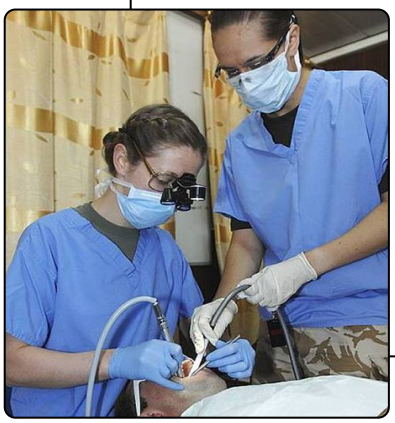
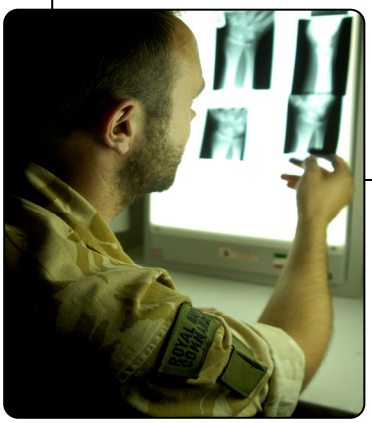
Defence Medical Services

A review of compliance with the essential standards of quality and safety

Summary report

June 2012





About the Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we make sure that people get better care. This is because we:

- Focus on quality and act swiftly to eliminate poor quality care, and
- Make sure care is centered on people's needs and protects their rights.

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Foreword by Dame Jo Williams

In 2008, the Defence Medical Services, which provides care and treatment to the British Armed Forces and their families, were reviewed by the Healthcare Commission and a report was published in March 2009. Over the past three years, the Defence Medical Services have addressed the recommendations from that review.

The Surgeon General approached the Care Quality Commission and requested a further review of their directly managed and provided services.

The Care Quality Commission accepted this invitation to undertake an exceptional piece of work recognising the importance of assessing the quality of medical services for those people serving their country in the most hazardous and difficult circumstances.

CQC followed up the recommendations of the previous review but used the new legislation to look at outcomes. This gave us the opportunity to use and test the applicability of our current methods of inspection in primary healthcare medical services, which we have yet to implement in the NHS.

Our review demonstrated the impact of the previous review and the improvements made as a result of independent external assessment. We found a number of areas of good practice across all of the services inspected. We also found exemplary care in the treatment of trauma in the field hospital in Afghanistan and across the regional rehabilitation units and the defence medical rehabilitation centre in the UK. We found compliance with the essential standards that relate to respecting and involving people so that they understand the care, treatment and support choices available to them and compliance with the standards for ensuring that people experienced effective, safe and appropriate treatment and support.

However, we found non-compliance with the essential standards relating to the governance, record-keeping and administration aspects of service rather than those relating directly to the delivery of clinical care. The lowest levels of compliance were for the standards relating to the safety and suitability of premises, safeguarding people from abuse and assessing and monitoring the quality of service provision.

We are sure that the outcomes from this review will help the continued development and improvement of the Defence Medical Services provided to the Armed Forces and their families.

Dame Jo Williams
Chair, Care Quality Commission

Foreword by Surgeon Vice Admiral Philip Raffaelli

As Surgeon General, I am responsible for medical operational capability and the end-to-end healthcare delivered by the Defence Medical Services. During 2011, I invited the Care Quality Commission (CQC) to review the performance of the Defence Medical Services in support of my commitment to provide that care to the highest quality.

CQC was given full access to wherever we deliver care. They were able to see and experience, at first hand, the delivery of clinical care on deployed operations in Afghanistan and overseas in Cyprus and Germany. They also visited a wide range of military medical and dental centres within the UK as well as Regional Rehabilitation Units and Departments of Community Mental Health. I was also especially keen that they saw the specialist Defence Medical Rehabilitation Centre at Headley Court.

I am pleased to report that the CQC has recognised as exemplary the management of trauma at the field hospital in Afghanistan and the subsequent rehabilitation of patients, both at regional level and at Headley Court.

The care and welfare support that we deliver to our patients in primary care was also observed to be of a high standard, but it is of concern to me that CQC identified that a number of primary healthcare facilities were not compliant with an essential standard. The evidence presented in this report will assist me in addressing the serious shortcomings especially in regard to infrastructure, and improving compliance with safeguarding and practice audit requirements. We will reinforce the areas of strength while tackling the identified weaknesses.

I am committed to the continuous improvement in the delivery of care across Defence, and independent, external review is a critical element of that process. I am most grateful to the CQC for this report.

Surgeon Vice Admiral Philip Raffaelli
CB QHP MSc MB ChB BSc FRCP FFOM MRCGP

Summary

Why we carried out this review

The Surgeon General requested that the Care Quality Commission (CQC) undertake a series of inspections and an overall review of their directly-managed health services – the Defence Medical Services (DMS). These healthcare services are provided to members of the Armed Forces and their families and some civilians. This was a follow-up to the review undertaken by the Healthcare Commission, the predecessor regulatory body to CQC, which was published in 2009.

CQC agreed to undertake a review of the DMS and we agreed that this review should be aimed at assessing compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These regulations describe the essential standards of quality and safety that people who use health and adult social care services in England, have a right to expect. The DMS is not subject to this legislation in delivering their directly-managed services and CQC has no enforcement powers similar to those that can be used to drive improvement in health and adult social care services in England. However, the review again exposed the DMS to external review and scrutiny and provided us with the opportunity to use and test our methods of inspection in primary healthcare medical services, which we have yet to implement in the NHS.

This report provides a summary the findings of our review, with examples of good and exemplary practice. The full, more detailed report is available on our website: www.cqc.org.uk

The aims of the review

The main aims of the review were to provide external review and scrutiny of the DMS, and to assess the impact of the previous review and how recommendations had been addressed.

The scope of the review

The scope of the review was extensive and focused on the range of routine healthcare services such as primary healthcare medical services, defence dental services, rehabilitation and community mental health services. We inspected a representative sample of services across the UK and in Germany and Cyprus. We also inspected medical services provided in Afghanistan, where the Armed Forces were on active service. Inspection visits took place between October 2011 and February 2012. The review followed up progress on recommendations made in the previous national review and on areas identified from current DMS internal assurance monitoring processes as a concern or risk. This included an analysis of some of the DMS internal assurance systems.

