CQC's inspection programme of

Defence Medical Services

Annual report for Year 3 (2019/20)

July 2020

Contents

Foreword from the Chief Inspector

I am pleased to present CQC's annual report of the quality of care in Defence Medical Services (DMS) for 2019/20. This report sets out the findings from inspections in Year 3 of this programme.

Armed forces personnel and their families deserve high-quality, accessible care as much as the rest of society. The Surgeon General therefore invited CQC to inspect health care and medical operational capabilities, which started with a programme of inspections in 2017/18. The Director General (DMS) came into post in summer 2019 and supports the continued CQC inspection programme of defence medical facilities.

The aim of our inspections is to highlight both notable practice and problems that we find, and to make sure that military health services address issues for the benefit of both patients and the staff working in them. Where we found concerns in the first two years of this programme we have carried out follow-up visits to ensure that the necessary improvements have been delivered. We found that almost all 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 specific characteristics at the heart of high-quality military healthcare services:

- mature external and internal relationships with key stakeholders, such as welfare teams, local NHS emergency departments, health visitors, rehabilitation services, and mental health services
- flexible use of regional staffing resource to ensure that priority areas are always adequately staffed
- failsafe systems to underpin safe and effective care, and comprehensive training so that staff know how to use them
- proactive engagement with patients, staff and military command to identify and meet the operational needs of the Force as well as the health and wellbeing needs of patients and their dependents
- shared learning across practice teams and the wider health and military communities
- strong, inclusive leadership teams that communicate consistently and encourage improvement and innovation across military, civilian, and regimental staff groups.

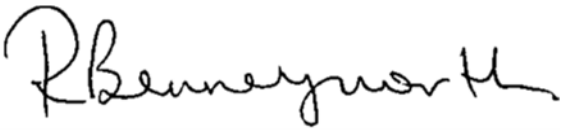
Any poor care that we identified in Year 3 was mainly on our first inspections of medical and dental centres; those centres that we have re-inspected have almost all improved. Encouragingly, almost all concerns raised in Year 1 around infrastructure of buildings have now been addressed in both dental and medical centres. The quality of care provided in regional rehabilitation units and in departments of defence community mental health facilities inspected in Year 3 was generally good.

In Year 3, we also inspected seven overseas medical facilities and published our findings as usual. However, we did not apply ratings to these services as these were pilot inspections to develop future methods.

This year we have worked with DMSR to enhance the learning and development for DMS specialist advisors, who we rely on to provide specialist and professional insight and judgement. This ongoing training programme is intended to build local capability and knowledge transfer.

I am pleased that the Director General and his team continue to recognise the value of CQC's inspections and the resulting improvements to care. 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 Director General DMS, Defence Medical Services Regulator, and CQC all 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 Director 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 Director 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 health care and medical operational capability, providing independent advice on patient safety, and evidence-based assurance, through regulation, where appropriate.

Defence Primary Healthcare (DPHC)

The purpose of DPHC is to provide and commission safe and effective health care that 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, 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.

The Director General came into post in summer 2019 and shares the same commitment to the CQC inspection programme as the former Surgeon General.

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 only. However, the service level agreement between CQC, the Director General 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 3

In 2019/20, CQC carried out **55** first comprehensive inspections comprising:

- **30** medical centres (including primary care rehabilitation facilities (PCRFs))
- **16** dental centres
- **4** regional rehabilitation units (RRUs)
- **5** military departments of community mental health (DCMH).

In Year 3, we also commenced overseas inspections and visited seven medical facilities in Cyprus. At the request of DMSR, we adopted a pilot approach in order to gain an initial view of the background of delivering health care in three medical centres, three dental centres and one military department of community mental health on a Sovereign Base. We have reported and published our findings in the usual way but not rated these services.

In this third year, we also carried out 28 follow-up inspections to ensure that services have resolved the concerns found on initial inspections. We re-inspected:

- **25** medical centres (including PCRFs)
- **2** dental centres
- **1** military DCMH.

Following our first three years of inspection work, 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 2019/20. 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 3

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 3, CQC continued the programme of inspections of DMS GP services in medical centres. The focus of our approach continues to be 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 2019/20, the DMSR was responsible for identifying which medical facilities should be inspected, and CQC was asked to inspect some services where there was a known risk as well as facilities where there were no known risks. DMSR identified several services that were geographically co-located, to maximise inspection efficiency. DMSR also requested that CQC inspect three overseas medical centres adopting a pilot approach, which were not given a rating.

It is important to remember that, although we have completed Year 3 of this inspection programme, we have only inspected a total of 89 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 seven 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 several ways, for example:

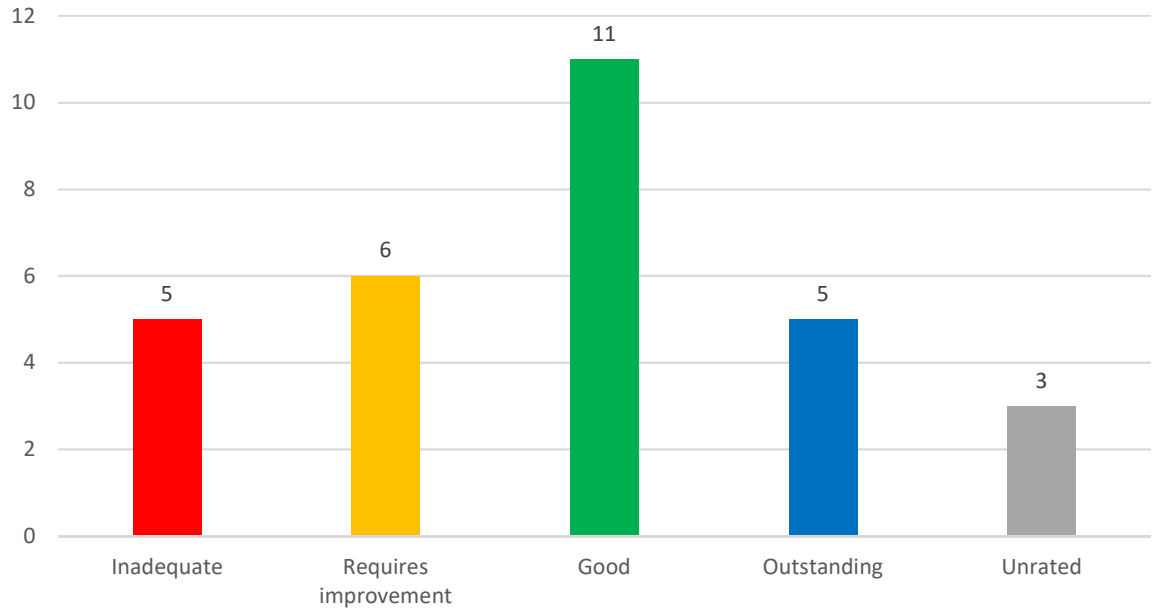
- DMS practice populations are much smaller than NHS practice
- providing services for families is far less common
- there is a greater focus on delivering occupational health throughout the DMS.

The epidemiology is also different for military medical centres, where staff see significantly higher numbers of patients with musculoskeletal injuries and fewer patients with chronic conditions.

Summary of findings

Figure 1 shows the overall ratings for first comprehensive inspections of medical centres in Year 3, which we determine by aggregating ratings for the five key questions.

Figure 1 : Overall ratings for medical centres in Year 3



- 5 were rated overall as inadequate
- 6 were rated overall as requires improvement
- 11 were rated overall as good
- 5 were rated overall as outstanding
- 3 overseas medical centres were not rated as these were pilot inspections.

We have carried out follow-up inspections in Years 2 and 3 to give assurance that our 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.

Ratings by key question for medical centres

As in Years 1 and 2, we found the majority of medical centres to be caring and responsive. Any problems 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. However, we draw attention to the fact that six medical centres inspected for the first time in Year 3 were rated as outstanding for the well-led key question. This demonstrates that, in some areas, leaders are learning from the systems and approaches of others in order to deliver care that exceeds the baseline standards. Figure 2 shows ratings for medical centres in Year 3 for each key question.

Figure 2: Ratings for medical centres by key question in Year 3

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 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.

In Year 3, 44% of medical centres inspected for the first time were rated as good or outstanding for the safe key question. However, as in Years 1 and 2, overall performance for safety is the poorest of all the five key questions, as 56% of medical centres inspected for the first time were rated as either inadequate or requires improvement. Many of the issues that we found in Years 1 and 2 of this inspection programme have continued to be raised throughout Year 3. As we reported at the end of Year 2, this continues to call into question the capacity of Defence Medical Services to acknowledge and implement organisational learning relating to safe care and treatment. There also continues to be a clear link between a lower rating for leadership (well-led) and a lower rating for safety.

SAFE: What contributes to a good rating?

