Defence Medical Services
Department of Community Mental Health Digby

Quality Report

Department of Community Mental Health
RAF Digby
Ashby De La Launde
Lincolnshire
LN4 3LH

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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 Digby	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall Summary

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

We carried out an announced inspection at the Department of Community Mental Health (DCMH) Digby between the 21 and 23 February 2023. Overall, we rated the service at Digby as Good.

We found the following areas of good practice:

- 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. 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.
- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist.
- 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.
- Staff were kind, caring and compassionate in their response to patients.
- Leaders were capable and worked well together to ensure safe and 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.
- 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 a range of clinical audits and 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 Digby addresses the following:

- There were some gaps in key posts that the team had not been able to fill with locum staff, this had impacted on waiting lists for treatment at the service which remained high.
- Despite the team escalating some concerns about the environment, including a lack of soundproofing to clinical rooms and a lack of means to observe the waiting area, these were yet to be addressed by regional headquarters.
- We found that patient risks had been assessed however not all records contained the standardised risk assessment tool.
- We found that the overall standard of recordkeeping was good however the quality of some records required improvement. Recurring IT connectivity issues, which had led to the loss of documents from the records system, needed addressing.

Are services safe?

Good

We rated the DCMH as good for safe because:

- The team had a process in place to share concerns about patients in crisis or whose risks had increased. Crisis plans were in place and where a known patient contacted the team in crisis, the team responded swiftly. We saw good evidence of the team following up on any known risks.
- 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 had undertaken mandatory and induction training.
- The team was based within a standalone building which was comfortable, well decorated and equipped, and fully accessible to anyone with a physical disability.
- Emergency and business continuity plans were in place and effective.

However:

- There were some gaps in key posts that the team had not been able to fill with locum staff, this had impacted on waiting lists for treatment at the service which remained high.
- Despite the team escalating some concerns about the environment, including a lack of soundproofing to clinical rooms and a lack of means to observe the waiting area, these were yet to be addressed by regional headquarters.
- We found that patient risks had been assessed however not all records contained the standardised risk assessment tool.

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 was in place 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.
- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. 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.

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 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 December 2022 had received overwhelmingly positive responses to all questions. The service had received positive comments from patients and other professionals.
- 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?

Good

We rated the DCMH as good for responsive because:

- The management team oversaw all referrals and the waiting lists to ensure that resources were shared appropriately, and blockages were addressed.
- The team had introduced 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.
- The team was meeting the response target for urgent and routine referrals.
- Travelling required by most patients for appointments was within an acceptable time allowance. Virtual appointments were available and welcomed by many patients.
- The team had a procedure regarding following up patients who did not attend their appointment (DNA process). The DNA rate was seven per cent which was below the DMS target.
- A comfortable waiting area was available for patients. 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 were minimal. Staff demonstrated awareness of the complaints process and had supported patients to raise concerns.

However:

- The service was very busy and there were waiting lists for treatment. These had remained high over previous year. 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.
- Not all treatment rooms were adequately soundproofed, however staff had adopted measures such as playing music in the waiting area and using alternate rooms to ensure privacy during treatments.

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. Staff reported that they felt supported by their colleagues.
- 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.
- Audit and quality improvement projects were being undertaken. Staff were fully engaged in this process. Staff were positive about the improvements and felt this was making a positive difference to the quality of care offered to patients.

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 Digby

The department of community mental health (DCMH) provides mental health care to a population of approximately 14,000 serving personnel from across all three services of the Armed Forces. The catchment for the service includes all service personnel based in at 13 military establishments across the counties of Lincolnshire, Nottinghamshire, Rutland, Cambridgeshire, Bedfordshire and Norfolk, and those who have returned to the catchment area on home leave. The service operates from a main base at RAF Digby.

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.

At the time of our inspection the DCMH Digby active caseload was approximately 178 patients.

The service at Digby 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. RAF personnel within the team also form part of Tactical Medical Wing. On a duty basis they may be required to perform psychiatric aeromedical evacuation of overseas Armed Forces personnel.

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 teams, we reviewed a range of information the DCMHs 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 and interviewed additional patients and staff via video conferencing between the 21 to 23 February 2023. During the inspection, we undertook the following:

- looked at the quality of the teams' environment;
- observed how staff were caring for patients;
- spoke with patients who were using the service;
- looked at clinical records of patients who were using the service;
- observed the duty worker and administrative staff;
- spoke with the management team;
- spoke with 8 other staff members including doctors, nurses, psychologists, social workers and administration staff;
- joined the multi-disciplinary team meeting;
- joined the management team meeting;
- 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 – Digby

Detailed findings

Are services safe?