Services provided by the DMS

The DMS provides healthcare to approximately 258,000 people, including Service personnel serving in the UK, overseas and those at sea. Some healthcare services are provided to family dependants of Service personnel and entitled civilians (non-military personnel who work for the Ministry of Defence and are eligible to receive some medical services). This can include local nationals where the Armed Forces are operating in a war zone or hostile areas. Within this remit, the DMS is responsible for ensuring that Service personnel are ready and medically fit to go wherever they are required in the UK and throughout the world with the minimum of notice. This is generally referred to as being 'fit for task'. This not only includes deploying to areas of conflict, such as war zones or on international peacekeeping missions, but also being ready to participate in humanitarian missions and responding to emergency situations for example, floods, earthquakes or other environmental or natural disasters, both in the UK and overseas.

How we carried out this review

We spoke with over 200 patients, received over 550 responses to a patient survey and interviewed over 500 military and civilian clinical and clinical support staff across the DMS. We carried out 47 inspections of services in the UK, Cyprus, Germany and Afghanistan. Our inspections looked at how patients were involved in their healthcare and decisions about treatment, what information was available for them and the care and treatment they received. In primary healthcare medical services we also looked at how services kept people safe, how they managed medicines, how they supported, trained and supervised staff, and the infrastructure of buildings and facilities where services were provided. In dental services, we also looked at the processes in place to manage and control infection. Additionally, in the field hospital, we looked at how nutritional needs were being met. Our inspections of rehabilitation and hospital services also looked at how services worked with other healthcare providers. Across all services, we looked at how staff continually reviewed and monitored their practice.

We also looked at processes the DMS use that collected information on areas such as patient safety incident (PSI) reporting and the DMS Common Assurance Framework (CAF). The CAF is an internal quality assurance framework implemented across the DMS following the review undertaken by the Healthcare Commission.

Key findings

Our review of the DMS found areas of good practice across all of the services inspected.

We found exemplary practice in the treatment of trauma in the field hospital in Afghanistan, across regional rehabilitation units and in the defence medical rehabilitation centre in the UK.

Compliance with the essential standards of quality and safety was high in dental services, community mental health and rehabilitation services in the UK and in primary healthcare medical services and hospital services in Afghanistan. The highest levels of compliance, across services inspected, were for the standards relating to respecting and involving people and the provision of effective, safe and appropriate care and treatment.

Primary healthcare medical services in the UK, Germany and Cyprus showed lower levels of compliance with the essential standards. The areas of non-compliance predominately related to governance, infrastructure, recording and administration aspects of service provision. The lowest levels of compliance were for the standards relating to the safety and suitability of premises, safeguarding people from abuse and assessing and monitoring the quality of service provision.

The problems with premises were often caused by old and dilapidated buildings and infrastructure constraints that went beyond the scope of the governance and administration systems of individual units. The concerns about safeguarding vulnerable people were most frequently due to a lack of local protocols and procedures for addressing actual or suspected abuse and some deficiencies with staff training. A quarter of primary healthcare medical services were not compliant with assessing and monitoring the quality of service provision, which indicated significant concerns with governance systems.

In over 60% of the primary healthcare medical services we inspected, we found areas of non-compliance with the essential standards. The majority were not compliant with one standard, but 25% were not compliant with two or more of the essential standards. If these services were within the NHS or independent healthcare sector, our regulatory response would be to apply a compliance action because they were not meeting one or more of the essential standards. People using the services may not be at immediate risk of serious harm, but we would ask the service to submit an action plan, stating how they would achieve compliance and what actions they would take to ensure that they achieve and maintain compliance.

Across all of the services inspected, Outcome 1: Respecting and involving people who use services was the strongest area of performance with no areas of non-compliance. Outcome 5: Meeting nutritional needs, Outcome 6: Cooperating with other providers, and Outcome 8: Cleanliness and infection control had similarly positive results, but we inspected far fewer services against these standards. Outcome 4: Care and welfare of people who use services was also a strong area of compliance across all services, with only one service inspected found to be non-compliant.

Across all services, performance was worst for Outcome 10: Safety and suitability of premises and Outcome 7: Safeguarding people who use services from abuse. For both these standards, 28% of all services inspected were non-compliant. Outcome 14: Supporting staff and Outcome 16: Assessing and monitoring the quality of service provision were the next worst performers with 19% non-compliance, followed by Outcome 9: Management of medicines where we judged 12% of services to be non-compliant with this standard.

Across all services inspected, the main issues stemmed from problems with infrastructure, governance and administrative systems, and training, rather than from the delivery of care and treatment.

Results from the survey of patients showed that the majority of respondents thought that the quality of clinical care was good. In particular, physiotherapy was reported as being especially good. The main concerns among respondents were administrative problems, understaffing, a reported lack of respect for minor injuries and having to travel long distances for some treatment.

An analysis of patient safety incident reporting showed the breakdown of patient safety incidents to be very similar in services under the Royal Navy, the Army and Royal Air Force. In all three areas of service provision, there were problems relating to clinical administration. Communication, issues with the electronic patient record system, confidentiality and issues relating to referral for treatment were prevalent throughout these services. Issues regarding medical records were also a recurrent theme.

The DMS Common Assurance Framework (CAF) is the internal assurance process used for inspecting governance in individual services. An analysis showed that areas of poor performance varied across different services. For services provided under the Permanent Joint Headquarters (PJHQ), which covered medical services in Cyprus, the outcome area with the worst CAF ratings was Outcome 7: Safeguarding people who use services from abuse. This was the same for services provided by the Royal Navy and the Royal Air Force. For the Army services, all units were rated at least partially compliant with the CAF standards mapped to this outcome. Outcome 10: Safety and suitability of premises was generally a poor area of performance across all the services. The worst area of performance was for primary healthcare medical services and dental services from the Army.

Although the DMS internal assurance systems identified many of the most pressing areas of concern that the CQC inspections highlighted, they failed to identify some issues. In particular, problems stemming from Outcome 14: Supporting staff and Outcome 16: Assessing and monitoring the quality of service provision received lower prominence in the DMS assurance checks than they did in the CQC's inspections. This suggests that the DMS monitoring systems may underestimate the impact that gaps in governance and training systems were having on other areas of practice.

Overall, the comparisons between the CAF reports and the CQC inspection reports indicated some correlation in identifying major issues. This suggests that the CAF was a useful governance tool for identifying compliance with the essential standards of quality and safety.

Comparisons with the findings from the Healthcare Commission review carried out in 2008 show that there have been significant improvements in practice across the DMS since the report of the review was published in March 2009. This includes the significant changes to governance and assurance systems. Similarly, the comparisons between the results of CQC's recent inspection visits and findings from the DMS internal assurance systems demonstrated that some of these improvements were attributable to the new DMS internal governance structure. Overall, the Inspector General's office was in a much better position to

be able to accurately identify many of the most pressing issues with service provision, and thereby target improvement actions, than it had been in 2008.

