safety team or regional headquarters to bid for funding for improvement work. Ownership of risk can therefore be unclear and medical centre staff are often unable to influence prioritising improvement work to infrastructure.

In 2011/12, CQC inspected 20 medical centres, and at that time our recommendations centred on improving poor infrastructure. We note that some work is underway to address these concerns, but we continue to identify issues with infrastructure across medical centres. Furthermore, we are finding that infrastructure issues that we identified in 2011 have still not been resolved. We have identified some common issues: damp, insufficient space, poor ergonomics, lack of sound-proofing, inadequate arrangements to protect privacy and dignity, and a history of vermin infestations. Many medical centres are not purpose-built to deliver primary care, as described in the following example.

> We recently inspected a medical centre with a primary care rehabilitation facility (PCRF) attached. The PCRF had been in an old building (once used as a gym) since May 2010. CQC inspected the facility in November 2011 and reported, "The current use of this facility poses an infection control risk." However, the PCRF had not received priority for urgent action as the building is not listed as a medical facility, but simply as an old gym and offices.
>
> At our recent inspection in January 2019, we found many of the same issues. In addition, only one sink in the whole facility had hot water, which was in the treatment room. A sink in the rest area for staff was blocked, with brown water overflowing. As a result, the PCRF had been closed for five days, which affected the care of 50 patients.
>
> There were no toilets for patients or showering facilities, and space was limited as it was shared with the military band. The band used the open space for marching and this had, over time, damaged the flooring. As a result, the PCRF had to introduce a 'no bare foot' policy, which is not ideal in a rehabilitation setting. The facility had one clinical room with four plinths to accommodate seven clinicians, with only two IT terminals. We escalated these concerns to the DMSR who took enforcement action as the issue had not been addressed since CQC raised it over eight years ago.

Infection prevention and control

As in Year 1, we continue to find that some medical centres are not following best practice guidance around infection prevention and control and safe disposal of clinical waste, as well as shortcomings in testing medical equipment. These failures in delivering consistently safe care result partly from a failure to have proper processes, formal training, and guidance for staff. In Year 2, we inspected a number of medical centres whose practice managers and infection control leads were required to be accountable for a number of areas, but without any training or guidance to support them in achieving this.

Information systems

Some practices alerted us to IT network and power failures which, in some cases, have resulted in extended periods without access to the military patient records system. Where this has happened, in line with policy, clinical staff have only seen urgent patients and delayed seeing patients at routine appointments until access to patient records was restored. There are clear risks around delayed appointments and seeing patients with no access to their records.

Factors influencing a rating of good for the safe key question

Where a medical centre was rated as good for the safe key question, staff were trained (to the appropriate level for their role) to understand their accountabilities around safeguarding vulnerable adults and children. Staff knew how to take action and worked in close partnership with the Chain of Command and welfare and pastoral teams to safeguard personnel and their families. Medical centres rated as good could demonstrate that they had failsafe systems to manage and recall patients with long-term conditions and patients taking high-risk drugs. Staff had the information they needed to deliver safe care and treatment. Clinicians took care to ensure that individual care records were written and managed in a way that kept patients safe, and that this information was shared with other agencies to enable them to deliver safe care and treatment. Medical centres rated as good had a failsafe and documented approach to managing test results and they audited referral letters to ensure that they included the necessary information and were sent to the right person or department. We have inspected a number of medical centres where infrastructure was not ideal. However, staff had identified and escalated concerns to the station’s health and safety team or regional headquarters, and we saw evidence that funding bids had been submitted to enable remedial work.

Safe: Examples of good practice in a medical centre rated as outstanding

Cranwell Medical Centre, Lincolnshire (December 2018)

- The centre had a protocol to support the safe and effective handover of children and vulnerable adults to other services. This was developed to keep the health visitor informed when a child transferred to another practice if their parent was posted, or another change of circumstances. Before de-registering the patient from the records, the GP was required to provide a formal handover to the health visitor and/or the new practice. This protocol also applied to service personnel who were considered to be vulnerable and were due to leave the military and transfer to NHS primary care. A dedicated member of staff managed the patient registration system and produced a report each month of patients seeking to de-register. We saw an example of how this protocol had enabled a patient aged under 18 to transfer seamlessly to an NHS practice.
- The medical centre used the Automated Significant Event Reporting system (ASER) to report good practice and quality improvement initiatives, such as the protocol for de-registering children under 18 and vulnerable adults, to ensure continuity of care. One of the medics was identified as an ASER representative for junior members of staff and had received training for the role. This role was introduced to enhance the culture of incident reporting among junior staff who may not feel confident or able to approach a higher ranked member of staff for advice. This process was working well, and junior staff were familiar with this lead role.
- There were rigorous processes to ensure that care records were of a high and consistent standard. For example, notes completed by exercise rehabilitation instructors were audited against a recognised standard in January 2017. The audit was repeated in June 2018 and improvement noted. An action plan was developed with a plan to repeat the audit again in 12 months. The SMO carried out an audit of doctors' clinical records in February 2018, which showed a high standard with actions discussed at a clinical development meeting, and an audit of nursing records was carried out in March 2018. Both audits were due to be repeated after 12 months.
- New patients registering with the practice had a health check at a face-to-face appointment. This also meant any lapsed recalls could be identified and addressed.
- Information on how to recognise and manage sepsis, a life-threatening condition, was displayed prominently in the reception area, including how to recognise symptoms in both children and adults. The receptionist said that patients had taken photographs of it. There was also information on recognising symptoms of sepsis for children of different ages in clinical rooms. Staff received face-to-face training in January 2018 and two further online training sessions included materials from the Sepsis Trust UK.

Effective

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. An effective medical centre routinely reviews the effectiveness and appropriateness of its care as part of quality improvement. When care and support is effective, people have their needs assessed and their care and treatment delivered in line with current legislation, standards and evidence-based guidance.

In Year 2, 48% of medical centres inspected for the first time were rated as good for the effective key question and 8% were rated as outstanding; 28% were rated as requires improvement and 16% were rated as inadequate for the effectiveness of care and treatment.

To support our judgements, we look at existing data around patient outcomes including Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. We also looked at performance against World Health Organisation vaccination targets and the Force Protection Dashboard for service personnel.

Where performance was outstanding, we found:

- clinical teams working together to discuss patient issues, agree treatment plans and ensure that they understand and apply new national guidance
- a comprehensive and broad cycle of improvement work, that was relevant to the patient population and delivering demonstrable improved outcomes for patients
- examples of staff going the extra mile to meet the needs of vulnerable patients
- proactive and extensive support for staff to develop the skills they need for their role, including an open and transparent approach to peer review
- a comprehensive approach to supporting patients to achieve a healthy lifestyle, coupled with a targeted programme of health assessments and screening
- an understanding of the challenges around Read coding and a commitment to apply codes consistently through ongoing review.

Where performance was poor for this question, we found some common themes in line with what we found in Year 1, as practices had been unable to:

- maximise the functionality of the DMICP patient records system to facilitate clinical searches, assure recall programmes and monitor performance
- ensure adequate staffing levels and skills mix at all times
- deliver a rolling programme of work to continuously improve patient outcomes
- ensure that all staff had received training relevant to their role
- improve uptake of national screening programmes
- maintain comprehensive childhood immunisation records.