Good

Our findings

Safe and clean environment

- The team was based in a standalone facility at RAF Digby. There was sufficient space for waiting, treatment rooms and offices. The facilities were clean, and staff reported that maintenance requests would usually be responded to in a timely way however there were some areas of the building that required updating. A comfortable waiting area was available for patients. Some meeting rooms were available on the ground floor that were accessible to anyone with a physical disability.
- Not all treatment rooms were adequately soundproofed, however staff had adopted measures such as playing music in the waiting area and using alternate rooms to ensure privacy during treatments.
- General health and safety and fire safety checks were in place. There was an environmental risk assessment in place supported by guidance for staff in managing environmental risks. The assessments highlighted the risk factors we observed including relevant clinical environmental risks. The team 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 building. The waiting area could not be observed from the reception area. The team had requested that an observation window be fitted however this request was yet to be actioned.
- The building was fitted with a safety alarm for staff to use in the event of an emergency. Procedures were in place for staff to respond in an emergency. 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 regularly, and the building was 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 when appropriate.
- Equipment logs were in place. Equipment was found to be clean and had been serviced.

Safe staffing

- The active clinical team totalled 23 people and consisted of medical, nursing, social work, psychology and administration staff. The team included three locum staff. The management team confirmed that there had been some success with recruitment in the previous 12 months however the team had three additional vacancies; for two band 6 nurses one band 7 nurse. This had impacted on waiting lists. Recruitment was ongoing at the time of the inspection. During previous months there had been staff sickness that had also impacted the service however at the time of the inspection two key staff had returned in to post. RAF staff also told us that their wider duties supporting aeromedical evacuation impacted on the delivery of their clinical roles.
- The team benefited from a full-time practice manager and three administrators. 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.
- The management team told us that due to a lack of capacity in the service staff had previously struggled to complete training however staff had recently updated this. At the time of the inspection overall training compliance had risen to an average of 78%. Eighty-nine per cent of staff had received training in basic life support and automated external defibrillator management.

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.
- A senior nurse or duty worker was available each working day to review all new referrals. Routine referrals were also clinically triaged by the nurse to determine whether a more urgent response was required.
- Once a patient was accepted by the team a risk assessment was undertaken. In all cases we reviewed we found that risks had been assessed however not all records contained the standardised risk assessment tool.
- 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 a process to ensure that patients with higher risks on the waiting list were contacted and risk assessed on a regular basis while they awaited treatment.
- 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 a number of safeguarding referrals 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 recommend medication, but ongoing prescribing would be undertaken by GPs with shared care
- agreements where appropriate. No delays or errors were reported in patients receiving their medication.
- 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.
- Since February 2022, there were 39 significant events recorded by the service. All events had resulted in low or no harm. The majority of these related to administration issues, data loss and IT issues. 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 and had been regularly reviewed for patients we looked at. 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 information sharing across mental health and

primary care services. Any paper records were scanned on to the system to ensure access and safe storage. We found that the overall standard of recordkeeping was good however some records required improvement. Staff told us, and significant incident records confirmed, that there had been recurring issues regarding the loss of documents from the records system. The management team had escalated this appropriately and there had been recent improvement.

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. The team was also working with the NHS to provide additional high intensity therapy capacity. 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 and anxiety. Treatments included the use of cognitive behavioural therapy, cognitive processing therapy and eye movement desensitization and reprocessing.
- In addition, the team delivered an anxiety management therapeutic group to 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 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, groupwork effectiveness and patient experience, consent, waiting lists and KPI adherence, risk management of patients of interest and treatment outcomes.

Skilled staff to deliver care

- The team consisted of a full range of mental health disciplines working under the clinical leadership of a consultant psychiatrist. These included psychiatrists, nurses, psychologists, therapists 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.
- Staff received a weekly continued professional development session which had included topics such as ASER completion, NHS Veterans Mental Health Transition, Intervention & Liaison Service (TILS), outpatients service, maternity and neonatal services, substance misuse, self-care and template completion.
- 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 however this had not always been recorded in the clinical record. 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 was involved in the unit health committees however the team described that they had limited capacity to fully engage in this. However, the team had provided specialist advice and training for primary health care staff and military units to raise mental health awareness.

