Defence Medical Services
Department of Community Mental Health Bulford and Central and Wessex Region

Quality Report

Department of Community Mental Health Bulford
DCMH Bulford
Bulford Healthcare Facility
Kandy Road
Bulford
Salisbury
SP4 9AA

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, and information given to us from the provider and patients.

Ratings

Overall rating for DCMH Bulford	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Good

Overall Summary

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

We carried out an announced inspection at the Department of Community Mental Health (DCMH) Bulford between the 07 to 24 February 2023. Since November 2021, the Bulford service had also been responsible for delivery of care to people across the Central and Wessex region including those based in the catchment areas of DCMH Brize Norton and the Mental Health Team at MOD St Athan. We rated the overall service as good.

We found the following areas of good practice:

- Due to concerns about staffing levels and a lack of available leadership at Brize Norton and St Athan, and a lack of a facility at Brize Norton the teams had merged with Bulford DCMH in November 2021. Following the merger, the team had developed working groups to ensure the best practice was taken 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.
- The team had implemented safe systems and processes to ensure clear clinical risk oversight of patients. All referrals were clinically triaged to determine whether a more urgent response was required and to monitor whether patients' risks had increased. Individual patient risk assessments were thorough and proportionate to patients' risks. The team had a process to share concerns about patients in crisis or whose risks had increased. We saw good evidence of the team reviewing risks through the multidisciplinary team and following up on any known risks.
- Staff had a good awareness of safeguarding and incident management procedures and practice. Staff had reported all relevant events and appropriate action had been taken to investigate and learn from these and was used to drive a safety culture.
- Staff could access mandatory and developmental training and a range of clinical support.
- Clinicians were aware of current evidence-based guidance and standards and patients could access a range of psychological therapies as recommended in NICE guidelines. The team used a range of outcome measures, and these were reviewed to provide an overview of service effectiveness. These indicated improved outcomes following treatment.
- Staff were kind, caring and compassionate in their response to patients. Patients said they were well supported, and that staff were kind and enabled them to get better.
- The team had met the response target for referrals in recent months.
- Leaders were capable and worked well together to ensure effective care to patients. Staff reported that morale had improved in recent times, and they felt 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 that had happened since the merger.
- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning, and systems and processes were in place to capture governance and performance information.
- All potential risks that we found had been captured within the risk and issues logs and the common assurance framework and included detailed mitigation and action plans and were escalated appropriately.

- The team was undertaking quality improvement projects to enhance patient care and was addressing any potential risks as they arose.

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

- There were substantial number of gaps in key posts that the team had not been able to fill with locum staff. Recruitment was underway but this had impacted on waiting lists for treatment at the service which had risen over the previous year. This had been further impacted by the large increase in the number of potential patients the service was responsible for.
- The team had a process to ensure that patients at most risk on the waiting list were contacted and risk assessed on a regular basis while they awaited treatment, however patients told us that this could be improved.
- The team did not have a permanent facility in the North of the region. While this was mitigated by staff home working and patients being offered virtual appointments this is required to ensure equitable access to all patients.
- The team had access to an electronic record system however staff we spoke with raised concerns with the stability of the system due to regular outages that left them working without being able to see the patient history. This presented a risk when needing to establish the risks associated with a patient.

Are services safe? **Good**

We rated the DCMH as good for safe because:

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

However:

- There were substantial number of gaps in key posts that the team had not been able to fill with locum staff. Recruitment was underway but this had impacted on waiting lists for treatment at the service which had risen over the previous year. This had been further

impacted by the large increase in the number of potential patients the service was responsible for.

Are services effective? **Good**

We rated the DCMH as good for effective because:

- Formal care plans were in place for all patients and were holistic and person centred. Care and treatment plans were reviewed regularly by the multidisciplinary team in weekly multidisciplinary team meetings.
- Patients could access a wide range of psychological therapies as recommended in NICE guidelines.
- Groupwork had been increased to provide more timely access to patients who required lower level, more practical or pre-therapy intervention.
- Clinicians were aware of current evidence-based guidance and standards and used this to guide their practice. The team used a range of outcome measures throughout and following treatment. The analysis of this indicated overall improved outcomes following treatment.
- Multidisciplinary team processes were working well. A standardised recording system was operating, and all new referrals were discussed at the multidisciplinary team.
- Staff could access developmental training and a range of clinical support and supervision.
- The team worked effectively in partnership with other agencies, both inside and outside the military, to manage and assess patient needs and risks.

However:

- The team had access to an electronic record system however staff we spoke with raised concerns with the stability of the system due to regular outages that left them working without being able to see the patient history. This presented a risk when needing to establish the risks associated with a patient.

