Defence community mental health services

Defence medical services provide occupational mental health assessment, advice and treatment through a network of departments of community mental health (DCMHs), mental health teams and additional staff at deployed locations.

By March 2022, we had caried out an initial inspection of all DCMHs and mental health teams as part of this programme. This has given us a clear understanding of the challenges faced by the services and the areas of practice that needed additional improvement.

During 2022/23, there were a number of key changes within the Defence community mental health services. Because of increased demand for services and challenges in workforce recruitment and retention, defence mental health services have needed to look for new solutions to deliver care and treatment. This has led to some formal merger of services and some DCMHs working collaboratively across regions. In line with these changes, we adapted our methods to look at how some of the systems that had been set up were working and to consider the role of the regional management teams in oversight and governance of the services. This included looking at:

- the London and South Region, which had developed a network across DCMHs Portsmouth, Aldershot and London
- the Central and Wessex Region where DCMHs Bulford and Brize Norton and the mental health team at St Athan had joined to form a single team.

During the year we:

- revisited DCMH Digby, which was previously rated as requires improvement for the well-led key question
- supported a wider DMSR-led review of the Aeromedical Evacuation Service based at RAF Brize Norton; this was to consider how the mental health transfer team undertook the medically supervised movement of patients to and between medical treatment facilities by air transport (we do not give a rating for DMS assurance reports or publish them on our website).

Figure 5: Ratings of Defence Community Mental Health Services in Year 6

	Safe	Effective	Caring	Responsive	Well-led	Overall
Central and Wessex Region (Bulford, Brize Norton and St Athan)	Good	Good	Good	Requires improvement	Good	Good
DCMH Digby	Good	Good	Good	Good	Good	Good

Portsmouth and London and South Region Network	Good	Good	Good	Requires improvement	Good	Good

DCMHs Portsmouth and the London and South Region Network

The Portsmouth team is part of a network of 3 DCMHs that cover London and the South of England. The other 2 services are based at Woolwich Barracks in London and the Centre for Health in Aldershot. Since September 2021, the 3 services have increasingly worked together as a single point of access (SPA) to respond to initial referral requests, assess patients and offer treatment across the teams.

DCMH Aldershot became the single point of access and undertook initial triage of all newly-referred patients. Following this, the team at Aldershot would transfer the patient's care to the most appropriate DCMH for detailed assessment and further treatment.

During this inspection, we looked in detail at the quality of care and treatment provided in Portsmouth and gave a rating. We considered how the 3 teams in the region had come together to undertake triage and assessment. We also looked at how the regional management team had taken oversight of the network and its plans to increase this integration. We did not rate this aspect of the inspection.

Overall, we rated the service at Portsmouth as good, although the responsive key question required improvement.

We found:

- Staff worked collaboratively across the 3 teams. Multidisciplinary team processes were working well. A standardised recording system was operating, and all new referrals were discussed at the multidisciplinary team.
- All referrals and the waiting lists were overseen by the management team to share resources appropriately and address blockages. The team had a process to contact patients on the waiting list who were most at risk and assess them regularly while they awaited treatment. More group work provided more timely access to patients who required lower level, more practical or pre-therapy intervention.
- Patient experience was good. Patients we spoke with during the inspection were positive about the service and the patient survey in November 2022 showed overwhelmingly positive responses to all questions. The service had received many positive comments from patients and other professionals.
- Leaders had worked well together to find effective solutions to deliver safe and effective care. Staff reported that morale had improved, they felt supported by their colleagues and said the management team were approachable and supportive of their work. Staff were involved in developing the single point of access and had contributed to developing and refining procedures and guidance for this function. They had access to all necessary supervision and a wide range of continuous professional development.
- The team had an overarching governance framework to help deliver the service, consider performance and ensure continuous learning. Potential risks that we found were captured in the risk and issues logs and had been escalated appropriately. The common assurance framework included detailed mitigation and action plans.

However, some areas required further work and action:

- There were some gaps in key posts that the team had not been able to fill with locum staff. Although recruitment was underway, this had affected waiting lists for treatment at the busy service, which had continually increased over previous months. Patients told us that although their care was good, the wait for treatment to start was frustrating.

At the time of the inspection:

- 70 people were waiting for low intensity therapy (the longest length of wait was 195 days)
- 69 people were waiting for high intensity therapy (the longest length of wait was 286 days)
- 15 people were waiting for psychology (the longest length of wait was 174 days).

However no people were waiting for psychiatry.

