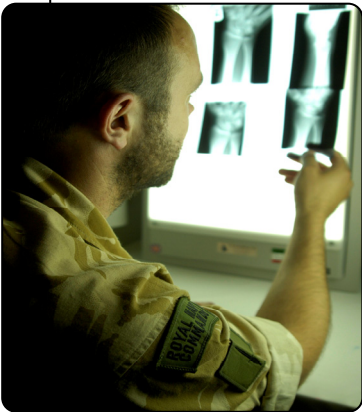


# Defence Medical Services

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

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.



# Contents

<b>Foreword by Dame Jo Williams</b>	<b>2</b>
<b>Foreword by Surgeon Vice Admiral Philip Raffaelli</b>	<b>3</b>
<b>Introduction</b>	<b>4</b>
<b>Details of our findings for the outcomes inspected:</b>	
<b>Section 1: Primary healthcare medical services</b>	<b>9</b>
Analysis of inspection reports: overall outcome judgements	38
Summary of comparison of inspection methodologies: CQC and CAF	40
<b>Section 2: Primary healthcare medical services deployed operations (Afghanistan)</b>	<b>42</b>
<b>Section 3: Hospital healthcare deployed operations (Afghanistan)</b>	<b>51</b>
<b>Section 4: Defence Medical Rehabilitation Centre</b>	<b>60</b>
<b>Section 5: Regional rehabilitation units</b>	<b>71</b>
<b>Section 6: Defence dental services</b>	<b>80</b>
Comparison of CQC inspection reports with CAF reports for individual units	89
<b>Section 7: Department of Community Mental Health</b>	<b>91</b>
<b>Summary of patient responses to the survey</b>	<b>96</b>
<b>Comparison with findings from the 2008 review</b>	<b>97</b>
<b>Appendix A: DMS services inspected in this review</b>	<b>102</b>
<b>Appendix B: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010</b>	<b>105</b>
<b>Appendix C: Definitions of CQC judgements in this review</b>	<b>112</b>

## 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 for people. 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 MRCCGP





# Introduction

The following sections of the report provide detailed information on the aims and scope of the review, the services provided by the DMS and how we carried out this review. This is followed by details of our findings. There is also a summary version of this report on our website: [www.cqc.org.uk](http://www.cqc.org.uk).

## Detailed aims of the review

- To provide external review and scrutiny of the DMS.
- To assess the impact of the previous review and how recommendations had been addressed.
- To identify areas of current concern or risk from internal DMS assurance processes.
- To consider which of the essential standards of quality and safety, used for assessing health and adult social care providers in England, would be the most useful to inspect the DMS against.
- To use current CQC methodology for inspection and review of the DMS.

The Healthcare Commission, one of the predecessor organisations of the Care Quality Commission (CQC), undertook a review of the DMS and published a report in March 2009, which made a number of recommendations. That review found areas of good practice and examples of exemplary care. However, the review also reported that there were areas in need of attention and development to ensure that services were safe and all clinical areas were suitable and 'fit for purpose'. The Healthcare Commission also recommended that the DMS reflected on the experience of external review and considered how to ensure independent review of its services in the future.

CQC agreed to undertake a follow-up review of the DMS, which was 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 NHS and independent healthcare services and adult social care services in England, have a right to expect. CQC has developed outcomes that we expect people using a service will experience when the provider of that service is meeting the essential standards.

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 NHS and independent health and adult social care services in England. However, the DMS had requested that the Care Quality Commission (CQC) base this review on the regulatory model for inspection used for assessing health and adult social care provision in England.

## Detailed scope of the review

The review covered healthcare services directly provided and managed by the DMS as follows:

- Primary healthcare medical services in the UK, Germany and Cyprus.
- Operational primary healthcare in Afghanistan.
- Operational hospital care in Afghanistan.
- The defence medical rehabilitation centre.
- Regional rehabilitation units.
- Defence dental services.
- Departments of community mental health.
- Headquarters Surgeon General.

## Services provided by the Defence Medical Services

The core functions of the DMS are:

- To ensure medical operational capability.
- To provide healthcare to all serving personnel and registered dependants and entitled civilians.
- To provide health advice to the military chain of command.

The DMS provides healthcare to approximately 258,000 people, including Service personnel serving in the UK and overseas and those at sea. Some healthcare services are provided to family dependants of Service personnel and entitled civilians. 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 international peacekeeping missions, but also being ready to participate in humanitarian missions and responding to emergency situations, including for example, floods, earthquakes or other environmental or natural disasters – both in the UK and overseas.

The DMS encompasses the medical, dental, nursing, allied health professional, paramedical and support personnel, including civilian healthcare staff employed by the Royal Navy, the British Army and the Royal Air Force. The DMS may also provide some aspects of healthcare to other countries' Service and civilian personnel in areas of conflict and war zones. The range of services provided by the DMS includes primary healthcare, dental care, hospital care, rehabilitation, occupational medicine, community mental health care and specialist medical care. The DMS provides healthcare in a range of facilities, including medical and dental centres, regional rehabilitation units and when on deployment on military operations, in field hospitals.

The Royal Naval Medical Service employs over 1,500 personnel who provide healthcare. Its work includes providing comprehensive healthcare to shore establishments and on ships, submarines and medical care to the Royal Marines.

The Army Medical Services employs approximately 4,900 personnel who provide healthcare. This includes British Forces Germany Healthcare Services, medical regiments and field hospitals, including the Territorial Army, and primary and pre-hospital emergency care.

The Royal Air Force Medical Services employs over 1,800 personnel who deliver primary, secondary and intermediate care, including the aero medical evacuation service to the Armed Forces through headquarters Tactical Medical Wing and the aero medical Evacuation Control Cell.

The Defence Dental Services (DDS), as a tri-Service dental healthcare organisation, delivers military oral health care and health advice to maximise the fighting power of the Armed Forces. The DDS employs approximately 900 personnel worldwide from the Royal Navy, the Army, the Royal Air Force and the Civil Service in both operational and non-operational environments.

The DMS are not formally subject to the provisions of Registration under the Health and Social Care Act (2008) and the following services were not part of this review:

- There are five Ministry of Defence hospital units in the UK, which are embedded into NHS acute trusts where the care is provided by those host trusts. These are located in Portsmouth, South Tees, Frimley Park, Derriford and Peterborough. In addition the Royal Centre for Defence Medicine is embedded within Birmingham Hospitals NHS trust. These services are assessed through assessment of the host NHS Trust's compliance with regulations under the Health and Social Care Act (2008).
- Care commissioned from other NHS providers and the independent healthcare sector will not be part of this review as these organisations are already subject to inspection and regulation by the Care Quality Commission.

Although an integral aspect of the DMS, Regular and Territorial Army field hospitals in the UK did not form part of this review, as until deployment, these hospitals do not deliver direct patient care. The Healthcare Governance process of these units will be reviewed as an integral aspect of the process review of Headquarters Surgeon General. However, the review did cover the hospital services in Camp Bastion in Afghanistan, provided by a Regular and Territorial Army field hospital.

## How we carried out this review

The work of CQC is to monitor and review health and adult social care services taking into account the experiences of patients and people who use services. All of the inspections carried out within DMS units included talking to patients. This included Service personnel, dependants and some entitled civilians.



Working closely with senior staff from the DMS, we considered which standards would be the most useful to inspect against. This was based on areas already identified as a risk or of some concern following internal DMS insurance assessments. We therefore focused on the following areas and the standards people should expect to receive from healthcare services.

- How patients were involved in their healthcare and decisions about treatment.
- Information available for patients and the care and treatment they received.
- How nutritional needs were met in a field hospital.
- How services worked with other healthcare providers involved in providing care.
- How services kept people safe.
- The management and control of infection.
- How medicines were managed.
- The infrastructure of buildings and facilities where services were provided.
- How staff working in the DMS were supported, trained and supervised.
- How staff continually reviewed and monitored their practice.

All the patients we spoke to were told that their comments, whether positive or not would be non-attributable. We took written notes but have not included any personal or confidential patient-identifiable information in our report.

We carried out 47 inspection visits to primary healthcare medical and dental services, rehabilitation units, and community mental health teams in the UK, Germany and Cyprus. Further inspection visits were made to an Operational area in Afghanistan. Site visit inspection reports were written, quality-assured and finalised. These reports informed this national report. Across the services, we spoke with over 200 patients and interviewed over 500 military and civilian clinical and clinical support staff.

As part of the overall review of DMS, we undertook a series of in-depth interviews with Service personnel who had undergone and experienced extensive medical care and treatment. This was within the DMS and in other services, either in the NHS or private healthcare. These interviews provided a rich source of additional qualitative data, tapping into people's experiences along their care and treatment pathway. This information has been used to inform this report.

We also undertook a survey, using an online webform, which requested Service personnel, their dependants and entitled civilians to comment on their experiences of care and treatment of DMS. People were asked to submit their comments on a confidential web form. We received over 550 responses. The analysis of these has also been used to inform this report.

This review assessed how well the DMS were meeting essential standards of quality and safety. These are described as the outcomes that people using services should experience. The outcomes are the same across all services, however, the way specific services demonstrate how they achieve these outcomes can differ. The DMS were asked to provide evidence of compliance with the standards taking into account the complexity of the service, the range of staff employed and the systems available to produce information.



## Details of our findings for the outcomes inspected

The following sections provide a breakdown of the services inspected. This includes examples of good practice found during individual inspection visits across a representative sample of services provided by the DMS. It gives details of the level of compliance found, minor concerns found, and also where services were judged as not being compliant with the essential standards of quality and safety.

## Section 1

# Primary healthcare medical services

In the primary healthcare medical services in the UK, Germany and Cyprus, we inspected against the following outcomes:

Outcome 1: Respecting and involving people who use services

Outcome 4: Care and welfare of people who use services

Outcome 7: Safeguarding people who use services from abuse

Outcome 9: Management of medicines

Outcome 10: Safety and suitability of premises

Outcome 14: Supporting workers

Outcome 16: Assessing and monitoring the quality of service provision

## Outcome 1: Respecting and involving people who use services

The standard states that people receiving services should:

- Understand the care, treatment and support choices available to them.
- Be able to express their views, so far as they are able to do so, and be involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

### Primary healthcare medical services - Outcome 1

All 32 primary healthcare medical services inspected were judged as compliant with this standard. This outcome showed the highest level of compliance of all of the standards assessed. Although all of the primary healthcare medical services were compliant, there were minor concerns in 25% of the services inspected. These minor concerns were that confidentiality was not maintained at all times with services compromised by poor infrastructure. A minority of services inspected had limited information available about health promotion. Some patients felt that increased attention to administration procedures would support the running of the medical centres.

In the medical services judged as compliant, across the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services, we found that patients were fully involved in their healthcare. 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 have their views and experiences taken 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 patient respect and involvement, services meeting patient needs, making informed choices about their healthcare and having the opportunity to comment on services provided.

### **Level of compliance**

All of the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services were judged to be compliant with this standard. Although compliant, in 25% of the services there were minor concerns.

### **Minor concerns**

Minor concerns related to confidentiality not being maintained at all times, with services compromised by poor infrastructure. A minority of services inspected had limited information available about health promotion.

### **Services not compliant with this standard**

No primary healthcare medical services were judged as non-compliant with this standard.

### **Services compliant with this standard**

Patients attending primary healthcare medical services overwhelmingly reported being treated with respect and dignity, and were fully involved in their treatment plans and decisions about their health. Systems were in place to seek views and feedback from patients, and their comments and suggestions were used to improve and develop services. Patients felt that staff were approachable, competent, caring and responsive. They said that they were given sufficient information about treatment options, risks and choices available and were supported to be as independent as possible and take responsibility for their health. The majority of primary medical services rated very positively in relation to patient respect and involvement, meeting patient needs, making informed choices about their health care and having the opportunity to comment on services provided. All of the primary healthcare medical services had information about health and health related issues. Overall this was well displayed and available.

We found several improvements to services as a direct result and response to patient feedback. Examples included improvements and changes to increase or vary times of accessibility to GPs and clinics, improved written patient information, and allocating appointments for emergency or urgent consultations. We also found examples of changes and improvements made to waiting areas and facilities.

## Examples of good practice

### Patient respect and involvement

Patients said they were involved in decisions about their care and treatment. Throughout our visit, we observed that staff were respectful and courteous to patients - *Medical Centre 42 CDO Royal Marines*.

Records showed that patients were offered choices about their care and treatment, for example, whether or not to have flu vaccinations. Patients told us that they were fully involved in their care and treatment, and could use processes like the 'choose and book' system to decide where they wanted to receive any secondary healthcare - *Medical Centre Dishforth*.

Patients being cared for on the recovery pathway said that they felt very involved in every part of their recovery. We saw one family, supported by a welfare officer, being involved in their injured relative's recovery - *HMS Drake*.

### Meeting patients' needs

Patients said that where particular wishes were expressed, such as a preference to be seen by a male or female doctor, this was recorded in the patient record. When staff made subsequent appointments for the patient, the records alerted them to the patient's preferences. We were able to view examples of preferences in patient's records - *HMS Nelson*.

The medical centre had introduced a new way for patients to book an appointment, referred to as the 'application system'. A form was available to detainees if they wanted to make an appointment at the medical centre. The appointments could be arranged around any courses or training those individuals might be attending. The forms were triaged and the appropriate appointment made. All emergencies were seen on same the day - *Military Corrective Training Centre Colchester*.

Examples were given of how staff recognised that a patient's social and cultural diversity, values and beliefs may influence their decisions in care and treatment - *RAF Wittering*.

Patients told us that they felt staff treated them as individuals, tailoring their treatment and support to them and their overall welfare - *Medical Centre Royal Navy Air Service Culdrose*.

### Making informed choices

Patients said their views were taken into account and they were given sufficient information to understand their condition and make choices about treatment. Patient information was available on both wall displays and in leaflet format - *HMS Neptune*.

Staff described how they ensured patients were aware of their choices and they provided them with information verbally and in written form. There was a patient information guide and we saw lots of information displayed in communal areas about medical conditions. Health advice was provided in both English and Ghurkali for Nepalese patients - *Medical Centre Maidstone*.

Patients told us that they were involved in all of the decision-making about their treatment and were helped by staff to understand the process of their treatment. We also saw that information leaflets and other information was freely available to patients. This included information on issues such as smoking cessation and weight management - *RAF Waddington*.

Crew members told us that they were given sufficient information to make decisions and be fully involved in their care. Options for referral to shore-based services in the base primary healthcare medical practice for medical assessment or diagnosis were fully explained - *HMS Dragon*.

### **Collecting feedback from people who use services**

Staff told us that a patient satisfaction survey was carried out during the last patrol with an intention to repeat it on the next. We found that based on a return of 21 questionnaires with a scoring system of 1 (poor) to 7 (outstanding), most areas had scores of 5, 6 or 7. No area scored below 4 (good) - *HMS Victorious*.

Patients who had used the medical centre for over six months said they had previously completed surveys. They were satisfied overall with the service and were confident their feedback was listened to and acted on - *Bielefeld Medical Centre*.

There was a suggestion box near to the reception desk that was emptied daily. The complaints procedure was displayed in the waiting area and in each consultation room. The results from the recent survey carried out were shown on the television monitor in the waiting area - *RAF Cranwell*.