Although these comparisons demonstrated significant improvements across the DMS, there were still ongoing issues that required action. In particular, infrastructure remains a major problem, causing deficiencies in the quality of patient care. Concerns over safeguarding arrangements were still apparent and there was no overall framework for identifying and managing safeguarding concerns at a local level across the DMS. Documentation and information capability systems remain in need of improvement, and problems associated with these issues have contributed to shortfalls in patient care.

Next steps

This is the second of two one-off reviews undertaken firstly by the Healthcare Commission and then by the Care Quality Commission. Neither regulatory body had any jurisdiction to require the healthcare providers to take any actions to improve.

It is recommended that the Defence Medical Services consider the findings of this review and take appropriate action to address the concerns raised. This will support the DMS to continue to build upon the developments and improvements to governance systems already implemented.

Given the success that the CAF methodology has had in assessing units against the 'Standards for Better Health' used in previous regulation of NHS healthcare, it is recommended that the DMS look into adapting this system to better fit with the Health and Social Care Act 2008 essential standards of quality and safety. These standards have a greater focus on assessing the impact on outcomes and experiences for people who use services, rather than on the systems and processes in place.

Our key findings

1 Primary healthcare medical services (UK, Germany and Cyprus)

Outcome 1: Respecting and involving people who use services

All 32 primary healthcare medical services inspected were judged as compliant with this outcome. This outcome showed the highest level of compliance of all of the standards assessed. Although all the primary healthcare medical services were compliant, there were minor concerns in 25% of the services inspected, which related to confidentiality not being maintained at all times, and services compromised by poor infrastructure.

A minority of services inspected had limited information available about health promotion. Some patients felt that more attention to administration procedures would support the running of the medical centres.

In the services judged as compliant, we found that patients were fully involved in their healthcare. They were given sufficient information to understand the care, treatment and support choices available to them and to manage their illnesses or injuries. Their privacy and dignity was respected and systems were in place to take their views and experiences into account in the way services were provided. Most, but not all services, had easy and timely access to appointments. The patients interviewed in primary healthcare medical services were, overall, very positive in relation to being respected and involved; having their needs met; making informed choices about their healthcare and having the opportunity to comment on services provided.

Outcome 4: Care and welfare of people who use services

All but one of the 32 primary healthcare medical services inspected were compliant with this standard. However, there were minor concerns in 25% of the services inspected. Services failed to ensure that all information was kept up to date, and some medical services did not have all the equipment needed for routine medical assessments readily available. Some patients experienced a lack of understanding and tolerance for assessment and treatment of minor ailments. Patients also found some inconsistencies in their care, stating that this was due to staff changes and the number of locum staff employed or, in some cases, attitudes to non-military patients. The non-compliance was due to inadequate systems regarding access to medical information.

In the 31 primary healthcare medical services judged as compliant, we found that patients experienced safe, effective and appropriate care, treatment and support. Their health needs were met in a way that protected their rights and involved them in decision-making. The patients interviewed in primary healthcare medical services were overwhelming positive about the primary healthcare services they received. This was supported by the positive comments in the patient survey.

Outcome 7: Safeguarding people who use services from abuse

Over 70% of primary healthcare medical services inspected were compliant with this standard. Minor concerns identified included inadequate information available for patients regarding safeguarding and some staff being unclear who the lead for safeguarding was within the practice. The evidence that contributed to a judgement of non-compliance for nearly 30% of services included the absence of a local documented procedure for staff to follow if they suspected abuse; a lack of information for patients; inadequate systems in place to record that all staff had undertaken relevant pre-employment checks; and incomplete records that were unable to show that relevant staff were up to date with clinical registration requirements. Some services had not developed effective relationships with local agencies with a responsibility or local lead role for safeguarding issues.

In the services judged as compliant with this standard, we found that patients were protected from abuse or the risk of abuse and staff had received training in safeguarding and were aware of their responsibilities to report actual or potential concerns. Information was available to patients and staff had access to relevant information and organisational policies. Local procedures were in place to deal with safeguarding issues. Effective relationships with relevant safeguarding and welfare organisations were also in place.

Outcome 9: Management of medicines

Just under 88% of primary healthcare medical services inspected were compliant with this standard. However, despite being judged as compliant there were minor concerns in 43% of these services. These included limited auditing and monitoring processes and some inadequate storage facilities. Just under 13% of the services inspected were judged as non-compliant with this standard. Evidence which contributed to this judgement included little or no audits being undertaken to ensure adherence to relevant legislation and DMS policy and procedures. There was also a lack of follow-up activity from outcomes of audits or from identified risks. Some medical services were not adequately monitoring controlled drugs. In some practices, there were risks associated with non-medical staff having to transcribe prescriptions, hand-written by medical officers, on to the electronic patient record database.

In the services judged as compliant with this standard, we found that medicines generally were handled safely, securely and appropriately. Information about medicines and explanations of their use, effect and possible side-effects was well communicated to patients and often accompanied by written information for patients to take away. Staff had access to relevant policies and guidance and clinical support.

Outcome 10: Safety and suitability of premises

Sixty nine percent of primary healthcare medical services inspected were compliant with this standard. However, although they were judged as compliant, over 60% of these services had minor concerns regarding maintenance of the premises and equipment and the management of fire procedures. Over 30% of all the services inspected were judged as non-compliant with this standard, which showed the lowest level of compliance across all of the standards inspected in primary healthcare medical services. Evidence that contributed to the judgement of non-compliance included medical services with very poor infrastructure, inadequate maintenance arrangements in place, facilities that did not always offer privacy and confidentiality for patients, infection control risks and inadequate facilities for all patients. Several of the medical centres had already been assessed as not fit for purpose or in need of urgent refurbishment.

In the services judged as compliant, we found that patients were receiving services in safe, clean and well maintained premises. Systems for monitoring the safety and suitability of premises were in place to maintain environmental standards. There were adequate facilities and business continuity plans in place in the event of an emergency, such as a power failure. Information about the services available to patients including, out-of-hours services, was clearly displayed.

Outcome 14: Supporting workers

Over 80% of primary healthcare medical services inspected were compliant with this standard. Minor concerns in a minority of services judged as compliant included inconsistent access to supervision and lack of cover for lead roles within the practice. Just under 19% of the services inspected were non-compliant with this standard. In some medical services, not all staff had attended mandatory training or staff had not received regular supervision or appraisals. Some medical services did not have adequate recording and assurance systems in place to provide evidence of training, staff appraisal or supervision attended. Some staff were not clear about lines of accountability and the management reporting systems in place.

In services judged as compliant with this standard, we found well-planned induction programmes for all military and civilian staff. Training needs were identified, staff attended the required mandatory training and received regular supervision and appraisals. Staff benefitted from well-led and well-managed medical services and felt supported and confident in their roles. The patients interviewed in primary healthcare medical services were generally very positive about the competence of staff providing the services.