Are services caring? **Good**

We rated the DCMH as good for caring because:

- We saw staff that were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them. This included both clinical and administrative staff.
- Staff showed us that they wanted to provide high quality care. Staff worked extremely hard to meet the wider needs of their patients. We observed some positive examples of staff providing practical and emotional support to people.
- Patient experience was good. Patients we spoke with during the inspection were positive about the service and the patient survey in February 2023 had received positive responses to all questions. The service had received many positive comments from patients and other professionals. Patients said they were well supported, and that staff were kind and enabled them to get better.
- Patients told us that staff provided clear information to help with making treatment choices. Records demonstrated the patient's involvement in their care.
- We saw staff working with patients to reduce their anxiety and behavioural disturbance.

- Staff understood confidentiality, and this was maintained.

Are services responsive to people's needs? **Requires improvement**

We rated the DCMH as requires improvement for responsive because:

- Following merger of the teams there was a large increase in the number of potential patients the service was responsible for. The service was very busy and there were waiting lists for treatment. These had increased over previous months. Patients told us that while the care received was good the wait for treatment to commence was frustrating. Action is needed to address the waiting lists.
- Long waiting times were impacting on some patients who were downgraded from their role and had only commenced treatment close to the time of their annual assessment by the medical board. This impacted army patients more who were assessed within 12 months of being downgraded. RAF and navy patients were assessed after 18 months and had more flexibility in the system to support recovery within set timescales.
- The team had a process to ensure that patients at most risk on the waiting list were contacted and risk assessed on a regular basis while they awaited treatment, however patients told us that this could be improved.
- The team did not have a permanent facility in the north of the region. While this was mitigated by staff home working and patients being offered virtual appointments this is required to ensure equitable access to all patients.

However:

- An assessment and allocations team oversaw all referrals and the waiting lists to ensure that resources were shared appropriately, and blockages were addressed.
- The team was meeting the response target for urgent and routine referrals.
- Virtual appointments were available and welcomed by many patients. Most patients felt their appointment was at a convenient location and at a convenient time.
- A comfortable waiting area was available for patients at Bulford. However, some patients did not feel it was appropriate that the waiting area was shared with other services.
- Information was available on display about treatments, local services, patients' rights, and how to complain.
- The team had a system for handling complaints and concerns and complaints. Staff demonstrated awareness of the complaints process and had supported patients to raise concerns.

Are services well-led? **Good**

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

- We found that leaders had worked well together to find effective solutions to ensure the safe and effective delivery of care.
- Staff we met were positive and told us that the team worked well together, and that leaders were approachable and supportive of their work. Staff reported that morale had improved at the team. All staff that we spoke with were positive about the leadership team and the improvements in practice that had happened since the merger.

- All staff we spoke with during this inspection were clear regarding the aims of the service and supported the values of the team.
- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. Systems and processes were in place to capture governance and performance information.
- 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. Risks had been escalated appropriately.
- A range of quality improvement projects were being undertaken. Staff were fully engaged in this process. Following the merger, the team had developed working groups to ensure the best practice was taken 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.

Our inspection team

Our inspection team was led by a CQC Inspection Manager Lyn Critchley. The team included an inspector and a specialist military mental health nursing advisor.

Background to Department of Community Mental Health Bulford and the Central and Region Network

The department of community mental health (DCMH) at Bulford provides mental health care to an overall population of approximately 40,000 serving personnel from across all three services of the Armed Forces. The catchment for the service includes all service personnel based at military establishments across the South Central and Southwest of England. In addition, the team also work with those who have returned to the catchment area on home leave.

Due to concerns about staffing levels and a lack of available leadership at Brize Norton and St Athan, and a lack of a facility at Brize Norton the teams had merged with Bulford DCMH in November 2021. Since, the service has operated from a main base at Bulford Camp with some staff operating from home and from medical centres in St Athan and Brize Norton. During this inspection we also looked at how the regional management team had taken oversight of the development of the single team and the merger. We did not rate this aspect of the inspection.

The department's aim is to provide occupational mental health assessment, advice and treatment. The aims are balanced between the needs of the service and the needs of the individual, to promote the well-being and recovery of those individuals in all respects of their occupational role and to maintain the fighting effectiveness of the Armed Services.

Following merger of the teams there was a large increase in the number of potential patients the service was responsible for. At the time of our inspection the active caseload was approximately 709 patients.

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting the team, we reviewed a range of information the DCMH and the Defence Medical Services had shared with us about the service and the network. This included: risk registers and the common assurance framework, complaints and incident information, clinical and service audits, patient survey results, service literature, staffing details and the service's timetable.