Patients were able to provide feedback and influence how the service was run. Immediate feedback could be given through the comments and suggestions book in the main waiting area. Following negative comments made in the patient satisfaction surveys completed in September 2011, changes were made to clinic provision - *Medical Reception Station Colchester*.

Feedback questionnaires were available in the waiting area. Results of the most recent feedback survey were displayed and feedback had been taken in to account when making improvements to the service. For example, the physiotherapy hours were increased as a result of concerns raised through feedback about limited access to *physiotherapy* - *Medical Centre Beaconsfield*.

### **Results from the survey**

Results from the survey found a number of very positive responses that referred to doctors and clinical staff being respectful, well-trained and professional. Comments included:

*"My medical centre is excellent. I have had fast access to my GP who listens to me and provides a professional approach."*

*"All medical personnel I have visited have been very helpful and are always willing to refer to onward investigation for medical issues as requested."*

*"An excellent patient-focused service with high quality care and skilled practitioners."*

*“Great service, we do not have to wait for appointments and they help us at short notice all the time.”*

Results also showed that there were both positive and negative comments about how easy or difficult it was to get an appointment for assessment or treatment. Several respondents mentioned that it was easy to get an appointment and waiting times were not long. However, several respondents stated that there was a lot of difficulty in getting an appointment, both in terms of long waiting times and contactable hours and distance to be travelled. Comments included:

*“When urgent cases occur, you still have to wait around a week or sometimes more for an appointment to see the doctor.”*

The administrative side of care was mentioned, often in a negative tone. Concerns were raised about the lack of administration staff due to posts being gapped, resulting in clinical staff having to cover administrative roles or insufficient administrative support.

### **Comparison with individual unit DMS Common Assurance Framework (CAF) reports**

As part of the inspection of the primary healthcare medical services, we reviewed the internal assurance process introduced by the DMS following the review of clinical governance undertaken by the Healthcare Commission. This is called the Common Assurance Framework (CAF). Of the 32 locations inspected there were three services for which there was no CAF report. Five CAF inspection reports were excluded from the comparison due to the age of the CAF (any CAF from before March 2010 was excluded).

The way in which the CAF reports were analysed as part of this review meant the focus was on the standards assessed in the services inspected. It is therefore possible that some of the issues found by the CQC inspection reports were picked up in other areas of the CAF but not in our analysis.

Comparison of the CQC inspection reports with the individual unit DMS CAF reports indicated that for outcome 1, respecting and involving people who use services, the majority of relevant concerns identified in the CAF reports had been resolved by the time of inspection. However, there were some issues raised in the inspection reports that had not been identified in the CAF reports for outcome 1. These tended to focus on problems with maintaining privacy and confidentiality often due to infrastructure constraints.

## Outcome 4: Care and welfare of people who use services

The standard states that people receiving services should expect to experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

### Primary healthcare medical services - Outcome 4

All but one of the 32 primary healthcare medical services inspected were compliant with this standard. There were, however, minor concerns in 25% of the services inspected. Services needed to ensure that all information was kept up to date and some medical services did not have all of the equipment for routine medical assessments readily available. Some patients have found a lack of understanding and tolerance for assessment and treatment of minor ailments. Patients also found some inconsistencies in their care provision, 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 services assessed as compliant, across the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services, we found that patients experienced safe, effective and appropriate care, treatment and support. They had their health needs 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.

### Level of compliance

All but one of the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services inspected were compliant with this standard.

### Minor concerns

Minor concerns identified were the impact of some poor infrastructure in some medical centres, and that communication with other service providers was not always as quick and efficient as it should be.

### Services not compliant with this standard

The medical centre judged as non-compliant with this standard had inadequate systems to ensure that all medical information was available and up to date for the treating clinician. This caused delays and risks to assessment and treatment.

### Services compliant with this standard

Patients were involved in their plan of care and treatment options and risks and benefits were fully explained. Medical services provided included occupational health, assessment and treatment of illnesses and injuries, chronic disease management, screening, vaccination and immunisation clinics and specialist health



care provision. These included, for example, aviation medicine and illness-related treatment and clinics for conditions such as heart disorders, child health and specific men's and women's health issues.

Across primary healthcare medical services we found that medical records were well managed, held on the electronic computer system, detailed and stored securely. Information was comprehensive and assessment and treatment plans clearly and appropriately documented. Staff were overall aware of the need to maintain health-related information confidentially and securely. We found a significant amount of evidence to confirm that guidance for best practice from the National Institute for Health and Clinical Excellence (NICE) was being used to ensure the most up to date treatments were in place.

In several medical services visited there was a primary healthcare rehabilitation facility. This offered assessment and treatment from teams of physiotherapists and rehabilitation exercise instructors. These facilities were well used and appreciated by patients who had access to prompt and efficient assessment and treatment programmes. This service was also valued by the medical centre staff who could refer patients for treatment quickly.

Access to a wide range of health promotional information and activities was available across the primary healthcare medical services. The most commonly run clinics were for smoking cessation, healthy eating and exercise programmes and weight management. A number of clinics were run according to the population served, commonly referred to as the 'population at risk'. These included for example, specific disease-related clinics such as those for people who were diabetic, had hypertension or heart related conditions and child health and welfare.

Several of the medical services visited provided 24-hour emergency care, which in some medical services included pre-hospital emergency care and primary healthcare 'out-of-hours' services. Where these were not provided, alternative arrangements were in place. Where treatment was provided for dependants, including children, this was described as good or excellent. Some concerns were expressed about the fact that not all defence primary healthcare medical services provided services for dependants.

### Examples of good practice

#### **Assessment, planning and delivery of care**

We found that patients were keen to tell us they rated their experiences of the service as good or excellent. This was especially in relation to accessing medical staff easily and not having to wait long for appointments. Patients emphasised how staff struck the balance between being friendly and professional and we were given examples of how staff 'went that extra mile' to ensure people received timely and individualised treatment and care - *Medical Centre Woolwich*

Patients told us they could easily get appointments at convenient times. Patients were satisfied their needs were met when requiring referrals to secondary healthcare providers. Patients said staff at the medical centre provided an efficient and responsive service - *Medical Centre Bielefeld*

Treatment plans were agreed with the patient and progress regarding a plan was reviewed and discussed on a regular basis. Patients said that staff were compassionate and professional in their duties no matter how big or small the problem they were experiencing - *Medical Centre Chester*

We reviewed a number of patient records and found that these were sufficiently detailed to inform relevant healthcare staff. We identified information related to information provision and decisions about treatment options, benefits and risks. There was a facility on the electronic patient record to label information as confidential. Access to this was restricted to specified staff - *Medical Centre Beaconsfield*

### **Managing risks**

There was a weekly meeting of a station wide multi-disciplinary team, which was attended by a medical officer from the medical centre. The purpose of the meeting was to review the needs of personnel assessed to be at high risk, and make sure they got the best outcomes for themselves and the Service - *HMS Nelson*

Patients' records contained clear assessments of the risks and benefits of treatments, and they showed that treatment plans were monitored for progress - *Medical Centre Sennelager*

Staff told us each person was risk-assessed in respect to their needs and where treatment was required, such as vaccinations additional risks were then assessed. Reviews of patient records and discussion with staff showed that vaccination risks explored areas related to general health, allergies, medication interactions and phobias - *RAF Brize Norton*

The community staff described the assessments they carried out, which involved completing risk assessments of vulnerability and determining any relationships the patients may have with social services. Risk for patients living alone was identified as part of the assessment process - *Medical Centre Bielefeld*

### **Services treating children**

There was a specific leaflet directly relating to child health matters for families and children. This included comprehensive information about inpatient services, specialist paediatric services and a range of other welfare support services - *Medical Centre Akrotiri*

Child services included child health surveillance, immunisation programme, and drop-in clinics in the community. Staff followed the Department of Health's Healthy Child Programme guidance with a programme of screening, immunisation, health and development reviews. These were supplemented by advice about health, wellbeing and parenting - *Medical Centre Bielefeld*

Parents said children received a good service and that staff were skilled in working with them. Children were always seen on the same day as an appointment was requested - *RAF Valley*

### **Risk of homicide or suicide**

Procedures were in place for dealing with patients who were considered to be at risk to themselves or others, to help ensure their safety - *HMS Collingwood*

Registers of people identified as 'at risk' were maintained and reviewed by the unit's health committee. Examples of individuals at risk were discussed with the inspection team - *Medical Reception Station Colchester*

Staff described the assessments for risk of homicide or suicide that they undertook for all patients. The assessments included using 'The Worthing Weighted Risk Indicator', Hospital Anxiety and Depression scores and step-by-step evidence based flowcharts for risk of deliberate self harm. In each nursing consultation, staff asked four questions, if there were two or more 'yes' answers then the nurses referred the patient to a doctor immediately. We saw mental health referral advice in each treatment room for staff and leaflets and information displayed about mental health for patients - *Medical Reception Centre Winchester*

### Results from the survey

The results from the survey were that the quality of care was considered, overall, to be very good. The main concerns of people accessing services were understaffing, use of locum medical staff or inconsistent medical care. Some respondents stated that they felt that there was a lack of respect for minor injuries or illnesses. Some dependants stated that they did not get the same service as their military partners.

### Comments regarding staffing and services

*"Within my medical centre, there are significant problems regarding manning of the reception. The service is fragmented as there are different people on reception each day."*

*"When you actually get to see a doctor the service is okay but there is a real shortage of doctors."*

*"A lack of continuity is a problem, with a life long condition it means that every time the doctors change or I change unit I have to start right back from the beginning. It means that the observation of my monitoring is never there."*

*"Inconsistent service, constantly repeating problems, due to the rapid change in doctors. When you do manage to get an appointment you never get the same doctor especially if you have a long term problem. Instead of your notes being checked you have to repeat everything to the new doctor, who then comes up with treatment that you have already been told you can't have, you then have to explain why you can't have these treatments despite the fact it is recorded in your notes."*

*"I rarely see the same doctor twice due to so many locums."*

*"Despite having to deal with not inconsiderable manning issues, the service I have received (quality and timing) has been consistently good."*

*"The staff are great and very helpful but pregnancy care falls between the DMS and NHS and is therefore very disjointed."*

### Comments regarding attitude and approach

*“Each time I have visited with the problem which affects exercise and general lifestyle due to pain I am told it is my age, or that it should be expected at my time of life after so long in the army, or even worse that: I should ‘man up’”.*

*“The second time I attended they did exactly the same thing and when I mentioned it to the boss I was told to ‘man up’. After the second time I was finally given an MRI where they discovered what I had told them all along – that I had physical damage to the bones of the knee, which needed surgery.”*

*“I was continually given tablets, on repeat, for joint swelling and pain in the joints but was never once given a blood test to establish the nature of the condition. Once I left the services, I was sent for blood tests by my GP and it was found out that I have rheumatoid arthritis.”*

### Comments regarding treating dependants

*“I also felt that they were more prepared to deal with military personnel than they were civilian personnel.”*

*“Sometimes the junior members of the teams seem to get frustrated by dependants though, and may require some training in dealing with the general public and the differences in their needs and expectations.”*

### Comments regarding patient perceptions

Results from the survey also showed that there was a perception from patients who had received care in the NHS that services provided by DMS primary healthcare were better. Patients reported being treated with more dignity and respect and excellent treatment for diagnosis and aftercare by the DMS. Comments included:

*“In comparison with the NHS, recently attended for an appointment, I was treated with more dignity and respect by DMS medical staff.”*

*“Very good service. Better than I had on civvy street.”*

### Comparison with individual unit DMS Common Assurance Framework reports

Comparison of the CQC inspection reports with the individual unit DMS CAF reports indicated that for outcome 4, care and welfare of people who use services, the majority of relevant concerns identified in the CAF reports had been resolved by the time of inspection. There were however, some issues raised in the inspection reports that had not been identified in the CAF reports for Outcome 4. These most frequently involved service delivery problems caused by equipment problems, infrastructure constraints, staffing levels and issues with records systems.

## Outcome 7: Safeguarding people who use services from abuse

The standard states that people receiving services should expect to be protected from abuse, or the risk of abuse, and their human rights respected and upheld.

### Primary healthcare medical services - Outcome 7

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 within the practice was.

Nearly 30% of the services inspected were not compliant. Evidence that contributed to a judgement of non-compliance included the absence of a local documented procedure for staff to follow if they suspected abuse and a lack of information for patients. There were inadequate systems in place to record that all staff had undertaken relevant pre-employment checks. We found services that did not have complete records to show that relevant staff were up to date with clinical registration requirements. Not all services had developed effective relationships with local agencies with a responsibility or local lead for safeguarding issues.

In services judged as compliant with this standard, across the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services, we found that patients were protected from abuse or the risk of abuse. 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 organisational policies. Local procedures were in place to deal with safeguarding issues. Effective relationships with relevant safeguarding and welfare organisations were in place.

### Level of compliance

Just over 70% of the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services inspected were compliant with this standard. Just under 30% of the primary healthcare services inspected were not compliant with this standard. This accounts for nine of the 32 services inspected being non-compliant.

### Minor concerns

Minor concerns identified included inadequate information available for patients regarding safeguarding and some staff being unclear who the lead for safeguarding within the practice was.

### Services not compliant with this standard

Evidence that contributed to the judgement of non-compliance included gaps in staff records to clearly state that all pre-employment checks had been undertaken for all staff. There was a lack of recording that all post-holders, who required registration with a professional body, were up to date with their registration. There

was also a lack of a local policy or guidance for staff to follow in the event of suspected or actual abuse. In other medical services, not all staff had undergone the required training. Services did not have effective links with other relevant organisations, for example local safeguarding boards. We also found services that did not have a designated lead for safeguarding issues.

### **Services compliant with this standard**

In the services inspected that were compliant, there was information for patients and staff on how to recognise and report actual or suspected abuse. This included poster displays in waiting and clinical areas and clear documented local procedures on what action staff should take if they had a safeguarding concern. Services had designated leads for safeguarding vulnerable adults and children, and staff had received relevant safeguarding training. Staff were able to demonstrate a clear understanding of what constituted abuse and their responsibilities in relation to reporting safeguarding concerns to the safeguarding lead.

Staff had undergone relevant police checks prior to taking up their post. This included processes in place to undertake the relevant checks for military, civilian or locum staff. These were clearly recorded in staff records. Systems were in place to record and review safeguarding issues and effective relationships and contacts were in place with local safeguarding agencies for guidance, support or referral. Chaperone policies and procedures for the consent to treatment for minors were in place and used by staff.