Outcome 16: Assessing and monitoring the quality of service provision

Seventy five per cent of primary healthcare medical services inspected were judged to be compliant with this standard. In 25% of those services, there were minor concerns relating to limited or incomplete monitoring systems in place. Of all the primary healthcare medical services inspected 25% were judged as not compliant with this standard. Evidence of non-compliance included very little or

no planned audit activity; a lack of effective processes to manage risk; little or no action taken in response to patient safety reporting, patient feedback or analysis of adverse incidents. There was also minimal or no opportunity for staff to discuss governance issues and a lack of clarity around responsibilities for governance, in particular lead governance roles.

We found that services judged as compliant with this standard had effective and efficient processes in place to monitor the safety and quality of services provided. These included programmed audits, risk assessment and risk registers, monitoring and implementing relevant clinical guidelines and patient involvement and feedback systems. Action taken as a result of these and other monitoring systems was clearly recorded, and the actions taken as a result clearly evident. Staff were aware of their roles and responsibilities for the safety and continuous improvement of services. These primary healthcare medical services had strong and effective clinical and managerial leadership.

Overall level of compliance across primary healthcare medical services

We judged a number of services to be compliant with the essential standards, but still identified minor concerns with them. When we inspect NHS or independent healthcare providers, we expect them to take action to maintain compliance with essential standards. These actions, referred to as 'compliance actions', are not legal requirements. However, we do not have any jurisdiction to require the DMS healthcare providers to take any actions to improve.

We found areas of non-compliance with an essential standard in over 60% of the primary healthcare medical services inspected. The majority were not compliant with one standard, but 25% of services inspected were not compliant with two or more of the essential standards. Again, when an NHS or independent healthcare service is not meeting one or more of the essential standards, and people using the service are not at immediate risk of serious harm, we set compliance actions that require the service to send an action plan to the CQC, stating how they will achieve and maintain compliance. Services are given a clear timeframe in which to respond.

2 Primary healthcare medical services deployed operations (Afghanistan)

Outcome 4: Care and welfare of people who use services

The primary healthcare medical services in Afghanistan were fully compliant with this standard. There were no minor concerns. The services were judged compliant as we found that military personnel and entitled civilians had efficient and quick access to a range of excellent primary healthcare and medical emergency services delivered by well trained, committed and competent staff.

The range of primary healthcare services included health needs assessment, screening and treatment, occupational health, dental services, rehabilitation, community mental health services and health promotion and emergency services. Patients were involved in their plan of care and treatment options, and risks and benefits were fully explained. Patients reported that they received clear information from the medical centre staff and were confident in the teams providing care and treatment.

Outcome 6: Cooperating with other providers

The primary healthcare medical services in Afghanistan were fully compliant with this standard. There were no minor concerns. The services were judged compliant as we found that patients who either had accidents, were injured or became ill whilst on military operations, received effective and well coordinated primary healthcare services. This included health promotion and education as well as treatment, delivered by teams of specialist staff working effectively together. Relevant information was shared in a confidential way and services providing medical transfer and transport worked and trained together to provide effective and well coordinated services.

Outcome 9: Management of medicines

The primary healthcare medical services in Afghanistan were compliant with this standard. However, there were, some minor concerns relating to communication difficulties, which did at times impact on the timely prescribing of medication. Medication storage in some of the forward operating bases did not always fully meet policy requirements. Risk assessments and actions to mitigate against risk were in place. We judged the service to be compliant as we found that medicines were handled safely, securely and appropriately. Patients were given clear information about medicines. The use, effect and possible side-effects of all medication was well explained to patients. Staff had access to relevant policies and clinical guidance and support.

Outcome 16: Assessing and monitoring the quality of service provision

The services in Afghanistan were compliant with this standard. However, there were some minor concerns about keeping medical records up to date when treatment was provided outside the main primary healthcare medical centre, and with the connectivity with IT recording systems for medical records in the UK. At times, operational issues caused communication delays between the primary healthcare medical centre and the forward operating bases. Nevertheless, services were judged compliant as we found that there was a culture of continuous improvement, which was promoted and supported. There was an audit lead and committee that oversaw audit and ongoing evaluation of services. The outcomes from these activities were used to change and improve services and to advise and educate Service personnel. Patients using the primary healthcare services provided regular feedback about the services they used, which was used to make improvements to services. Staff were supported through a network of clinical supervision. Services identified the risks of working in hostile and remote conditions and took action to mitigate or remove risks as far as possible.

3 Hospital healthcare deployed operations (Afghanistan)

Outcome 4: Care and welfare of people who use services

The hospital services in Afghanistan were fully compliant with this standard. There were no minor concerns. The services were judged compliant as we found that patients experienced exemplary hospital treatment, care and support. Fundamental to this was the multi-disciplinary approach to effective team working from all the staff we encountered. The hospital provided intensive care and high-dependency facilities, as well as surgical, medical and accident and emergency services. The hospital had an extensive range of diagnostic testing facilities, including access to a well-equipped, X-ray department with computerised tomography (CT) scanners and laboratory facilities.

The hospital was designed primarily to manage and provide acute resuscitation and damage control surgery for battle injury casualties. Non-battle injuries resulting from accidents or illness were also treated. We considered the provision of trauma care to be exemplary. The hospital was UK-led, but multi-national in its staffing complement. This included clinicians from the USA and Denmark working alongside the predominantly territorial army field hospital unit, who were staffing and managing the hospital at the time of the inspection visit. Patients told us that they were impressed with the care they had received and by the instruction and information that was shared with them about their care and treatment.

Outcome 5: Meeting nutritional needs

The hospital services in Afghanistan were fully compliant with this standard. There were no minor concerns. The service was judged compliant as we found that patients were supported to have adequate nutrition and hydration. The hospital provided choices of food and drink for patients to meet their diverse needs, ensuring that the food they provided was nutritionally balanced and supported their health. The hospital could cater for special diets.

Outcome 6: Cooperating with other providers

The hospital services in Afghanistan were fully compliant with this standard. There were no minor concerns. We found that patients received safe and coordinated care, treatment and support where more than one provider was involved or where patients were moved between services. The care and treatment provided within the field hospital involved a range of clinical and clinical support staff at every stage of the patient pathway. These staff worked very closely together and developed systems so that the care provided was both seamless and integrated. Regular clinical meetings were held to review and monitor patients within the hospital and those transferred to the UK for further treatment.

Outcome 8: Cleanliness and infection control

The hospital services in Afghanistan were fully compliant with this standard. There were no minor concerns. The hospital was clean, well-lit and well-maintained. There were appropriate arrangements in place to safely manage infection prevention and control. These included regular monitoring and auditing, clear cleaning schedules, protective clothing for staff and training for staff. Patients were protected against the risk of exposure to infections through the systems and processes in place.