Central and Wessex Region – DCMHs Bulford and Brize Norton and mental health team St Athan

The Central and Wessex Region DCMH was formed following concerns about staffing levels and lack of available leadership at Brize Norton and St Athan, together with no facility at Brize Norton. These teams merged with Bulford DCMH in November 2021. Following the merger, the team developed working groups to ensure it adopted best practice from each site to develop a standard approach across all areas. This resulted in a review of operating procedures for triage, assessment, allocation and review, a shared governance system, and integrated information systems.

Overall, we rated the service at Central and Wessex Region as good, although it did require improvement in the responsive key question.

We found that:

- Leaders were capable and worked well together to unite the service. Staff reported that morale had improved, and that the management team were approachable and supportive of their work. All staff that we spoke with were positive about the leadership team and the improvements in practice since the merger. Staff could access mandatory and developmental training and a range of clinical support.
- The team had implemented safe systems and processes to ensure clear oversight of clinical risk to patients. All referrals were clinically triaged to determine whether they needed a more urgent response and to monitor whether patients' risks had increased. Individual patient risk assessments were thorough and proportionate. The team had a process to share concerns about patients in crisis or whose risks had increased. We saw good evidence of the multidisciplinary team reviewing and following up any known risks.
- Staff had a good awareness of safeguarding and the procedures and practice around managing incidents. They had reported all relevant events and had taken appropriate action to investigate and learn from these, which was used to drive a safety culture.
- The team had met the response target for referrals in recent months.

However, some areas required further work:

- The team had a process to ensure they regularly contacted and risk assessed patients on the waiting list who were at most risk while they awaited treatment, but patients told us that this could be improved.
- Patients did not have equal access to mental health care as this depended on where they were based. The team did not have a permanent facility at Brize Norton. While this was mitigated by staff working at home and offering patients virtual appointments, this is required to ensure all patients have equal access.

- Although the merger had ensured a timelier response to assessments, waiting lists were very high across the whole service at the time of our inspection. There was a substantial number of gaps in key posts that the team had not been able to fill with locum staff. Recruitment was underway but the team was approximately 54% staffed, with 29 additional vacancies, for posts across all disciplines. This had affected waiting lists for treatment at the service, which had risen over the previous year.

At the time of the inspection:

- 139 people were waiting for low intensity therapy (the average wait was 82 days)
- 176 people were waiting for high intensity therapy (the average wait was 181 days)
- 120 people were waiting for psychiatry (the average wait was 52 days).

DCMH Digby

We inspected DCMH Digby previously in June 2018 and rated the service as good overall, but it required improvement under the well-led key question.

In our Year 6 inspection, we found improvement and rated the service as good for all key questions. We found that:

- Leaders worked well together to ensure safe and effective care for patients and to address the previous leadership concerns at the service. Staff reported better morale, with support from the management team. They could access mandatory and developmental training and a range of clinical support.
- The team had implemented safe systems and processes to ensure clear oversight of clinical risks for patients. There was good awareness of safeguarding and incident management procedures and practice, with all relevant events reported and appropriate action taken to investigate and learn from these for continuous improvement.

- Improved governance processes supported the delivery of the service and helped to consider performance and ensure continuous learning. All potential risks that we found had been captured in the risk and issues logs and the common assurance framework. They included detailed mitigation and action plans and were escalated appropriately.

However, as with other community mental health facilities, some further action was required at DCMH Digby.

- Despite the team escalating some concerns about the environment, including a lack of soundproofing in clinical rooms and no way of observing the waiting area, regional headquarters had still not addressed them.
- The team had not been able to fill some key posts with locum staff, which resulted in large waiting lists for treatment at the service.

At the time of the inspection:

- 83 people were waiting for low intensity therapy
- 18 people were waiting for high intensity therapy
- 12 people were waiting for psychology
- the average waiting time overall was 140 days.

Key challenges to address

From February 2023, the newly-formed Defence Healthcare Recovery Group (DHRG) had taken over leadership of all mental health services within the military. This provides an opportunity to address core concerns that we have found throughout the programme, to consider standardised processes and look for the most effective and equitable way to provide community mental health support.

The key areas to address include:

- **Insufficient staff**: staffing levels did not meet the demand of the services we have looked at. Recruitment and retention remain a challenge across all services. While locum staff had been used to fill gaps in services, locum recruitment had not been successful at all services.
- **Waiting lists:** All DCMHs had waiting lists for treatment following assessment, particularly for psychiatric appointments or high intensity treatment. Although some services had addressed waiting lists by developing therapeutic groups, using the psychiatrist's time in different ways or by commissioning external IAPT (Improving Access to Psychological Therapies) services to increase capacity, overall waiting lists are growing in terms of the number of people waiting for treatment and the length of time that people wait.
- **IT connectivity**: Throughout these inspections we found recurring issues, which led to access problems and the loss of documents from records systems. This issue is a concern given the levels of virtual therapy that the teams now offer.