Effective: Examples of good practice in a medical centre rated as outstanding

Cranwell Medical Centre, Lincolnshire (December 2018)

- The PCRF held a clinical governance meeting that included feedback to the team on relevant matters from clinical development meetings, for example, best practice guidance outcome measures and audit. The lead physiotherapist attended the regional 'Injuries in training working group' that monitored injury statistics and worked to an action matrix for injury prevention. A GP and the lead physiotherapist attended the 'Injuries in training steering group'.
- The practice had developed and introduced a specific range of codes for disease monitoring based on population need. Adding a code to a patient's clinical record enabled staff to search the system to identify specific patients. For example, there were codes for patients referred for a colonoscopy, gout monitoring, thyroid disease monitoring and cardiac disease monitoring. Importantly, two codes were specific to mental health: 'psychiatric monitoring' and 'mental health review follow up'. These codes were used effectively to search for and monitor patients with mental health needs.
- Patients were referred to the Department of Community Mental Health (DCMH) at about six weeks if no improvement was seen. Using this coding system alongside the protocol for transferring vulnerable patients meant patients had a seamless transfer of care when they moved to another practice.
- Examples of clinical audit included: contraception, minor surgery, cytology, QRISK assessments for patients at risk of developing cardiovascular disease, hypertension, asthma, depression and antibiotic prescribing. Clinical audit was a standing agenda item at clinical development meetings where clinicians presented their audits. For example, at the September 2018 meeting the annual antibiotic audit was presented, along with the aircrew logbook audit and the secondary coronary heart disease audit.
- The practice had good working relationships both internally and with health and social care organisations. For example, doctors and PCRF staff held regular meetings to discuss and monitor patients under the care of PCRF. The SMO and lead physiotherapist attended the monthly Unit Health Committee (UHC) meetings for each squadron. These reviewed the needs of patients who were medically downgraded and those who were vulnerable. The practice also worked closely with the Regional Rehabilitation Unit (RRU) and the DCMH, and had good links with the local midwifery service, health visiting team, local safeguarding boards and the University of Lincoln. The SMO was a member of the Local Medical Committee, which enabled them to keep up-to-date with local NHS activity.

Caring

Compassionate care has a lasting impact on people's experience of their medical centre. Practices rated as good or outstanding knew and understood their patients as individual people and were sensitive to their preferences and requirements. As well as observing how staff interact with patients, we base our judgements on patient feedback from comment cards, interviews with patients and data from the practice's own patient surveys.

We found that the vast majority (88%) of the 25 medical centres inspected for the first time in Year 2 provided caring services to their patients, with caring once again being the best performing key question. We saw improvement from Year 1 around staff proactively identifying and supporting patients who are carers. For example, providing links with carers' organisations and ensuring that the carer's emotional and healthcare needs are met.

At the one medical centre where performance was inadequate, this was because the privacy and dignity of patients was compromised as patients sat side-by-side in the PCRF during consultations and no screens were used.

Caring: Examples of good practice in a medical centre rated as outstanding

Lichfield Medical Centre (January 2019)

Several patient feedback comments indicated that 'staff went the extra mile' and we found evidence to support this, with examples of staff:

- reporting broken heating in trainee accommodation in cold weather to the Chain of Command
- personally driving a patient without transport to the Department of Community Mental Health for a critical appointment after normal practice opening hours
- collecting a patient's medication from the pharmacy and delivering it to their accommodation as the patient was ill and/or had no transport
- looking after a patient's children as they had no childcare and needed to attend the practice for a medical
- arranging for military transport to take a patient from their home off the base to the A&E department 11 miles away as they had acute pain so were unable to drive. Staff also arranged transport to secondary care and provided a guardian if the patient was under 18 years old
- continuing to coordinate patients' care at their request, despite them moving a considerable distance away, even to a different country
- providing a 'virtual practice' for those transitioning out of service
- providing home visits to a housebound patient who lived a 40-minute drive away.

Responsive

Good quality care is organised so that it responds to, and meets, the needs of the practice's local population. This includes access to appointments and services, choice and continuity of care and meeting the needs of different people, including those in vulnerable circumstances. As well as face-to-face consultations, a responsive medical centre will carry out consultations by telephone and offer tailored appointment lengths, home visits and extended opening hours.

In Year 2, 4% of medical centres were rated as outstanding for providing a responsive service, 80% were rated as good, 12% rated as requires improvement and 4% were rated as inadequate.

Where we judged care to be good, we often found that medical centres had undertaken work to understand the needs of their patient population. They had gathered feedback from patients and staff and used this knowledge to ensure that care was as convenient and accessible as it could be. We found that medical centres offered longer appointments to patients who required them and that both staff and patients were clear about when home visits were appropriate. Patients told us that online services for requesting repeat prescriptions, a dedicated line for obtaining test results and being able to arrange transport to hospital appointments were helpful. Responsive medical centres worked in close partnership with rehabilitation facilities to enable timely access to physiotherapy and exercise rehabilitation.

Responsive: Examples of good practice in a medical centre rated as outstanding

Lichfield Medical Centre January 2019

- There were young trainees in the patient population, but they were restricted on taking telephone calls. Staff therefore used text messaging to remind patients about appointments and advise them to contact the practice for test results.
- Following an access audit as defined in the Equality Act 2010, the practice made reasonable adjustments to the premises. Patient services were on ground floor, with disabled parking and toilet facilities, and wheelchairs, including a self-propelling wheelchair, were available in the foyer.
- Feedback showed that patients felt uneasy discussing their health needs within earshot of the whole administration team. The practice implemented a process where the reception was always staffed to avoid this, which worked well. The change was communicated to patients as a 'You said...We did' display in the waiting area.
- To help patients check that they were performing their exercises correctly outside of the facility, the PCRF staff videoed the patient carrying out the exercise with their own mobile phone if they asked.
- A 'Mental Wellbeing First Aid Box' was displayed in the waiting area to guide and advise patients who were struggling with emotional or stressful issues.

- The Patient Participant Group meeting in September 2018 discussed lifestyle issues. This led to a further meeting to explore how units could work jointly to look at ways to improve population fitness, weight, alcohol use and mental health.
- The practice introduced a system where the duty doctor and nurses had simultaneous triage slots each day. For example, a patient with an urgent need was initially seen by the nurse. If they then needed to see a doctor they could do so seamlessly. This reduced disruption to attendance on courses as patients did not have lengthy waits or needed to return later in the day to see a doctor. This system had been well received by patients, unit commanders and staff.
- Access to aviation and diving medicals were prompt and timely as doctors were available at the practice to undertake these. The practice brochure explained about home visits and telephone consultations.

Where responsiveness needed to improve, we identified some common themes:

- Patients sometimes waited over three weeks to see an aviation qualified GP (some patients who are pilots or involved in flying activities need to see a GP with a specific qualification).
- Although written complaints were generally dealt with in line with Defence Primary Healthcare policy, there was scope to ensure that verbal complaints were reported, investigated and learned from in the same way.
- Staff and patients were not always clear about the policy on home visits.

Well-led

We looked at governance arrangements, culture, leadership capacity, vision and strategy, managing risks, issues and performance and continuous improvement under this key question. As we find in all types of health and care services, poor performance under the well-led key question affects all areas, in particular the safety and effectiveness of care and treatment.

In Year 2, 16% of medical centres were rated as outstanding for the well-led key question and 43% were rated as good; a further 25% were rated as requires improvement and 16% were rated as inadequate.