Outcome 9: Management of medicines

The hospital services in Afghanistan were fully compliant with this standard. There were no minor concerns. The hospital was keeping patients and staff safe by having systems in place to ensure that medicines were managed and handled safely and securely. Systems were in place for auditing and monitoring medicines and staff had access to relevant policies and guidance, training and clinical support.

4 Defence Medical Rehabilitation Centre

Outcome 1: Respecting and involving people who use services

The Defence Medical Rehabilitation Centre was fully compliant with this standard. There were no minor concerns. Patients benefited from a working ethos that promoted their right to be treated with dignity and consideration, and that promoted privacy, understanding and confidentiality. Patients understood the care, treatment and the support available to them. They were able to express their views, which were taken into account in the way the services were provided. The patients we spoke with in the centre were very positive in relation to patient respect and involvement, services meeting their needs and making informed choices about their healthcare.

Outcome 4: Care and welfare of people who use services

The Defence Medical Rehabilitation Centre was compliant with this standard. However, there were some minor concerns that some patients were distressed at having to relocate from their accommodation from one ward to another at weekends. Other patients said that they felt there was a need for medical boards to receive more direction to assist with grading and continued treatment. The centre was judged as compliant because patients experienced effective and appropriate care tailored to meet their individual needs. The use of the social model of disability, with its emphasis on ability and independence, allowed patients to take risks, to build confidence and to attain their full rehabilitation potential. Patients felt they received a high standard and quality of care from a committed and competent team of staff.

Outcome 6: Co-operating with other providers

The Defence Medical Rehabilitation Centre was fully compliant with this standard with no minor concerns. Patients received coordinated care, treatment and support where more than one provider was involved, or when they were moved between services. Staff had developed very effective relationships with a number of healthcare providers, government departments and charitable organisations to work in cooperation with others. This provided coordinated care, treatment and support when patients received services from other organisations.

Outcome 14: Supporting workers

The Defence Medical Rehabilitation Centre was fully compliant with this standard with no minor concerns. Staff had access to training, support and supervision, and guidance for the care and treatment of patients. We found that well-planned induction programmes were in place for all military and civilian staff. Safe recruitment processes for the employment of locum staff were in place. Training needs were identified, staff attended the required mandatory training and they received regular supervision and appraisals. We found well-led and well-managed teams of staff, and staff felt supported and confident in their roles. The patients we spoke with in the centre were very positive about the competence of staff providing the services and the help and support they received.

Outcome 16: Assessing and monitoring the quality of service provision

The Defence Medical Rehabilitation Centre was fully compliant with this standard. There were no minor concerns. Processes and systems were in place to manage risks and influence decision-making so that patients benefited from safe, quality, care, treatment and support. These included programmed audits, risk assessment and risk registers, research programmes, implementing relevant clinical guidelines and patient feedback systems. Clear governance arrangements were in place. Staff in the centre were involved in training to develop treatment and rehabilitation services, not just at the centre, but throughout the rehabilitation services. Staff were aware of their roles and responsibilities for the safety and continuous improvement of services. The defence medical rehabilitation centre had strong and effective clinical and managerial leadership.

5 Regional rehabilitation units

Outcome 1: Respecting and involving people who use services

All the regional rehabilitation units inspected were judged as compliant with this standard. There was a minor concern in one of the units, which related to the age and layout of the building and the inadequate accommodation for patients attending rehabilitation treatment programmes. A further minor concern related to the lack of immediate accessibility of all patient information on the electronic

patient record system. In the regional rehabilitation units inspected, we found that patients were fully involved in their rehabilitation programme. Patients were given sufficient information to understand the care, treatment and support choices available to them and to manage their illnesses or injuries. Their privacy and dignity was respected and systems were in place to take account of their views and experiences to influence the way services were provided. The patients interviewed in the regional rehabilitation units were very positive about services meeting their needs and in providing information about their current and future healthcare needs.

Outcome 4: Care and welfare of people who use services

All of the regional rehabilitation units we inspected were judged as fully compliant with this standard. We found that patients were fully involved in the planning and monitoring of their treatment plans. Their needs were thoroughly assessed by a multidisciplinary team of staff to ensure that there was clear diagnosis of their needs and a tailored treatment plan implemented. We found that patients experienced effective and appropriate individual care and treatment programmes. The patients interviewed in the regional rehabilitation units were very positive about the level of individual support they received and the quality of treatment provided.

Outcome 6: Cooperating with other providers

All the regional rehabilitation units inspected were judged as fully compliant with this standard. We found that patients received coordinated care, treatment and support where more than one provider was involved, or where patients were moved between services. Regional rehabilitation units had developed effective working relationships with a number of other service providers across the NHS for investigations and specialist healthcare treatment.

Outcome 14: Supporting workers

All the regional rehabilitation units inspected were judged as fully compliant with this standard. Staff working in these units had access to a range of training and development opportunities to develop and maintain their knowledge and practice. Staff felt well-supported, and received regular supervision and appraisals. Patients attending the regional units for treatment were confident that care was delivered by competent teams of staff.

Outcome 16: Assessing and monitoring the quality of service provision

All the regional rehabilitation units we inspected were judged as fully compliant with this standard. We found that patients benefitted from treatment and support as there were effective processes in place to manage risks and monitor hoe services were delivered. Planned programmes of audit activity were in place, risk registers were used to effectively manage risks, and feedback from patients was used to inform and develop practice. Staff were aware of their responsibilities for the safety and quality of care and treatment. We found these units to be very well-led and managed.

6 Defence dental services

Outcome 4: Care and welfare of people who use services

All of the defence dental services inspected were compliant with this standard. Minor concerns identified in one practice related to the management of emergency medicines. Patients were fully assessed and involved in their treatment plans. They were given information about treatment and risks. Treatment plans were comprehensive and contained all relevant information. Patients had access to a wide range of information about oral health and hygiene and general health issues. The patients we spoke with in the dental services inspected were very confident in the competence of dental staff. Most of the comments in the survey stated that clinical care and staff in dental services was good or excellent. However, a number of comments were made about the lack of dental staff in some areas and the distance that Service personnel had to travel to access the dental services.

Outcome 8: Cleanliness and infection control

The defence dental services inspected were compliant with this standard, although minor concerns identified in one practice related to the removal of clinical waste. Patients were protected against the risk of exposure to infections through the systems and processes in place. Premises were clean and hygienic and the centres had a designated lead for overseeing the management of infection control. Staff were aware of relevant polices and protocols to follow, for example, the Defence Dental Services Standard Operating Procedures Chapter 13 and Health Technical Memorandum (HTM) 01-05. Surgeries were fitted with the appropriate hand-washing facilities and staff and patients had access to appropriate protective clothing. There was information and guidance available for staff on issues such as the management of sharps, dealing with clinical waste and infection prevention and control. The dental services had appropriate sterilization processes in place.