We carried out an announced inspection between the 07 and 24 February 2023. During the inspection, we visited the team at Bulford, and met virtually with staff working at home and the Central and Wessex regional management team and reviewed additional information about the other parts of the service. Specifically, we undertook the following:

- looked at the quality of the teams' environment;
- observed how staff were caring for patients;
- spoke with six patients who were using the service;
- observed the duty worker and administrative staff;
- spoke with the management team;
- spoke with 11 other staff members including doctors, nurses, psychologists, therapists, social workers, and administration staff;
- spoke with the Commander of Defence Healthcare Recovery Group (DHRG)
- spoke with the regional clinical director and governance lead;
- joined the multi-disciplinary team meeting;
- joined the management team meeting;
- looked at clinical records of patients;

- looked at a range of policies, procedures and other documents relating to the running of the service;
- examined minutes and other supporting documents relating to the governance of the service.

Defence Medical Services

Department of Community Mental Health Bulford and Central and Wessex Region

Detailed findings

Are services safe?

Good

Our findings

Safe and clean environment

- The team was based with other primary care services in a purpose-built healthcare facility at Bulford Camp. The building was close to, but outside the main perimeter of Bulford Camp making it accessible to patients from other bases. The building had been built to NHS standards and was well decorated and equipped, and fully accessible to anyone with a physical disability. There was sufficient space for the whole team within the main building, in part because some team members worked from home and from medical facilities at Brize Norton and St Athan. The facilities were clean, and staff reported that maintenance requests would be responded to in a timely way.
- The facilities used at St Athan consisted of a room within the medical centre used for face-to-face appointments. At Brize Norton, the existing building had been closed due to safety concerns. Since staff had worked mainly from home and used facilities within the medical centre to see patients face to face when necessary. Most patients were seen via video conferencing or at Bulford Medical Centre.
- Treatment rooms were adequately soundproofed at Bulford. We did not visit the facilities used at Brize Norton and St Athan but spoke with staff who worked from there who had no concerns about privacy during treatments.
- A comfortable waiting area was available for patients at Bulford. The design took account of patient confidentiality when at reception. However, the waiting area was shared with the regional rehabilitation unit and regional occupational health team. Patients we spoke with would prefer to not use a shared waiting area and added that filling in a mental health questionnaire whilst waiting made them feel uncomfortable.
- General health and safety and fire safety checks were in place. There was an environmental risk assessment in place for each location supported by local guidance for staff in managing environmental risks. The assessments highlighted the risk factors we observed including the presence of ligature anchor points and other relevant clinical environmental risks. Each location had undertaken an additional risk assessment of potential ligature points. Staff mitigated these risks by meeting patients within the reception areas and always escorting them around the buildings.

- There was an emergency alarm system in each room at Bulford. This was supported by a process for other staff to respond if alerted. Staff also had access to personal alarms. Lone working practices were in place including arrangements for logging which staff were in or out of the building.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. Hand wash facilities and hand gels were available, and staff adhered to infection control principles, including handwashing. Cleaning and infection prevention audits were undertaken, and the buildings were found to be clean throughout. A risk assessment was in place and appropriate systems based on national guidance had been put into place to manage the risks associated with Covid 19. This included the accessibility and use of personal protective equipment (PPE), Covid testing and safe distancing measures.
- Equipment logs were in place. Equipment was found to be clean and had been serviced.

Safe staffing

- Due to concerns about staffing levels and a lack of available leadership at Brize Norton and St Athan the teams had merged with Bulford DCMH in November 2021. This had ensured a timelier response to assessment however at the time of the inspection staffing levels remained a concern and waiting lists were very high across the whole service.
- The active clinical team totalled 37 people across all locations and consisted of medical, nursing, social work, psychology, and administration staff. The team was approximately 54% staffed, with 29 additional vacancies, for posts across all disciplines. Recruitment was ongoing at the time of the inspection and locum cover was available for 5 of the posts. The team had attempted to gain locum cover for remaining key posts however this was not available.
- Due to vacancies and sickness, there were only two consultant psychiatrists working at the team, this was equivalent to 1.6 full time posts. The service had vacancies for a further two psychiatrist posts. The regional management team had attempted to fill these posts and recruitment remained open. We were concerned about the long-term impact this may have on the service and the medical team.
- The administrative function at Bulford was shared across all of the services based within the medical centre. For the whole service there was a full-time practice manager and six administrators. There were 3 vacancies being recruited to at the time of the inspection. The reception area was always staffed, and patients spoke highly about the welcome they received at the service and the responsiveness of administration staff to any queries.
- All new starters, whether locum or permanent, were provided with induction training and a copy of the induction booklet. Up to twenty-nine training courses were classed as mandatory dependent on role. At the time of the inspection overall compliance averaged 86%.