### **Examples of good practice**

#### **Reducing the potential for abuse**

There was a large well displayed information board about safeguarding located in a communal corridor. This included flow charts, procedures and local contact numbers. Material supporting this was also displayed in every room in the practice. Details regarding the subject matter expert for safeguarding included their contact details - *Medical Centre Woolwich*

Any children on the 'at risk' register were reviewed at the monthly Care and Concern meetings, which were chaired by the Caldicott Guardian. The meetings were attended by health care professionals, including the health visitors - *Medical Centre Shorncliffe*

There was a designated lead for safeguarding and, in their absence, any concerns were raised with the senior medical officer. Both these staff were trained at level 3 in the protection of children and vulnerable adults. Information displayed on notice boards raised awareness of abuse and guided staff on the actions to be taken if they had a safeguarding concern. The information included contact details for local authority safeguarding teams - *Medical Reception Centre Winchester*

Staff told us the chaperone service was available to all patients attending appointments at the medical centre. Notices about the chaperone service available to patients were displayed in the reception area and in each of the consultation rooms. Staff said cadets would always attend appointments with a chaperone from their unit, with the consent to treatment forms signed by their parents or guardian - *RAF Cranwell*

'Cause for Concern' meetings were held on a monthly basis in conjunction with the health visitors. These meetings discussed vulnerable families with children under five years old - *RAF Wittering*

The child protection register had been replaced some years ago by the process to put in place a Child Protection plan in accordance with Working Together to Safeguard Children 2010 - *Medical Centre Sennelager*

### **Working with other agencies**

The medical centre had good working relationships with the NHS primary healthcare trust named nurse for child safeguarding, who was a source of information and advice for the staff - *Medical Reception Station Catterick*

The medical centre had a designated lead for safeguarding who liaised with local agencies and Police as necessary. Through their attendance at meetings, links had been developed with the local authority, primary care trusts and Police safeguarding leads - *RAF Leeming*

There was evidence of close working links with the local NHS primary care trust. Some civilian staff worked in the community for the NHS, which enhanced communication with external agencies - *Medical Centre Royal Navy Air Service Culdrose*

### **Staff training and information about safeguarding**

Records showed us that all staff had received training about safeguarding children and adults. Staff confirmed this when we spoke to them, and they demonstrated a clear understanding of how to identify and report any safeguarding issues - *Medical Centre Dishforth*

During the tour of the medical centre, we saw a range of information such as leaflets and posters that were available to patients and staff about safeguarding adults and Caldicott procedures. When we spoke to staff they confirmed that they had received training about safeguarding adults and children and Caldicott principles - *RAF Waddington*

We saw that formal safeguarding guidance was available to all staff, which outlined staff responsibilities and the safeguarding lead's responsibility. We explored the role of the staff member nominated as the safeguarding lead. We found that a referral log was maintained for any reported concerns or allegations and this included details of the investigation carried out - *RAF Cramwell*

The safeguarding procedure outlined reporting procedures and this was displayed at various points throughout the practice, including the reception area and clinical rooms - *Medical Reception Centre Aldershot*

Staff at the primary healthcare rehabilitation facility told us they had an intensive four-week induction covering amongst other subjects, both adult and child safeguarding training. The medical centre had a named doctor lead and a named nurse lead for safeguarding and staff knew who they were - *Medical Centre Hohne*

## Comparison with individual unit DMS Common Assurance Framework reports

Comparison of the CQC inspection reports with the individual unit DMS CAF reports indicated that for Outcome 7, safeguarding people who use services from abuse, the majority of relevant concerns identified in the CAF reports had been resolved by the time of inspection. There were however, some issues raised in the inspection reports that had not been identified in the CAF reports for Outcome 7. These most frequently involved a lack of local policies and procedures for raising and responding to safeguarding concerns.

## Outcome 9: Management of medicines

The standard states that people receiving services should expect to have their medicines at the times they need them, in a safe way, and that wherever possible, information about the medicine being prescribed is made available to them or others acting on their behalf.

### Primary healthcare medical services - Outcome 9

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 primary healthcare medical services inspected were judged as not compliant with this standard. Evidence that contributed to this judgement included few or no audits being undertaken to ensure that relevant legislation and DMS policy and procedures were being adhered to. There was also a lack of follow through 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, written by medical officers, onto the electronic patient record database.

In services judged as compliant with this standard, across the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services, we found that medicines generally were handled safely, securely and appropriately. Information about medicines and explanation of their use, effect and possible side-effects was well explained to patients and often accompanied by written information for patients to take away with them. Staff had access to relevant policies and guidance and clinical support.



### **Level of compliance**

Eighty-eight per cent of the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services inspected were compliant with this standard. However in 43% of those services judged as compliant, there were minor concerns. Of the primary healthcare medical services inspected, 13% were judged as not compliant with this standard.

### **Minor concerns**

These related to limited auditing practices in place to continually check and verify that policies and standards for the effective management of medicines were adhered to. In some medical services, pharmacy risk registers were not up to date. Some storage facilities were not adequate and the arrangements for the disposal of waste pharmaceutical products were not sufficiently secure.

### **Services not compliant with this standard**

Evidence that contributed to the judgement of non-compliance included controlled drugs not being stored adequately or the required monitoring processes, as dictated by DMS medicines management policy, were not being correctly implemented. There was little or no audit activity or outcomes from audits and risk assessments not always followed through. In one practice, we found that, occasionally, when receiving treatment in secondary care, patients obtained prescriptions that were not written in English. In such circumstances, when translation was required, drug errors had been made and the likelihood was that they could happen again in the future under the current procedure in place.

In another practice hand written prescriptions, although in English, needed to be transcribed and entered onto the electronic record system. Although this had been identified as unsafe practice, the procedure continued to be in place. In one practice we found that patients did not always have access to the dispensary due to variable opening times depending on staff availability. This restricted access to the dispensary and patients could not be confident in knowing when the dispensary would be open.

### **Services compliant with this standard**

In the services inspected that were compliant, there were effective and efficient systems in place for ordering, receiving, storing, dispensing, monitoring and disposing of medicines. Medicines were stored in suitably locked storage facilities with restricted access to designated staff. Procedures were in place for checking fridge temperatures for medication that needed to be stored in refrigerated conditions. Some medical services had their own pharmacies or dispensaries and others held contracts with a local pharmaceutical provider.

Detailed protocols were in place for the management of controlled drugs. In accordance with the Misuse of Drugs legislation, controlled drugs were stored, monitored, prescribed and dispensed in accordance with the directives stated in the relevant DMS management of medicines policies. Patient Group Directions (PGDs) were in place for the supply and/or administration of medicines to groups of patients who may be individually identified before presentation of treatment. Medical Service Medics Issuing Protocols (MIPs) were also in place. Patient safety incident reports were completed for any incidents or near misses connected with medicines management. This included detailed records of action taken, including professional advice from others. Some medical services produced a pharmacy newsletter on a regular basis and this was available to staff on the intranet.

## Examples of good practice

### Effective use of medicines

Patients told us that the pharmacy service was very efficient. They said that they could collect their prescriptions easily and quickly when they had seen a doctor. They said that repeat prescriptions were usually ready within 24 hours of ordering them - *HMS Nelson*

The Standard Operating Procedures for managing medicines were displayed in the dispensary and staff told us how it was adhered to. There was a contract in place with an external pharmacy to supply medicines and during our visit we saw a delivery from the external pharmacy. In line with procedural arrangements, the container security seal tag was removed within the dispensary in the presence of the nurse. Each item was checked by two members of staff with the order note and the patient details. Individual items were signed for - *Medical Centre Maidstone*

Once a patient was issued with a prescription, it was also recorded on the electronic system as 'a task' for pharmacy staff. This provided a process of monitoring when patients collected their medication - *Medical Centre Catterick*

Prescriptions were dispensed to patients directly following consultations with doctors. Staff said that repeat prescriptions were issued on a two-monthly cycle, which helped them to review a patient's medication effectively. We saw records that confirmed this. Repeat prescriptions for military personnel going on deployment were dispensed for a six-month period - *RAF Waddington*

Staff demonstrated that they were familiar with the procedures, guidance and protocols to follow for the safe management of medicines. In addition, prompts for medicines management were displayed around the dispensary for quick reference - *HMS Collingwood*

### Information for patients and staff

Staff received a local induction to the department. As part of their professional development, staff completed competency modules related to the pharmacy service. There was a quiz for staff to complete to test their knowledge of medicines management - *RAF Brize Norton*

We heard from patients that medicines were explained to them, including what to do if they had any adverse reactions. We observed staff informing a patient about safety issues associated with their medication prior to dispensing the medication. In addition we heard staff give a detailed response when asked questions about whether a medication had side-effects that may impact on another medical condition the patient had. The practice's information leaflet included information about the dispensary opening times and guidance about repeat prescriptions. Other patient leaflets were available including information about eye drops and suppositories - *Medical Reception Station Aldergrove*

Patients had access to information about the dispensary service, medicines management and their medicines. There was a range of information posted around the dispensary entrance, including advice about repeat prescribing, the roles and responsibilities of dispensary staff and health screening - *Episkopi Medical Centre*

Policies and standard operating procedures were in place, in both hard copy and electronically. Patients told us that they never had any problems obtaining their medication and said that staff told them what the medication was for and how to take it. Patients also added that they were given written information about their medicines and rarely had to wait for their prescriptions to be dispensed - *Medical Centre Hohne*

Medication alerts were distributed by the lead for risk and were copied to pharmacy technicians. A database was held in the dispensary. Staff checked through the patient records to identify if any patients were taking the medication that the alert related to. The patient was then informed at their next appointment and changes were then made to their prescription - *Medical Centre Dhekelia*

Information for patients was displayed near the dispensary window. This included dispensary opening hours, repeat prescription information, dosage changes and how to report an adverse reaction to medicines. Patients were told about their medicines at the point of dispensing, and we saw some examples of this. Patients with whom we spoke confirmed that they had received useful instructions from dispensary staff regarding their medicines - *RAF Valley*

### **Monitoring**

Audits were in place to record and check that the medicines levels were correct. We did a random check which confirmed that the controlled drug stock correlated with the register - *Medical Centre 42 CDO Royal Marines*

The dispensary had checks and controls in place that ensured medicines were managed safely. These included internal and external inspections of accountable and controlled drugs and daily checking of the minimum and maximum fridge temperatures - *Medical Centre Royal Navy Air Service Culdrose*

Pharmacy audits were carried out on a regular basis. We looked at the audit carried out in September 2011 which concluded that the standards of compliance achieved were good overall - *Medical Centre Chester*

There were arrangements in place to manage the ordering, receipt, storage, security, dispensing and monitoring of medicines. There were also arrangements in place to manage controlled drugs, including quarterly returns to command, a log of all transactions and counter-signing systems - *RAF Valley*

We looked at audits that had been carried out by pharmacy staff. The outcomes of audits were used to improve practice. For example, improvements were made to the recording of and collection of pharmaceutical waste - *RAF Leeming*

### **Comparison with individual unit DMS Common Assurance Framework reports for primary healthcare medical services**

Comparison of the CQC inspection reports with the individual unit DMS CAF reports indicated that for Outcome 9, management of medicines, the majority of relevant concerns identified in the CAF reports had been resolved by the time of inspection. There were however, some issues raised in the inspection reports that had been missed in the CAF reports for Outcome 9. These most frequently involved issues around the storage of medications and the lack of effective audit programmes.

## Outcome 10: Safety and suitability of premises

The standard states that people receiving services and people who work in or visit the premises should expect to be in safe, accessible surroundings that promote their wellbeing.

### Primary healthcare medical services - Outcome 10

Sixty nine percent of primary healthcare medical services inspected were compliant with this standard. However, in over 60% of those medical services, judged as compliant, there were minor concerns regarding maintenance of the premises and equipment and the management of fire procedures.

Over 30% of the services inspected were judged as not compliant with this standard. This outcome showed the lowest proportion 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 services judged as compliant, across the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services, we found that patients were receiving a service 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 on out-of-hours services was clearly displayed.

### Level of compliance

Of the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services inspected, 69% were compliant with this standard. However in over 60% of those services judged as compliant, there were minor concerns. Over 30% of the services inspected were judged as not compliant with this standard. This meant that 10 of the 32 primary healthcare medical services inspected were judged not compliant with the standard for the safety and suitability of premises. This outcome showed the lowest proportion of compliance across all of the standards inspected in primary healthcare medical services.

### Minor concerns

These related to a lack of routine maintenance programmes and inadequate maintenance of some equipment. In some medical centres safety for patients and staff was compromised by the use of door wedges keeping fire doors open and in one large medical centre the required fire marshals had not been appointed.

### **Services not compliant with this standard**

Evidence that contributed to the judgement of non-compliance included parts of buildings not in use due to extreme damp and infection control risks, leaking pipes, stained and uneven flooring and areas, because of their design, that could not be adequately cleaned. These areas included staff showers and pharmacy dispensary and storage facilities that were not water resistant and could not prevent spillages seeping into wooden shelving.

Three of the medical centres inspected had been assessed as 'not fit for purpose' prior to our inspections. One of these was about to move into a new building but there were no immediate plans for the other two. A further three medical centres had been assessed as in need of urgent refurbishment. In one medical centre some of the medical consultation rooms did not have regular hot running water for effective hand washing, a problem which had been on-going for some time. Several centres had inadequate or no ongoing maintenance programmes in place. In one medical centre staff were unable to use some patient treatment areas due to the regular infestation of flies preventing the use of rooms. Several medical centres did not have adequate storage facilities; this included inadequate storage for clinical waste or no appropriate system in place for the immediate disposal of clinical waste.

Patient privacy and dignity were compromised by inadequate screening, conversations being overheard from one consultation room to another, inadequate waiting areas and no toilet facilities for patients using wheelchairs.

Some office areas and consultation rooms were cramped. In one medical centre we found a fire door required to be unlocked by a member of staff in the event of an emergency. The layout and design of some medical centres did not provide easy access for all patients. Access to some medical centres was difficult for some patients with mobility problems or those with push chairs or buggies due to heavy doors, no external call bells or no ramps. Some medical centres were very poorly decorated, with peeling paint on walls and around doors, broken blinds and sheets used as curtains and generally poor furnishings.

### **Services compliant with this standard**

In the services inspected that were compliant we found that premises provided appropriate accommodation to meet the needs of patients and people who worked in or visited the premises. Medical centres were clean, well lit and ventilated with adequate space for patients to wait and be treated in.

General maintenance issues were dealt with quickly and appropriately. Clinical waste was suitably managed. Risk assessments for all of the Control of Substances Hazardous to Health (COSHH) items were in place and dated. Hazardous substances were stored safely in locked cabinets. There was information about the latest guidance and protocols on safety, health, the environment and fire safety that applied to medical centres. There were clear signs at the entrance of the centres and in the waiting areas that described what to do and who to contact in an out-of-hours emergency. Services had business continuity plans in place, which were understood by staff, detailing what action to take in the event of an emergency, for example a serious outbreak of illness or power failure.