During the second year of medical centre inspections, we have found examples of outstanding leadership in four medical centres. Key to their success was visible leadership and a strong governance framework coupled with a collaborative team approach to promote learning and innovation. We met with staff who were trained for their roles and knew where lines of accountability lay. Medical centres rated as outstanding fostered a culture where challenge and transparency allowed teams to fulfil their duty of candour. Civilian staff often provide stability and continuity of care within a medical centre and they may provide many years of care at the same

place under the steer of many different military staff. A good practice will acknowledge and make good use of the acquired knowledge and advice that civilian staff can bring to their work. In return, the practice will benefit where civilian staff quickly engage with, and guide and support new military staff who often move to new practices every two years.

Well-led: Examples of good practice in a medical centre rated as outstanding

Condor Medical Centre (July 2018)

- On the day of inspection, the leaders in the practice demonstrated that they had the experience, capacity and capability to run the practice and ensure high-quality care. Everything we saw on the inspection day, and communication with the practice following the inspection, supported this.
- The leadership structure was clear, with clearly allocated responsibilities and named deputies to cover for absence. Staff felt supported by management, saying the practice leaders were approachable and always took the time to listen to all members of staff. They were involved in discussions about how to run and develop the practice. An open culture gave them the opportunity to raise any issues at team meetings and they felt confident and supported in doing so.
- Staff from all disciplines referred to the practice leadership as inclusive, caring and inspiring. They were committed to their role, showing their ability to work independently and as a practice team for continual improvement. This investment in staff resulted in positive engagement and interaction with patients. This was confirmed by the high number of compliments from patients.
- Leaders were aware of the dangers of being a small, single-handed, geographically separated practice and had taken proactive steps to reduce isolation and share experience, learning and processes with Leuchars to benefit both clinicians and patients. The practice team was forward-thinking, and the practice development plan provided a 'roadmap' for short-term, intermediate and longer-term goals for the practice, and an example of insightful forward planning. Examples from the plan include implementing improved audiometry, employing a dedicated receptionist and the GP working towards re-accreditation as a trainer.
- There was a focus on continuous learning and improvement at all levels, with a focus on improving the speed and quality of delivering care. Improvements were implemented following quality improvement projects, outcomes of audits and investigation into significant events. The practice used its audit work to identify learning and make change. For example, the work around health promotion and screening.
- The PCRF team, led by the physiotherapist, was starting a research project looking at the effect of load on biomechanics, and the potential influence on injury. The aim was to identify potentially modifiable risk factors for musculoskeletal injury. This physiotherapist had gained support from universities including the Institute of Naval Medicine and was obtaining ethics approval.

Although CQC only inspected 35 medical centres in Year 1 and 25 in Year 2, we can see a number of common themes where we have rated them as requires improvement or inadequate for the quality of their leadership.

Military medical centres often work to a culture of 'being proactive with what we have'. When deployed on overseas work, clinicians are accustomed to working with only the resources at hand to deliver the best possible outcomes for patients. This means that staff may have to act without the optimal level of information and/or resource to address risks. When staff return home and assume day jobs in medical centres, this cultural legacy can live on. Staff may be aware of suboptimal resource, gaps in the workforce and inadequate infrastructure, but their commitment to deliver the mission is paramount and so they continue to strive to deliver against the odds. At a regional level, management teams adopt differing approaches: some feel powerless and devolve accountability; some escalate resource shortfalls to headquarters and some use their regional resources flexibly to deliver in priority areas.

Furthermore, lines of accountability for managing risk are at times blurred. Practices, regional teams and headquarters staff are not always clear about who should be addressing issues, which can lead primary healthcare teams to tolerate an inappropriate degree of risk. CQC has inspected a number of medical centres where patient care is suboptimal because of poor infrastructure or workforce gaps. Sometimes these issues are known at a local, regional and national level but have not been addressed. Sometimes local staff feel they are struggling in isolation to deliver against the odds.

Governance systems are not always effective and do not support the delivery of consistently high-quality services. As in the first year of the programme, we identified the following common issues in Year 2:

- Although there are often policies and procedures in place, leaders may not be assured that their teams are following them.
- There is a lack of quality improvement programmes.
- Practices do not always understand and monitor their own performance.
- The arrangements for identifying, recording and managing risks and issues, and implementing mitigating actions, are ineffective.
- Staff were not always aware who had a lead role and was accountable for overseeing issues such as infection control, managing long-term conditions and safeguarding.

Communication across practice and clinical teams was sometimes ineffective. Practice and clinical meetings were not always held regularly, which meant that staff did not always discuss standing agenda items, recent clinical guidance, patient safety alerts and the risk register, and so actions were overlooked.

Professional isolation and lack of resilience is an issue at some practices. Small practice teams (often with a lone GP at the helm or NHS GPs contracted in to provide a service) find it difficult to implement and maintain strong governance systems to deliver continuity of safe and effective care. Small practice teams are also disproportionately affected by gaps in staffing. We have inspected a small number of practices where there is little evidence of oversight and support from regional teams or connection with other local practices. Therefore, they do not learn and share with others. Some care at these practices has been very poor. However, we note some examples of group practice working that have enabled smaller medical centres to work collaboratively with other medical centres and therefore improve their leadership potential (see example of an effective group model rated as good on page 24).

Feedback did not always drive improvement. Although most medical centres used surveys to collect feedback from patients, only a few proactively asked for formal feedback from their staff. This meant that opportunities to drive improvement and innovation were lost and staff did not always feel empowered to drive change at their practice.

At the end of Year 1, we identified concerns around the significant challenges in delivering safe and effective care because of gaps in the workforce. In Year 2, this issue continues to hinder continuity of good care. It is still the case that medical centres with poorer ratings tend to have more vacancies and posts that have not been covered by locums. Primary care teams continue to face staffing gaps when military healthcare staff are deployed, sometimes at short notice, on operational and Navy/Army/RAF tasks, and the lack of available civilian and locum staff means that some practices struggle to deliver continuity of service. As we found in Year 1, there is a direct link between poorer ratings in medical centres when the Regimental Medical Officer (RMO) is deployed elsewhere. The role of RMO is to support personnel at home and on deployment, therefore there can be a loss of clinical leadership at the medical centre when they are away.

Regional management teams are able to use their regional staffing resource flexibly and at times can provide support to priority areas. However, this has not always been the case and we have inspected medical centres without the key personnel to provide essential clinical leadership. In two cases this led to patients being at risk of harm. As in Year 1, DPHC has been unable to ensure that Suitable, Qualified and Experienced Personnel (SQEP) are in the right posts at all times. Practices are unable to address staffing concerns directly and rely on regional teams, Headquarters and Service (Navy/Army/RAF/Civil Service) prioritisation and recruitment practices. In places, staffing gaps have been tolerated for prolonged periods, with demonstrable impact on the safety of patient care.

Some medical centres are operating within group models with shared governance systems and staffing resource. However, we noted an inconsistency in the way these group models are set up and run. For example, we have found approaches where

local leaders are not working within terms of reference and without a memorandum of understanding to outline the aims and delivery objectives of the group approach. We have also inspected practices where the group model has been successful in providing good quality care within a shared resource.