Where we rated medical centres as good for the safe key question, we found a number of contributory factors:

- A local baseline assessment of safe staffing levels and skills mix had been undertaken and consideration given to ensuring staffing resilience through a balance of military and civilian expertise.
- Staff were trained (to the appropriate level for their role) to understand their accountabilities around safeguarding vulnerable adults and children. They 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 could demonstrate that they had failsafe systems to manage and recall patients with long-term conditions and patients taking high-risk medicines.
- 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.
- There was a failsafe and documented approach to managing test results. Staff audited referral letters to ensure that they included the necessary information and sent them to the right person or department.

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

Windsor Combermere Medical Centre (April 2019)

- This practice had effective and well-managed systems to maintain an accurate and up-to-date register of patients subject to safeguarding arrangements, and patients assessed to be 'at risk'. Read codes were used appropriately within the electronic patient record system to identify patients who were vulnerable, including patients with low mood or who were subject to formal safeguarding arrangements. A weekly search of the electronic patient record system (DMICP) informed the register of vulnerable patients.
- Appointments were prioritised for vulnerable patients, including those aged under 18.
- Risks to patients were proactively minimised by providing and/or sourcing appropriate support from external stakeholders. For example, the SMO met with the Multi Agency Safeguarding Hub (MASH) if there were concerns about a patient or their family.
- Staff reported incidents effectively and changes were made as a result of significant events. In one example, when a new patient registered at the medical centre it became clear that the previous unit had not discussed their cancer diagnosis and care with them. This was raised as an ASER and shared with the clinicians at the previous practice so that it could make improvements to the handover processes.

Areas for improvement in safety

In Year 3, although we recognised some improvements where we had concerns from the previous two years, we highlighted some common areas for improvement across medical centres.

Safe levels of staffing

Defence Medical Services have yet to undertake a comprehensive baseline assessment of the staffing establishment and skills mix that is necessary to deliver safe care within each of its care services. This is because it is outside the remit of the individual medical centre to decide the baseline requirement for its staffing.

Medical centres told us that they are unable to easily influence and change the historical staffing establishments already in place. Coupled with staffing gaps due to deployment or posts that have not been filled, some medical centres find themselves without the baseline resource to deliver a consistent service that meets the occupational and healthcare needs of its patients. Specialist staff are not always being placed optimally to address the needs of patient populations. DPHC is staffed primarily by civilian healthcare staff whose terms and conditions of service do not allow easy redeployment to areas of high need. Access to training is sometimes a barrier to ensuring that the skills mix across medical centres is appropriate at all times.

We saw examples of this issue in different medical centres:

- At one medical centre, staff spoke of challenges in achieving the required staffing levels and skill mix to meet the needs of the centre's patients. There was a mix of military and civilian staff, but the high levels of deployment among the military staff often left the centre with significant staff shortages, which affected patient care. As an example, a nurse had been unable to carry out health checks because of time constraints.
- Low staffing levels at another medical centre were a potential risk to patients as there was limited capacity for clinical leadership. The civilian medical practitioner (CMP) had recently come into post without previous military experience and was also acting as the senior medical officer (SMO), with the post previously filled by locum staff. The CMP and practice manager had lead roles relating to healthcare governance, but training and support had been lacking. We identified a key gap in nursing provision, which had resulted in weekly clinics being cancelled.
- Clinical staffing levels were a potential risk at another medical centre. There was weak resilience in the system as it relied on one permanent military doctor (the SMO), one physiotherapist, and one practice nurse. There was also a fluctuating registered patient population as service personnel who were not registered at the practice had not been taken into account, including reservists, and a fluctuating 'sick at home' population from units around the country. These extra patients generated a higher workload for staff.

- The practice nurse had been absent from another medical centre for an undefined period. The regional nurse was providing some clinical support while the regional team sourced alternative nursing input, including the option of a locum nurse. With no nurse, and the GP provision of only 10.5 hours a week, clinical availability was limited. Although this had been added to the risk register, there was no long-term solution for the centre.

Information systems

In Year 3, some practices continued to alert us to failures in IT networks and power. In some cases, these 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 patients with urgent needs and delayed seeing patients at routine appointments until access to patient records was restored. There are clear risks around delaying appointments and seeing patients with no access to their records.

We inspected the three medical centres in Cyprus in September 2019 and noted challenges around timely access to accurate patient records. Cypriot medical centres have access to DMICP Hybrid, which is a system with reduced functionality and some outage periods. We identified a need for Defence Digital to review the functionality of DMICP Hybrid in partnership with Cyprus medical centres and deliver solutions to improve access to up-to-date records. This work is likely to extend to all overseas medical facilities.

Managing high-risk medicines

We are seeing generally positive work around managing high-risk medicines. There were fewer findings of medical centres with unsafe systems to manage patients prescribed high-risk medicines, or with no shared care protocols. Nevertheless, we continued to find that some patients had not received the monitoring required to maintain their health and wellbeing. Funding for the ‘Dispensing for Doctors’ training, which previously informed prescribers about these areas of prescribing, was withdrawn for the DMS in Year 2, and in Year 3 this was still the case.

We reviewed records of patients taking high-risk medicines. One patient at a medical centre had not received a key test for over 12 months. Although there were shared care agreements for most patients on high-risk medicines, the Read codes were not accurate on the electronic patient notes.

At another medical centre, although there was a register of patients prescribed high-risk medicines, it was not accurate. We noted that a patient who was prescribed a medicine for a gastric disorder was not on the register, and there was no indication from the clinical records how often they should have their blood tested while taking this medicine. We noted another patient on the register did not have a shared care agreement in place.

Central Alerting System

In Years 1 and 2 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 3, all the medical centres inspected had a system to manage CAS. However, we identified gaps in the management of patient safety alerts at some centres. At one medical centre the system for receiving and acting on safety alerts needed to improve. The centre documented alerts on a register, which were cascaded by email and discussed at practice meetings. However, the discussion was not clearly documented, meaning those unable to attend could miss important information. The register also did not include a recent CAS alert issued in August 2019 warning of increased risk of breast cancer with hormone replacement therapy. Other medical centres had missed recent MHRA alerts and so not actioned them, and some staff told us that although alerts had been actioned there was no evidence of this in the patient record.

Infrastructure

Practices are unable to address environmental concerns themselves and they 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 improvements to infrastructure.

Improvements to infrastructure take time, as shown in the following example.

In October 2017, an inspection of a medical centre identified well-documented concerns with the building and its fittings. Statements of need (requests for improvement) were submitted to Regional Headquarters (RHQ) as the building, a 1946 guardroom, was not suitable to function as a medical centre. This was outlined as an area of risk in the June 2017 biannual assurance report, with risks including damp, insufficient space, poor ergonomics, lack of sound-proofing and a history of vermin infestations. Our review of the premises and equipment supported these concerns.

When we returned to re-inspect the medical centre in August 2018, an alternative building had been identified and funding worked out for the refurbishment project. However, because of the many competing priorities for funding, the project had not progressed beyond the build design stage. The Defence Academy, Surgeon General, Defence Primary Health Care and Joint Funding Committee representatives met to discuss funding options and agreed to re-profile the infrastructure priorities for 2018/19 to establish whether funding could be found.

When we returned to re-inspect the medical centre in August 2019, staff confirmed that refurbishment of an existing building on site to relocate the medical and dental centre had been reinstated and was well underway. The practice manager confirmed funding had been allocated and released. We will continue to monitor progress of this project until adequate infrastructure has been provided.

Many medical centres are not purpose-built to deliver primary care, as described in the following example.

> The ageing infrastructure included fixtures and fittings that were not fully compliant with infection prevention and control (IPC) standards. For example: sink taps in some clinical rooms and the cleaning and hazardous products storage cupboard did not comply with guidelines, tiling in the men's toilet was damaged, the roof in the medical centre leaked regularly, there was damp in the waiting area and the heating system was temperamental. The practice manager confirmed that a corridor contaminated with mould had been condemned and medics no longer used it to store their kit.
>
> The primary care rehabilitation facility (PCRF) was too cold to treat patients in winter months and this had been raised as a significant event. The facility received an additional free-standing heater and the room temperature was regularly monitored. Concerns with the building and compliance with IPC standards were identified on the risk register, and although discussions were in progress regarding the future of the building, there were no firm plans to make long-term improvements.

Infection prevention and control

As in Years 1 and 2, we continue to find that some medical centres are not following best practice guidance around infection prevention and control (IPC) and safe disposal of clinical waste, as well as shortcomings in testing medical equipment. These failures to deliver consistently safe care result partly from a failure to have proper processes, formal training, and guidance for staff. In Year 3, we inspected several medical centres whose practice managers and infection control leads were required to be accountable for a number of areas, but gaps in training meant that staff did not always feel confident to undertake a lead role.