## Examples of good practice

### Design and layout of practice/service area

The treatment rooms were spacious and well equipped. Staff told us that they were satisfied that the areas they used to carry out treatment were appropriate and safe. During our visit all areas of the medical centre were clean, well lit and appropriate for the services provided - *Medical Centre Maidstone*

The medical centre was a purpose-built facility shared with the dental services and an administration unit. Waiting areas were spacious, well decorated and comfortable. The design and layout of the building provided easy access to all care and treatment areas. Treatment and consultation rooms were spacious and equipped to promote patient privacy and dignity - *HMS Collingwood*

Patients told us the waiting area had adequate seating and discussion about other patients could not be overheard. Information was provided about privacy, patient rights and chaperones - *Military Correction and Training Centre Colchester*

The medical centre was purpose-built and single storey, with level access at both the main and emergency entrances. The premises were fully accessible to people with disabilities and two accessible toilets were available. Baby changing facilities and a hearing loop were also in place - *Medical Centre Akrotiri*

Staff said that they thought the facilities available were excellent for the ship's crew to be treated with dignity, in private and in facilities that provided space and sufficient equipment for the care and treatment they provided - *HMS Dragon*

### Managing risk

Building work for an extension to create a larger physiotherapy room was nearing completion at the time of the inspection. As the medical centre remained open during the work, a risk assessment had been conducted to determine the risk to patients, staff and others. Measures had been taken to minimise the spread of dust around the medical centre. A safety, health, environment and fire assessment was completed for 2011/12. We observed that this was reviewed in October 2011 - *Medical Centre Chester*

Specific risk assessments were undertaken, including display equipment assessments and those related to safety, health, environment and fire - *Hohne Medical Centre*

Risk assessments had been undertaken of the environment and were displayed on the notice boards - *RAF Brize Norton*

Records showed that spot checks of the environment were carried out regularly. Cupboards containing hazardous substances were locked and risk assessments were available for those substances stored - *RAF Waddington*

A dedicated notice board in the corridor displayed information regarding safety, health and environmental protection. We noticed that there was a culture of learning from incidents and staff all spoke of their individual responsibility towards ensuring the facilities were safe for patients and staff alike. Risk management was high on everyone's agenda and quarterly practice manager meeting minutes recorded the sharing and analysis of regional risk outcomes - *Medical Centre Woolwich*

### **Maintenance**

General maintenance and repairs were dealt with in a timely manner. There was a business continuity plan in place in the event of an emergency - *Medical Centre Maidstone*

There was an ongoing maintenance programme in place and we saw the management action plan made ongoing reference to improving the premises. For example, the replacement of damaged and cracked flooring - *Medical Reception Centre Winchester*

We heard from staff that maintenance requests, particularly those with a high priority, were generally dealt with promptly and efficiently. In the main, high priority requests were addressed within 24 hours - *Medical Centre Aldergrove*

### **Protocols for dealing with emergencies**

When we asked to see the business continuity plan we could see that it described fully what actions needed to be taken in the event of an emergency. Staff were familiar with the contents of this plan and informed us that a copy of this plan was also held in the guardroom - *Medical Centre Woolwich*

There were procedures in place for dealing with unforeseeable medical emergencies. Major accident prevention plans were tested regularly and there was graphical information about the station layout displayed throughout the premises - *RAF Wittering*

A major incident plan was in place and had been tested from both a whole base and a medical centre perspective. There were also weekly fire alarm tests and bomb threat tests on the base. The medical centre had a business continuity plan to cover events such as serious outbreaks of illness, power failure, loss of running water, IT failure - *Medical Centre 42 CDO Royal Marines*

There was a business continuity plan in place that was followed in the event of system failure related to services such as gas or electricity. Senior staff reviewed the health and safety and the environmental risk assessments on a regular basis - *RAF Cranwell*

A dedicated disaster room provided a store for all emergency equipment required to set up a casualty clearing centre, in the event of a major incident. It had external access to support efficient dispatch. Staff told us that a major incident exercise, involving 32 casualties had taken place in December 2011 and had been very successful - *Medical Centre Akrotiri*

### **Staff on call**

Staff told us that the medical centre provided 24 hour emergency cover where immediate treatment was provided. Where needed, a referral was made to the local accident and emergency department. Staff on call could communicate with each other and with non-medical staff by radio. There was a local resuscitation coordinator and staff on call received regular training updates. On-call staff remained on site in the medical centre and undertook a 'sleeping watch' in suitable segregated accommodation with en-suite bathroom facilities, catering facilities and access to food and drinks - *HMS Collingwood*

For access to services out of hours, there was a telephone on call service, which directed patients to the appropriate hospital provider or called the on call duty doctor or nurse as appropriate. Patients were encouraged to contact the emergency services directly in the event that an ambulance was required - *Medical Centre Hohne*

An out-of-hours, weekend and bank holiday service was in place. This was provided by the local PCT and was based at the medical centre - *Medical Reception Station Catterick*

On-call services were not provided by medical centre staff. There were clear signs at the entrance of the centre and in the waiting areas that described what to do and who to contact in an out-of-hours emergency - *Medical Centre Royal Navy Air Service Culdrose*

### **Patient access to outdoor spaces, communal spaces or toilet and bathroom facilities**

There was easy access to the medical centre, which included wide, level entrances and corridors. All areas were clearly signposted and there was car parking, with specific allocated bays for patients with disabilities at the front and side of the building. There were easy to use, automatic opening systems on toilet doors for patients with mobility issues or those with pushchairs or prams - *Sennelager Medical Centre*

Access to the building promoted the independence of people with limited mobility and people who were wheelchair users. There was a level access entrance to both the medical centre reception area and the side entrance, which was used by staff and where the ambulance bay was located. The medical centre had wide corridors and lift and stair access to all floors, which made it accessible for all - *HMS Neptune*

Throughout the premises we observed that access and facilities were designed to accommodate people with limited mobility and wheelchair users. The communal reception and waiting area was spacious with dedicated reception desks and seating areas for patients waiting for the various services provided from the health centre. Security arrangements were in place for access from the waiting area to the consultation and treatment rooms. Patients could only access these areas if accompanied by a member of staff - *Medical Centre Aldershot*

### **Results from the survey**

There were comments from the survey relating to staff in medical centres doing their best to manage poor infrastructure and surroundings. Comments about the inadequacy of clinical areas included the following:

*"The only drawback is that the medical centre building is poor and equipment is old and outdated."*

*"Many are dirty and most are poorly equipped and fitted with incorrect clinical infrastructure, especially fixtures and fittings."*



## Comparison with individual unit DMS Common Assurance Framework reports

In contrast to the other outcomes, for Outcome 10: safety and suitability of premises, around half of the issues identified in the DMS CAF reports were still apparent at the time of the CQC inspection visits. In addition to many of the overt infrastructure issues raised in the CAF reports, the CQC inspection visits found problems with decoration, accessibility, infection control constraints or maintenance issues. Out of the outcomes assessed, Outcome 10 had the highest number of issues that appeared to be missed in the CAF reports.

## Outcome 14: Supporting workers

The standard states that people receiving services should expect to be safe and their health and welfare needs met by competent staff.

### Primary healthcare medical services - Outcome 14

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 judged as not compliant with this standard. Evidence that contributed to the judgement of non-compliance included medical services where not all staff had attended mandatory training or staff did not receive 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 management reporting systems in place.

In services judged as compliant with this standard, across the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services, we found that well planned induction programmes were in place for all military and civilian staff. Training needs were identified, the required mandatory training was attended and staff 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.

### **Level of compliance**

Just over 80% of the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services inspected were compliant with this standard. Minor concerns were identified in a small number of services. Just under 19% of the primary healthcare services inspected were not compliant with this standard.

### **Minor concerns**

Minor concerns identified in some of the medical services included inconsistent access to supervision and staff training needs not identified in the practice development plans. In some medical centres, staff absences or 'gapped' posts impacted on leadership or leadership roles with the medical centre.

### **Services not compliant with this standard**

Evidence that contributed to the judgement of non-compliance included medical services where not all staff had attended mandatory training, for example, for infection control and not all staff had been appraised as required. Staff training needs were identified but had not been met, or there were inadequate recording systems in place to provide evidence of training, staff appraisal or supervision attended. Some staff did not have any or regular supervision and some staff were not clear about lines of accountability and management reporting systems in place.

### **Services compliant with this standard**

In the services that were compliant, there were clear arrangements in place for induction programmes for military, civilian and locum staff. Induction programmes included information related to policy, procedures and mandatory training requirements and where required, competencies to be achieved. Several of the medical services held weekly, fortnightly or monthly practice training or information sessions or best practice forums. Systems were in place for regular staff supervision, support and appraisal for all staff, both military and civilian.

Staff were clear about their roles and responsibilities, had access to relevant training and were aware of the lines of accountability. Many staff we spoke with talked about how effective clinical and managerial management and leadership supported them in their roles. Staff were also aware of policies relating to bullying or harassment and felt able to raise concerns should they need to do so.

### **Examples of good practice:**

#### **Staff induction, training and development**

Records showed that new staff, including locum staff, attended an induction programme when they started work at the medical centre. Staff records confirmed that they had access to an ongoing training programme. This included a number of online courses available on computer and specific medical centre-based training sessions. Staff were up to date with mandatory training - *Medical Centre Dishforth*

Staff told us they had access to a good mandatory training package with various forms of learning such as formal training, e-learning and informal learning. This was available for all civilian and Service personnel. We saw guidance and training records of relevant staff, which included the subject to be completed, the frequency of training and how staff accessed the learning programme - *RAF Cranwell*

Examples of the training provided included radiation protection, healthcare governance, first aid, fire, fractures, burns, climatic injuries, bleeding, wounds, heart disorders, shock, CPR practical and health physics refresher. The records showed that the sick bay team had completed all training identified as mandated for patrol - *HMS Victorious*

There were clear systems in place for procuring locum staff. Locum staff generally worked across all six medical practices. They were provided with information packs that contained protocols and laminated flow charts of procedures for quick reference, for example reporting an incident or making a safeguarding referral - *Medical Reception Station Winchester*

Staff had access to resources to support their learning and development. Each member of staff received induction training and this was recorded. Staff said there were opportunities for training, which were reasonably easy to access and were satisfied with the level of training provided - *RAF Valley*

The requirements for mandatory training were clearly outlined for all staff roles and completion of mandatory training was monitored electronically. Reminders were sent to staff when their training was due, with continual reminders until the training was completed. A training needs analysis review was in progress at the time of the inspection. We observed that data was being collected to map training needs with the staff roles and responsibilities - *Medical Centre Chester*

A programme was being developed to enable movement between civilian GPs and military GPs to provide both with experience of a spectrum of patients of all ages and health care needs - *HMS Drake*

### **Staff supervision**

All clinical staff received relevant clinical supervision regularly. The four GPs discussed cases monthly and also opportunistically as they worked closely together. The nurses met for clinical supervision monthly as part of their study days. The physiotherapists and exercise rehabilitation instructors had arrangements in place for appropriate supervision. The RAF medics were clinically supervised by a medical officer and they told us about a task workbook they completed to demonstrate competencies in a range of clinical skills - *RAF Wittering*

A system of clinical supervision was in place, which had clear lines of clinical supervisory accountability whilst at sea. While alongside, not all staff were directly clinically supervised but did have access to clinical advice and support - *HMS Dragon*

### **Staff work environment**

Staff were very positive about the team and the level of support they received from colleagues, line managers and senior staff. They said there were clear lines of accountability and that they were familiar with their roles, responsibilities and accountabilities, as well as being aware of those of others - *Medical Centre Episkopi*

Staff said they felt there was an appropriate range of health care professionals within the practice to meet patients' needs. They said that expert advice and support was readily available to them from other professionals such as dentists and mental health teams. They described an effective team approach to their work and weekly team meetings helped to support their practice - *Medical Centre Sennelager*

Patients felt the relaxed atmosphere of the medical centre attributed to the way the staff worked well together. Staff told us they worked well as a team. They spoke highly of the leadership and support received from senior clinical and managerial staff - *RAF Leeming*

Patients told us they had confidence in staff abilities and complimented the care they received. They described staff as friendly and very professional. We were told that staff had shown empathy and been motivational when needed. Staff felt there was a good team spirit and enjoyed their work - *Medical Centre Shorncliffe*

Staff felt there was a good team spirit; which had a positive impact on patient care - *Medical Reception Station Colchester*

### **Comparison with individual unit DMS Common Assurance Framework reports:**

Comparison of the CQC inspection reports with the individual unit DMS CAF reports indicated that for Outcome 14: supporting staff, the majority of relevant concerns identified in the CAFs had been resolved by the time of inspection. There were however, some issues raised in the inspection reports that had been missed in the CAFs, for Outcome 14. These most frequently involved deficiencies in supervision arrangements and lack of clarity in reporting lines.

### **Outcome 16: Assessing and monitoring the quality of service provision**

This standard states that people receiving services should expect to benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

#### **Primary healthcare medical services - Outcome 16**

Seventy five per cent of primary healthcare medical services inspected were compliant with this standard. Of those services judged to be compliant, 25% had minor concerns that related to limited or incomplete monitoring systems in place.

Of the primary healthcare medical services inspected, 25% were judged as not compliant with this standard. Evidence that contributed to the judgement 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 or lack of clarity around responsibilities for governance, in particular lead governance roles.

In services judged as compliant with this standard, across the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services, we found that services 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.

### **Level of compliance**

Seventy five per cent of the Royal Navy, Army, Royal Air Force and Permanent Joint Operating Base primary healthcare medical services inspected were compliant with this standard. However, there were minor concerns in 25% of those services judged as compliant.

### **Minor concerns**

Minor concerns related to limited audit activity, limited systems in place to monitor the safety and quality of service provision and incomplete risk registers.

### **Services not compliant with this standard**

Twenty five per cent of the primary healthcare services inspected were not compliant with this standard. Evidence that contributed to the judgement of non-compliance included no planned programme of audits and no connection between risk, audit or evaluation of service provision. We found inadequate risk reporting processes or the lack of the effective use of a risk register. This included, for example, issues identified in a risk register that did not lead to management action or to an audit of services. We found that in some medical services, audits were undertaken but the outcomes were not analysed or used to develop or improve services. In other services action required, as stated in action plans to address concerns or problems from the internal DMS assurance process, had not been taken. We also found that information from some patient satisfaction surveys was not being used to maintain or improve practice. In some medical services the responsibility and accountability for governance processes were not being effectively managed.

### **Services compliant with this standard**

In the services inspected that were compliant, there were systems and processes in place to continually monitor the quality and safety of services provided. These included clear and detailed audit plans, audits implemented and the results of audits analysed and used to develop or improve services. Risk assessments and risk registers were in place with clear actions to be taken to resolve or mitigate against risks. Information from patient surveys, patient complaints, patient safety reporting, risks and audits and adverse events were recorded, discussed and analysed on a regular basis and actions agreed and taken. In several primary healthcare medical services we saw the outcomes of monitoring processes clearly displayed in patient waiting areas.

Monitoring systems also included chronic disease registers and analysis of the health needs of the population served. Staff were aware of their roles and responsibilities, especially those with governance leads, for example, for the audit programme, risk management, health and safety, patient involvement and feedback, staff recruitment and training or clinical issues. We found most medical practices had regular practice and healthcare governance meetings or forums for staff to discuss any risks or concerns about the services provided. It was particularly evident that services that were compliant with this outcome had strong and effective clinical and managerial leadership.