Well-led: Example of an effective group model rated as good

South Scotland Group Practice September 2018

Based on a hub and branch model, South (Scotland) Group Practice was formed in 2015, combining MRS Edinburgh (hub) and Caledonia (branch). A practice manager oversaw the day-to-day running of each practice with the SMO responsible for the overall leadership and governance structure of the Group Practice. The regional management team worked closely with the SMO. Staff we spoke with were extremely positive and spoke highly of the inclusive Group Practice model, management structure and leadership. The management team understood the risks to the service and kept them under scrutiny through the risk register for each practice that the SMO had oversight of.

Improvement on re-inspection

Between March 2018 and April 2019, we re-inspected 11 medical centres (figure 3 on the next page).

Nine of the 11 services demonstrated sufficient improvement on the next inspection to confirm that the quality of care had improved. Many services responded well to inspection findings and engaged with CQC and DPHC to understand what they could do to improve. Some practices had received support from regional teams to create and deliver improvement action plans. As a result, they are now providing safer, more effective care.

However, not all services improved sufficiently and the quality of care in two medical centres had deteriorated such that the overall rating went down to inadequate. We noted that these services had lacked defined and proactive support from regional teams and we escalated concerns to the DMSR to enable them to take further action to prompt urgent improvement.

We will continue to follow up the recommendations made during Year 2 to ensure that the services implement improvements for patients.

Figure 3: Outcomes of re-inspections of medical centres by key question in Year 2

		Safe	Effective	Caring	Responsive	Well-led
Northwood	1st	Inadequate	Requires improvement	Good	Good	Requires improvement
	2nd	Requires improvement	Good	Good	Good	Good
St Athan	1st	Requires improvement	Requires improvement	Good	Good	Requires improvement
	2nd	Good	Good	Good	Good	Good
Shrivenham	1st	Requires improvement	Good	Good	Requires improvement	Good
	2nd	Requires improvement	Good	Good	Good	Good
Bovington	1st	Inadequate	Requires improvement	Good	Good	Requires improvement
	2nd	Good	Good	Good	Good	Good
Boulmer	1st	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement
	2nd	Inadequate	Inadequate	Good	Requires improvement	Inadequate
Sandhurst	1st	Inadequate	Requires improvement	Good	Good	Requires improvement
	2nd	Good	Good	Good	Good	Good
Shorncliffe	1st	Requires improvement	Good	Good	Requires improvement	Requires improvement
	2nd	Good	Good	Good	Good	Good
Fort George	1st	Inadequate	Inadequate	Good	Requires improvement	Inadequate
	2nd	Requires improvement	Good	Good	Good	Good
Woolwich	1st	Inadequate	Requires improvement	Good	Good	Requires improvement
	2nd	Inadequate	Requires improvement	Good	Good	Inadequate
Brawdy	1st	Inadequate	Inadequate	Good	Requires improvement	Inadequate
	2nd	Requires improvement	Requires improvement	Good	Good	Requires improvement
High Wycombe	1st	Inadequate	Inadequate	Good	Requires improvement	Requires improvement
	2nd	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

Dental services

CQC inspects only 10% of high street dental services each year and we do not formally rate these providers. The same approach is echoed in the DMS inspections – although there is no rating, we judge whether the service is meeting standards and we make recommendations in the inspection report.

In Year 2, at DMSR's request, CQC was only asked to carry out first comprehensive inspections at three dental centres. We found that two were meeting the regulations for all key questions and one was not.

Safe

Overall findings from our inspections identified that:

- staff had a clear understanding of the requirements of the DMS-wide Automated Significant Event Reporting (ASER) system
- there was a high level of understanding of safeguarding responsibilities
- services followed relevant safety procedures when using needles and other sharp dental items
- dentists used rubber dams when providing root canal treatment, in line with national guidance
- staff were trained to deal with medical emergencies and received refresher training every six months
- where appropriate, all staff were registered with the General Dental Council and had adequate indemnity cover
- organisation-wide health and safety policy and protocols were in place to support with managing potential risk
- practices had suitable arrangements to ensure the safety of the X-ray equipment, and a Radiation Protection Advisor and Radiation Protection Supervisor were identified for all practices
- poorly-maintained buildings meant that some practices were unable to achieve 'best practice' as detailed in guidelines issued by the Department of Health and Social Care (Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: 'Code of Practice about the prevention and control of infections and related guidance').

Effective

Overall findings from our inspections identified that:

- dental care records were detailed, containing comprehensive information about the patient's current dental needs, past treatment, medical history and treatment options
- dentists assessed patients' treatment needs in line with recognised guidance
- staff were generally well-trained and supported with their professional development required for registration with the General Dental Council
- practices had referral arrangements with local NHS trusts if oral surgery was required
- prevention was at the heart of each practice's approach, to avoid oral healthcare issues while patients were deployed; however, at one dental centre, we found that gaps in the workforce were reducing its capacity to maximise oral health promotion.

Caring

Overall findings from our inspections identified that:

- staff were aware of their responsibility to respect diversity and people's human rights
- staff were professional and respectful and provided an honest and understandable explanation of each stage of their treatment plan.

Responsive

Overall findings from our inspections identified that:

- there was a high level of satisfaction regarding the responsiveness of the practice, including access to a dentist for an urgent assessment and emergencies out of normal hours
- there were processes for documenting and managing complaints, and all staff were trained in handling complaints, so were familiar with the policy and their responsibilities.

Well-led

Overall findings from inspections identified that:

- a high standard of clinical care was underpinned by high standards of governance
- there was a framework of organisation-wide policies, procedures and protocols, as well as dental-specific protocols and standard operating procedures that took account of current legislation and national guidance
- the lines of communication within practices and with the base chains of command were structured, robust and of value to all parties and at all organisational levels
- practices reviewed dental fitness targets and failure to attend at appointments (FTA) and shared relevant outcomes with staff at the practice meetings
- one practice had gaps in its workforce, which resulted in cancelled clinics, unmanned telephones and lost opportunities to promote oral health; we identified a need for regional teams to be more flexible in arrangements to cover key workforce gaps, to ensure that priority areas were always resourced.

Improvement on re-inspection of dental centres

We also carried out re-inspections of four dental centres in Year 2 to follow up recommendations from Year 1. One site (Catterick) was re-inspected twice (figure 4).

Following our recommendations from initial inspections, two dental centres had complied with standards regarding decontamination, but two were unable to. Because of poorly designed and maintained buildings, these dental centres were unable to achieve ‘best practice’ as detailed in guidelines issued by the Department of Health and Social Care – Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: ‘Code of Practice about the prevention and control of infections and related guidance’.

As with all DPHC facilities, dental centres are unable to address environmental concerns themselves and are mostly rely on the Station's Health and Safety Team or Regional Headquarters to bid for funding for improvement work.

Figure 4: Outcomes for first and follow-up inspections of key questions for dental centres

		Safe	Effective	Caring	Responsive	Well-led
Drake	1st	Standards not met	Standards met	Standards met	Standards met	Standards met
	2nd	Standards not met	Standards met	Standards met	Standards met	Standards met
Leeming	1st	Standards not met	Standards met	Standards met	Standards met	Standards met
	2nd	Standards not met	Standards met	Standards met	Standards met	Standards met
Tidworth	1st	Standards not met	Standards met	Standards met	Standards met	Standards not met
	2nd	Standards met	Standards met	Standards met	Standards met	Standards met
Catterick	1st	Standards not met	Standards met	Standards met	Standards met	Standards met
	2nd	Standards not met	Standards met	Standards met	Standards met	Standards met
	3rd	Standards met	Standards met	Standards met	Standards met	Standards met

Regional rehabilitation units

During the second year of the DMS inspection programme, CQC delivered four inspections of regional rehabilitation units (RRUs) in line with our agreement. Inspections used a bespoke inspection framework involving inspectors with a background in physiotherapy, with inspection teams supported by military specialist advisors working in RRUs.