Adherence to mental health legislation

- The Mental Health Act was used very infrequently at the service. 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 DCMH 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 worker had acted as lead 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 full 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.
- In all patient files we reviewed we found records of consent to treatment and share information.

Are services caring?

Good

Our findings

Kindness, dignity, respect and support

- Staff showed us that they wanted to provide high quality care. 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.
- The patients we spoke with told us that staff were kind and supportive, and that they were treated with respect.
- The team undertook patient experience surveys on an ongoing basis. In December 2022, 31 people had participated in the survey. All participants stated they were treated with kindness and compassion by staff and that their privacy and dignity was respected.
- Staff demonstrated that they were knowledgeable about the history, possible 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 at all times. 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

- Care plans demonstrated the patient's involvement in their care. Records confirmed a copy of the care plan had been offered to the patient and patients 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.
- The team undertook patient experience surveys on an ongoing basis. In December 2022, 31 people had participated in the survey. Ninety-four per cent of participants stated they would recommend the service to friends and family should they need to use it and where happy with their care. All relevant participants felt staff would listen to their concerns if they had any.

- Since September 2022, 5 patients had made 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.
- Staff also confirmed times when they had offered support and advice to family members.

Are services responsive to people's needs?

Good

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. In addition, RAF personnel within the team also form part of Tactical Medical Wing. On a duty basis they may be required to perform psychiatric aeromedical evacuation of overseas Armed Forces personnel.
- At the time of the inspection, three 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.
- Clear referral pathways were in place. Referrals came to the team from medical officers, GPs and other DCMHs. These were indicated as either urgent or routine. Urgent referrals were considered by the end of the next working day. The target to see patients for a routine referral was 15 days. The DMS performance target for assessing patients within 15 days of routine referral was set at 95%. Since September 2022, the team had fully met the target for responding to urgent cases. During 2022 the team had not always met the target for responding to routine referrals however they had met the target in November 2022. The majority of occasions when the target had been missed were related to a date recording error in the electronic system rather than a lack of response.
- A senior nurse or duty worker was available each working day to review all new referrals. Routine referrals were clinically triaged by the nurse to determine whether a more urgent response was required. All fresh cases were also taken to the weekly multidisciplinary team meeting to ensure an appropriate response.
- At the time of the inspection the team's active caseload was 178. There had been 315 new referrals between January and November 2022.
- There were waiting lists for treatment. At the time of the inspection 83 people were waiting for step 2 – low intensity therapy. 18 people were waiting for step 3 - high intensity therapy. 12 people were waiting for psychology. The average waiting time overall was 140 days. The waiting list was reviewed weekly by the clinical lead and department manager to ensure that

all clinical risks were appropriately managed. The team was running further group sessions at the time of the inspection to further address the waiting lists.

- Within the Armed Forces, personnel can be ordered to attend for a medical appointment. However, personnel do not have to accept treatment. The team had a procedure regarding following up patients who did not attend their appointment (DNA process). The team confirmed that usually only patients who had been deployed to other duties at short notice did not attend. The DNA rate in November 2022 was 7%. The team had a process in place to follow up on any patients that failed to attend their appointment and there had been an overall reduction throughout the year.
- 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 the base to allow greater access to face to face appointments.

The facilities promote recovery, comfort, dignity and confidentiality

- The team was based at a standalone facility within RAF Digby. Patients we spoke with confirmed that they were able to access the team's base easily.
- Some treatment rooms were available on the ground floor at the base, which allowed for patients with disabilities to access the service.
- A comfortable waiting area was available for patients. Information was available on display about treatments, local services, patients' rights, and how to complain.
- There were sufficient treatment rooms at the base. Not all treatment rooms were adequately soundproofed, however staff had adopted measures such as playing music in the waiting area and using alternate rooms to ensure privacy during treatments.

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 DCMH serves patients based at 13 military establishments across the counties of Lincolnshire, Nottinghamshire, Rutland, Cambridgeshire, Bedfordshire and Norfolk, Travelling required by most patients for appointments was within an acceptable time allowance. Some patients stated that they had found virtual appointments extremely welcome as this had cut down on travel and had allowed greater flexibility.
- The team undertook patient experience surveys on an ongoing basis. In December 2022, 31 people had participated in the survey. The majority of patients (75%) had undertaken their appointments virtually. Ninety 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 December 2022 found that all patients knew how to make a complaint and felt they would be listened to.
- In the 12 months prior to our inspection, there had been one formal complaint at the service. This had related to changes in the treating clinician. The practice manager confirmed that this had fully investigated and responded to. This had not resulted in an armed service complaint or referral to the Armed Forces Ombudsman.
- Since September 2022, the team had received 5 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 occupation-focused community mental healthcare service, responsive to the needs of our patients and the chain of command to support force generation and sustain the physical and moral components of fighting power".