### Examples of good practice

#### Monitoring the quality of services people receive

The book of reference also covered instructions about sick bay handovers, weekly reporting, executive health care meeting minutes, patient safety incident reporting and infection control logs. In addition, the Common Assurance Framework (CAF), an internal assurance tool, also formed part of the governance framework and was continually updated to reflect the ongoing picture of risk and compliance with outcomes - *HMS Victorious*

We observed that Patient Safety Incident Reports (PSIRs) were subject to regular audit and staff were in the process of compiling a PSIR summary report for October 2011. It took account of trends and patterns in relation to the types of incidents reported. Named staff were identified as leads for specific subject areas. In addition to a Caldicott Guardian, leads were identified for medical records, health and safety, complaints, equality and diversity and COSHH - *Medical Centre Aldershot*

Monthly clinical governance meetings were led by the senior medical officer. They offered an opportunity to look at all areas related to health care outcomes, and discussion of patient care-related matters and responses to patient questionnaires or comments. For example, there was a discussion about improving waiting times in reception for appointments. An audit had been undertaken as a result and the service was now looking at extending appointment times - *Medical Centre Dhekelia*

#### Risk management

We looked at a sample of the risk assessments which had been carried out to ensure the safety of both patients and staff. They included fire, trip hazards, and pregnant staff, attending accidents, manual handling, burns, infection control prevention and control of substances that are hazardous to health - *RAF Leeming*

The Sickbay had processes in place to continually review and evaluate service provision. These included a risk register which was reviewed on a monthly basis at the Health Governance meetings. Issues were escalated to the Navy Command if appropriate. The risk register in place clearly identified the risk and actions taken or control measure put in place. Risks that had been resolved were recorded on a 'retired' risk register - *HMS Dragon*

Records showed that up-to-date risk assessments were in place. Some staff in the medical centre had undertaken risk management training. The risk assessments included slips, trips and falls; use of display screens; emergency procedures; and cleaning arrangements. We saw that the unit risk register was updated every month - *Medical Centre Dishforth*

### **Continuous improvement**

We looked in detail at two completed audits. A diabetes audit report demonstrated that the audit took account of identified criteria, standards and data collection methods. In line with one of the recommendations from the audit, a lead for diabetes had been identified within the staff team. A splenectomy audit was conducted in September 2011 with the aim to identify patients at risk who required vaccinations. It took account of both best practice nationally and organisational policy - *Medical Reception Station Catterick*

We found that frequent audits had taken place and that a senior member of staff was the designated audit lead. Audits took place as a result of patient safety incident reports and as part of a planned programme. An audit presentation meeting held in July 2011 had shared with staff the outcome of, or progress with 12 audits. Audit topic had included smoking cessation, diabetes, hypertensive risk and medical record-keeping - *Medical Centre Episkopi*

National Institute of Health and Clinical Excellence (NICE) guidelines were received and assessed for relevance by the medical officer whilst on shore. Relevant guidelines were printed and added to the ready reference pack that was then taken on board at the start of the patrol. All the Sickbay staff then had access to the guidance when needed - *HMS Victorious*

Examples of audits undertaken included audits about diabetes, cervical cytology, overdue medicals and urinary tract infections in children. An audit concerning the prescribing of Methotrexate demonstrated a clear cycle of quality improvement. Instigated following a PSIR, results of the audit identified an absence of safeguards in relation to prescribing. As a result measures were put in place to address this. A re-audit was conducted in July 2011, which showed that the safeguards introduced were having the desired outcome in terms of reducing the risks associated with the prescribing of Methotrexate - *Medical Centre Aldergrove*

### **Comparison with individual unit DMS Common Assurance Framework reports**

Comparison of the CQC inspection reports with the individual unit DMS CAF reports indicated that for Outcome 16: assessing and monitoring the quality of service provision, the majority of relevant concerns identified in the CAFs had been resolved by the time of inspection. There were however, some issues raised in the inspection reports that had been missed in the CAFs, for Outcome 16. These most frequently involved the lack of a risk register or general poor recording of risk and the lack of a formal audit programme.

## Analysis of inspection reports of primary healthcare medical services: overall outcome judgements

Table 1

Outcome	Compliant (some with minor concerns)				Not compliant			
	Royal Navy (n=8)	Army (n=15)	RAF (n=6)	PJOBS (n=3)	Royal Navy (n=8)	Army (n=15)	RAF (n=6)	PJOBS (n=3)
1	100%	100%	100%	100%	0%	0%	0%	0%
4	88%	100%	100%	100%	13%	0%	0%	0%
7	51%	87%	84%	33%	50%	13%	17%	66%
9	88%	87%	100%	66%	13%	13%	0%	33%
10	76%	80%	34%	67%	26%	20%	67%	33%
14	75%	87%	100%	33%	25%	13%	0%	67%
16	76%	80%	66%	66%	25%	20%	33%	33%

Army primary healthcare medical services had the highest average proportion of compliant outcome judgements (table 1). The Permanent Joint Operating Base (PJOBS) primary healthcare medical centres, which included medical services in Cyprus, had the highest proportion of non-compliant judgements. The Royal Navy primary healthcare medical services had the second highest proportion.

However, there were significant differences in the sample sizes. For example, we inspected 15 Army primary healthcare medical centres but only three Permanent Joint Operating Base primary healthcare medical services in Cyprus.

Table 2 below shows the results of all CAF assurance visits in terms of the proportions of Green and Red ratings for the relevant outcomes.

Table 2

Outcome	% Green				% Red			
	Royal Navy (n=29)	Army (n=41)	RAF (n=67)	PJOBS (n=30)	Royal Navy (n=29)	Army (n=41)	RAF (n=67)	PJOBS (n=30)
1	62.69%	68.29%	62.11%	78.64%	7.25%	0.70%	3.52%	1.46%
4	46.64%	77.12%	59.71%	79.56%	27.35%	1.57%	5.73%	2.67%
7	10.34%	63.41%	22.39%	40.00%	62.07%	0.00%	26.87%	13.33%
9	17.24%	35.00%	24.19%	36.67%	62.07%	7.50%	20.97%	3.33%
10	41.82%	41.46%	44.70%	61.67%	25.45%	10.98%	13.64%	6.67%
14	33.62%	53.96%	55.09%	74.58%	34.50%	1.83%	7.49%	2.12%
16	35.75%	57.32%	55.41%	59.83%	23.98%	2.13%	9.01%	2.14%



Comparison of tables 1 and 2 show similar rankings for the different service areas, although there was a significant difference in the results for primary healthcare medical services within the PJOB in Cyprus. However, it is worth noting the large difference in sample sizes and the fact that table 2 includes assessments of more than just primary healthcare locations making any comparisons tentative.

Furthermore the red, amber, yellow and green rating system in the CAFs are not directly comparable with the 'compliant', 'compliant with minor', 'not compliant with moderate' and 'not compliant with major concerns' judgements from the CQC inspections. The outcome scores for the CAF assessments have also been pulled together from what were judged to be the most applicable CAF standards i.e. CAF assessments do not specifically form judgements of compliance with the CQC essential standards.

Despite these limitations some comparisons can be made from the results from the two inspection methodologies, as follows:

### **Royal Navy primary healthcare medical services**

In general, Royal Navy primary healthcare medical services were less compliant with standards assessed compared with services provided by the Army and the Royal Air Force, in both assessment methodologies. For both methodologies Outcome 1 was the strongest performing area while Outcome 7 was the weakest performer. The area of biggest discrepancy between the two sets of results was in relation to Outcome 9, which performed relatively well in the CQC inspections but was the second worst performing outcome in the CAF assessments.

A possible explanation for this difference was that most medicines management concerns were resolved during the time period between the last CAF assessment and the CQC inspection. From the analysis of individual unit CAF reports, all of the Outcome 9 concerns for Royal Navy primary healthcare medical services had been resolved by the time of the CQC inspections. It is also possible that the differences were due to the particular sample of units inspected.

### **Army primary healthcare medical services**

For both assessment methods the two outcomes with the highest proportions of top level ratings (i.e. green/compliant) were Outcomes 1 and 4. Although Outcome 1 performed better than 4 in the CQC inspections, but it was the other way round for the CAF results. The two worst performing outcomes, 9 and 10, were the same in both assessments, although again the order of performance differed. While Outcome 7 received the similar proportions of green and compliant ratings, it was the only outcome with no red ratings in the CAF assessments while there were two services in the CQC inspections found to be not compliant with moderate concerns.

This does highlight a difference in the two assessment methodologies with the lack of CAF red ratings possibly attributable to the fact there has only recently been a DMS-wide safeguarding policy for safeguarding children for services to be judged against. While the CQC inspections found the lack of local safeguarding procedures to be one of the main concerns for Outcome 7.

### **Royal Air Force primary healthcare medical services**

Again, there were some similarities in the two sets of results with Outcomes 1, 4 and 14 performing the best in both. As with the Royal Navy primary healthcare medical services, there was a large difference in the performance for Outcome 9 with the CQC inspections indicating only minor concerns for most services with no services judged as non-compliant. The CAF assessments showed over 20% units receiving red ratings for the relevant standards. There was also a notable difference in the performance for Outcome 10 with the CAF assessments suggesting a higher degree of compliance against this outcome than the CQC inspections. Again these differences may be purely due to sample sizes and differences in the inspection methodologies.

### **Permanent Joint Operating Base primary healthcare medical services**

There was a marked difference in performance for PJOB primary healthcare medical services in Cyprus, between the two assessment methodologies. These services performed much worse in the CQC inspections.

Overall analysis of CQC inspection reports and CAF assessments indicated that the Army primary healthcare medical services were on average the most compliant with standards assessed, followed by the Royal Air Force primary healthcare medical services while the Royal Navy primary healthcare medical services had the lowest levels of compliance with the standards assessed.

## **Summary of comparison of inspection methodologies: CQC inspections and the DMS Common Assurance Framework (CAF) for primary healthcare medical services**

The best and worst performing outcomes across all CAF results provided for primary healthcare medical services were compared with the findings from the CQC inspection reports. This showed that, of the outcomes assessed in both methodologies, the two best performers were Outcome 1: respecting and involving people who use services and Outcome 4: care and welfare of people who use services.

However, there were some differences in the rankings of worst performing outcomes. In the CAF assessments, the worst performers were Outcome 9: management of medicines, followed by Outcome 7: safeguarding people use services from abuse and then Outcome 10: safety and suitability of premises.

In the CQC inspections it was Outcome 10: safety and suitability of premises, followed by Outcome 7: safeguarding people from abuse that performed worst.

These differences may have been due to the particular services visited or the fact that the majority of issues raised in the CAF reports had been resolved by the time of the CQC inspection. However, Outcome 10 had fewer issues resolved and more

issues not identified in the individual unit CAF reports, which provides some explanation as to why this outcome performed relatively worse in the CQC inspections than it did in the DMS CAF inspections.

The manner in which the CAF reports were analysed, as part of this review, meant the focus was on the standards assessed in the services inspected. It is possible that some of the issues found by the CQC inspection reports were picked up in other areas of the CAF but not in our analysis. However, there were numerous issues not identified in the CAF reports, indicating that there is room for development in the CAF assurance methodology.

## Section 2

# Primary healthcare medical services deployed operations (Afghanistan)

We inspected against the following outcomes:

Outcome 4: Care and welfare of people who use services

Outcome 6: Cooperating with other providers

Outcome 9: Management of medicines

Outcome 16: Assessing and monitoring the quality of service provision

## Outcome 4: Care and welfare of people who use services

The standard states that people receiving services should expect to experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

### Primary healthcare medical services: Deployed operations - Outcome 4

The primary healthcare medical services in deployed operations were fully compliant with this standard. There were no minor concerns.

The service was judged compliant as we found that patients experienced safe, effective and appropriate care, treatment and support. Military personnel and entitled civilians had 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 medical and nursing assessment and treatment, occupational health, treatment and screening services, dental services, rehabilitation and community mental health services and health promotion.

Patients were involved in their plan of care and treatment options and risks and benefits were fully explained. Patients said that they received clear information from the medical centre staff and were confident in the teams providing care and treatment.

### Level of compliance

The primary healthcare medical services were fully compliant with this standard. There were no minor concerns.

## Section 2: Primary healthcare medical services deployed operations (Afghanistan)

### **The service was compliant with this standard**

Primary healthcare services in the medical centre comprised medical and nursing care, occupational health, treatment and screening services, dental services, rehabilitation and community mental health services and health promotion. In addition, the service provided a medical emergency response capability. This involved taking teams of medical, nursing and support staff to provide care and treatment to Service personnel who were hurt or injured on exercise or on the battlefield. The team were flown to the site of injured personnel by helicopter. The team had been well trained in specialist emergency response skills. Pre-hospital treatment was given to casualties at the point of wounding and during the flight to the hospital. Helicopters were well resourced with the necessary equipment and medication required for urgent emergency care.

An out-of-hours emergency service was provided through the emergency department at the hospital where Service personnel could be seen and treated when the medical centre was closed. A significant amount of work in primary healthcare services related to illnesses and non-battle injuries such as skin rashes, back and joint problems and digestive disorders or infections. The team also treated more chronic illnesses, generally from entitled civilians, such as contractors, who tended to be older and less fit.

Patients were involved in their plan of care and treatment options, and risks and benefits were fully explained. Patients said that they received clear information from the medical centre staff and were confident in the team providing care and treatment. A chaperone service, for female patients, was available and could be accessed easily.

### **Examples of good practice**

#### **Assessment, planning and delivery of care**

Patients said that they could easily access services provided by the medical centre and found staff to be approachable, professional, helpful and efficient. They said that they did not have to wait long for appointments and were often seen the same day or within 24 hours - *Medical Centre, Camp Bastion, Afghanistan*

There was a patient information booklet available for all patients who attended the medical centre. This had been reviewed in October 2011. It contained information on how patients could register with the medical centre, opening times, what to do when the medical centre was closed and how to contact out-of-hours services, along with information on clinics. It also provided information on medication and how to access the pharmacy, repeat prescriptions, access to the rehabilitation and mental health teams, medical reviews and screening and vaccinations. The information booklet informed patients about patient satisfaction surveys, complaints and feedback and patient confidentiality - *Medical Centre Camp Bastion Afghanistan*

Primary healthcare services in the main base included a dental centre attached to the medical centre. This was new and purpose built. Staff were very pleased with the working environment, commenting that it compared very favourably with any similar facility in the UK. The centre had a central sterilisation unit on site between the two

## Section 2: Primary healthcare medical services deployed operations (Afghanistan)

surgeries. The dentists also saw patients in forwarding operating bases, outside the main base - *Medical Centre (dental services) Camp Bastion Afghanistan*

Primary healthcare services in the medical centre included the field mental health team. The team provided advice, assessment, treatment, education and training. Access to members of the team was available 24 hours a day, seven days a week - *Medical Centre (community mental health team), Camp Bastion, Afghanistan*

A further service offered by the primary healthcare medical centre was physiotherapy and rehabilitation exercise instruction. In addition to providing a range of physiotherapy programmes, the team also provided advice and training to medical staff. Injuries treated included those caused by sport, training or injuries sustained in vehicles, as well as battle injuries. All acute injuries that had been assessed as in need of physiotherapy were generally seen the same day or within 24 hours - *Medical Centre (physiotherapy team), Camp Bastion, Afghanistan*

### **Managing risks**

The team (mental health) also offered a single 'advice only' service to any member of the military. This service was through self referral, was confidential and was aimed at providing a one-off session to support individuals suffering from stress or anxiety - *Medical Centre (community mental health team) Camp Bastion, Afghanistan*

The medical centre on the main base provided health promotion clinics. These included, for example, a clinic set up to help Service personnel to give up smoking. To the surprise of staff, this had been well attended and the benefits evident. Patients told us that the clinic helped them in their determination to give up smoking - *Medical Centre Camp Bastion Afghanistan*

Combat medical technicians, known as medics, were trained in advanced first aid and life support techniques and dealing with trauma and battle injuries. All military personnel had received battlefield first aid training and carried some basic equipment to provide first aid in the event of an accident or injury. This included for example, tourniquets and bandages. Each unit had a team first aider who had received further first aid training to support colleagues when on military Operations or exercises - *Medical Centre Camp Bastion Afghanistan*

## Outcome 6: Cooperating with other providers

The standard states that people receiving services should expect to receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

### Primary healthcare medical services: Deployed operations - Outcome 6

The primary healthcare medical services in Deployed operations were fully compliant with this standard. There were no minor concerns.

The service was judged compliant as we found that patients who had accidents, were injured or became ill whilst on Operations overseas, received safe, 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 medical transfer and transport services worked and trained together to provide effective and well coordinated services.