A gymnasium at a medical centre gave us concerns about infection control and equipment safety. The gym equipment was not part of DPHC assets as it belonged to the station gym, and the Physical Education Flight on station were responsible for maintaining the facility and equipment. However, safety checks for the equipment in the gym (where patients did exercise rehabilitation work) were overdue, and the service contract had expired. The boiler was not working, which made the gym cold, and standards of cleanliness in the gym were also inadequate. We saw evidence that medical centre staff had escalated this issue on several occasions to station infrastructure personnel. After our inspection, we learned that the gym had been closed to patients while equipment was safety checked and the boiler repaired.

We also inspected a medical centre that had been recently IPC audited, which resulted in a management action plan (MAP). Staff and the regional team identified that the ageing infrastructure, fixtures and fittings were not fully compliant with IPC standards. We found a lack of appropriate handwashing facilities in some clinical rooms, and details of environmental cleaning checks by external contractors were vague, with no mention of deep cleaning.

Managing test results

In Year 3, we continued to identify a number of medical centres whose systems to manage test results were not failsafe.

For example, at one medical centre the register of samples requested had not been checked and completed for seven months before our inspection. We found evidence that samples had not been processed correctly and no significant event was raised.

At another medical centre, we found that the system to manage results was robust when key staff were on site, but an oversight around providing cover when staff were on leave left patients at risk. The practice nurse usually processed and tracked sample testing results every day, but the system was not failsafe when they were absent. The nurse had been on annual leave before we visited, and we saw evidence of 12 unactioned results dating back four weeks.

Safeguarding

In Years 1 and 2, we found that some medical centres were not fulfilling their duties to safeguard vulnerable people, including children. In Year 3, we have issued fewer recommendations in this area with a notable improvement in the way that vulnerable patients are recorded, and alerts applied in the patient record system. However, pockets of poor performance remain. At one medical centre, not all staff were clear on who the safeguarding lead was (there were no terms of reference or job descriptions that related to safeguarding roles) and the referral process in the adult safeguarding policy did not make it clear who to go to for further guidance. Although multidisciplinary team (MDT) meetings were used to discuss vulnerable patients, the minutes did not record any discussion and notes were not added to the patient record. There had been some liaison with the welfare team, but the GPs were yet to attend Unit Health Committee (UHC) meetings and so an opportunity to get feedback on patients identified as vulnerable was being missed.

In another example, Regimental Aid Post (RAP) staff working at a practice had not received safeguarding training and update training at a level appropriate to their role. RAP staff are clinicians who are attached to units rather than employed to work directly at the medical centre. It is important that all staff delivering care within a medical centre have received the appropriate mandated training, regardless of separate line management arrangements.

Staff working in isolation

Where staff teams are small, clinics are run outside normal opening hours and if physiotherapists and exercise rehabilitation instructors work in separate buildings, staff sometimes need to work in isolation. Where this happens, medical centres do not always have the necessary risk assessments to ensure the safety of lone workers.

We saw a medical centre with no emergency alarm in the gym (where the exercise rehabilitation instructor worked with patients). Although there was a phone in the gym, there were no emergency phone numbers on display by the phone. A lone worker risk assessment had been carried out to ensure the safety of the instructor while working in isolation – but this plan was not being followed in practice.

A number of medical centres had a fixed alarm system in the clinical areas of the practice, but regular testing had highlighted that staff may not be able to hear it. In several instances, this issue had been noted but not resolved.

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 is delivered in line with current legislation, standards and evidence-based guidance.

In Year 3, 45% of medical centres inspected for the first time were rated as good for the effective key question and 7% were rated as outstanding; 33% were rated as requires improvement and 15% 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.

EFFECTIVE: What contributes to an outstanding rating?

Where performance was outstanding, we found:

- an understanding of the challenges around Read coding and a commitment to apply codes consistently through ongoing review
- 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
- 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.

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

Innsworth Medical Centre February 2020

- Patients with a mental illness and/or depressive symptoms were managed effectively and safely, often in conjunction with the Department of Community Mental Health (DCMH). The centre used appropriate templates to assess patients and plan their care and the SMO attended quarterly meetings with the regional DCMH centre.
- The patient database was used effectively to monitor injury trends, access to the PCRF, and to share information with unit commanders at Unit Healthcare meetings. This helped units to understand the specific injuries associated with their operational activity and explore ways to minimise them based on specific trends.
- Quality improvement was clearly embedded and seen as the responsibility of all staff. It included clinical audit, with the PCRF integrated in the wider audit programme. There was an identified lead and deputy for audit and an audit programme was established for 2020. All audit activity from 2015 was logged on the health governance workbook, clearly showing that audits were regularly repeated. Audits showed that the medical centre acted on the outcomes to improve the service. For example, a mental health clinical audit reviewing all presentations and referrals was in its third cycle and demonstrated how the medical centre had developed care to support these potentially vulnerable patients closer to home.
- There were good working relationships both internally and with health and social care organisations. For example, the SMO sat on the monthly local safeguarding board meetings and one of the doctors was the lead for networking with the local commissioning care group (CCG). Participation in the safeguarding board resulted in regular email contact with the health worker and social worker. Nurses participated in a CCG-led continuing professional development group, which resulted in the nursing team developing in-house services including cytology and implants. The SMO developed links with school nurses and wrote to 52 local NHS GP practices to establish links and offer support. For example, the centre provided GP practices with information to support military veterans and had worked with an NHS GP to support a military veteran suffering from post-traumatic stress disorder (PTSD).

Improvements required to deliver effective care

In Year 3 we continued to identify concerns at some medical centres that had not improved from Years 1 and 2, including:

- ensuring that all staff had received training relevant to their role
- assessing patients and providing care and treatment in line with national standards and guidance, supported by clear clinical pathways and protocols

- making best use of the DMICP patient records system to facilitate clinical searches, assure recall programmes and monitor performance
- delivering a rolling programme of work to continuously improve patient outcomes
- improving uptake of national screening programmes
- maintaining comprehensive childhood immunisation records.

Using DMICP for effective recall and monitoring

Some medical centres had not been able to set up a consistent and accurate approach to manage and assign a Read code for patients with a long-term condition.

We identified concerns at one medical centre where Read codes were applied inconsistently; this resulted in inaccurate clinical searches to inform recalling patients with a long-term condition. We noted that Read codes for the diagnoses of some patients were incorrect, so they had not been correctly monitored, nor had they received the appropriate medicines review. Where reviews did take place, they did not follow national best practice guidance, as they did not use consistent review templates or adhere to recommended timelines.

At another medical centre we found no structured approach to patient recall and monitoring. We found instances where diabetic patients had been recalled for tests and had received abnormal results, but there had been no subsequent follow-up. The medical centre could not indicate the hypertensive patients who had a record for their blood pressure taken in the past nine months. Less than half of asthmatic patients had been reviewed within the preceding 12 months.

Across a number of medical centres, we identified inconsistencies in the way that patients with a diagnosis of anxiety or low-level depression were Read coded. As a result, these medical centres cannot assure themselves that they are providing comprehensive and consistent follow-up care to these patients.

Staff training

We issued fewer recommendations around staff training in Year 3 than in Years 1 and 2. Nevertheless, we did identify some pockets of poor performance and found some staff who had not received the training that is required to work effectively and safely, as these examples show:

- In the absence of the nurse, a medical centre's practice manager (a combat medical technician by trade) was carrying out clinical tasks such as audiometric assessments and changing dressings without receiving clinical training and competency checks. Although this risk had been identified on the medical centre's risk register, the ongoing risk to both patients and the staff member had not been addressed.

- Three CMTs (combat medical technician) had not been added to a medical centre's staffing database. Although they were added during our inspection, this identified key gaps in mandatory training.
- Opportunities for learning and improvement through peer review were limited at several medical centres. Some staff worked in professional isolation and received only remote support and appraisal.

Better outcomes for patients through clinical improvement

In Year 3 we continued to identify that a number of medical centres had gaps in their clinical improvement work. It was not always clear who was leading improvement work, what objectives had been set and how the medical centre would measure its success in improving outcomes for patients.

For example, at one medical centre we found that quality improvement was in the early stages of development. Although there was some work on clinical audit, when we spoke with staff it was unclear how the practice had decided its approach to this work: no lead staff member had been appointed, and there was no evidence of discussion to ensure that clinical audit was relevant to the practice population to drive ongoing improvement in outcomes.

Another medical centre had no structured programme of quality improvement work; limited clinical data sets had been compiled, but were not part of an audit cycle, and so there was no evidence of improvement.

Mental Capacity Act

Military patients have the same right to consent to care as patients using an NHS service. We have concerns that, following the withdrawal of JSP 950 Leaflet 1-2-2 in 2015, there is no Defence-wide policy on consent to treatment and that the Defence Primary Healthcare guidance, while extant, is significantly overdue for review. This potentially constitutes a risk to safeguarding patients' rights under the Mental Capacity Act (2005).