Assessing and managing risk to patients and staff

- Referrals came to the team from medical officers and other DCMHs. These were indicated as either urgent or routine. Urgent referrals were considered by the end of the next working day. The Defence target to see patients for a routine referral was 15 days although this had been extended by DMS headquarters to 20 days in light of staff shortages across the team.
- Routine referrals were clinically triaged by the single point of access duty worker to determine whether a more urgent response was required and allocated to the next available clinician to undertake full assessment.

- Once a patient was accepted by the team, a risk assessment was undertaken. In all cases we reviewed we found that a risk assessment was in place and addressed known concerns. Crisis plans were in place and where a known patient contacted the team in crisis, the team responded swiftly. Patients we spoke with were aware of their crisis plans and what to do in an emergency. Both staff and patients confirmed access to the psychiatrist should a full assessment be required.
- All fresh cases were taken to the multidisciplinary team meeting to assure an appropriate response. The team recorded all clinical risk and decisions made at the multidisciplinary team and operated a process to share concerns with colleagues about specific patients whose risks had increased. This included risks due to safeguarding concerns and all patients recently discharged from hospital. The team met weekly to discuss any urgent risk issues and all at risk cases were discussed at multidisciplinary meetings.
- The team had introduced a process to ensure that patients on the waiting list were contacted and risk assessed on a regular basis while they awaited treatment. However, patients we spoke with felt that communication could be improved, and the email came across as more generic than tailored.
- Processes were in place to identify, report and manage safeguarding concerns. The Ministry of Defence had introduced policies for safeguarding vulnerable adults and children. The team had developed local procedures to manage safeguarding. Nearly all staff had undertaken required training as appropriate to their role. The team demonstrated an understanding of safeguarding principles and practice and had made 17 referrals to safeguarding in the previous year. Safeguarding concerns were discussed at governance and multidisciplinary team meetings.
- Appropriate arrangements were in place for the safe management of medicines. The DCMH did not dispense medication. Instead, the consultant psychiatrists would prescribe medication, but ongoing prescribing would be undertaken by GPs through a shared care agreement. Patients we spoke with reported some delays in receiving their medication when the item was not available from the dispensary within Bulford Medical Centre or had not been communicated to the dispensing community pharmacy.
- Business continuity plans for major incidents, such as security threat, power failure or building damage were in place and had been updated to reflect the risks in relation to the Covid 19 pandemic. Appropriate actions had been taken in response to the pandemic to mitigate the risk of infection to patients and staff and to ensure the service could operate safely. Where appropriate, staff had worked at home to minimise risk however the team had offered both virtual and face to face appointments where necessary throughout the pandemic and since.

Reporting incidents and learning from when things go wrong

- The team used the standardised DMS electronic system to report significant events, incidents and near misses. Staff received training at induction regarding the processes to report significant events. Staff were aware of their role in the reporting and management of incidents.
- Between June and November 2022, there were 17 significant events recorded across the service. Most events had resulted in low or no harm and related to administrative issues or clinical processes however two resulted in moderate harm. These had related to a missed patient assessment and to an emergency incident. Root cause analysis investigations had been undertaken where appropriate and were thorough. These provided evidence of learning and had led to improvements in practice.

- Staff confirmed significant events were discussed at team and governance meetings including the outcome and any changes made following a review of the incident. Learning and recommendations were noted within the minutes of these meetings. Staff were aware of learning from previous events.

Are services effective?

Good

Our findings

Assessment of needs and planning of care

- Formal assessment was undertaken once a patient's referral was accepted by the team. Following this, an assessment of the patient's needs was undertaken. Care and treatment plans were developed with patients. Formal care plans were used at the team and were in place for patients we reviewed. The team had been undertaking regular audits of care plans.
- The team had access to an electronic record system which was shared across all DMS healthcare facilities. This system facilitated effective information sharing across mental health and primary care services. Any paper records were scanned on to the system to ensure access and safe storage. However, staff we spoke with raised concerns with the stability of the system due to regular outages that left them working without being able to see the patient history. This presented a risk when needing to establish the risks associated with a patient.

Best practice in treatment and care

- Clinicians were aware of relevant evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. NICE and other guidance was reviewed within team and governance meetings. Clinical records reviewed made reference to NICE guidance. Staff told us of therapeutic practices that met this guidance.
- The team employed psychologists and all nurses were trained in a range of psychological treatments. Patients were therefore able to access a wide range of psychological therapies as recommended in NICE guidelines for depression, post-traumatic stress disorder (PTSD), alcohol misuse, eating disorder and anxiety. Treatments included the use of cognitive behavioural therapy, cognitive processing therapy and eye movement desensitization and reprocessing, psychological therapy, and social work intervention.
- In addition, the team delivered a range of therapeutic groups to prepare patients for psychological intervention and to provide more timely access to patients who required lower level, more practical or pre-therapy intervention. At the time of the inspection four courses were underway for PTSD (post-traumatic stress disorder) support, anxiety management (AMC), Military Behaviour Activation and Rehabilitation (MBARC) and the Acceptance and Commitment Therapy (ACT) Mindfully Group.
- The team used a range of outcome measures throughout and following treatment. These included the work and social adjustment scale, patient health questionnaire, generalised anxiety disorder scale, the PTSD checklist, and the alcohol use disorder identification test.