Outcome 10: Safety and suitability of premises

All but one of the defence dental services inspected were compliant with this standard. However, even though judged as compliant, there were minor concerns in over 60% of the services inspected. Concerns related to the infrastructure of the premises and included maintenance requirements not being met, poor access for patients with limited mobility and inadequate toilet facilities. In the dental service judged as non-compliant with this standard, the premises did not provide all of the treatment rooms required, had insufficient space for briefing new patients and inadequate toilet facilities. Additional treatment rooms were in portacabins, which were cramped and bad weather had caused the roof to bow. The internal temperature could not be maintained in these surgeries.

In the services judged as compliant, we found that premises provided appropriate accommodation to meet the needs of patients and staff who provided dental care and treatment. Despite many maintenance issues, premises were kept clean and hygienic. Risk management systems and business continuity plans were in place.

Spillage kits were available, radiography was well managed and Ionising Radiation (Medical Exposure) Regulations 2000 protocols were displayed and adhered to. Patients were treated in adequate facilities and not at risk from unsafe equipment or facilities.

Outcome 16: Assessing and monitoring the quality of service provision

All the dental services inspected were compliant with this standard. However, minor concerns were identified in over 40% of practices inspected.

These related to services that had not carried out a risk assessment of all environmental risks or had not taken all actions as a result of concerns raised in environmental audits. Although there was clinical audit activity in some services, this was not part of a planned programme of clinical audit.

In the dental services judged as compliant, we found that services had effective and efficient processes in place to monitor the quality and safety of services provided. These included programmes for audits, risk assessments and monitoring and implementing relevant clinical guidelines. Staff were aware of their roles and responsibilities for the safety and continuous improvement of services. Staff were aware of relevant polices and procedures for the safe practice and governance of dental services. Staff felt confident to raise or report any concerns. Services had systems to effectively manage risks to patients' health, welfare and safety.

7 Departments of community mental health

Outcome 1: Respecting and involving people who use services

We inspected two services that provided community mental health care. Both were fully compliant with this standard and there were no minor concerns. Patients were fully involved in all aspects of the planning and delivery of their care and treatment, and were given sufficient information to understand the care, treatment and support choices available to them. Their privacy, dignity and confidentiality were respected and they were able to express their views about the services they received.

Outcome 4: Care and welfare of people who use services

Both services were compliant with this standard. There were minor concerns within one service that related to the limited access, or delay in getting assessment and treatment, from the psychology services. Patients were fully involved in the assessment of their mental health needs and in planning support and treatment programmes. They were supported by committed, knowledgeable well-trained and up-to-date staff, who understood their roles and responsibilities.

Outcome 16: Assessing and monitoring the quality of service provision

Both of the services inspected were fully compliant with this standard, and there were no minor concerns. The departments of community mental health had effective and efficient processes in place to monitor the quality and safety of services provided. These included a programme for audits, risk assessments and monitoring, and implementing relevant clinical guidelines.

Comparison of inspection methodologies: CQC inspections and the DMS Common Assurance Framework

Overall analysis of the CQC inspection process and the DMS Common Assurance Framework (CAF) assessment indicated that of the primary healthcare medical services provided by the Royal Navy, the Army and the Royal Air Force, the Army was, on average, the most compliant with the standards being assessed.

Comparisons between the results of the two assessment methodologies indicated that, despite some differences, there were many similarities. This indicates that the CAF assessment methodology was a reasonable estimate of compliance with the CQC essential standards of quality and safety – at least in terms of the strongest and worst performing areas.

Comparison with findings from the 2008 Healthcare Commission review

Comparison with both the results of CQC's recent inspection visits and the DMS internal assurance systems against the findings from the 2008 Healthcare Commission review show significant improvements in practice across the DMS since the report of the Healthcare Commission review was published in March 2009. The comparison demonstrates how these improvements were attributable to the considerable changes in the DMS internal governance structure and assurance systems. Overall, the Inspector General's office was in a much better position to be able to accurately identify many of the most pressing issues with service provision, and thereby target improvement actions, that it had been in 2008.

Although the comparisons demonstrate significant improvements across the DMS, there were still ongoing issues that needed to be addressed. In particular, infrastructure was clearly a major problem causing deficiencies in the quality of patient care at some premises. Concerns with safeguarding arrangements were still apparent and an overall framework for identifying and managing safeguarding concerns at a local level across the DMS was still required. Documentation and information capability systems were still in need of improvement, with the problems associated with the electronic patient record

system having contributed to shortfalls in patient care in some areas. Further improvements to governance systems were also required, for example a basic mandatory audit programme could be implemented for all services and improved training arrangements for risk management.

Given the success of the CAF methodology in assessing units against the Standards for Better Health introduced in the NHS in 2004, it is recommended that the DMS look into adapting this system to better fit with the current Health and Social Care Act 2008 essential standards of quality and safety, which have a greater focus on assessing the impact on outcomes for people who use services.

Appendix A: DMS services inspected in this review

Royal Navy primary healthcare medical centres and sick bays

HMS Collingwood	Fareham, Hampshire
HMS Nelson	Portsmouth, Hampshire
HMS Dauntless	Portsmouth, Hampshire
42 Commando Royal Marines	Plymouth, Devon
HMS Drake	Plymouth, Devon
HMS Neptune	Helensborgh, Argyll
HMS Victorious	Helensborgh, Argyll
RNAS Culdrose	Helston, Cornwall
HMS Dragon	Portsmouth, Hampshire

Army primary healthcare medical centres

Medical Centre Dishforth	Dishforth Airfield, North Yorkshire
Medical Centre Chester	The Dale Barracks, Chester, Cheshire
Medical Reception Centre Colchester (inc primary healthcare rehabilitation facility)	Merville Barracks, Colchester, Essex
Military Correction Training Centre Colchester	Colchester, Essex
Medical Centre Maidstone	Invicta Park, Maidstone Kent
Medical Centre Woolwich (inc primary healthcare rehabilitation facility)	Woolwich, London
Medical Reception Station Shorncliff (inc primary healthcare rehabilitation facility)	Sir John Moore Barracks, Shorncliffe, Kent
Medical Reception Station Catterick (inc primary healthcare rehabilitation facility)	Duchess of Kent Barracks, North Yorkshire
Medical Reception Station Beaconsfield (inc primary healthcare rehabilitation facility)	Defence School of Language, Wilton Park, Beaconsfield, Buckinghamshire
Medical Reception Station Aldershot (inc primary healthcare rehabilitation facility)	Aldershot centre for Health Aldershot, Hampshire
Medical Reception Station Winchester (inc primary healthcare rehabilitation facility)	Sir John Moore Barracks, Winchester Hampshire