Caring

A caring medical centre puts its patients at the heart of each service it provides. Confidentiality is particularly significant in military settings as clinicians provide occupational health support to military patients alongside meeting their health and welfare needs. 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 (93%) of the 30 medical centres inspected for the first time in Year 3 provided caring services to their patients, with caring once again being the best performing key question. Building on improvements delivered in Year 2, staff continued to proactively identify and support patients who are carers. For example, providing links with carers' organisations and ensuring that the carer's emotional and healthcare needs are met.

In a few instances we found room for improvement:

- not all staff were aware of the translation service and there was no information available or on display to let staff and patients know about this service
- staff had not been proactive in identifying patients with a caring need
- patient confidentiality and privacy were not adequately protected in PCRF treatment bays where curtains had either not been provided or were not used.

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

Hyde Park Medical Centre November 2019

- The medical centre had a diverse patient population. Feedback was very positive, specifically about the personalised approach to care and clinicians not having a 'one size fits all' approach. Patients spoke about the importance of their records being kept confidential, with details only shared with external stakeholders when absolutely necessary. All patients spoke highly of clinical staff, saying they were approachable and good at listening. One patient said that the approachable and trustworthy approach of the GP had been instrumental in them having the confidence to come forward and discuss a significant and potentially life-threatening condition.
- Three patients who had recently experienced poor mental health specifically wanted to speak with inspectors to give feedback about the high standard of care they had received. They particularly emphasised how the unobtrusive and calm demeanour of the clinicians had encouraged them to come forward and seek advice and support. They spoke about being 'respected' and 'not labelled'. They also felt that their clinical diagnoses would not be divulged without their consent to the Chain of Command, and this played an important role in encouraging them to come forward and speak about their issues.

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. DPHC has yet to undertake a comprehensive system-wide baseline assessment of the needs of its patient population as a tool for

ensuring that services are fully meeting needs. However, some individual medical centres have carried out extensive work to ensure that they understand the needs of their patients.

In Year 3, 15% of medical centres were rated as outstanding for providing a responsive service, 70% were rated as good and 15% rated as requires improvement.

Where we judged care to be good, medical centres understood the needs of their patient population. They had gathered feedback from patients and staff and used this knowledge to ensure that care was convenient and accessible. 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.

Responsive medical centres anticipated the unmet needs of patients and sought to address them, for example, giving information to all patients on how to get advice and support with domestic abuse, concealed pregnancy, fabricated illness, child sexual exploitation and female genital mutilation. Responsive medical centres worked in close partnership with rehabilitation facilities to enable timely access to physiotherapy and exercise rehabilitation. They also worked with a number of internal and external stakeholders to identify and meet the needs of personnel who were being medically discharged, and military veterans who were in the surrounding communities.

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

Hyde Park Medical Centre November 2019

- The practice understood the needs of its population and tailored services in response, for example by aligning the opening hours with the working hours of soldiers on stable duties. Sick parade therefore routinely started at 07:00 on week days and sometimes at 01:00 when the Regiment was preparing for certain duties. The medical centre also opened to provide care to personnel during weekend ceremonial activities. Deploying units were offered bespoke force preparation clinics on request. Medical centre clinicians provided an immediate response on site to injuries caused by the horses (falls/bites/kicks).
- Staff engaged with Chain of Command to find ways to balance the requirements for delivering traditional mounted ceremonial duties, while preventing injuries among military personnel. Examples included the appropriate use of saddles during Guard Exercise and testing the use of air body protectors for mounted personnel.
- The practice had designed a bespoke ‘fitness to work’ note, which was more detailed and less ambiguous than the standard sick note (FMed566). This enabled clinicians to improve how they followed guidance around sickness periods for personnel and gave Chain of Command a clearer idea of the tasks that personnel could undertake safely.

- Many personnel working at Hyde Park Barracks were living away from home, their families and often their children. Clinicians had invested significant time in accessing care services closer to a patient's home if they had sustained injury or were experiencing poor mental health, as this better supported their recovery and emotional needs. A number of patients confirmed to us that clinicians had 'gone the extra mile' to secure care at their home so that their families could support their recovery. Patients demonstrated that this had led to improved outcomes for them.

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

- patients sometimes experienced longer than average waits to receive a specialist medical review
- there was no access audit for the premises, as defined in the Equality Act 2010
- trends resulting from complaints were not identified, so there were missed opportunities to improve care
- 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 – particularly the safety and effectiveness of care and treatment.

In Year 3, 22% of medical centres were rated as outstanding for the well-led key question and 37% were rated as good; a further 22% were rated as requires improvement and 19% were rated as inadequate.

During the third year of medical centre inspections, we have found examples of outstanding leadership in six medical centres (compared with four in Year 2 and four in Year 1). Key to their success was a strong governance framework that staff understood and could deliver against, visible leadership, consistent communication and a collaborative team approach to promote learning and innovation.

Outstanding leadership focuses not only on the decisions and work carried out in a medical centre, but it encourages and enables partnership working with internal and external stakeholders to deliver meaningful improvements for patients. Staff in outstanding medical centres had the capacity, experience, and skillset to lead, teams were resilient, and deputies able to support during periods of high demand or where key staff were deployed.

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. 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. Strong leadership teams often benefit from the rotation of military staff who bring new ideas and share best practice, coupled with the stability of civilian staff. Across our three years of inspection work, we have found outstanding leadership delivered by both civilian and uniformed SMOs: the key to their success being an underlying team ethos which empowers all team members to influence and improve the processes and issues they deal with on a daily basis.

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

Innsworth Medical Centre February 2020

- The leaders demonstrated managerial experience, capacity and capability, and it was clear they had vision and passion with a focus on providing the best possible service for their patients.
- Staff said managers consistently led through a collaborative approach and practice staff felt highly valued and engaged. The regional management team worked closely with the staff team and had given an award of recognition to the centre.
- The team had developed their own mission statement with input from all staff: “Make the patient your priority.” The statement was included on practice documents, for example, minutes of meetings, and it was clear that the whole practice team had embraced the statement and held it central to their aims and objectives.
- Leaders encouraged and supported staff to be the best they could through training and developing their skills, and all staff had supervision and appraisals. The practice had introduced two reward schemes to recognise staff who had gone the extra mile. All members of the team had received an award in the past 12 months. For example, the practice manager received an award for supporting a nearby practice, the hospital administrator was rewarded for developing a resilient tracking system, and the regional management rewarded the team for their work in meeting the targets for ‘fit to deploy’ on a short notice deployment, despite having staffing issues at the time.

To date, CQC has inspected 89 individual medical centres and we continue to see a number of common themes that contributed to a rating of requires improvement or inadequate for the quality of their leadership.

Leadership capacity

In Years 1 and 2 we identified professional isolation and lack of resilience as 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. In Year 3, we continued to identify concerns with some practices that had insufficient GP hours to provide a good level of clinical oversight.

For example, we inspected one practice that employed two NHS GPs to provide just 10.5 hours clinical care and leadership for the medical centre each week. This did not give the lead GP enough time to provide effective and consistent clinical leadership. The issues identified on inspection showed that regional support was lacking, which resulted in staff not feeling valued or supported. The shortage of staff meant the practice could not ensure that all lead roles were effectively covered, with clinical improvement work under-developed, particularly clinical audit.

Nevertheless, the size of a practice is not necessarily an indicator of quality of care. We have identified poor care at a medical centre with a staff team of over 40, and we have seen outstanding care at medical centres with six staff working together. Across the three years of inspections, we continue to find that those medical centres that collaborate, affiliate, and share resource are more resilient to overcome challenges and are more likely to deliver consistently good care.

Raising and addressing concerns

In previous years we have concluded that military medical centres often work to a culture of ‘being proactive with what we have’. 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.

In Year 3, we inspected medical centres where staff had escalated concerns about the challenges they face (sometimes on multiple occasions) but were unable to influence outcomes. In a number of these cases, staff had not achieved the resolution they hoped for, either because regional support was not available or because the issue was within the remit of another department (for example regarding health and safety and corporate governance).

We also met with staff who told us that they have stopped raising concerns as they felt that nothing will be resolved. They have become disaffected in a system where they cannot influence the level of resource they require or the state of the infrastructure in which they work. Sometimes local staff felt they were struggling in isolation to deliver against the odds. At a regional level, we found a lack of clarity about what regional teams could and should be delivering. 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.

Effective clinical leadership

The capacity and capability for clinical leadership varies vastly and depends largely on the individuals in post at a medical centre at any one time, their personal experience and the continuity of their service. Staff working in medical centres told us that they cannot access central training around risk management, good governance, quality improvement, clinical audit, clinical leadership and managing clinical performance. There is no set baseline training and experience for practice managers, and we have inspected medical centres where practice managers have no previous practice management experience and have received little or no training – instead they are asked to train on the job. Without basic leadership training, it is difficult for leaders in medical centres to develop and improve their clinical leadership approach.