### Level of compliance

The primary healthcare medical services were compliant with this standard. There were no minor concerns.

### The service was compliant with this standard

Patients, who had accidents, were injured or became ill whilst on operations overseas, received safe, 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. Primary healthcare staff had immediate access to specialist clinical staff based in the hospital. Access to advice or referral was easily available. The hospital also provided access to diagnostic testing such as x-rays. Information about patients was held securely.

### Examples of good practice

#### Coordinating care

One of the main tasks of all of the teams involved in treating military personnel in Operational areas was to ensure that the casualty was treated quickly and effectively. The medical emergency response teams, the ground ambulance crews and the fire officers worked extremely closely together to coordinate the process of taking a battlefield casualty to the field hospital for immediate treatment - *Medical Centre, Camp Bastion, Afghanistan*

Programmes of joint training within the main base were in place to review how some services were delivered, particularly where this involved more than one team. For example the emergency evacuation team, the ambulance teams and the fire

## Section 2: Primary healthcare medical services deployed operations (Afghanistan)

service personnel regularly trained together. Training and practice was based on particular potential scenarios - *Medical Centre, Camp Bastion, Afghanistan*

The field mental health team was an integral part of the primary healthcare service. It was viewed as a necessary and valued asset to support staff dealing with stressful and traumatic incidents. The team had developed very effective working relationships across medical services, and in particular, with colleagues within the hospital and colleagues working in the medical emergency recovery team - *Medical Centre Camp Bastion Afghanistan*

### Information sharing

Members of the primary healthcare team provided training and information sessions on the Reception, Staging, Onward movement and Integration (RSOI) programme. The RSOI programme was attended by all military personnel arriving in Operational areas. The programme included a number of training and educational and briefing sessions - *Medical Centre, Camp Bastion, Afghanistan*

Translation services were available to medical, nursing and dental centre staff treating local nationals. These were provided by a well led, well managed and dedicated team of staff. Translation was mainly required for hospital services but could be accessed by primary healthcare staff assessing and treating local national detainees or local military, police or civilian personnel in the forward operating bases - *Medical Centre Camp Bastion Afghanistan*

There were regular meetings between senior medical staff working in the medical centre and the base commander and the commander of medical services. These focused on all aspects of running the base, for example, accommodation, equipment and facilities as well as healthcare - *Medical Centre, Camp Bastion, Afghanistan*

## Outcome 9: Management of medicines

The standard states that people receiving services should expect to have their medicines at the times they need them, and in a safe way, and wherever possible, will have information about the medicine being prescribed made available to them or others acting on their behalf.

### Primary healthcare medical services: deployed operations - Outcome 9

The primary healthcare medical services in deployed operations was compliant with this standard. However, there were some minor concerns that related to communication difficulties, which did at times, impact on the timely prescribing of medications. Medication storage in some of the forward operating bases did not always meet policy requirements.

The service was judged compliant as we found medicines generally 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 guidance and clinical guidance and support.



## Section 2: Primary healthcare medical services deployed operations (Afghanistan)

### Level of compliance

The primary healthcare medical services in deployed Operations were compliant with this standard. There were, however, some minor concerns.

### Minor concerns

The minor concerns related to communication difficulties that did, at times, impact on the timely prescribing of medications. Medication storage in some of the forward operating bases did not always meet policy requirements. This had been risk assessed and actions to reduce risks were in place.

### The service was compliant with this standard

The service was judged as compliant with this standard, as we found that the medical centre had processes in place for the safe prescribing, ordering, recording, storage and disposal of medicines. Medication arrangements for patients attending the medical centre ensured that patients received their medication in a timely and safe way. Patients were given clear explanations of their medicines and possible side effects.

## Examples of good practice

### Effective use of medicines

The system to collect prescribed medications for patients who were seen and treated in the medical centre, was that all medication scripts were printed and sent straight through to the pharmacy. The system therefore did not rely on patients taking their prescriptions to the pharmacy by hand - *Medical Centre, Camp Bastion, Afghanistan*

The pharmacy was staffed by pharmacists and pharmacy technicians. Staff demonstrated a clear understanding of their roles within the pharmacy and an up to date knowledge of working protocols for the management of medication including controlled and accountable drugs - *Medical Centre Camp Bastion Afghanistan*

Within the forward operating bases the storage of medicines was said to be problematic because of climatic conditions. To mitigate the risk all medicines were destroyed and replaced on at least an annual basis - *Medical Centre, Camp Bastion, Afghanistan*

As a result of significant event reporting and analysis of reporting, there had been changes to the dispensing of medications for detainees held on the base. All medication for detainees was prescribed by a medical officer from the medical centre and dispensed and recorded by one of the practice nurses on regular drug administration visits to the centre. A small stock of prescribed medications was held securely within the detention centre - *Medical Centre, Camp Bastion, Afghanistan*

### Information for patients and staff

Patients told us that they were given information about the medications they were prescribed. They said that medical, nursing or pharmacy staff explained about any potential side-effects they might experience and what to do if they did - *Medical Centre Camp Bastion Afghanistan*

## Section 2: Primary healthcare medical services deployed operations (Afghanistan)

Records showed that management of these medications was in line with military policy and guidance. There was always a qualified pharmacist on duty when the pharmacy was open. The pharmacy team were able to provide specialist primary healthcare medication advice and hospital medication advice - *Medical Centre, Camp Bastion, Afghanistan*

### Monitoring

Medication stock held in the pharmacy was recorded on the military computer database system. This enabled staff to monitor the ordering, receipt and disposal of medicines. Regular checks of the environment and equipment within the pharmacy had been undertaken - *Medical Centre, Camp Bastion, Afghanistan*

Arrangements were in place for reporting adverse incidents, adverse drug reactions, incidents or errors. Near misses were also logged and reported. Staff were familiar with the system for dealing with medical and healthcare products regulatory agency (MHRA) drug alerts - *Medical Centre, Camp Bastion, Afghanistan*

Audits had been carried out in relation to the management of medicines. These included for example, audits related to the scope and supply of medications that medics could undertake. As a result of the audit, standard operating procedures had been changed and the scope of drugs that could be supplied increased - *Medical Centre, Camp Bastion, Afghanistan*

## Outcome 16: Assessing and monitoring the quality of service provision

The standard states that people receiving services should expect to benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

### Primary healthcare medical services: deployed operations - Outcome 16

The primary healthcare medical services in deployed Operations were compliant with this standard. However, there were some minor concerns relating to keeping medical records up to date when treatment was provided outside the main primary healthcare medical centre, and 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.

The service was judged compliant as we found that it promoted and supported a culture of continuous development. An audit lead and committee oversaw audit and ongoing evaluation of services. The outcomes from these 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. The risks of working in hostile and remote conditions were identified and actions to mitigate or remove these risks were taken as far as possible.

## Section 2: Primary healthcare medical services deployed operations (Afghanistan)

### Level of compliance

The primary healthcare medical services in deployed Operations were compliant with this standard. However, there were minor concerns.

### Minor concerns

These concerns related to keeping medical records up to date when treatment was provided outside the main primary healthcare medical centre and the lack of connectivity with IT recording systems for medical records in the UK. At times there were communication delays between the primary healthcare medical centre and the forward operating bases due to operational issues.

### The service was compliant with this standard

The service was judged compliant as there was an audit lead and committee, which oversaw audit and ongoing evaluation of services. A culture of continuous development was promoted and supported. Outcomes from audit and service evaluation 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. This information was used to make improvements to service provision. Staff were supported through a network of clinical supervision. Risks of working in hostile and remote conditions were identified and actions taken to mitigate or remove risk were taken as far as possible.

## Examples of good practice

### Monitoring the quality of services people receive

The patient satisfaction survey undertaken in October 2011 stated that there was 100% patient confidence in the ability of the medical centre and other staff to keep their information confidential - *Medical Centre, Camp Bastion, Afghanistan*

The team followed a model that demonstrated how significant event reporting would inform risk, which would in turn inform audit activity. Staff followed the National Institute of Health and Clinical Excellence (NICE) guidelines and the Scottish Intercollegiate Guidelines Network (SIGN) guidelines in the provision and monitoring of health care. A culture of continuous development and learning from audit and service evaluation was clearly evident - *Medical Centre, Camp Bastion, Afghanistan*

Training sessions within the medical centre were held each Tuesday. Regular team meetings were also held for staff to discuss any issues relating to the services provided. The service had an identified clinical supervision lead and clinical supervision was provided by a system referred to as 'one clinical network'. This included, for example, clinical advice, support and supervision of medics in areas of Operations outside the main base as well as staff working within the medical centre - *Medical Centre, Camp Bastion, Afghanistan*

### Risk management

The service had an identified lead for risk and risk management and an identified Caldicott lead. A risk register was maintained and regularly reviewed to monitor and mitigate against known risks - *Medical Centre, Camp Bastion, Afghanistan*

## Section 2: Primary healthcare medical services deployed operations (Afghanistan)

There were two infection control link nurses based in primary healthcare. One covered the medical centre and one covered the dental centre. Risk assessments had been undertaken and several audits of infection control had taken place to ensure that the required standards of cleanliness were in place. The infection control link nurses advised and worked closely with cleaning staff and the cleaning staff supervisor to determine the required levels of hygiene and cleanliness - *Medical Centre, Camp Bastion, Afghanistan*

Prior to deployment, staff working in primary healthcare provision, both within the medical centres and in the field, attended the 'Battlefield Advanced Life Support' programme. This programme, referred to as the BATLS training course, provided military personnel with an understanding of how to prioritise casualties for treatment and evacuation so that survival of the maximum number of casualties was ensured - *Medical Centre, Camp Bastion, Afghanistan*

### **Continuous improvement**

Audits included the morbidity of patients and equipment and stores. As a result of audits in dental services, all ration packs now contained chewing gum, ISO (International Organization for Standardization) energy drinks and fluoride toothpaste - *Medical Centre, Camp Bastion, Afghanistan*

Staff carried out some short focused audits that could be completed within a specific timeframe so that they were completed within a tour of duty period. An example was an audit about the use and value of wearing protective ballistic boxer shorts. The results showed that the boxer shorts reduced injuries sustained in a blast, so the wearing of this protective clothing increased - *Medical Centre, Camp Bastion, Afghanistan*

Audits of infection control identified an infection control risk due to some of the furnishings within the medical centre. Other nurse-led audits included audits of wound dressings, panton-valentine leukocidin (PVL) which is associated with some strains of bacteria, smoking cessation clinics, record-keeping and tracking and tracing contacts of personnel with communicable diseases - *Medical Centre, Camp Bastion, Afghanistan*

The physiotherapy team were involved in an audit and data collection of information about the injuries suffered by member of the Territorial Army in deployed Operations. This group of staff tended to be an older age group and some had long term injuries or postural problems which were exacerbated whilst on Operations - *Medical Centre, Camp Bastion, Afghanistan*

Members of the field mental health team had audited referral rates of Service personnel presenting with symptoms of anxiety or stress. Referral rates had been audited over the last two months when 16 people had accessed the self-referral service. A third of those were referred on for further assessment and treatment. Interventions included teaching 'coping skills' and understanding reactions to stress - *Medical Centre, Camp Bastion, Afghanistan*

## Section 3

# Hospital healthcare deployed operations (Afghanistan)

In hospital healthcare deployed operations in Afghanistan, we inspected against the following outcomes:

Outcome 4: Care and welfare of people who use services

Outcome 5: Meeting nutritional needs

Outcome 6: Cooperating with other providers

Outcome 8: Cleanliness and infection control

Outcome 9: Management of medicines

## Outcome 4: Care and welfare of people who use services

The standard states that people receiving services should expect to experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

### Hospital healthcare: deployed operations - Outcome 4

The hospital services in deployed operations were fully compliant with this standard. There were no minor concerns.

The service was judged compliant as we found that patients experienced safe, effective and appropriate care, treatment 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 CT and laboratory facilities. The hospital was designed primarily with acute resuscitation and damage control surgery in mind for battle injury casualties. Non-battle injuries resulting from accidents or illness were also treated. We considered the provision of trauma care as 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.

### Level of compliance

The hospital healthcare services in deployed operations in Afghanistan were fully compliant with this standard. There were no minor concerns.

### Examples of good and exemplary practice

#### Assessment, planning and delivery of care

Whilst visiting the ward, patients told us that they were impressed with the care they had received. More specifically the speed with which treatments were arranged, for example, physiotherapy, and by the instruction and information that was shared with them about their care and treatment - *Hospital Camp Bastion Afghanistan*

We saw initiatives and techniques that had all contributed to the increased survival rates for major trauma cases. These included better equipped soldiers and the use of the combat application tourniquet in the field. Within the hospital, this included the multiple medical consultant approach to damage control surgery, the use of pressure infusers and massive blood transfusion. It also included the ability to utilise rotation thromboelastometry (ROTEM) at the bedside to establish an individual analysis of the patient's cause of bleeding and to inform their ongoing coagulation management. (ROTEM is a system that analyses blood samples and in minutes provides an individualised picture of a patient's cause of bleeding.) This information can then be used to inform their coagulation management and optimises their fluid replacement - *Hospital, Camp Bastion, Afghanistan*

The use of multiple consultants in a 'swarm approach' involved one consultant assuming the role of trauma team leader, standing slightly back from participating in the resuscitation and treatment themselves, but directing and controlling the rest of the team. The hands-on team comprised consultant surgeons and anaesthetists, nursing and radiography staff alongside operating theatre staff. The overall aim of this 'swarm approach' was to both improve the chances of recovery and the quality of the surgery - *Hospital, Camp Bastion, Afghanistan*

All patients, irrespective of their status, received the same level of care and treatment. The ward was well equipped and had a storage area for additional equipment. We talked with a number of staff on the ward and they all spoke favourably about the working environment and positively about the team work - *Hospital, Camp Bastion, Afghanistan*

We observed that the padre attended each major trauma case that was received. The padre then followed the patient through their pathway, helping to ensure that the staff observed any religious or cultural requirements as far as possible. A briefing always took place after each major trauma case to reflect and review its management. This was led by the consultant who had coordinated the team and staff reported they found this a very supportive and helpful process - *Hospital, Camp Bastion, Afghanistan*

#### Managing risks

The initial communication from the unit in the field was a process referred to as a 9-liner. This was a standard request for medical evacuation and included details of the location, radio frequency and details about the number and severity of the casualties - *Hospital, Camp Bastion, Afghanistan*

### Section 3: Hospital healthcare deployed operations (Afghanistan)

All the information about each patient's care and treatment in the emergency department was captured and later shared with the academic unit in the UK, where it was used to inform and improve future practice. Examples of the data collected and recorded were drugs used in resuscitation and the intervals between their administration, the number and types of fluid replacement used and details of any episodes of defibrillation - *Hospital, Camp Bastion, Afghanistan*

The reception of patients and the subsequent speed of their treatment were down to a number of factors. The whole process of receiving patients from the Medical Evacuation Response Team, onto the ambulance and into the emergency department was well rehearsed. Staff told us that effective communication and everyone knowing their role in the team was crucial to success - *Hospital, Camp Bastion, Afghanistan*

#### Extracts from interviews with members of the Armed Forces

*"We spoke to a person who had been shot at close range...a bullet went into his body just below his rib cage. He does not remember exactly what happened next...he was aware of coughing up a lot of blood and he remembered hearing his sergeant saying the helicopter would soon be there... he does not remember anything of being on the helicopter or arriving in Camp Bastion or having any treatment. He later found out that he sustained multiple internal injuries and was transfused with 75 litres of blood platelets. He was stabilised in Camp Bastion before being flown by a highly skilled US army medical team to a hospital in Germany. His heart stopped four times. He was not expected to survive..."*  
Junior rank: Army

*"...he put tourniquets on his legs himself because he thought he was losing rather a lot of blood....the medic came straight over to him and he was given morphine and then the medical emergency evacuation team arrived...he did not know how long it was but it seemed like a lifetime...he blacked out and woke up on the operating table in Camp Bastion....there was a doctor telling him he was going to have to put him out.... he checked his 'privates' and found that they were ok and said 'happy days' you can put me out now..."*  
Senior rank: Army

*"...so I woke up with two big bandages wrapped round my legs and the doctor said that they had removed my right leg. I kind of accepted this straight away. The nurses in the hospital in Bastion were fantastic..."*  
Senior rank: Army

## Outcome 5: Meeting nutritional needs

The standard states that people receiving services should expect to be supported to have adequate nutrition and hydration.