The team also audited patient outcomes following each groupwork course. Outcomes were reviewed throughout the treatment process and collated and audited to provide an overview of service effectiveness. These indicated improved outcomes following treatment.

- A range of audits were undertaken by the team. These included DMS mandated audits such as for clinical record keeping, patient experience, supervision levels, significant events trend analysis, complaints process, security, cleanliness, and environmental audits. Additional audits were undertaken of safeguarding procedures, Covid measures, groupwork effectiveness, triage assessment and discharge processes. However, the management team confirmed that audit completion had been impacted recently by low staffing levels.

Skilled staff to deliver care

- The team consisted of a full range of mental health disciplines. These included psychiatrists, nurses, psychologists, and social workers.
- New staff, including locums, received a thorough induction.
- Development training, such as in cognitive behaviour therapy (CBT) and cognitive processing therapy (CPT) was available to staff across DMS although staff told us that access to this was limited by the demands of the service.
- Staff received a weekly continued professional development session which had included topics such as hospital admissions process, obsessive compulsive disorder, bereavement, perinatal mental health, distress tolerance, QI and audit principles, triage procedures, and safeguarding.
- Staff had support through weekly team, multidisciplinary and professional development meetings. Staff were also involved in monthly governance meetings and took lead roles on the governance agenda.
- Staff confirmed that they had protected time for supervision and professional development and received regular supervision and caseload management. Records confirmed good compliance with clinical supervision and caseload management. Psychologists at the team also offered bespoke supervision to staff following complex work and debriefs following any incidents.
- All staff had received appraisals in the previous six months.

Multidisciplinary and inter-agency teamwork

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

when handing care over on discharge of a patient from the service, the team met with the receiving NHS teams.
- The team had developed good working relationships with the defence primary care teams across the catchment area and operated from some medical centres where required. 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 engaged in unit health committees where appropriate to ensure effective support to their patients.

Adherence to mental health legislation

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

Good practice in assessing capacity and consent

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

Are services caring?

Good

Our findings

Kindness, dignity, respect and support

- We saw staff that were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them. This included both clinical and administrative staff.
- Patients we spoke with told us that staff were kind and supportive, and that they were treated with respect. We received several positive comments from patients about the treatment that they had received.
- Staff showed us that they wanted to provide high quality care. We observed staff working hard to meet the wider needs of their patients. Patients told us that staff would help them to

access all possible support that they could but wait times to be seen were long and felt that they could be better supported during these times. Staff spoke of frustration with not having the capacity to provide treatment across the patients at risk due to staffing shortages.
- Staff demonstrated that they were knowledgeable about the history, risks, and support needs of the people they cared for. We saw staff working with patients to reduce their anxiety and behavioural disturbance.
- Confidentiality was understood by staff and maintained. Staff maintained privacy with people, who were asked if they would like their information shared with their relatives, within the chain of command and other bodies, including CQC. Information was stored securely, both in paper and electronic format.

The involvement of people in the care they receive

- Formal care plans were used at the team and were in place for patients. Care plans demonstrated the patient's involvement in their care. Patients we spoke with confirmed they had been involved in their care planning. Care plans were updated and were useful.
- Information was available at the service about a range of organisations that would provide advice and support to serving and former Armed Forces personnel. Staff told us about many positive relationships with support organisations.
- The team provided access to a range of information regarding the service delivered and clinical conditions and treatments available to support the conditions. These were shared with patients routinely. Patients reported positively regarding these.
- The team undertook patient experience surveys on an ongoing basis. In February 2023, 31 people had participated in the survey. Most participants stated they would recommend the service to friends and family should they need to use it and where happy with their care. Most participants felt staff would listen to their concerns if they had any.
- In the 12 months to December 2022, 37 patients and external professionals had made written comments about the service. These were overwhelmingly positive about the team, the welcome they had received at the service and the outcomes of their treatment.
- Several patients confirmed their families had been involved appropriately within their care. Staff also confirmed times when they had offered support and advice to family members.

Are services responsive to people's needs?

Requires improvement

Our findings

Access and discharge

- In line with DMS requirements the service operated during office hours only. There was no out of hours' service directly available to patients: instead, patients had to access a crisis service through their medical officers or via local emergency departments. The team participated in a National Armed Forces out of hours' services on a duty basis. This provided gatekeeping and procedural advice regarding access to beds within the DMS independent service provider contract with NHS providers.