In Year 3, we escalated some concerns around the performance of individual practitioners to DMSR. In these cases, clinical leaders at the medical centres had not taken adequate action to challenge poor practice and poor behaviour, and patient care had been substandard at times as a result.

Good governance

Governance systems are not always effective and do not support practices to deliver consistently high-quality services. As in Years 1 and 2, we identified the following common issues in Year 3:

- lines of accountability are unclear where staff do not know the arrangements for lead roles and deputies
- staff do not always know about policy and procedure and cannot demonstrate that they are following them
- there are not always planned improvement programmes focused around delivering meaningful and improved outcomes for patients
- practices do not always understand and monitor their own performance
- the arrangements to identify, record, and manage risks and issues, and implement mitigating actions, are sometimes ineffective
- meetings can be ineffective, either due to poor attendance, irregularity or poor agenda management, and discussions do not always include standing agenda items, recent clinical guidance, patient safety alerts and risk registers, so actions are overlooked.

Workforce gaps

Previously we identified concerns around the significant challenges in delivering safe and effective care because of gaps in the workforce. In Year 3, 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 duty 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 Years 1 and 2, where the Regimental Medical Officer (RMO) is also the clinical lead, there is a direct link between the proportion of time the RMO spent deployed away from the facility and poorer ratings. 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.

Driving improvement through the Defence Medical Services Regulator

As described in the well-led key question, medical centres are not empowered to influence and address some issues and under-performance, as accountability sits with another department. In these cases, CQC's recommendations are not directed at the medical centre to address. Instead, we have escalated concerns directly to DMSR to drive improvement through the correct accountable department. Sometimes the accountable body is DPHC or the regional team. This was the case in Cyprus where we identified a need to review staffing requirements to ensure that there are enough staff with the right skills and experience to deliver both primary care and pre-hospital emergency care (PHEC).

Issues around infrastructure require action from station commanders and Defence Infrastructure Organisation; issues around digital access to patient records are the responsibility of Defence Digital; and sustaining safe staffing levels requires input and resource from the Army, RAF and Naval personnel departments and the civil service. Evidence shows that DPHC alone has insufficient power to influence positively where responsibility for action lies elsewhere in the Joint Medical Group or wider MOD.

Improvement on re-inspection

Where we identify shortfalls in the quality of care, we return to re-inspect to ensure that the service has made sufficient improvement. Between March 2019 and April 2020, we re-inspected 25 medical centres (figure 3). Of these, 18 were re-inspected for the first time and seven were re-inspected for the second time.

Of the 25 services we re-inspected, 23 demonstrated sufficient positive improvement to confirm that the quality of care had improved.

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

		Safe	Effective	Caring	Responsive	Well-led
Abingdon	1st	Inadequate	Good	Good	Good	RI
	2nd	Good	Good	Good	Good	Good
Aldergrove	1st	RI	Good	Good	Good	Good
	2nd	Good	Good	Good	Good	Good
Bicester	1st	Good	RI	Good	Good	Good
	2nd	Good	Good	Good	Good	Good
Blandford	1st	Good	RI	Good	Good	Good
	2nd	Good	Good	Good	Good	Good
Boulmer	1st	Inadequate	RI	Good	RI	RI
	2nd	Inadequate	Inadequate	Good	RI	Inadequate
	3rd	RI	Good	Good	Good	RI
Bulford	1st	Inadequate	Inadequate	RI	RI	Inadequate
	2nd	Good	Good	Good	Good	Good
Chatham	1st	Good	RI	Good	Good	Good
	2nd	Good	Good	Good	Good	Good
Chester	1st	RI	RI	Good	Good	RI
	2nd	RI	Good	Good	Good	Good
Chicksands	1st	Good	RI	Good	Good	Good
	2nd	Good	Good	Good	Good	Good
Colchester	1st	Inadequate	RI	Inadequate	RI	Inadequate
	2nd	RI	Good	Good	Good	Good

Collingwood	1st	Inadequate	Inadequate	Good	Good	Inadequate
	2nd	Good	Good	Good	Good	Good
Culdrose	1st	RI	RI	Good	Good	RI
	2nd	RI	Good	Good	Good	Good
Dartmouth	1st	RI	Good	Good	Good	Good
	2nd	Good	Good	Good	Good	Good
Fort George	1st	Inadequate	Inadequate	Good	RI	Inadequate
	2nd	RI	Good	Good	Good	Good
	3rd	RI	Good	Good	Good	Good
Honington	1st	RI	RI	Good	Good	RI
	2nd	Inadequate	Good	Good	Good	RI
Hounslow	1st	RI	RI	Good	Good	RI
	2nd	Inadequate	Inadequate	Good	Good	Inadequate
	3rd	RI	RI	Good	Good	Good
Kineton	1st	Inadequate	RI	RI	Inadequate	Inadequate
	2nd	Good	Good	Good	Good	Good
Lympstone	1st	RI	Good	Good	Good	Good
	2nd	Good	RI	Good	Good	Good
Northwood	1st	Inadequate	RI	Good	Good	RI
	2nd	RI	Good	Good	Good	Good
	3rd	Good	Good	Good	Good	Good
Raleigh	1st	RI	Good	Good	Good	Good
	2nd	Good	Good	Good	Good	Good
Shrivenham	1st	RI	Good	Good	RI	Good
	2nd	RI	Good	Good	Good	Good
	3rd	RI	Good	Good	Good	Good
St Mawgan	1st	RI	Good	Good	Good	Good
	2nd	Good	Good	Good	Good	Good
Valley	1st	RI	Good	Good	Good	Good
	2nd	Good	Good	Good	Good	Good
Woolwich	1st	Inadequate	RI	Good	Good	RI
	2nd	Inadequate	RI	Good	Good	Inadequate
	3rd	Good	Good	Good	Good	Good

Almost all services responded well to our 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. We noted that DPHC had been instrumental in driving improvement at a number of medical centres by providing additional staff resource. We also saw evidence of medical centres seeking support and guidance from high-performing teams and working collaboratively to deliver positive solutions as the following examples show.

Example of an affiliation approach to deliver improvement

Woolwich Medical Centre September 2019

- The practice was part of a newly-formed affiliation with two other larger London based practices, which aimed to provide business resilience and to support each other at times of staffing shortages. There were weekly joint meetings and some shared governance, with more in development. This included access to Microsoft SharePoint, a repository for service information, support with induction, group training and notably weekly mentorship for junior practice managers.

Example of improvement journey from inadequate to good

Collingwood Medical Centre May 2019

- At our previous inspection, some clinical staff were unaware of the new system to highlight vulnerable patients in clinical records. A register of patients prescribed high-risk medicines had since been established and alerts were now in place in DMICP records. Staff were now aware of the policy on disease-modifying anti rheumatic drugs (DMARDs). Patients who took DMARDs had shared care protocols uploaded into their notes and we saw evidence of recall dates being set for blood testing.
- The medical centre had conducted searches to ensure that patients currently using an ACE inhibitor or ARB* had had their renal function checked in the last 12 months.
- We previously found that some hypertensive patients who were prescribed medicines to manage their condition had not been appropriately recalled. We also noted Read coding errors. The Deputy Principal Medical Officer (DPMO) had carried out work to address the risks and improve care for these patients. This included review of Read coding, clinical templates and an overhaul of the recall system. He confirmed that the Read coding work was ongoing and that he was in the early stages of establishing a ‘long-term conditions working group’.

* ACE inhibitors (angiotensin converting enzyme inhibitors) are medicines used to treat high blood pressure, scleroderma and migraines among other conditions; ARBs (angiotensin receptor blockers) are used to manage high blood pressure, treat heart failure and reduce risk of stroke.

- The DPMO had also improved the recording and Read coding around asthmatic care. All patients had had an asthma review in the preceding 12 months, which included an assessment of asthma control using the three Royal College of Physicians questions. Staff had agreed to use a consistent template to record asthma reviews (which prompted decision making around immunisations). Care records for asthmatic patients showed that care was now in line with national clinical guidelines.

Of the two medical centres that had not made sufficient improvement, one needed significant building work to deliver the necessary improvements, which has not yet been completed, and the second medical centre had made insufficient improvement to improve its rating for the safe key question.

Although quality of care had not deteriorated significantly in any re-inspections in Year 3, nine medical centres will require a further re-inspection in Year 4 as there are still areas that require improvement.