CQC gained additional powers to rate services during 2018, and we applied these to the RRU sector from July 2018. Before this, we did not apply ratings for services that we inspected.

During Year 2, overall inspection ratings for the regional rehabilitation units inspected were:

- Catterick – rated overall as good
- St Athan – rated overall as good
- Honington – rated overall as good
- Edinburgh – not rated (inspected before July 2018).

Figure 5: Ratings for first inspections of key questions for RRUs

	Safe	Effective	Caring	Responsive	Well-led
Catterick	Good	Good	Good	Good	Requires improvement
St Athan	Good	Good	Good	Outstanding	Good
Honington	Good	Good	Good	Good	Outstanding

We carried out two inspections in England, one in Scotland (Edinburgh) and one in Wales (St Athan).

Overall, the inspections found no specific themes for improvement, but we identified minor issues that were specific to a unit.

Safe

Across all RRUs, there was a good safety culture among staff. Staff were aware of their responsibilities and understood how to report incidents. There were few reportable incidents at these units, but there were changes to practice as a result of learning.

We identified minor issues at RRU Edinburgh regarding the correct systems for the management of medicines on the unit, for example, issuing and collecting medicines.

At RRU Catterick, we identified some concerns regarding the classification of an incident, and in some cases a lack of action taken following incidents.

All staff had received appropriate training. This included safeguarding training at the level appropriate for the unit. There were systems to ensure that the necessary risk assessments had taken place, including infection prevention.

Effective

Overall, patients had their clinical needs assessed in line with national clinical standards. Care was planned together with each patient individually. The assessment was carried out by a multidisciplinary team of medical and physiotherapy staff, exercise rehabilitation instructors, and included podiatry staff where necessary.

Multidisciplinary team working was seen to be particularly effective and embedded in all the units inspected.

Units used outcome measures to assess the effectiveness of treatment as well as structured formal course assessments that involved patients. Staffing levels at the times of the inspections were acceptable. Staff changes were frequent, partly due to the rotation of staff though different military units. However, all staff were flexible and between the two main groups (physiotherapists and exercise rehabilitation instructors) courses were well run.

Patient records were electronic, and used DMICP, which allowed staff to access patient information from any location and for information sharing with the wider primary care team.

Caring

All interactions we observed between staff and patients were appropriate. Staff demonstrated empathy towards patients and took appropriate steps to maintain patients' privacy and dignity, including chaperones, where necessary.

Patient satisfaction was generally very high. There were a number of formal and informal opportunities for patients to provide feedback, and unit staff actively encouraged this.

The patients we spoke with all indicated that they were involved in decisions about their care. There were very few complaints made at any of the units.

Responsive

RRUs provide bespoke services. Their purpose is an occupational one, to support injured service personnel to achieve functional fitness.

Services such podiatry were available, but there were some challenges in accessing them as this depended on staff availability, and the size of area covered by individual RRUs. This was particularly evident in RRU Edinburgh, as it covered the whole of Scotland, and took a significant amount of time to reach other military bases. Additional peripatetic clinics had been established to reduce the travel requirement for patients.

Unlike Year 1, facilities were not identified as a major problem during Year 2. The main issues were at RRU Edinburgh, where the building was a challenge in terms of access to some parts of the unit.

Targets were generally met, including access to multi-disciplinary injury assessment clinics or injury assessment clinics (MIAC or IAC clinics) (first referral within 20 working days), although RRU Honington had seen performance drop in quarter 4 2017/18.

Only RRU St Athan and Edinburgh had met the access target for an RRU course within 40 working days of the MIAC appointment.

All units met the target for access to a podiatrist. Although RRU Honington did not meet this target in 2017/18, its performance improved in 2018/2019 to above the target and RRU average.

Responsive: Example of good practice in an RRU rated as outstanding

St Athan RRU

The unit had established a trickle feed model, which was a specifically adapted rehabilitation course that catered for the increased demand from military staff and the need to reduce waiting times. This model enabled individuals to be ready for active duty within defined timeframes of their operational commitments. The trickle-feed service provided services to the specialist infantry population at risk, or high-performance individuals (those awaiting promotion courses or about to deploy in a front-line role).

The nature of the rehabilitation was bespoke to meet the needs of the individual's role. The model enabled the rehabilitation service to be delivered flexibly and tailored specifically for patients who were unable to spend a full three weeks away from work or patients who needed longer away from their role due to their injury.

Well-led

Leadership at the units was generally exemplary. Staff were engaged in the development and leadership of the units. Staff groups were cohesive and worked well together to provide a high-quality service. Leaders were visible and all staff were encouraged to share their views and take part in developing the service.

Governance arrangements were in place, with clear lines of accountability and reporting. There were appropriate meetings (for example risk), which were minuted and staff were aware of outcomes.

Quality improvements were encouraged, both from feedback from patients as well as audit outcomes.

We did identify some concerns at RRU Catterick, related to oversight of risk. We identified that risks did not always have associated actions, or when discussed at governance meetings, outcomes would carry over from one meeting to the next, rather than taking action to resolve them. We had also been informed before the inspection that eight of the 12 eligible staff had no data relating to security vetting clearance; this risk was not recorded on the service risk register.

Well-led: Examples of good practice in an RRU rated as outstanding

Honington RRU

Although leadership at all units was very good, at RRU Honington we identified additional elements that we judged to be outstanding:

- Staff contributed to the development of the mission statement for the unit.
- Governance and risk management was embedded throughout the unit, all staff knew what was on the risk register, what the governance arrangements were and actively contributed to the management of risk, at all levels.
- The culture was that of one team driven to deliver the best care, in line with evidence-based practice and with patients at the heart of everything they did.

Community mental health services

The departments of community mental health (DCMH) aim to provide occupational mental health assessment, advice and treatment. Their aims are balanced between the needs of the service and the needs of the individual, to promote the wellbeing and recovery of the individual in all respects of their occupational role and to maintain the fighting effectiveness of the Armed Services. They operate during office hours: out of normal hours, the teams participate 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 independent service provider contract between Defence Medical Services and NHS providers.

CQC's inspection team used a bespoke inspection framework using the skills of inspectors with a mental health background. The inspection team was supported by a specialist advisor in military mental health nursing. During inspections, we spoke with patients to understand the quality of care from the perspective of people who use the service. We also spoke with staff and observed how staff were caring for patients.

In October 2017, CQC began a programme of inspection of DCMHs and was commissioned to undertake four inspections a year. During this second year of inspection activity, we carried out four inspections of services as agreed. In Year 2, we inspected DCMH Digby and its satellite mental health team at RAF Marham, and DCMH Colchester. We also re-inspected DCMH Scotland (Faslane and Kinloss), and DCMH Brize Norton and the mental health team at its satellite service at MOD St Athan (this service was not operational at CQC's initial inspection at Brize Norton in 2017).

It is early days for the programme and we have not yet carried out the level of work needed to establish a clear baseline of quality. However, to date we found all services visited to be caring and they provided effective care and treatment. Where we have found problems, they related to the team's approach to safety, the responsiveness of care and treatment and how well the service is led and managed. Where we have re-inspected services, there has been improvement and previously identified concerns were being addressed.