### Hospital healthcare: deployed operations - Outcome 5

The hospital services in deployed operations 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, making sure that the food they provided was nutritionally balanced and supported their health. The hospital catered for special diets.

### Level of compliance

The hospital healthcare services in deployed operations in Afghanistan were fully compliant with this standard. There were no minor concerns.

### The service was compliant with this standard

Patients were supported to have adequate nutrition and hydration. The hospital provided choices of food and drink for patients to meet their diverse needs, making sure that the food they provided was nutritionally balanced and supported their health. We found that the hospital catered for patients from the UK Armed Forces and from International Security Assistance Forces (ISAF). The hospital also treated local nationals. Patients were supported to have adequate nutrition and hydration. The hospital provided choices of food and drinks for all patients including local nationals and their relatives and catered for special diets including those for people who had food intolerances or preferences such as a vegetarian diet. Food provided was varied and plentiful and supported health and recovery.

### Examples of good practice

We saw a range of weekly menus, which showed that several choices were available at each meal time. Menus were balanced and included all of the major food groups. We were told that special diets could be catered for. This included, for example, meals for people who required gluten free or wheat free diet. A vegetarian option was available for all meals – *Hospital, Camp Bastion, Afghanistan*

A range of snack foods was also available. The catering staff were aware of the food normally eaten by the local population and tried to ensure that all local national patients in the hospital and their relatives, had a nutritious and well balanced diet that mirrored their usual dietary intake. The catering staff were also very aware of the local dietary habits and made a considerable effort to ensure that these were met. This included, for example finding the recipes for particular local speciality breads and preparing these – *Hospital, Camp Bastion, Afghanistan*



## Outcome 6: Cooperating with other providers

The standard states that people receiving services should expect to receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

### Hospital Healthcare: deployed operations - Outcome 6

The hospital services in deployed Operations 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 patients were moved between services. The care and treatment provided on military Operations 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 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 evacuated to the UK for further treatment.

### Level of compliance

The hospital healthcare services in deployed operations in Afghanistan were fully compliant with this standard. There were no minor concerns.

### The service was compliant with this standard

We found that the care and treatment provided on military Operations 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 and developed systems so that the care provided was both seamless and integrated. Treatment was provided by anaesthetists, emergency medicine practitioners, orthopaedic and general surgeons, plastic and burns specialists, intensive care specialist clinicians and a range of staff providing clinical diagnostic services, medical evacuation and transportation services.

Although the hospital was UK-led, there was specialist clinical staff from the United States of America and Denmark working as part of the hospital team. We found that care patient focused and supported by a number of clinical meetings.

Staff working within the hospital had developed care networks all designed to meet the needs of the patients. With military patients there was regular communication between the hospital staff and the medical liaison officers who were able to keep, families, next of kin and commanding officers updated. Local national patients often needed family support to facilitate their discharge and ongoing care. A locally employed liaison officer was employed to trace family members. The international committee of the Red Cross were also used in helping with this task.

A welfare team within the hospital of civilian staff provided range of goods such as toiletries and items of clothing to military personnel. They visited the ward within the hospital daily and saw their role as providing informal pastoral support to patients and staff.

### Examples of good or exemplary practice

#### Coordinating care

There was a daily hospital clinical meeting. This was attended by all senior clinical staff from all the departments in the hospital. The meeting focused on a review of all patients in the hospital, what had happened to bring about their admission, for example illness, accident or battle injury. There was then a discussion about each patient and their current status in terms of their response to treatment – *Hospital, Camp Bastion, Afghanistan*

A weekly morbidity and mortality meeting was chaired by the deployed medical director and attended by all senior medical staff. At the meeting, all the week's previous admissions were presented and discussed at length. The lead clinician presented and discussed the individual treatment pathway for each patient, from point of injury, accident or illness through to the patient's current status. In this milieu, treatment plans were constructively challenged to ensure that best practice was followed at all times. Weekly clinical meetings attended by all medical staff had also been established to review all of the week's previous admissions – *Hospital, Camp Bastion, Afghanistan*

The deployment of burns and plastics specialist clinical staff was a result of a review of the injuries of casualties within the Royal Centre for Defence Medicine in the UK and was established to provide specialist advice to surgeons and nurses in the treatment of wounds. Blast wounds were often contaminated and having specialist advice to hand informed techniques that gave the best chance of post operative wound healing, skin grafts and the subsequent fitting of prosthetics – *Hospital, Camp Bastion, Afghanistan*

#### Information sharing and transfer

Clinical advisory group (CAG) meetings were held fortnightly and were attended by all heads of service. This was a multi-disciplinary group set up to review existing standard operating procedures, clinical guidelines, policy and ways of working. An example of this was the proximal control of catastrophic haemorrhage, where a local process had been developed. We attended a meeting of the CAG and the issues raised for discussion included development of a laboratory testing handbook, which included information on what tests were available and what wasn't and an update on treating and dealing with insect and animal bites – *Hospital, Camp Bastion, Afghanistan*

A joint theatre clinical case conference was also held weekly. This involved senior medical staff from the hospital linking via teleconference with the Royal Centre for Defence Medicine, other field hospitals, the Defence Medical Rehabilitation centre, the Aero Medical Evacuation team and Permanent Joint Headquarters. This forum was originally conceived as a formal clinical feedback system and was used to consider and review the patient's pathway. To maintain confidentiality each patient was given an ID number, and their names were not used during the meeting – *Hospital, Camp Bastion, Afghanistan*

A team of local nationals provided a translation service to local nationals admitted to the hospital. This team was led by a medically qualified member of the local national military and provided a 24-hour, seven day a week service. They provided support services and were involved in facilitating ongoing care in the local

healthcare system. We saw translation services being used for local military and police personnel and the relatives of children being treated in the hospital – *Hospital, Camp Bastion, Afghanistan*

### Outcome 8: Cleanliness and infection control

The standard states that people receiving services should be cared for in a clean environment and protected from the risk of infection in healthcare premises that are compliant with The Code of Practice for health and audit social care on the prevention and control of infections and related guidance.

#### Hospital healthcare: Deployed Operations – Outcome 8

The hospital services in deployed Operations 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 staff training. Patients were protected against the risk of exposure to infections through the systems and processes in place.

#### Level of compliance

The hospital healthcare deployed operations were fully compliant with this standard. There were no minor concerns.

#### The service was compliant with this standard

The hospital had an infection prevention and control nurse who was supported by a team of eight link nurses. The infection prevention and control nurse had instigated a programme of ‘Saving Lives’ audits within the clinical areas. This is a simple web-based system that allows health organisations to easily record and update their compliance with the Hygiene Code. Within the hospital, there were a number of standard committees that dealt specifically with infection prevention and control issues. These included the Infectious Diseases Working Group and the Force Protection Committee. An outbreak monitoring committee has also been established to deal with specific outbreaks. An external contract was in place for cleaning the hospital. In addition to the routine cleaning the contractor also provided an on call service for high use and heavily contaminated areas such as the emergency department and the operating theatre.

#### Examples of good practice

Staff were clear that cleanliness was the responsibility of all staff and cleaned the clinical environments as required. Appropriate personal protective equipment was available for staff. We saw that the hospital premises were very clean, well lit and well maintained. We also saw staff involved in cleaning equipment in the store room and saw that equipment was labelled with the date it was last cleaned – *Hospital Camp, Bastion, Afghanistan*

## Section 3: Hospital healthcare deployed operations (Afghanistan)

Throughout the hospital, hand gels were in place and used to assist with infection control. There was clear evidence of infection prevention and control related information on notice boards, signs about hand washing, the management of sharps injuries and details of the 'bare below the elbow strategy' - *Hospital Camp, Bastion, Afghanistan*

### Outcome 9: Management of medicines

The standard states that people receiving services should expect to have their medicines at the times they need them, and in a safe way, and wherever possible, will have information about the medicine being prescribed made available to them or others acting on their behalf.

#### Hospital healthcare: Deployed Operations - Outcome 9

The hospital services in deployed Operations 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 and clinical support.

#### Level of compliance

The hospital healthcare deployed operations were fully compliant with this standard. There were no minor concerns.

#### The service was compliant with this standard

We found that medicines were handled safely, securely and appropriately. Auditing and monitoring processes were in place. Staff had access to relevant policies and guidance and clinical support.

#### Examples of good practice

##### Effective use of medicines

Medicines management training was mandatory for all staff. Pharmacy staff said that the emphasis on medicines management training had impacted upon the relatively low number of medicines errors. This training was started in pre-deployment and was continued whilst deployed - *Hospital Camp, Bastion, Afghanistan*

We saw that all clinical areas had suitable, lockable storage facilities for medicines. Drug fridges were temperature controlled and staff monitored and recorded those temperatures daily - *Hospital Camp, Bastion, Afghanistan*

## Section 3: Hospital healthcare deployed operations (Afghanistan)

### Information for patients and staff

Staff told us that prescribing whilst on Operations was determined by clinical guidance for Operations and in accordance with the tri-service formulary. Prescribing compliance was audited by the pharmacy team. Staff told us that there were occasions when prescribing deviated from the clinical guidance but this was always only after a consultation with the pharmacist and deployed medical director to ensure clinical acceptability - *Hospital Camp, Bastion, Afghanistan*

### Monitoring

All controlled drugs were checked and accounted for when handing over at the end of a tour of duty. All controlled drugs for the hospital were ordered through the Role 3 pharmacy, which also had a responsibility for monitoring controlled drug usage. Additionally, each clinical department checked their controlled and accountable drugs daily. Staff told us that all controlled and accountable drugs were also checked monthly by the Commanding Officer with any discrepancies raised and investigated in accordance with guidance. Any such discrepancy would also be reported as a significant event - *Hospital Camp, Bastion, Afghanistan*

Pharmacy staff checked prescriptions for accuracy before dispensing. Any queries were raised with the prescriber. It was usual for one of the pharmacists to spend much of their time on the hospital ward. They were very much part of the ward team and accompanied the rest of the clinical team on ward rounds. This included being involved in the daily 'pain round' when a doctor, nurse and pharmacist would focus specifically on the pain management of their patients. Being on the ward also enabled the pharmacist to be involved in stock checking and top up, checking of prescriptions and dispensing of discharge medicines - *Hospital Camp, Bastion, Afghanistan*

## Section 4 Defence Medical Rehabilitation Centre

In the Defence Medical Rehabilitation Centre (DMRC), we inspected against the following outcomes:

Outcome 1: Respecting and involving people who use services

Outcome 3: Care and welfare of people who use services

Outcome 6: Cooperating with other providers

Outcome 14: Supporting workers

Outcome 16: Assessing and monitoring the quality of service provision

### Outcome 1: Respecting and involving people who use services

The standard states that people receiving services should:

- Understand the care, treatment and support choices available to them.
- Be able to express their views, so far as they are able to do so, and be involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

#### Defence Medical Rehabilitation Centre - Outcome 1:

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 which 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 patient needs and making informed choices about their healthcare.

#### Level of compliance

The defence medical rehabilitation centre was fully compliant with this standard. There were no minor concerns.

### **The service was compliant with this standard**

The DMRC is the principal medical rehabilitation centre for the Armed Forces. It provides acute medical rehabilitation across the spectrum of injury from sports, exercise and industrial accidents to the more serious neurological conditions and complex trauma casualties. The DMRC aims to provide maximum functional outcome for all patients by providing consultant-led multidisciplinary care, high quality prosthetics and adaptations, manufactured on site to the specific patient. The centre also provides neuro-rehabilitation for brain injured patients.

We spoke with junior ranks, non-commissioned officers and officers. They included male and female patients attending outpatients and inpatients. All groups of patients said their care was excellent and that it was delivered on an equal basis regardless of gender, disability, rank or how their injury or illness was sustained. Information for patients was displayed and available throughout different areas of the unit. This included an overview of the unit, health promotion material and how to access welfare and counselling services. Display boards included literature regarding confidentiality, patients' rights and how to register complaints or suggestions.

Patients described a holistic and comprehensive service, supported by access to useful and appropriate exercise leaflets, which complemented their treatment programmes. They reported that staff were vigilant in ensuring they fully understood their injuries and the personal exercise regimes designed for their recovery. Patients told us this was very helpful and they felt comfortable asking for further clarification if needed.

### **Examples of good practice**

#### **Patient respect and involvement**

During our visit we saw that patients were being supported and spoken to in a respectful and professional manner. There was an "open curtain" policy in place, which recognised that the majority of patients preferred to receive treatment in an open environment. Staff explained how this approach was more therapeutically beneficial for patients, but that they always remained mindful to offer patients more private facilities if they preferred. Information on the walls beside individual treatment couches and areas stated clearly that patients can have curtains closed if they wished to be treated in private – *Defence Medical Rehabilitation Centre, Headley Court*

#### **Making informed choices**

Patients were very keen to be involved in their care and took an active part in developing their treatment programmes and solutions. For example, staff had installed long mirrors in the bays on wards and in rehabilitation areas. These were to encourage patients to check their posture and balance and work on improving these for themselves – *Defence Medical Rehabilitation Centre, Headley Court*

#### **Collecting feedback from people who use services**

Changes had been made to the environment in the ward area as a direct response to patient comments regarding accessibility. This had included refurbishment of toilet and bathroom facilities in a ward area specifically to accommodate independent access for patients. We were shown examples of how dignity and

respect had been promoted following patient feedback. One example was how a drinks dispense machine had been adapted and installed in the ward communal area to allow patients to access drinks without relying on other people to dispense them - *Defence Medical Rehabilitation Centre, Headley Court*

### **Extract from an interview with a member of the Armed Forces**

*"...the army's 'can do' attitude and 'things happen' philosophy have helped me to remain motivated and determined to overcome my injuries and enjoy life to the full." Senior rank: Army*

*"...I've survived catastrophic injuries and trauma.... but I feel that I was treated differently to other injured Service personnel because externally, I don't look like I've sustained serious life-threatening injuries... people do not realise the restrictions I have because of the severe internal damage my injuries have caused." Junior rank: Army*

## **Outcome 4: Care and welfare of people who use services**

The standard states that people receiving services should expect to experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

### **Defence Medical Rehabilitation Centre - Outcome 4**

The Defence Medical Rehabilitation Centre was compliant with this standard. Minor concerns identified included some patients who were distressed at having to relocate from their accommodation to one ward 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.