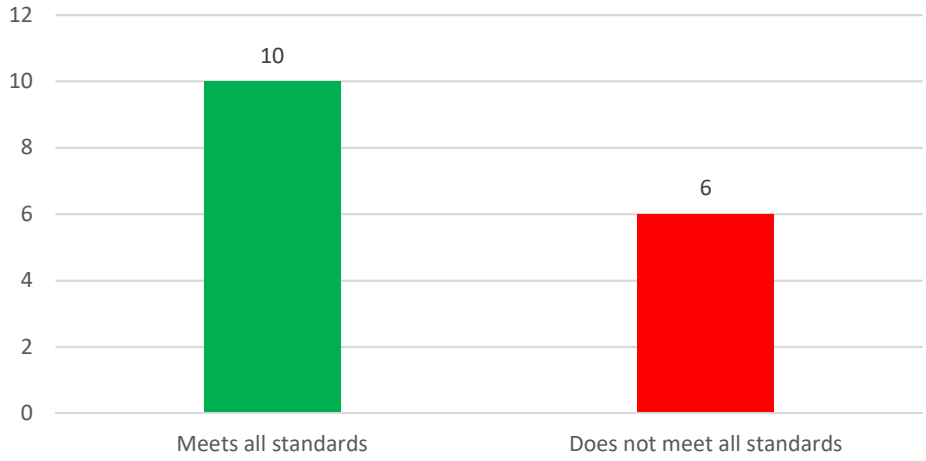
We will continue to follow up the recommendations made during Year 3 to ensure that the services implement improvements for patients.

Dental services

CQC inspects 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 3, at DMSR's request, CQC was asked to carry out first comprehensive inspections at 16 dental centres. We found that 10 were meeting the standards for all key questions and six were not. For five dental centres, recommendations made were all within the safe key question. For one dental centre, we made recommendations for the effective key question (figure 4).

Figure 4: Overall outcomes of first dental inspections in Year 3



Safe

For the 10 dental centres that met standards, we found:

- staff had a clear understanding of the requirements of the DMS-wide Automated Significant Event Reporting (ASER) system
- staff understood their 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

- staff were registered with the General Dental Council where appropriate, and had adequate indemnity cover
- organisation-wide health and safety policy and protocols to support with managing potential risk
- suitable arrangements to ensure the safety of the X-ray equipment, and a Radiation Protection Advisor and Radiation Protection Supervisor were identified
- compliance with national infection prevention and control guidance.

However, five dental centres did not meet standards around safety in Year 3. The common issues were:

- improving management of national patient safety and medicines alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and the Central Alerting System (CAS)
- ensuring staff safety through an effective alarm system
- ensuring that infrastructure, fixtures and fittings comply with guidelines issued by the Department of Health - 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'
- recording the immunisation status of staff
- managing significant events and access to the reporting system for all staff
- ensuring a safe water system in accordance with national guidance - HTM 04-01: Safe water in healthcare premises.

Effective

In Year 3, 15 of the dental centres inspected met standards in this key question:

- 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 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 patients needed oral surgery
- prevention was at the heart of each practice's approach to avoid oral healthcare issues while patients were deployed.

However, one dental centre had gaps in the workforce that were reducing its capacity to maximise oral health promotion.

One dental centre did not meet standards, because it needed to implement:

- a failsafe system to monitor referrals
- appropriate recording of patient consent
- policies, protocols, and risk assessments that are current and relevant to the practice.

Caring

All 16 inspected dental centres met standards for the caring key question in Year 3. Overall findings 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 a patient's treatment plan.

Responsive

All 16 inspected dental centres met standards for being responsive in Year 3. 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

All 16 inspected dental centres met standards for leadership in Year 3. Overall findings from inspections identified that:

- 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
- a high standard of clinical care was underpinned by high standards of governance

- 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.

Improvement on re-inspection of dental centres

We also re-inspected two dental centres in Year 3 to follow up recommendations from Years 1 and 2. Both sites have been re-inspected twice (figure 5).

Figure 5: Dental re-inspections in Year 3

		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**
	3rd	**Standards 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**
	3rd	**Standards met**	**Standards met**	**Standards met**	**Standards met**	**Standards met**

Following our recommendations from initial inspections, both Leeming and Drake dental centres had been unable to comply with standards regarding decontamination. 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 rely on the Station's Health and Safety Team or Regional Headquarters to bid for funding for improvement work. A second re-inspection at each dental centre demonstrated that the required funding had been secured and building work carried out such that national infection prevention and control and decontamination guidance could be followed.

Regional rehabilitation units

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

During Year 3, overall ratings for the regional rehabilitation units inspected were:

- Aldershot: rated overall as good
- Tidworth: rated overall as good
- Colchester: rated overall as good
- Cranwell: rated overall as good

Figure 5: Ratings for first inspections by key question for RRUs

	Safe	Effective	Caring	Responsive	Well-led
Aldershot	Good	Good	Good	Good	Good
Tidworth	Requires Improvement	Good	Good	Good	Good
Colchester	Good	Good	Good	Good	Good
Cranwell	Good	Good	Good	Good	Good

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 most understood how to report incidents. There were few reportable incidents at these units, and the learning from them resulted in changes were made to practice.

We identified some issues at RRU Colchester. There was no adult safeguarding procedure in place, and staff had not completed the training for safeguarding vulnerable adults. At RRU Cranwell, we identified that not all incidents were being reported in a consistent way, and staff had not received training in safeguarding vulnerable adults.

At RRU Tidworth, we identified some concerns regarding the storage of patient outcome measures, which meant information that could identify patients was not always stored securely. In addition, we identified concerns with how the duty of candour was being applied and a lack of openness and transparency with patients when things went wrong.

Apart from the exceptions noted above, 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 been completed, including infection prevention.

Effective

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

We saw that multidisciplinary team working was particularly effective and embedded in all the units inspected.

Most units used outcome measures to assess the effectiveness of treatment as well as structured formal course assessments that involved patients in most services. RRU Colchester used patient reported outcome measures (PROM), although the unit did not identify where improvements could be made based on that data. At RRU Cranwell there was a limited approach to monitoring and benchmarking the quality of the service and the outcomes for patients following an episode of treatment.

Staffing levels at the times of the inspections were acceptable. 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 share information 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 their 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 the availability of staff and the size of area covered by individual RRUs.

Facilities overall were suitable, but there were some concerns at both RRU Aldershot and Tidworth.

Targets were generally met, but with variation across all units. At RRUs Colchester and Cranwell, there was good access to a podiatrist and to multi-disciplinary injury assessment clinics or injury assessment clinics (MIAC or IAC clinics) (first referral within 20 working days).

At RRUs Aldershot and Tidworth, access to a course following a MIAC was below the RRU average. RRU Cranwell had achieved 100% in Q2 2019/20, but only 50% in Q3.

Well-led

Leadership was generally exemplary, with staff 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.

The governance arrangements included clear lines of accountability and reporting. There were appropriate meetings (for example regarding risk), which were minuted and staff were aware of outcomes.

Quality improvement was encouraged, both from feedback from patients as well as audit outcomes.

Community mental health

The Defence Medical Services deliver mental health support through a network of departments of community mental health (DCMHs), mental health teams (MHTs), and additional locations. Almost 250 personnel, both military and civilian, provide care from 20 permanent locations, comprising 11 DCMHs, six MHTs, and three other locations with a permanent community mental health nurse present.

The aim of departments of community mental health is 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.

CQC began a programme of inspection of the departments of community mental health in October 2017. Since then, we have inspected eight DCMHs and four satellite mental health teams across the UK and overseas. During Year 3, we undertook initial inspections at Tidworth, Aldershot, Portsmouth, and Plymouth (figure 6). We also inspected the mental health team based at RAF Akrotiri in the Sovereign Base of Cyprus, and we re-inspected 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).

Our inspection team used a bespoke inspection framework using the skills of inspectors with a mental health background. The inspection team was supported by specialist advisors who work within military mental health teams. 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.

We have now carried out two thirds of the inspection programme and are developing a clearer baseline of standards within the community mental health teams. To date, we have found all services visited to be caring and providing 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 2019/20

	Safe	Effective	Caring	Responsive	Well-led	Overall
Tidworth	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Aldershot	Good	Good	Good	Good	Good	Good
Portsmouth	Good	Good	Good	Good	Good	Good
Plymouth	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement

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.

As in Years 1 and 2 of the programme, overall performance for the safe key question in Year 3 is the poorest of all the five key questions. Some of the issues we found in Years 1 and 2, such as infrastructure and staffing, have continued to be raised in Year 3.

Recruitment remained challenging across most services. Staffing levels were sufficient at Aldershot, Portsmouth, Tidworth and Brize Norton, as gaps in staffing were covered by locum staff. However, at Plymouth staffing was at 60% against establishment, and there had been a region-wide freeze on using locum staff to fill gaps in posts. This was not enough to meet the demand of the service, and had resulted in long waiting lists for treatment.

We continued to find that the infrastructure at some bases did not meet the needs of patients or the teams. At Plymouth, the team occupied the first and second floor of a shared building. This meant that people with a disability could not access the building and there was a risk to patients from the base who were unaccompanied until they reached the first floor of the building. At Tidworth, we found that the team needed to work across three separate buildings to ensure sufficient and appropriate space for treatment. In Cyprus, there were insufficient offices and treatment rooms at Akrotiri and the facilities at all bases that the team worked from did not promote dignity and confidentiality. However, we found that all services visited during the year were clean and generally well-maintained, and had developed a clinically-based risk assessment of the environment to consider relevant risk factors.