Figure 6: Ratings by key question and overall for first inspections of community mental health services during 2018/19

	Safe	Effective	Caring	Responsive	Well-led	Overall
Digby & Marham	Good	Good	Good	Good	Requires improvement	Good
Colchester	Good	Outstanding	Outstanding	Good	Outstanding	Outstanding

Safe

Safe community mental health services ensure that people are protected by a strong comprehensive safety system, with a focus on openness, transparency and learning when things go wrong.

We found that the infrastructure at some bases was poor and presented risks to patients. However, all services visited had a clinically-based risk assessment of the environment to consider relevant risk factors. At Marham, we had concerns that the building was not secure due to an unstaffed reception and the requirement to leave a fire exit unsecured. However, the team at Marham moved to a different facility to manage this risk after our inspection. In Scotland, there were plans to ensure safer and more accessible premises for the teams at Faslane and Kinloss.

Recruitment remained challenging across services, however, staffing levels were sufficient. Gaps in staffing were covered by locum staff, who received induction and mandatory training in line with permanent staff.

The teams used the standardised ASER system to report significant events, incidents and near misses. Staff received training at induction in the processes to report significant events and were aware of their role in reporting and managing incidents. The incidents that were reviewed had been recorded as serious events and investigated appropriately. Significant events were discussed at monthly governance or business meetings at all services. Learning and recommendations were noted from these meetings.

All teams that we visited received child protection training. Adult safeguarding training is not yet mandatory in DMS since the policy does not yet reflect the latest legislative guidance. Some teams had delivered bespoke adult safeguarding training and developed information to support the team's awareness. Generally, staff demonstrated an understanding of what constituted a safeguarding matter, but some staff had limited awareness of their personal adult safeguarding responsibilities.

At all services, the mental health team clinically triaged routine referrals to determine whether a more urgent response was required or to monitor whether patients' risks had increased. Once patients were using a service, individual patient risk assessments were thorough and proportionate to risks. Teams had developed processes to share concerns about known patients in crisis, or whose risks had increased.

Safe: Examples of good practice at a DCMH service rated as good

DCMH Digby and Marham June 2018

- At Digby, the team had recently moved to a refurbished standalone facility. This was spacious with enough space for waiting, treatment rooms and offices. The move had a positive impact on patient experience. Environmental risk assessments were in place and environmental concerns were being addressed.
- All referrals were clinically triaged by the mental health team to determine whether a more urgent response was required and taken to the weekly multidisciplinary team meeting to ensure an appropriate response. 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. This included risks due to safeguarding concerns.
- Reported incidents had been appropriately investigated and used to inform practice. The team's social workers acted as the designated safeguarding lead at the respective bases. Most staff had undertaken Level 3 child protection training. One of the social workers in the team had delivered a session for staff on adult safeguarding awareness. The team had also developed a clear local procedure for reporting adult safeguarding concerns. Staff demonstrated their understanding of safeguarding during the inspection.

Effective

Effective community mental health services ensure that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

All the services inspected during the programme were offering effective care.

In practice, treatment plans were agreed with patients, who were generally asked for their consent. Some services had started to develop care and treatment plans although this was not always clearly documented in all services.

In all services, clinicians were aware of current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. In some services staff had made specific reference to evidence-based decisions within treatment records.

Patients could access a wide range of psychological therapies as recommended in NICE guidelines, although there were delays at some services.

Teams used a range of outcome measures during and following treatment. Outcomes were reviewed throughout the treatment process and collated and audited to provide an overview of service effectiveness.

Teams consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. These included psychiatrists, nurses, psychologists and social workers. All teams included skilled and experienced staff who worked in partnership with other agencies to manage and assess patient needs and risks. Staff had access to appropriate supervision, case management and appraisal, and could access developmental training.

As occupational mental health services, the role of DCMHs was to assist patients to retain their occupational status or to support them as they leave the armed services. Patients could also use the DCMH during the first six months following discharge from the military. All teams worked closely with Military Welfare Services, the NHS Veterans Mental Health Transition, Intervention & Liaison Service (TILS), the NHS and a wide range of third sector organisations to ensure effective support with employment, housing and wider welfare. Teams provided several positive examples where partnerships had jointly helped patients to remain in the military.

Although the services did not have access to formal training in the Mental Capacity Act or mental health legislation, some teams had developed their own bespoke training and information. Most staff understood the principles of the Mental Capacity Act. Colchester and Brize Norton had adopted consent to treatment processes, and these were developing in Scotland, recognising the different mental health legislation in Scotland.

Effective: Examples of good practice in a DCMH service rated as outstanding

DCMH Colchester October 2018

- All newly-admitted patients had a formal care plan. Care plans were holistic and person-centred. The whole team reviewed care and treatment plans regularly in weekly multidisciplinary team meetings, and all staff present were effectively engaged in the decision making.
- Patients could access a wide range of psychological therapies as recommended in NICE guidelines. The team also offered a range of therapeutic groups to provide more timely access to patients who required lower level and more practical intervention.

- The team used a range of outcome measures during and following treatment. They reviewed outcomes throughout the treatment process and collated and audited them to provide an overview of service effectiveness. These indicated improved outcomes following treatment.
- They also carried out a wide range of audits. The deputy team manager carried out monthly caseload management reviews of all patient records and the clinical lead also audited clinical involvement every month.
- The team worked effectively in partnership with other agencies, both inside and outside the military, to manage and assess patient needs and risks. A peripatetic service was offered to all the medical facilities within the catchment area, which included bespoke treatment sessions, and advice and training for primary health care staff. The team participated in unit health committees, which was a collaborative base-wide approach to managing risks and agreeing support to service personnel who were struggling to cope with military life. This was a highly supportive approach that enhanced the mental health treatment available. The team also provided in-reach services to patients at the Military Corrective Training Centre (MCTC) in Colchester. Healthcare and welfare staff at this facility spoke of very positive relationships with the DCMH staff.
- Staff had received bespoke training in the Mental Capacity Act and were all aware of the principles of the Act and the need to assess capacity and ensure appropriate consent. Patients told us that the need for consent to treatment was explained clearly, and a consent to treatment form had recently been introduced

Caring

Caring community mental health services ensure that people are supported, treated with dignity and respect, and are involved as partners in their care.

All the services inspected during the programme were offering good or outstanding care.

Staff showed us that they wanted to provide high-quality care. 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. Patient satisfaction was also demonstrated by positive patient experience survey results and the feedback we received.

Patients told us that staff provided clear information to help with making treatment choices. The care records reviewed demonstrated that patients were involved in planning their care.

Caring: Examples of good practice in a DCMH service rated as outstanding

DCMH Colchester October 2018

- We received several extremely positive comments from patients about the treatment and courtesy that they had received from both clinical and administrative staff. Patients said they were well-supported and that staff were kind and enabled them to get better. More than one patient described the service as life changing.
- We observed some very positive examples of staff providing practical and emotional support. The department manager told us that the team went the extra mile to support patients as this was 'the right moral thing to do'. This included active involvement in unit health committees that considered the wider support needs of people who were struggling to cope with military life.
- Staff worked with patients to reduce their anxiety and behavioural disturbance. One patient told us that his nurse had met him outside the building and walked in the grounds with him to alleviate his anxiety about attending the appointments.
- 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. This is above the standards laid down by the service across the country.

Responsive

Responsive community mental health services ensure that services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.