- At the time of the inspection, seven patients were in a bed within the NHS. Staff told us that there were positive relationships between the DCMH and the local NHS inpatient service providers which facilitated timely access to a bed. The team had a dedicated liaison worker and deputy who participated in hospital ward rounds and met with the patient on a regular basis when DCMH patients were admitted as inpatients. Where a patient was placed a significant distance from the team, the local DCMH performed this role with the patient.
- Due to concerns about staffing levels and a lack of available leadership at Brize Norton and St Athan the teams had merged with Bulford DCMH in November 2021. This had ensured a timelier response to assessment however at the time of the inspection waiting lists were very high across the whole service.
- Following merger of the teams there was a large increase in the number of potential patients the service was responsible for. At the time of the inspection the team's active caseload was 709. There had been 567 new referrals in the 12 months to March 2023. Referrals came to the team from medical officers and other DCMHs. These were indicated as either urgent or routine. Urgent referrals were considered by the end of the next working day. The Defence target to see patients for a routine referral was 15 days although this had been extended by DMS headquarters to 20 days in light of staff shortages across the team. The DMS performance target for assessing patients who have been routinely referred was set at 95%. Since July 2022, the team had fully met the target for responding to urgent cases and for routine referrals within 20 days. Most assessments had been completed within the overall DMS target of 15 days.
- The assessment duty team clinically triaged routine referrals to determine whether a more urgent response was required and allocated to the next available clinician to undertake full assessment.
- The management team told us that the service was very busy and waiting lists for treatment were increasing. At the time of the inspection 139 people were waiting for step 2 – low intensity therapy, the average wait was 82 days. 176 people were waiting for step 3 - high intensity therapy, the average wait was 181 days. There were 120 people waiting for psychiatry, the average wait was 52 days. The waiting list was reviewed weekly at an allocations' meeting to ensure that clinical risks were considered, and appropriate treatment had been prescribed. The team was running further group sessions at the time of the inspection to further address the waiting lists.
- Long waiting times were impacting on some patients who were downgraded from their role and had only commenced treatment close to the time of their annual assessment by the medical board. This impacted army patients more who were assessed within 12 months of being downgraded. RAF and navy patients were assessed after 18 months and had more flexibility in the system to support recovery within set timescales.
- Where a known patient contacted the team in crisis during office hours the team responded promptly. The team confirmed this included rapid access to a psychiatrist.
- Throughout the pandemic staff had mainly worked at home to minimise risk however the team had offered both virtual and face to face appointments where necessary. Since, the team had increased their office presence at Bulford to allow greater access to face to face appointments.

The facilities promote recovery, comfort, dignity and confidentiality

- The team main base was close to, but outside the main perimeter of Bulford Camp making it easily accessible to patients from other bases.
- The building was fully accessible to anyone with a physical disability.

- A comfortable waiting area was available for patients. The design took account of patient confidentiality when at reception. However, the waiting area was shared with the regional rehabilitation unit and regional occupational health team. Patients we spoke with would prefer to not use a shared waiting area and added that filling in a mental health questionnaire whilst waiting made them feel uncomfortable.
- There were sufficient treatment rooms at the base. Treatment rooms were adequately soundproofed to ensure privacy during treatments.
- Information was available on display and within an introductory booklet (given to patients at their first DCMH appointment) about treatments, local services, patients' rights, and how to complain.

Meeting the needs of all people who use the service

- The team could offer flexible appointment times during office hours. Patients confirmed that they were given time off to attend appointments and the chain of command was supportive of this.
- The team served patients based at military establishments across the South Central and Southwest of England. Some patients, posted a distance from Bulford, told us that travel to appointments could take significant time therefore they had found virtual appointments extremely welcome as this had cut down on travel and had allowed greater flexibility. The team also used facilities at Brize Norton and St Athan to cut down on travel.
- The team undertook patient experience surveys on an ongoing basis. In February 2023, 31 people had participated in the survey. The majority of patients (77%) had undertaken their appointments virtually. Eighty-seven per cent of participants stated their appointment had been easily accessible.
- The team confirmed that they had access to interpreters should this be required.