All teams that we visited received child protection training. As in previous years, we found that adult safeguarding training is not yet mandatory in DMS and that the policy

does not yet reflect the latest legislative guidance. To address this, 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.

Further work was required to ensure that significant events are fully investigated and that learning from these is shared and used to drive a safety culture. All teams used the standardised electronic system to report significant events, incidents and near misses. Staff were aware of their role in reporting and managing incidents and these were usually discussed at governance or business meetings. However, at some services incidents had not been recorded as serious events or investigated appropriately. At Tidworth, staff had not reported all adverse incidents that should have been reported nor had managers fully investigated incidents that had been reported. At Plymouth, not all aspects of incidents had been fully investigated. Further work was required to ensure all concerns are captured and learning shared from all adverse events.

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. Where a known patient contacted the teams in crisis, the teams usually responded swiftly and there was usually easy access to the psychiatrist should a full assessment be required.

In Cyprus, we were impressed that the team went above and beyond to support patients in crisis. This included working out of hours and visiting any patient placed in a bed in the island's hospital to ensure a safer and more timely response. This was despite the lack of any standard operating procedures in place for this work.

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

DCMH Aldershot August 2019

- The team was located in a facility that was clean, well-decorated and equipped, and maintained to a very good standard. The building was shared with NHS services, which positively enhanced the patient's experience.
- All referrals were clinically triaged by the mental health team to determine whether a more urgent response was required and to monitor whether patients' risks had increased. Individual patient risk assessments were in place and proportionate to each patient's risks. The team had developed a process to share concerns about patients in crisis or whose risks had increased. We saw good evidence of the team following up on any known risks.

- Overall staffing arrangements were sufficient to meet the needs of patients. Staff had undertaken required training.
- Adult safeguarding training had been delivered to the team and the staff had a good awareness of safeguarding procedures and practice.
- Incidents had been reported appropriately or were fully investigated. Lessons learned from incidents were shared with staff.

Effective

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

As in Years 1 and 2 of the programme, overall performance for the effective key question was positive. All the services inspected were offering effective care.

Teams comprised a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist, including 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. However, at a number of services we found that the recording of supervision was not effective.

Previously we had found that care and treatment plans had not been available at all services. During Year 3, we found all services had begun to develop care and treatment plans although this was not always clearly documented in all services. In practice, we found that treatment plans were discussed and agreed with patients.

Generally, record keeping was of a higher standard in Year 3. However, In Cyprus, the team used DMICP Hybrid for record keeping, which has reduced functionality compared with the UK patient records system. The system had a number of challenges including planned and unplanned outages, failures during updates, and conflicting records. In addition, there was a separate system at each base the team operated from. This meant that patients could have more than one medical record and therefore mental health staff may not have had access to a full contemporaneous record or all information on risk. The system is 'practice based' meaning that mental health information is open to the wider staff within the medical centre so may not be fully confidential. Despite the shortfalls of the system the team had found practical work-arounds to ensure risk information and referrals were shared across the team and with primary care staff.

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

As occupational mental health services, the role of a DCMH is to assist patients to retain their occupational status or to support them as they leave the armed services. Patients could also use a 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 many 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. All services visited this year had adopted consent to treatment processes and staff were aware of their responsibility to ensure ongoing consent.

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

DCMH Plymouth February 2020

- The team worked very closely with the Military Welfare Services and the NHS Veterans Mental Health Transition, Intervention & Liaison Service (TILS) and a wide range of third sector organisations to ensure effective support with employment, housing and wider welfare.
- Where necessary, when handing care over on discharge of a patient from the service, the team met with the receiving NHS teams.
- The team had developed good working relationships with the defence primary care team. Staff described the advice and support they would give to colleagues in primary medical services and the chain of command around specialist mental health monitoring. The team provided specialist advice and training for primary healthcare staff and offered a peripatetic service to several medical facilities within the catchment area. The team had also provided mental health awareness training to over 300 team managers across the region.
- The team took an active role in HMNB Devonport's welfare committee. This is a collaborative base-wide approach to managing risks and agreeing support to personnel who are struggling to cope with naval life. The team confirmed that while this was resource intensive, it provided a highly supportive approach that enhanced the mental health treatment they were able to offer. During the inspection we met with the captain of the base for HMNB Devonport who was highly appreciative of the team's role to support mental health awareness across the base.

Caring

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

As in previous years, all the services inspected during Year 3 of the programme were offering good 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 at all services visited. We were impressed that the team in Cyprus offered an out-of-hours crisis response to patients on a voluntary basis, through supporting medical staff with advice, guidance and assessment. At the time of the inspection, the team had supported a patient to access the Ygia Polyclinic in Limassol until they were able to be repatriated to the UK by the aeromedical evacuation team.

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. During Year 3 we spoke with 42 patients and received feedback from patients through 184 comment cards. This was almost unanimously positive about the attitudes and the support they received from staff. Patients at all services were particularly positive about the attitude of reception staff and the initial welcome they received at the services.

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 practice in a DCMH service rated as good

DCMH Tidworth July 2019

- We noted some occasions when staff had found creative ways to meet the needs of individual patients. The acting practice manager saw a need to support military personnel who were experiencing financial difficulties and had engaged with charities to assist. The team adopted the scheme, which had provided food and baby product vouchers for a number of patients.
- Staff provided practical and emotional support and worked hard to meet the wider needs of their patients. This included active involvement in unit health committees that considered the wider support needs of people who were struggling to cope with military life.
- We saw staff that were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them. Almost all of the patients we spoke with told us that staff were kind and supportive, and that they were treated with respect.

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.

As in Years 1 and 2 of the programme, overall performance for the responsive key question was generally positive. Most of the services inspected were offering responsive care. However, there is further work to do to address waiting times and treatment space requirements at most services.

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. 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 although all teams were meeting targets for urgent response, some teams were not always meeting their targets for assessing routine referrals. In most cases, we found that this information related to recording errors rather than practice. However, work is needed to ensure that staff are clear about procedures to ensure that referral and assessment dates are recorded correctly on the electronic system.

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 or by using the psychiatrist's time in different ways. Some services had commissioned external IAPT services (Improving Access to Psychological Therapies) to increase capacity. In most services, patients were allocated a key worker to keep oversight of their needs and to monitor whether their risks had increased. However, at Plymouth six patients told us that they had waited too long to commence treatment. Overall, the team had a waiting list of 113 people who had been waiting up to 27 weeks for appropriate treatment.

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.

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. The team at Tidworth was developing a system for handling complaints and concerns, but this required further improvement to fully capture and learn from patients' concerns.

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

DCMH Portsmouth October 2019

- In a previous patient survey, two patients had commented negatively that military staff were wearing uniforms, which could present a barrier. Following this, the team conducted a bespoke survey of 95 patients, which found that the majority of patients would prefer civilian dress. In response, the team had trialed civilian dress and was about to conduct a further survey to gauge the impact.
- Following a request from a patient, the team had proactively worked with the base commander and security to allow therapy dogs to accompany their owners to appointments.
- The team told us that there had been significant waiting lists at the service, so they introduced a number of measures to address this. They carried out a clinical efficiency audit and population at risk review, which led to better diary management and increased output. The team had commissioned an NHS IAPT team to provide additional high intensity therapy capacity. Group work had been introduced to provide more timely access to patients who required lower level, more practical or pre-therapy intervention. The team had introduced telepsychiatry through a video link to support remote access. The keyworker role had been formalised to ensure all patients had oversight and access. A patient tracking system was also introduced and refined to gain a clearer view of patient's treatment.

Well-led

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

Overall performance for the well-led key question was positive this year. This was an improvement on findings in Years 1 and 2. Most services inspected were well-led, but there is further work to do to address lines of accountability and ensure fully safe and responsive care.

As we found with the medical centres, the capacity and capability for clinical leadership varies vastly across DCMHs and depends largely on the individuals in post at the service at any one time, their personal experience, and the continuity of

their service. In addition, management structures within the DCMHs are complex, with multiple and sometimes unclear lines of accountability. Despite this leadership was generally considered by staff to be good. At most services staff reported that their management team was approachable and supportive of their work. Staff morale was found to be good and improving at most services. However, staff at Tidworth reported that morale had been very poor and there had been some bullying at the team. At the time of our inspection, staff confirmed that they felt supported by their immediate colleagues, the department manager and interim clinical lead, and that morale had improved in recent months.

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. In most services staff felt engaged in the development of the service.

Management systems and governance structures were in place, but in some services further work was needed to embed governance and learning. Most risks that we found on inspections had been captured within the risk and issues logs and reflected within the common assurance framework. However, we found that a number of known issues such as the environment, critical human resources issues and waiting lists remained unresolved at some services. At all services we found inaccurate recording of performance in relation to managing referrals. At most services we found that improvement was needed for the recording of supervision and training.