Medical Reception Station Aldergrove (inc primary healthcare rehabilitation facility)	Joint Helicopter Flying Station, Aldergrove, Northern Ireland
Bielefeld Medical Centre	Catterick Barracks, Bielefeld, Germany
Sennelager Medical Centre	Normandy Barracks, Germany
Hohne Medical Centre	Haig Barracks, Germany

Royal Air Force primary healthcare medical centres

RAF Brize Norton	Brize Norton, Oxfordshire
RAF Leeming	Leeming, North Yorkshire
RAF Valley	Valley Anglesey, North Wales
RAF Waddington	Waddington, Lincolnshire
RAF Wittering	Wittering, Cambridgeshire
RAF Cranwell	Cranwell, Lincolnshire

Permanent Joint Headquarters

Operational Primary Healthcare Medical Centre	Camp Bastion, Afghanistan
Operational Field Hospital	Camp Bastion, Afghanistan
Dhekelia Medical Reception Station	Dhekelia, Cyprus
Episkopi Medical Centre	Episkopi, Cyprus
Akrotiri Medical Centre	Akrotiri, Cyprus

Regional rehabilitation centres

Regional Rehabilitation Centre Aldershot	Aldershot, Hampshire
Regional Rehabilitation Centre Catterick	Catterick, North Yorkshire
Regional Rehabilitation Centre Edinburgh	Edinburgh, Scotland
Regional Rehabilitation Centre as part of primary healthcare medical centre provision	Camp Bastion, Afghanistan

Defence Military Rehabilitation Centre

Defence Military Rehabilitation Centre Headley Court	Epsom, Surrey

Defence dental services

Dental Centre Cranwell	Cranwell, Lincolnshire
Dental Centre Catterick	Scotton Road, Catterick, North Yorkshire
Dental Centre Catterick	Helles Barracks, Catterick, North Yorkshire
Dental Centre Minley	Gibraltar Barracks, Camberley, Surrey
Dental Centre Marchwood	McMullen Barracks, Marchwood, Southampton, Hampshire
Dental Centre HMS Culdrose	Helston, Cornwall
Dental Centre Dartmouth	Britannia Royal Naval College, Dartmouth, Devon

Departments of community mental health

Department of Community Mental Health Portsmouth	HM Naval Base, Portsmouth
Department of Community Mental Health Leuchars	RAF Leuchars, Fife Scotland
Department of Community Mental Health as part of primary healthcare medical centre provision	Camp Bastion, Afghanistan

Appendix B: The Health and Social Care Act 2008 (Regulated activities) Regulations 2010

Care and welfare of service users

Regulation 9 Outcome 4

9.—(1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of—

(a) the carrying out of an assessment of the needs of the service user; and

(b) the planning and delivery of care and, where appropriate, treatment in such a way as to—

(i) meet the service user's individual needs,

(ii) ensure the welfare and safety of the service user,

(iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment, and

(iv) avoid unlawful discrimination including, where applicable, by providing for the making of reasonable adjustments in service provision to meet the service user's individual needs.

(2) The registered person must have procedures in place for dealing with emergencies which are reasonably expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the provision of services, in order to mitigate the risks arising from such emergencies to service users.

Assessing and monitoring the quality of service provision

Regulation, 10 Outcome 16

10.—(1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to—

(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

(2) For the purposes of paragraph (1), the registered person must—

(a) where appropriate, obtain relevant professional advice;

(b) have regard to—

(i) the complaints and comments made, and views (including the descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf, pursuant to sub-paragraph (e) and regulation 19,

(ii) any investigation carried out by the registered person in relation to the conduct of a person employed for the purpose of carrying on the regulated activity,

(iii) the information contained in the records referred to in regulation 20,

(iv) appropriate professional and expert advice (including any advice obtained pursuant to sub-paragraph (a)),

(v) reports prepared by the Commission from time to time relating to the registered person's compliance with the provisions of these Regulations, and

(vi) periodic reviews and special reviews and investigations carried out by the Commission in relation to the provision of health or social care, where such reviews or investigations are relevant to the regulated activity carried on by the service provider;

(c) where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to—

(i) the analysis of incidents that resulted in, or had the potential to result in, harm to a service user, and

(ii) the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies;

(d) establish mechanisms for ensuring that—

(i) decisions in relation to the provision of care and treatment for service users are taken at the appropriate level and by the appropriate person (P), and

(ii) P is subject to an appropriate obligation to answer for a decision made by P, in relation to the provision of care and treatment for a service user, to the person responsible for supervising or managing P in relation to that decision; and

(e) regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users.

(3) The registered person must send to the Commission, when requested to do so, a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (1) are being complied with, together with any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.

Safeguarding service users from abuse

Regulation 11, Outcome 7

11.—(1) The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of—

(a) taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and

(b) responding appropriately to any allegation of abuse.

(2) Where any form of control or restraint is used in the carrying on of the regulated activity, the registered person must have suitable arrangements in place to protect service users against the risk of such control or restraint being—

(a) unlawful; or

(b) otherwise excessive.

(3) For the purposes of paragraph (1), "abuse", in relation to a service user, means—

(a) sexual abuse;

(b) physical or psychological ill-treatment;

(c) theft, misuse or misappropriation of money or property; or

(d) neglect and acts of omission which cause harm or place at risk of harm.

Cleanliness and infection control

Regulation 12, Outcome 8

12.—(1) The registered person must, so far as reasonably practicable, ensure that—

(a) service users;

(b) persons employed for the purpose of the carrying on of the regulated activity; and

(c) others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity, are protected against identifiable risks of acquiring such an infection by the means specified in

paragraph (2).

(2) The means referred to in paragraph (1) are—

(a) the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection;

(b) where applicable, the provision of appropriate treatment for those who are affected by a health care associated infection; and

(c) the maintenance of appropriate standards of cleanliness and hygiene in relation to—

(i) premises occupied for the purpose of carrying on the regulated activity,
(ii) equipment and reusable medical devices used for the purpose of carrying on the regulated activity, and

(iii) materials to be used in the treatment of service users where such materials are at risk of being contaminated with a health care associated infection.

Management of medicines
Regulation 13, Outcome 9

13. The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

Meeting nutritional needs

Regulation 14, Outcome 5

14.—(1) Where food and hydration are provided to service users as a component of the carrying on of the regulated activity, the registered person must ensure that service users are protected from the risks of inadequate nutrition and dehydration, by means of the provision of—

(a) a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs;

(b) food and hydration that meet any reasonable requirements arising from a service user's religious or cultural background; and

(c) support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.