There were clear referral pathways at all teams. Referrals were received from medical officers, GPs and other DCMHs, and 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 at all services to review all new referrals by the following day. In all services, the nurse clinically triaged routine referrals to determine whether a more urgent response was required. All new cases were also taken to multidisciplinary team meetings to ensure an appropriate response.

Information provided during inspections showed that teams were not always meeting their targets for routine referrals. However, in most cases, this information related to recording errors rather than practice. All teams were meeting targets for urgent response.

Most DCMHs had waiting lists for treatment following assessment, particularly for psychiatric appointments or high intensity treatment. Some services had addressed waiting lists by developing therapeutic groups and by using the

psychiatrist's time in different ways. For example, Brize Norton had introduced collaborative clinics providing joint clinic appointments involving both a nurse and psychiatrist. At Digby, the psychiatrists also implemented a notes review system to add additional clinical oversight. In addition, the psychiatrists scheduled weekly slots in their diaries to respond to emergency appointments.

At all times, the teams responded promptly where a known patient in crisis contacted them during office hours.

Not all DCMH bases were accessible to people with a disability. However, most services had made arrangements to treat people at alternative accessible facilities. Some patients told us that this was not ideal due to their lack of confidentiality.

Generally, there were sufficient treatment rooms, although this was not the case at Colchester where the team worked hard to make best use of the space available to them. Not all services had adequately soundproofed rooms to ensure privacy during treatments.

Most teams could offer flexible appointment times during office hours and the travelling time for patients to get to appointments was within an acceptable time allowance (generally less than one and a half hours). Where this was not possible, teams usually offered peripatetic clinics at other locations to provide easier access.

All teams had systems for handling complaints and concerns. Most patients we spoke with during inspections knew how to complain and felt that they would be listened to if they needed to complain. Learning was captured from complaints and usually shared with staff at team and governance meetings.

Responsive: Examples of good practice in a DCMH service rated as good

DCMH Colchester October 2018

- There were clear referral pathways and the team was meeting the response target for urgent and routine referrals, with no waiting lists for treatment. Where a known patient contacted the team in crisis during office hours the team responded positively. This included rapid access to a psychiatrist.
- Travelling to appointments was within an acceptable time, at generally less than one and half hours. Most patients felt their appointment was at a convenient location and at a convenient time.
- The team had a procedure to follow up patients who failed to attend their appointment (FTA process). The FTA rate was 4%, which was below the DMS target. The team was auditing this and had recently improved the text appointment reminder system to support better attendance.
- Learning was captured from complaints. Following a recent verbal complaint, the practice manager had proactively spoken with the patient and had engaged them in developing the service.

Well-led

Well-led community mental health services have strong leadership, management and governance, to ensure the delivery of high-quality and person-centred care, to support learning and innovation, and to promote an open and fair culture.

At all services, staff wanted to do a good job and were positive and clear about their own role in delivering the vision and values of the service.

We found a mixed picture of leadership and differing levels of morale. At some services staff reported that their management team was approachable and supportive of their work; staff morale was good and they were engaged, enthusiastic and proud to work at the service. However, at both Faslane and Digby, staff reported that they had not always been clear on who was in charge and they were aware of differences of opinion within the management team. Managers told us that they were working hard to improve the culture. Staff told us that morale had been poor but was improving steadily.

Management systems and governance structures were in place, but in some services further work was required to embed governance and learning. The role of the practice manager varied between services. At some, the practice manager role was well-developed and was pivotal in supporting effective governance. At others, the role required further development to ensure that systems were effective. We found that a number of known issues such as the environment and critical human resources issues remained unresolved at some services. At all services we found that there was inaccurate recording of performance in relation to managing referrals.

Not all risks that we found on inspections had been captured within the risk and issues logs or reflected within the common assurance framework. For example, at Marham, we were concerned that the lack of a decision about the long-term future of the mental health base had not been captured within the team's risk register.

Well-led: Examples of good practice in a DCMH service rated as outstanding

DCMH Colchester October 2018

- There was clear and accountable leadership at DCMH Colchester. All staff reported good morale and locums, administration and cleaning staff supported this view and felt an integral part of the team. Staff felt supported by their colleagues and that the management team were approachable and highly supportive of their work. All staff were clear about 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 and ensure continuous learning. Effective systems and processes had been set up 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 and safeguarding. The management team had access to detailed information about performance against targets and outcomes.
- 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. The team actively engaged with stakeholders to gather feedback about the service and make necessary improvements.
- There was a range of audit and quality improvement projects. For example, the practice manager had gathered feedback from patients and wider stakeholders. While this found a high level of satisfaction overall, a number of actions were implemented including providing additional guidance and support to primary medical staff at the Military Corrective Training Centre on mental health and wellbeing, improvements to information in the waiting area and the development of patient forums. Staff were positive about the improvements and felt this was making a positive difference to the quality of care offered to patients.

Re-inspections of DCMH facilities

Where a DCMH is rated as inadequate following an initial inspection, we usually carry out a follow-up inspection of the service within six months of publishing the inspection report. Where a DCMH is rated as requires improvement following an initial inspection, we usually re-inspect the service within 12 months of publication. To date, we have re-inspected DCMH Scotland and DCMH Brize Norton.

Figure 7: Ratings by key question and overall for re-inspections of community mental health services

		Safe	Effective	Caring	Responsive	Well-led	Overall
Brize Norton	1st	**Requires improvement**	**Good**	**Good**	**Requires improvement**	**Requires improvement**	**Requires improvement**
	2nd	Final ratings pending	Final ratings pending	Final ratings pending	Final ratings pending	Final ratings pending	Final ratings pending
Faslane & Kinloss	1st	**Requires improvement**	**Good**	**Good**	**Inadequate**	**Inadequate**	**Inadequate**
	2nd	**Good**	**Good**	**Good**	**Requires improvement**	**Requires improvement**	**Requires improvement**

In Year 1, we carried out an announced comprehensive inspection of DCMH Scotland in March 2018. The DCMH was rated as inadequate overall, with a rating of inadequate for the key questions of responsive and well-led, and rated as requires improvement for the safe key question.

We carried out an announced follow-up inspection in October 2018. At this inspection we found improvement in a number of areas:

- Overall staffing arrangements had improved and were sufficient to meet targets for assessment following routine and urgent referrals.
- The mental health team at Kinloss had addressed concerns about the environment. Works had been requested and approved to secure these areas.
- The overall compliance rate for mandatory training was 85% and all clinical courses had been completed.
- Patients who did not attend appointments were being followed up appropriately.
- The team had also begun to offer peripatetic clinics at a number of locations to provide easier access to some patients.
- Management and leadership had improved and was starting to have a positive impact on the service. Morale and team relationships had improved. The management team had begun to form and had established clearer roles and responsibilities.

Although improvements had started in other areas, further work was required to fully address these issues:

- More work was needed to address waiting lists, particularly for high intensity treatment.
- The FTA rate remained high at 10% in September 2018.
- The location at Faslane made access difficult and stressful for both patients and staff. Business cases had been developed to address concerns about the configuration and infrastructure of the service, but further strategic action was required to ensure a long-term solution.
- Systems and processes had been improved to better capture governance and performance information, but these were not yet embedded in the governance process or had brought about all required change.

Following this inspection, DCMH Scotland was re-rated as requires improvement overall.