- The leadership 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 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. In addition, weekly team meetings and 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 practice manager was the nominated risk manager. Risk and issues were identified and logged on the regional headquarters and local risk and issues registers. These had been overseen by the regional operations team. The risk and issues logs included: waiting lists, staff vacancies including inability to recruit locum staff, staff retention and wellbeing, infrastructure issues, and impact of staff involvement in aeromedical evacuation rota. 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.
- We found a number of positive aspects at DCMH Digby. These included:
    - The team had met the response target for urgent referrals. The team had also begun to meet the target for response to routine referrals.
    - 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 and the team had improved the allocations process to ensure that resources were shared appropriately, and blockages were addressed.
    - 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.
    - There was a good reporting culture and incidents of concern had been used to drive improvements and aid learning.
    - Care plans and consent documentation was noted to be of a high standard.
    - Staff had access to all necessary supervision and a wide range of continuous professional development. Most staff had undertaken necessary mandatory training.
    - Patient experience was good. The patient survey in December 2022 had received overwhelmingly positive responses to all questions. The service had received positive comments from patients and other professionals. There were minimal complaints at the service.
    - The team had developed good working relationships with the defence primary care teams across the catchment area and operated from medical centres where required.

However, some areas required further work including:

- There were some gaps in key posts that the team had not been able to fill with locum staff. In addition, sickness and additional duties for RAF staff had impacted on capacity within the team. Recruitment was underway and some key personnel had returned to the team, but this had impacted on waiting lists for treatment at the service which remained high.
- Despite the team escalating some concerns about the environment, including a lack of soundproofing to clinical rooms and a lack of means to observe the waiting area, these were yet to be addressed by regional headquarters.
- In all cases we reviewed we found that risks had been assessed however not all records contained the standardised risk assessment tool.
- We found that the overall standard of recordkeeping was good however the quality of some records required improvement. Staff told us, and significant incident records confirmed, that there had been recurring issues regarding the loss of documents from the records system. However, the management team had escalated this appropriately and there had been recent improvement.

- The team was involved in the unit health committees however the team described that they had limited capacity to fully engage in this.

Leadership, morale and staff engagement

- The management team consisted of a clinical lead, a military department manager and a deputy department manager (all military) as well as a band 7 nurse and a practice manager. At the time of the inspection the clinical lead role was being handed over to another military psychiatrist. The practice manager and the deputy department manager had recently joined the team.
- Leaders told us that they had worked proactively to improve the culture of the service. Staff told us that morale had previously been very poor at the service however had significantly improved. We found that the leadership team was forming well and delivering improvement to ensure effective care to patients. Staff we met were positive and told us that the team worked well together, and that leaders were approachable and supportive of their work
- Staff were clear regarding their own roles and responsibilities. Job plans, objectives and expectations were in place for the team.
- Previously there had been significant gaps in the team that had not been filled by locum staff. In addition, there had been some long term sickness. This had impacted on waiting lists for treatment at the service. There had been some improvement in staffing levels, recruitment was underway and key staff had returned to post.
- 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) and two staff members acted as champions for this function. Staff knew about the whistleblowing and FTSU processes and stated they would feel confident to use these should they need to. 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 which was overseen by an audit working group. 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, groupwork effectiveness and patient experience, consent, waiting lists and KPI adherence,

risk management of patients of interest and treatment outcomes. 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.

- The team was undertaking additional quality improvement projects and addressing any potential risks as they arose. These included:
    - The team had made improvements to the allocations process. The ‘golden ticket’ procedure allows the team to track patients through their care journey from referral to discharge and had led to a more robust allocations process, ensured that resources were shared appropriately, and blockages were addressed.
    - A project had been undertaken to promote supervision and caseload management. There was good compliance with both at the time of the inspection.
    - The team had a health promotion lead whose role it was to deliver the NHS Health prevention timetable to promote mental health well-being at the team.
    - The team had undertaken a range of health promotion activities to support mental health awareness across the units and other services. This had included open days, training on ‘skills and drills’ to support primary care staff, work with the station on suicide and drink driving prevention.