Listening to and learning from concerns and complaints

- The team had a system for handling complaints and concerns. The practice manager was the designated person responsible for managing all complaints. A policy was in place and information was available to staff. Staff demonstrated awareness of the complaints process and had supported patients to raise concerns about other services.
- Patient waiting areas had posters and leaflets explaining the complaints process and information about how to complain was shared with patients at the commencement of their treatment. The patient experience survey in February 2023, found that most patients knew how to make a complaint and felt they would be listened to. Patients spoken with during the inspection understood how to make a complaint and felt they would be listened to if they complained.
- In the 12 months prior to our inspection, there had been 12 formal complaints at the service. These had related to delays in treatment, clinical outcome and staff conduct. The practice manager confirmed that they had fully investigated and responded to. One of the complaints had resulted in an armed service complaint which was under review however none had been referred to the Armed Forces Ombudsman.
- In the 12 months to December 2022, the team had received 37 written compliments about the service. During this inspection we received feedback from patients and heard positive comments about the staff, and the service patients had received.

Are services well-led?

Good

Our findings

Vision and values

- The team's mission was:
  "To provide a safe, effective and evidence based community mental health service to our population at risk. This is to ensure defence personnel are fit for operational duties".

- The team told us of their commitment to deliver quality care and promote good outcomes for patients. Staff were positive and clear about their role in delivering the vision and values of the service. Staff felt positive about the team and their own work and that this was making a positive difference to the quality of life of patients.

Good governance

- The team had an overarching governance framework to support the delivery of the service, to consider performance and ensure continuous learning. The team had a monthly governance and business meeting which all staff attended and took an active role in. The meeting considered good practice guidelines, policy development, risk issues, learning from complaints and adverse events, patient experience, team learning, quality improvement (QI) and service development. The team had also developed five governance working groups to consider assurance against the 5 CQC domains. In addition, weekly team meetings, continuous professional development sessions and multidisciplinary meetings considered areas of governance and practice. Minutes for these meetings showed the service had effective governance and administration procedures in place.
- Effective systems and processes were in place to capture governance and performance information. Local processes and a dashboard had been developed, including information about complaints, training, supervision and key performance indicators, and local procedures for managing referrals, waiting lists, risk and safeguarding where in place. The management team had access to detailed information about performance against targets and outcomes.
- The common assurance framework (E-HAF) is a DMS structured self-assessment internal quality assurance process, which forms the basis for monitoring the quality of the service. Members of the team were allocated lead roles on areas of the HAF and governance agenda and would meet regularly to update assurance information. We found that this document was up to date, was detailed and all issues and risks relevant to the service had been incorporated in the document. An update in the form of a progress report on the HAF and associated action plan was submitted to the regional headquarters (RHQ) on a regular basis.
- The department manager was the nominated risk manager. Risk and issues were identified and logged on the regional headquarters and local risk and issues registers. These were overseen by the regional clinical director and operations manager. The risk and issues logs included: waiting lists, staff vacancies including inability to recruit locum staff, a lack of facility in the North of the region and staff welfare due to the service demands. The risks included detailed mitigation and action plans and had been escalated to regional headquarters appropriately. Potential risks that we found had been captured within the risk and issues logs and the common assurance framework action plan.
- The regional management team confirmed that they had undertaken detailed monitoring of the team since the merger of the three services in November 2021. The regional operations manager had worked closely with the team to support governance and assurance processes.

- We found a number of positive aspects at the DCMH. These included:
    - 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 an assessment and allocations team to ensure that resources were shared appropriately, and blockages were addressed.
    - Groupwork had been increased to provide more timely access to patients who required lower level, more practical or pre-therapy intervention.
    - The team had met the response target for urgent and routine referrals in recent months.
    - Staff had been engaged in the development of procedures for triage, assessment, allocation, and review, a shared governance system and integrated information systems.
    - Staff had access to all necessary supervision, training, and a wide range of continuous professional development.
    - Patient experience was good. Patients we spoke with during the inspection were positive about the service and the patient survey in February 2023 had received positive responses to all questions. The service had received many positive written comments from patients and other professionals.
    - The team had developed good working relationships with the defence primary care teams across the catchment area and operated from medical centres where required.
    - The environment at Bulford Camp was good and environmental risk assessments were in place and included all relevant risks.

However, some areas required further work including:

- There were large number of gaps in key posts that the team had not been able to fill with locum staff. Recruitment was underway but this had impacted on waiting lists for treatment at the service which had risen over the previous year. This had been further impacted by the large increase in the number of potential patients the service was responsible for.
- The team had a process to ensure that patients at most risk on the waiting list were contacted and risk assessed on a regular basis while they awaited treatment, however patients told us that this could be improved.
- The team did not have a permanent facility in the north of the region. While this was mitigated by staff home working and patients being offered virtual appointments this is required to ensure equitable access to all patients.