Conclusion

At the end of the second year of our inspections, we can conclude that the quality of care remains mixed across the different services provided by DMS. Given the relatively small number of inspections carried out so far, we remain cautious about drawing firm conclusions, as a baseline of quality has yet to be established.

Our inspections have found a number of internal factors that contribute to high-quality care, and factors that may inhibit it. The DMS provides caring services that are generally highly responsive. Military personnel and entitled dependants receive timely access to almost all services and most experience a very short wait to see a GP or a physiotherapist. However, we recognise the need for clearer lines of accountability around regional workforce management, improved processes for addressing poor infrastructure, along with broader sharing of best practice and innovation across all service types.

In Year 2, CQC has re-inspected a number of services where we made recommendations on the first inspection. These have shown that the direction of travel across all service types is generally positive, demonstrating some organisational learning and improved quality. However, we note that there are pockets of poor practice where improvements have not been delivered, and, in some cases, where quality of care has deteriorated.

Most dental and medical centres provide good care although there are still some examples of continuing poor quality or deterioration. CQC has made recommendations so that care can improve for the benefit of patients and the profession. Our inspections of DCMH facilities indicate that mental health units are starting to learn from one another and sharing effective ways of working, and that RRUs are providing safe, effective and responsive care. DMSR has taken enforcement action where CQC has escalated concerns.

We will continue to work with and support the DMS so that all military personnel and their dependants receive good, high-quality care. We will continue to inspect military healthcare services to extend our view of quality and to provide a baseline. We will also continue to follow up the recommendations we have made.

Response from Head Defence Medical Services Regulator

CQC's Year 2 report on Defence Primary Healthcare (DPHC) demonstrates the value that an independent inspection programme delivers when seeking to highlight areas of both good practice and concern. Where CQC has escalated issues concerning DPHC, the DMSR has taken appropriate action, including regulation or enforcement notices, to ensure that Defence responds accordingly. Where regulatory action has been required, the DPHC staff have invariably shown a clear commitment to learn, which in the majority of cases has then delivered tangible improvements. A wider Defence response will however now be required if DPHC are to deliver CQC's recommendations with regard to poor medical infrastructure and the enduring workforce challenges. Moving forward, the challenge will remain embedding and sustaining recent improvements.

Response from Director Healthcare, Joint Medical Group

I welcome the Care Quality Commission's second annual report into Defence Primary Healthcare and thank them for the hard work of their inspectors and the Specialist Advisors from the DMS who provide valuable military medical context. The programme is now almost half way through and it delivers the external assurance that we have lacked for years and it must continue. Importantly it also provides impetus for change and the lessons are becoming clearer.

It is pleasing to see such good evidence that Defence Healthcare is learning and improving. Last year, CQC reported that 48% of medical centres were rated as 'good' or 'outstanding' at their initial inspection. This year, 58% of medical centres were rated 'good' or 'outstanding' at initial inspection. At re-inspection, 81% have demonstrated clear improvement. The report demonstrates the very high standards of care provided by our Dental Centres and Regional Rehabilitation Units and that the care provided by our Departments of Community Mental Health has improved. It is also worth noting that as an occupationally focussed service, support to the employer is an integral component of what we do but is not currently assessed. Over the same period, Defence Primary Healthcare's performance, measured by its Key Performance Indicators, has shown significant improvement.

Of course, we cannot and must not be complacent. We are still not where we need to be and must do better in sharing the best practice that our ‘good’ and ‘outstanding’ practices demonstrate every day and we need to better support practices in those areas of concern where they cannot fix matters for themselves. I acknowledge that CQC’s concerns continue to centre around the Ministry of Defence’s approach to its medical infrastructure and its medical workforce. I also note that CQC has highlighted new concerns around the quality of care provided by our very small practices.

There is already a significant amount of work being undertaken to improve the service and we have instituted a transformative change programme to look, not just at how we might fix the issues identified by CQC, but to fundamentally change how we deliver care. This will see patients’ position at the centre of their own care strengthened, consolidation into larger bases, the introduction of digital services and better management of information along with better use of our workforce and real-time management of capacity and demand. The Defence Healthcare Delivery Optimisation programme is already investigating and piloting changes and the new operating model will be implemented from 2020. The real prize, and challenge, comes with delivering the step change that addresses the underlying issues whilst not missing the opportunity to make improvements where we can today.

Appendix: Overall inspection outcomes 2018/19

Medical centres: overall ratings

Year 2 First inspections	
Service	**Overall**
Benson	Good
Bicester	Good
Birmingham	Good
Blandford	Good
Brecon	Requires improvement
Bulford	Inadequate
Colchester	Inadequate
Collingwood	Inadequate
Condor	Good
Cranwell	Outstanding
Culdrose	Requires improvement
Dartmouth Medical Centre	Good
Deepcut	Inadequate
Dishforth	Good
High Wycombe	Requires improvement
Honington	Requires improvement
Leeming	Good
Lichfield	Outstanding
Linton on Ouse	Good
Lympstone	Good
Northolt	Good
Odiham	Requires improvement
South (Scotland) Group Practice	Good
St Mawgan	Good
Waddington	Requires improvement

Follow-up inspections	
Service	**Overall**
Boulmer	Inadequate
Bovington	Good
Brawdy	Requires improvement
Fort George	Good
High Wycombe	Requires improvement
Northwood HQ	Good
Sandhurst	Good
Shorncliffe	Good
Shrivenham	Good
St Athan	Good
Woolwich	Inadequate

Dental services: overall outcomes

Year 2 first inspections	
Service	**Overall**
Bulford	**Standards met**
Harrogate	**Standards not met**
Chester	**Standards met**

Follow-up inspections	
Service	**Overall**
Drake	**Standards not met**
Leeming	**Standards not met**
Tidworth	**Standards met**
Catterick	**Standards not met**
Catterick (3rd inspection)	**Standards met**

Regional rehabilitation units: overall ratings/outcomes

Year 2 first inspections	
Service	**Overall**
Catterick	**Good**
Honington	**Good**
St Athan	**Good**
Edinburgh	**Standards met**

Community mental health services: overall ratings

Year 2 first inspections	
Service	**Overall**
Digby & Marham	**Good**
Colchester	**Outstanding**

Follow-up inspections	
Service	**Overall**
Scotland	**Requires improvement**

Glossary of terms

ASER	Automated Significant Event Reporting
CQC	Care Quality Commission
CAF	Common Assurance Framework
CAS	Central Alert System
DAC	Defence Audit Committee
DCMH	Department of Community Mental Health
DMICP	Defence Medical Information Capability Programme
DMS	Defence Medical Services
DMSR	Defence Medical Services Regulator
DPHC	Defence Primary Healthcare
ECG	Electrocardiogram
FTA	Failure to attend
GP	General Practitioner
HIV	Human immunodeficiency virus
HGAV	Healthcare Governance Assurance Visit
IAC	Injury Assessment Clinic
IT	Information technology
JFC	Joint Force Command
MCTC	Military Corrective Training Centre
MHRA	Medicines and Healthcare products Regulatory Agency
MIAC	Multi-disciplinary Injury Assessment Clinic
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
PCRF	Primary Care Rehabilitation Facility
QOF	Quality and Outcomes Framework
RMO	Regimental Medical Officer
RRU	Regional Rehabilitation Unit
SG	Surgeon General
SMO	Senior Medical Officer
SQEP	Suitable, Qualified and Experienced Personnel
TILS	Transition, Intervention and Liaison Service

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