(2) For the purposes of this regulation, "food and hydration" includes, where applicable, parenteral nutrition and the administration of dietary supplements where prescribed.

Safety and suitability of premises

Regulation 15, Outcome 10

15.—(1) The registered person must ensure that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of—

(a) suitable design and layout;

(b) appropriate measures in relation to the security of the premises; and

(c) adequate maintenance and, where applicable, the proper—

(i) operation of the premises, and

(ii) use of any surrounding grounds, which are owned or occupied by the service provider in connection with the carrying on of the regulated activity.

(2) In paragraph (1), the term "premises where a regulated activity is carried on" does not include a service user's own home.

Respecting and involving service users
Regulation 17, Outcome 1

17.—(1) The registered person must, so far as reasonably practicable, make suitable arrangements to ensure—

(a) the dignity, privacy and independence of service users; and

(b) that service users are enabled to make, or participate in making, decisions relating to their care or treatment.

(2) For the purposes of paragraph (1), the registered person must—

(a) treat service users with consideration and respect;

(b) provide service users with appropriate information and support in relation to their care or treatment;

(c) encourage service users, or those acting on their behalf, to—

(i) understand the care or treatment choices available to the service user, and discuss with an appropriate health care professional, or other appropriate person, the balance of risks and benefits involved in any particular course of care or treatment, and

(ii) express their views as to what is important to them in relation to the care or treatment;

(d) where necessary, assist service users, or those acting on their behalf, to express the views referred to in sub-paragraph (c)(ii) and, so far as appropriate and reasonably practicable, accommodate those views;

(e) where appropriate, provide opportunities for service users to manage their own care or treatment;

(f) where appropriate, involve service users in decisions relating to the way in which the regulated activity is carried on in so far as it relates to their care or treatment;

(g) provide appropriate opportunities, encouragement and support to service users in relation to promoting their autonomy, independence and community involvement; and

(h) take care to ensure that care and treatment is provided to service users with due regard to their age, sex, religious persuasion, sexual orientation, racial origin, cultural and linguistic background and any disability they may have.

Complaints
Regulation 19, Outcome 17

19.—(1) For the purposes of assessing, and preventing or reducing the impact of, unsafe or inappropriate care or treatment, the registered person must have an effective system in place (referred to in this regulation as "the complaints system") for identifying, receiving, handling and responding appropriately to complaints and comments made by service users, or persons acting on their behalf, in relation to the carrying on of the regulated activity.

(2) In particular, the registered person must—

(a) bring the complaints system to the attention of service users and persons acting on their behalf in a suitable manner and format;

(b) provide service users and those acting on their behalf with support to bring a complaint or make a comment, where such assistance is necessary;

(c) ensure that any complaint made is fully investigated and, so far as reasonably practicable, resolved to the satisfaction of the service user, or the person acting on the service user's behalf; and

(d) take appropriate steps to coordinate a response to a complaint where that complaint relates to care or treatment provided to a service user in circumstances where the provision of such care or treatment has been shared with, or transferred to, others.

(3) The registered person must send to the Commission, when requested to do so, a summary of the—

(a) complaints made pursuant to paragraph (1); and

(b) responses made by the registered person to such complaints.

Supporting workers
Regulation 23, Outcome 14

23.—(1) The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by—

(a) receiving appropriate training, professional development, supervision and appraisal; and

(b) being enabled, from time to time, to obtain further qualifications appropriate to the work they perform.

(2) Where the regulated activity carried on involves the provision of health care, the registered person must (as part of a system of clinical governance and audit) ensure that healthcare professionals employed for the purposes of carrying on the regulated activity are enabled to provide evidence to their relevant professional body demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise.

(3) For the purposes of paragraph (2), "system of clinical governance and audit" means a framework through which the registered person endeavours continuously to—

(a) evaluate and improve the quality of the services provided; and

(b) safeguard high standards of care by creating an environment in which clinical excellence can flourish.

Cooperating with other providers
Regulation 24, Outcome 6

24.—(1) The registered person must make suitable arrangements to protect the health, welfare and safety of service users in circumstances where responsibility for the care and treatment of service users is shared with, or transferred to, others, by means of—

(a) so far as reasonably practicable, working in cooperation with others to ensure that appropriate care planning takes place;

(b) subject to paragraph (2), the sharing of appropriate information in relation to—

(i) the admission, discharge and transfer of service users, and

(ii) the co-ordination of emergency procedures; and

(c) supporting service users, or persons acting on their behalf, to obtain appropriate health and social care support.

(2) Nothing in this regulation shall require or permit any disclosure or use of information which is prohibited by or under any enactment, or by court order.

Appendix C: Definitions of CQC judgements in this review

Under the Health and Social Care Act 2008, health and social care providers have a legal responsibility to make sure their services meet essential standards of quality and safety. The public has a right to expect these whenever or wherever they receive care.

This review was carried out using CQC's previous regulatory model, which was replaced on 1 April 2012 with a refined model that has simplified our regulatory approach.

Under the previous model, when a service met the standards that the law for health and adult social care in England says people should expect, we said the service was 'compliant' and when it was failing to meet those standards, we said it was 'not compliant'. There were a number of decisions we could make as a result of our inspections and, in this review using the previous regulatory model, we used four:

Compliant – this meant the service was meeting the standards and no action was needed to improve.

Compliant, minor concern – this meant the service was meeting the standards we expect, but it needed to take action to make sure it kept meeting the standard. In this case, we set the service an 'improvement action' to try to prevent them falling below the bar.

Non-compliant, moderate concern – this meant the service was not meeting the standards we expect and although people were generally safe, there were some unacceptable risks to their health and wellbeing. In this case, CQC set a 'compliance action' in place for the service, which required them to carry out the action we told them by a set date or face further action.

Non-compliant, major concern – this meant the service was not meeting the standards we expect, and people were not protected from unsafe or inappropriate care. In this case, we would also use a 'compliance action' but we may have used one of our most serious powers – which could include suspending or even closing services – to protect people from harm.

When a service is non-compliant, it does not mean everyone who uses that service will experience poor care. It means there is an increased risk of people receiving poor care. We found many examples of good care in non-compliant services that we inspected. Our judgements try to capture the overall quality of care and we try to tackle problems that increase the risk of poor care in any given case.

Using our new regulatory model, we judge a provider or manager to be either 'compliant' or 'non-compliant' with one or more of the regulations. Where we judge them to be non-compliant, we assess the impact of this on people who use the service (and others, where appropriate) and judge it to be either 'minor', 'moderate' or 'major' and this, in turn, determines our regulatory response.

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