Leadership, morale and staff engagement

- The management team consisted of an acting department manager, a lead for healthcare governance, a band 7 nurse team leader and a practice manager with representation from the senior psychologist, senior social worker, a psychiatrist, and the assessment team lead. At the time of the inspection the clinical lead had recently left the service. Since, the wider management team had taken shared responsibility for clinical oversight with the support of the regional clinical director.
- Due to concerns about staffing levels and a lack of available leadership at Brize Norton and St Athan, and a lack of a facility at Brize Norton the teams had merged with Bulford DCMH in November 2021. Since, the service has operated from a main base at Bulford Camp with

some staff operating from home and from medical centres in St Athan and Brize Norton. Following the merger, the team had developed working groups to ensure the best practice was taken 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.

- During this inspection, we met with the regional clinical director and regional operations manager. They confirmed the high level support they had given to the team to address any emerging risks and aid development. Throughout this change process the regional operations manager dedicated additional time to support the team. Since the regional management team had provided ongoing support and taken enhanced oversight of the team. The DCMH leadership team confirmed that the regional leadership team had been supportive of their work.
- During the inspection we also met with the Commander of the newly formed Defence Healthcare Recovery Group (DHRG). From February 2023, this group had taken over leadership of all mental health services within the military. The Commander acknowledged the challenges that the team faced in regard to staffing, waiting lists and appropriate facilities and confirmed ongoing support to the team to address these issues.
- While the merger had ensured immediate safety for existing patients it had also affected the team's morale and the functioning of the team. Staff told us that initially morale had been poor, and this had resulted in a number of staff leaving the service. However, since then morale had improved despite significant recruitment gaps, and we found that leaders had worked well together to find effective solutions to ensure safe and effective delivery of care. All staff that we spoke with were positive about the leadership team and the improvements in practice that had happened since the merger. Staff told us that leaders were approachable and supportive of their work and that they felt part of a cohesive team. Staff were clear regarding their own roles and responsibilities. Job plans, objectives and expectations were in place for the team.
- Staff confirmed that there had been supportive working arrangements throughout the Covid pandemic. The team had developed and updated risk assessments and business continuity plans for the management of Covid-19 and had ensured that the staff had access to IT to enable homeworking, PPE and access to Covid testing. The team had worked effectively and safely through virtual and rotational office working meaning they could offer both virtual and face to face appointments where necessary. Since, the team had increased their office presence at the base to allow greater access to face to face appointments.
- A whistleblowing process was in place that allowed staff to go outside of the chain of command. Staff also had access to a Freedom to Speak Up Guardian (FTSU). Staff knew about the whistleblowing and FTSU processes and stated they would feel confident to use these should they need to. There had been no formal reported cases of whistleblowing or bullying at the team during in the previous year.
- Where required staff performance issues had been managed appropriately.
- Staff had access to regular professional development, clinical supervision, and caseload management appropriate to their role. The team regularly audited attendance and the quality of clinical supervision. All staff had undertaken an appraisal in the previous six months.
- All staff attended team meetings, governance meetings and weekly multidisciplinary meetings. Staff told us that service developments were discussed at these meetings, and they were offered the opportunity to give feedback on the service and input into service development. Staff took lead roles in supporting the improvement agenda.

Commitment to quality improvement and innovation

- An annual audit programme was in place and staff were involved in conducting and identifying audit topics. Topics included DMS mandated audits such as for clinical record keeping, patient experience, supervision levels, significant events trend analysis, complaints process, security, cleanliness, and environmental audits. Additional audits were undertaken of safeguarding procedures, Covid measures, groupwork effectiveness, triage assessment and discharge processes. Audits were used to inform changes to practice. Feedback and changes as a result of the audits were taken to the governance meetings and used to plan future development and the ongoing audit programme. However, the management team confirmed that audit completion had been impacted recently by low staffing levels.
- The team was undertaking additional quality improvement projects and addressing any potential risks as they arose. These included:
    - The team had set up a duty system, known locally as the point of contact (POC). This formed a single contact point for all referrals and undertook the triage and allocation of all new cases. Policies and processes had been developed to ensure that the POC had oversight of staff availability to undertake assessment so that the task was distributed efficiently and fairly across clinicians.
    - A process had been put in place to effectively manage the allocation of treatment. This was overseen by a regular allocations meeting that considered the best option for patients in line with their location, treatment type and risk.
    - The team had increased the range and availability of therapeutic groups to address waiting lists, prepare patients for psychological intervention and to provide more timely access to patients who required lower level, more practical or pre-therapy intervention. The team was about to begin to offer the group sessions in the north of the region to ensure wider access to patients.
    - Due to increase in demand and reduction in clinician availability consultant liaison clinics have been established. The clinics were for medical officers and occupational health staff to discuss cases or seek advice on grading, treatment, or medication. These have been successful in reducing the amount of new and re-referrals to the team, and the requirement for psychiatrist appointments.
    - The team had developed a team SharePoint site as a single point to access all required documentation and processes.
    - A working group was reviewing the multidisciplinary team process to ensure the most efficient use of this time.