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

DCMH Portsmouth October 2019

- Staff reported that morale had improved greatly at the team. Staff reported that they felt supported by their colleagues and that the management team were approachable and supportive of their work. All staff we spoke with during this inspection were clear regarding the aims of the service and supported the values of the team. Staff were positive about the improvements and felt this was making a positive difference to the quality of care offered to patients.
- The team had an overarching governance framework to support the delivery of the service, consider performance and ensure continuous learning. Systems and processes captured governance and performance information. All potential risks that we found had been captured within the risk and issues logs and the common assurance framework. All risks identified included detailed mitigation and action plans, and these were escalated appropriately.
- Staff felt engaged in the development of the team and undertook a wide range of audit. A range of QI initiatives had been developed that had led to significant improvements in the service.

Re-inspection of DCMH facilities

In Year 1, we carried out an announced comprehensive inspection of DCMH Brize Norton in October 2017. We rated the DCMH as requires improvement overall, with a rating of requires improvement for the key questions of safe, responsive and well-led.

At the initial inspection we had found that:

- governance processes had not led to improvement in the service
- the regional headquarters had not always offered sufficient support to the team to address key issues, including staffing, the environment and critical human resources issues
- routine referrals were not clinically triaged by the mental health team to determine whether a more urgent response was needed or to monitor that patients' risks had not increased
- staffing levels were not sufficient and had led to the satellite service at St Athan being suspended
- not all relevant incidents found had been recorded as serious events
- the team was not meeting its targets for urgent and routine referrals
- the environment was not fit for purpose and the Disability Discrimination Act was not being considered.

When we returned to the service in April 2019, we found improvement in most areas where we previously had concerns:

- recruitment was successful and there was sufficient staffing to ensure a full service at St Athan
- the team clinically triaged all referrals and individual patient risk assessments were thorough and proportionate to patients' risks
- formal care plans and consent to treatment forms were introduced, and patients told us that staff provided clear information to help make treatment choices
- the team was meeting the response target for urgent and routine referrals and there were no waiting lists for treatment
- improved systems and processes captured governance and performance information, all potential risks that we found were captured in the risk and issues logs and the common assurance framework, and all risks identified included mitigation and action plans
- staff morale had improved, and staff were very positive about their role in delivering the vision and values of the service.

Following this inspection, DCMH Brize Norton and MHT St Athan was re-rated as good for all key questions and overall.

Figure 7: Ratings by key question and overall for re-inspection

		Safe	Effective	Caring	Responsive	Well-led	Overall
Brize Norton	1st	**Requires improvement**	**Good**	**Good**	**Requires improvement**	**Requires improvement**	**Requires improvement**
	2nd	**Good**	**Good**	**Good**	**Good**	**Good**	**Good**

Conclusion

At the end of the third year of our inspections, we can conclude that direction of travel is mostly positive within DMS services. Where CQC has identified issues with the quality of care, these have mostly been addressed and services have been improved.

Our inspections highlight a number of internal factors that contribute to high-quality care, as well as factors that may inhibit it. Military personnel and entitled dependants continue to receive timely access to almost all services, and most experience a very short wait to see a healthcare professional. Most staff working in medical facilities engage their specialist skillset to balance the delivery of effective occupational healthcare alongside meeting the individual needs of patients.

Most dental and medical centres provide good care; our inspections of community mental health facilities indicate that mental health units continue to learn from one another and share effective ways of working, and RRUs are providing safe, effective and responsive care.

However, there are still some examples of poor-quality care, and the contributory factors range from a continued need for clearer lines of accountability around workforce management, lack of training in leadership and governance, and the inability of departments to measure their own performance, to addressing poor infrastructure.

Where we have found concerns on inspection, we have made recommendations so that care can improve for the benefit of patients and the professions. DMSR has taken enforcement action where CQC has escalated concerns.

In Year 3, we re-inspected a number of services to follow up recommendations from first and second inspections. These have shown positive improvement across all service types, demonstrating organisational learning and improved quality. Sharing best practice and innovation across some services has reaped significant benefits for staff and patients. There remains scope to broaden this shared learning to benefit the whole patient population.

The inspection programme was suspended in March 2020 in response to the outbreak of COVID-19 and it is currently unclear when the inspection programme might be re-instated. A number of medical centres, dental centres, RRUs and DCMHs have not yet had an initial inspection, and there is an ongoing need to re-inspect those service where improvement is required.

Appendix: Overall inspection outcomes 2019/20

Medical centres: overall ratings

Year 3 First inspections	
Service	**Overall**
Akrotiri Medical Centre	**Not rated**
Bickleigh Medical Centre	**Good**
Bramcote Medical Centre	**Requires improvement**
Brize Norton Medical Centre	**Good**
Catterick ITC Medical Centre	**Inadequate**
Catterick Medical Centre	**Good**
Chepstow Medical Centre	**Outstanding**
Corsham Medical Centre	**Good**
Cottesmore Medical Centre	**Requires improvement**
Dhekelia Group Practice	**Not rated**
Episkopi Medical Centre	**Not rated**
Halton Medical Centre	**Outstanding**
Holywood Medical Centre	**Good**
Hyde Park Medical Centre	**Outstanding**
Innsworth Medical Centre	**Outstanding**
Kineton Medical Centre	**Inadequate**
Lisburn Medical Centre	**Good**
Marchwood Medical Centre	**Good**

Year 3 Follow-up inspections	
Service	**Overall**
Aldergrove Medical Centre	**Good**
Bicester Medical Centre	**Good**
Blandford Medical Centre	**Good**
Boulmer Medical Centre	**Requires improvement**
Bulford Medical Centre	**Good**
Chatham Medical Centre	**Good**
Chester Medical Centre	**Good**
Chicksands Medical Centre	**Good**
Colchester Group Practice	**Good**
Collingwood Medical Centre	**Good**
Culdrose Medical Centre	**Good**
Dartmouth Medical Centre	**Good**
Fort George Medical Centre	**Good**
Honington Medical Centre	**Requires improvement**
Hounslow Medical Centre	**Requires improvement**
Kineton Medical Centre	**Good**
Lympstone Medical Centre	**Good**
Northwood Medical Centre	**Good**

Middle Wallop Medical Centre	**Requires improvement**
Newcastle Medical Centre	**Inadequate**
Norton Manor Medical Centre	**Requires improvement**
Shawbury Medical Centre	**Good**
Swanton Morely Medical Centre	**Requires improvement**
Tidworth Medical Centre	**Requires improvement**
Windsor Combermere Medical Centre	**Outstanding**
Windsor Victoria Medical Centre	**Outstanding**
Wittering Medical Centre	**Requires improvement**
Woodbridge Medical Centre	**Inadequate**
Wyton Medical Centre	**Inadequate**
Yeovilton Medical Centre	**Good**

Raleigh Medical Centre	**Good**
Shrivenham Medical Centre	**Good**
St Mawgan Medical Centre	**Good**
Valley Medical Centre	**Good**
Woolwich Medical Centre	**Good**

Dental services: overall outcomes

Year 3 first inspections	
Service	**Overall**
Bicester Dental Centre	**Standards met**
Cottesmore Dental Centre	**Standards met**
Lisburn Dental Centre	**Standards not met**
Lympstone Dental Centre	**Standards met**
Marham Dental Centre	**Standards met**
Warminster Dental Centre	**Standards not met**
Wittering Dental Centre	**Standards not met**
Holywood Dental Centre	**Standards not met**
Aldergrove Dental Centre	**Standards not met**
Woodbridge Dental Centre	**Standards met**
Winchester Dental Centre	**Standards met**
High Wycombe Dental Centre	**Standards not met**
Raleigh Dental Centre	**Standards met**
Akrotiri Dental Centre	**Not rated**
Episkopi Dental Centre	**Not rated**
Dhekelia Dental Centre	**Not rated**

Year 3 Follow-up inspections	
Service	**Overall**
Drake Dental Centre	**Standards met**
Leeming Dental Centre	**Standards met**

Regional rehabilitation units: overall ratings/outcomes

Year 3 first inspections	
Service	**Overall**
Aldershot RRU	**Good**
Colchester RRU	**Good**
Tidworth RRU	**Good**
Cranwell RRU	**Good**

Community mental health services: overall ratings

Year 3 First inspections	
Service	**Overall**
DCMH Aldershot	**Good**
DCMH Portsmouth	**Good**
DCMH Tidworth	**Requires improvement**
DCMH Plymouth	**Requires improvement**
DCMH Cyprus	**Not rated**

Year 3 Follow-up inspections	
Service	**Overall**
DCMH Brize Norton & St Athan	**Good**

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
DG	Director General (DMS)
DMICP	Defence Medical Information Capability Programme
DMS	Defence Medical Services
DMSR	Defence Medical Services Regulator
DPHC	Defence Primary Healthcare
DSA	Defence Safety Authority
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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