Patients experienced safe, effective, and appropriate care tailored to 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.

### **Level of compliance**

The defence medical rehabilitation centre was compliant with this standard. There were some minor concerns.

### **Minor concerns**

The minor concerns related to some patients who were distressed at having to relocate from their accommodation to one ward 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 service was compliant with this standard**

The unit provided medical consultant-led services with facilities and therapy staff to manage patients with complex rehabilitation needs. This included patients requiring complex trauma care and care and treatment of severe brain injuries. Some of the injuries were a result of battlefield injuries. However, most of the patients seen and treated at the unit were patients with more complicated musculoskeletal injuries than could be managed in the regional rehabilitation services. The unit had 110 hostel beds for those who do not need inpatient care and services and 106 inpatient ward beds to support complex trauma. This included patients who were being fitted with prosthetic limbs and patients with neurological injuries.

Patients told us that their needs were always at the centre of the care and support provided. They told us that staff explained all procedures before they took place, and discussed treatment options and effects with them. Patients said they were the person who made treatment decisions.

### **Examples of good and exemplary practice**

#### **Assessment, planning and delivery of care**

Each patient had their own team of multi disciplinary therapy and support staff. This could include for example, a named physiotherapist, occupational therapist, speech and language therapist, psychologist or social worker. Patients also had access to community psychiatric nurses, a psychologist and a psychiatrist. All these staff were based within the centre so that patients had easy access to them. Staff also made referrals to other agencies such as the Stroke Association, the Multiple Sclerosis Society and St Dunstan's for specialist advice - *Defence Medical Rehabilitation Centre, Headley Court*

Patients and staff said that equipment needed to support patient independence was easy to access. This included amputees having two sets of prosthetic limbs because of their reliance on them. In addition equipment such as memory watches, laptops linked to mobile phones and communication aids were available. Occupational therapists carried out assessments and were able to support patients to obtain equipment such as chairs and perching stools, with the emphasis on return to work - *Defence Medical Rehabilitation Centre, Headley Court*

#### **Managing risks**

Staff explained how they managed the transition of patients from hospital in to the unit. A link member of staff spent time in Birmingham with the patient prior to them being transferred. This helped staff to understand the patient's wound management plan that has been put in place and how this would need to be continued in the unit - *Defence Medical Rehabilitation Centre, Headley Court*

The centre used the social model of disability and information for patients was presented in a positive way with the emphasis placed on ability and skills. For example we saw the disability magazine 'Pos'ability' in many areas of the unit together with advertisements for 'Battle Back' which provides sports and adventure training. In addition opportunities for sailing, rowing and climbing were advertised. Patients were encouraged to identify obstacles to their independence and to find solutions. For example, patient parking was an issue and patients were

involved in finding solutions within the existing boundaries of the unit. Another example identified how the height of the washing machines for use on the ward had recently been raised to enable patients in wheelchairs to use them independently - *Defence Medical Rehabilitation Centre, Headley Court*

### Extracts from interviews with members of the Armed Forces

*"....I have had several admissions to the [Defence Medical Rehabilitation Centre] unit and found the focus of care and treatment very much about identifying what you can do, rather than what you can't, really motivating and encouraging. Being in a military environment and watching other people overcome significant injuries and multiple amputations had an enormous impact on my determination to get back to the life I had before." Senior rank: Army*

*"....care was provided in four-person bays and there was not much privacy. Considering some of the disfiguring injuries to younger lads, I thought they'd have individual rooms. I did not mind and felt confident to show my injuries to anyone, but for some of the younger lads it's different. It was the same in the new block, perhaps due to the volume of patients. I was surprised that officers and lads who have been in the Services for 10 years or more were sharing with young lads. I thought they would have been single rooms or double at least..." Senior rank: Army*

*"... the rehabilitation and the quality and crafting of my prosthetic limb from the defence medical services, surpasses, I believe, the services provided by the NHS. I am concerned that I will not have this centre of excellence at my fingertips providing the very best and most up-to-date aids when I am medically discharged from the army." Senior rank: Army*

*"I was referred to the Defence Medical Rehabilitation Centre and had several admissions. I found individual physiotherapy very helpful as I had difficulty moving my arms, but struggled with a six-hour-a-day exercise regime. Being able to talk about things with the other military personnel and staff helped..... I was able to talk to other services like welfare and legal services, which I found helpful...." Junior rank: Army*

*"I thought that the prosthetics facility at Headley Court was fantastic. At first, one-to-one and the same faces, but later I got moved onto someone else. It's the high volume of people going through, and I thought that by now, after being in Iraq and Afghanistan for 10 years or so, that there would be more than just the one rehabilitation centre because there is a massive number of amputees now. So in the prosthetic centre I have been seen by about five different guys during my rehabilitation, so every time I had someone new I had to explain everything all again. They asked the same questions and I gave the same answers that I have given over the past two years..... I will need prosthetics for the rest of my life..." Senior rank: Army*

*"Headley Court sorted out a wheelchair .... I was told that I could have any chair I wanted, within reason. Tried a chair at Stoke Mandeville hospital and wanted that one – Headley Court had to get a new contract in for the different chair. I chose the lighter, more expensive one, but got lightest chair on the market and much easier to use. This helped me to be more independent." Junior rank: Army*

## Outcome 6: Cooperating with other providers

The standard states that people receiving services should expect to receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

### Defence Medical Rehabilitation Centre - -Outcome 6

The Defence Medical Rehabilitation Centre was fully compliant with this standard. There were no minor concerns.

Patients received safe and coordinated care, treatment and support where more than one provider was involved, or 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 providing care, treatment and support. This provided coordinated care, support and treatment when patients received services from other organisations.

### Level of compliance

The defence medical rehabilitation centre was fully compliant with this standard. There were no minor concerns.

### The service was compliant with this standard

Staff in the centre were aware that the patient care pathway from point of wounding, in the case of a battle injury, or from the time of their accident or the onset of ill health could be a long and complex one. In the case of some patients with complex trauma, the move along the patient pathway to recovery can take years and involve a range of health and social care professionals. Staff had developed very effective relationships with a number of health care providers, government departments and charitable organisations to work in cooperation with others providing care, treatment and support. This provided coordinated care, support and treatment when patients received services from other organisations.

## Examples of good practice

### Co-ordinating care

Every patient on a recovery pathway had a tailored an Individual Recovery Plan, which was developed, coordinated and managed by a Personnel Recovery Officer. This aimed to ensure that individuals were able to access the particular support they needed at each stage of their recovery - *Defence Medical Rehabilitation Centre Headley Court*

Weekly teleconferences were held between staff from a number of units and services to keep in touch with, and track, the progress of patients with complex injuries. These meetings involved staff from the Headquarters Army Primary Healthcare Service, the Royal Centre for Defence Medicine, the Army Recovery Capability, British Forces Healthcare Services Germany, the Hasler Company and the unit itself. The Hasler Company was formed in 2009 by the Royal Navy and

Royal Marines to specifically to help aid the recovery, rehabilitation and re-integration of marines needing focused and individual attention - *Defence Medical Rehabilitation Centre, Headley Court*

Patients said their military liaison officer was a key member of their therapy and support team, providing the link between services and aiding smooth transition for patients. One liaison officer who was leaving the unit spoke with us and described how he was in the process of providing an on site induction programme for his replacement. Patients told us that the liaison officers were really well appreciated and did a brilliant job - *Defence Medical Rehabilitation Centre, Headley Court*

### **Information sharing and transfer**

Staff in the social work department explained how they worked with various organisations to ensure that patients were fully supported throughout their period of rehabilitation. We heard how they worked and liaised with organisations such as Headway, the Brain Injuries Rehabilitation Trust, the Multiple Sclerosis Society and the Stroke Association. Communication with the Department of Work and Pensions had resulted in them reducing the time taken for patients to obtain their disability living allowances from twelve weeks to three - *Defence Medical Rehabilitation Centre, Headley Court*

Patients told us that aside from the involvement of a multi-disciplinary clinical team, their families were also involved in their care and treatment. One patient told us that their wife and daughter had been included in their first admission visit when their treatment programme had been discussed and agreed - *Defence Medical Rehabilitation Centre, Headley Court*

### **Extracts from interviews with members of the Armed Forces**

*"I am being supported through one of the Personal Recovery Assessment Centres established by the charity Help for Heroes. The unit has given me structure to my day, encouragement with studies, help to build my confidence and improve my physical health." Junior rank: Army*

*"I found it very helpful to be assigned a personal recover officer to help with the transition to civilian life ..... but found a problem with the chain of command. This included, for example, accessing funds from charities like Help for Heroes, and the fact that I had to go through so much red tape to get to the funds. I am very grateful that so much money has been collected for injured military personnel, but felt I had to bend over backwards just to get a small amount. ....my personal experience of needing a new mattress due to severe back pain, meant I had to wait for an assessment, get quotes, get a report from a physiotherapist, pass this to my recover officer and then wait for authorisation....several frustrating weeks chasing and waiting..." Senior rank: Army*

*"With the personal recovery officers now, it's a lot better. However I feel that with the Army everything takes so long. ...they don't do simple solutions....I think the whole service could be a bit more personal but again it's the numbers of people needing help these days. I feel that it's easier for me as I 'just get on and get things done' but I was concerned that younger lads injured don't want to be waiting around for weeks waiting for decisions to be made to get the help, support and aids they need..." Senior rank: Army*

*“I feel that I have been let down by medical care and services not working together or being coordinated. I want to be seen and treated as a whole person with multiple health problems ....my experiences of receiving specialist care (in the military defence hospital units in the NHS) is that I believe that the clinical staff treating me were, sometimes, only interested in one aspect of my condition. For example, when I was being treated for my respiratory injuries I did not feel that staff were concerned about my damaged liver. When I was under a liver specialist I did not think I was asked about his heart condition...” Junior rank: Army*

*“...frustration along the way has included being ‘messed around’ by cancellation of outpatients, both within the NHS and from Defence Medical Services. This had at times required me to have to rearrange appointments myself to ensure that I attended the right appointments in the required order. For example, no point in having a medical consultation if required tests had not been undertaken. The reluctance of one NHS hospital to share the outcome of investigations with another NHS hospital was also a particular low point. This resulted in x-rays having to be repeated.” Senior rank: Army*

### Outcome 14: Supporting workers

The standard states that people receiving services should expect to be safe and their health and welfare needs met by sufficient numbers of appropriate staff.

#### Defence Medical Rehabilitation Centre - Outcome 14

The Defence Medical Rehabilitation Centre was fully compliant with this standard. There were no minor concerns.

Staff had access to training, support 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, the required mandatory training was attended and staff received regular supervision and appraisals. Patients benefitted from 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.

#### Level of compliance

The defence medical rehabilitation centre was fully compliant with this standard. There were no minor concerns.

## Examples of good practice

### Staff induction, training and development

All military and civilian staff, including locum staff, attended a mandatory introduction programme. This included for example, health and safety and incident reporting, fire and the environment, complaints and confidentiality, infection control, safeguarding children and vulnerable adults and security. Additional mandatory induction training for clinical staff included risk management and consent to treatment, mental health, basic life support and the Data Protection Act - *Defence Medical Rehabilitation Centre, Headley Court*

We spoke to several patients who were undergoing a range of treatment programmes. All of the patients we spoke with were extremely complimentary and confident about the competence, professionalism and dedication of staff. They described staff as caring and treating patients as individuals. They told us that staff were flexible, committed and completely patient focused - *Defence Medical Rehabilitation Centre, Headley Court*

### Staff supervision

A range of supervision and clinical supervision practice was in place. For example, nurses were required to choose a clinical supervisor to provide support and supervision of their clinical practice. Set times for the interval between supervisory sessions were established along with how supervision should be recorded. We also found evidence of clear lines of supervision for medical staff and physiotherapy and exercise rehabilitation staff - *Defence Medical Rehabilitation Centre, Headley Court*

Staff working in the research department offered supervision, support and advice to colleagues undertaking research either as part of a degree programme or as part of their agreed role with the rehabilitation services. Support was available for writing a research proposal, what research methods or research path to follow, ethics and information about the Defence Medical Services research approvals processes, policies and protocols - *Defence Medical Rehabilitation Centre, Headley Court*

## Outcome 16: Assessing and monitoring the quality of service provision

The standard states that people receiving services should expect to benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

### Defence Medical Rehabilitation Centre - Outcome 16

The Defence Medical Rehabilitation Centre was fully compliant with this standard. There were no minor concerns.

Processes and systems were place to manage risks and to affect decision making that ensured that patients benefited from safe quality care, treatment and support. These included programmed audits, risk assessment and risk registers, research programmes, monitoring and implementing relevant clinical guidelines and patient involvement and 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.

### **Level of compliance**

The defence medical rehabilitation centre was fully compliant with this standard. There were no minor concerns.

### **Examples of good and exemplary practice**

#### **Monitoring the quality of services people receive**

Staff told us how the strong team culture together with a focused leadership contributed towards the strength in the unit delivering a first class service. There was a process of constant review in place and staff described a team driven and focused on continuous improvement in all aspects of service provision - *Defence Medical Rehabilitation Centre, Headley Court*

All staff were aware of the healthcare governance policy, which included arrangements for whistle blowing, harassment and bullying and described fully the procedures to be followed. Staff were confident about how they would deal with any poor practice and how they would raise concerns about another person's practice - *Defence Medical Rehabilitation Centre, Headley Court*

#### **Managing risk**

During the visit we reviewed the governance arrangements in place which incorporated the processes to manage risk, undertake audit and develop continuous improvement. Staff demonstrated an excellent understanding of governance procedures including, the unit objectives and programme of audit and review process - *Defence Medical Rehabilitation Centre, Headley Court*

The unit had a designated lead for incident management Staff demonstrated a sound knowledge of the policy relating to incident management and were confident in using it. Staff said they were actively encouraged to report incidents at all times and gave us examples of when and how they would report issues - *Defence Medical Rehabilitation Centre, Headley Court*

#### **Continuous improvement**

The unit had a lead clinician overseeing clinical audit. Achievements reported for the year 2010/11 included the development of key performance indicators and best practice guidelines, overseeing all audit activity and developing outcome

measures using the Defence medical information capability programme. The latter involved working with Defence Analytical Services and Advice (DASA) - *Defence Medical Rehabilitation Centre, Headley Court*

An innovative and graphic poster had been developed to display the results of audits undertaken by the department for lower limb rehabilitation during 2011. It displayed the aims of each audit, together with the methods used, headline results, conclusions and actions. Audits undertaken included infection control, analysis of professional quality of life, diagnosis, treatment and exertional compartment syndrome (a condition in that can occur from repetitive loading or exertional activities). Audits had also been undertaken on the effectiveness of re-education courses, extracorporeal shockwave therapy and medical notes - *Defence Medical Rehabilitation Centre, Headley Court*

Papers submitted for publication included *Strength training in rehabilitation, a systematic review*, to be published in the British Journal of Sports Medicine. Publications accepted also included *Outstanding results from TNF (tumour necrosis factor) blocking therapy in Ankylosing Spondylitis patients with young age and short disease duration*, published by the European league against rheumatism 2011 and *The effects of exercise for the prevention of overuse anterior knee pain: a randomised control trial* published in the American Journal of Sports Medicine. Presentations were also made at national conferences including the British Association of Sports and Exercise Medicine 2011, the British Olympic Association and the English Institute of Sport conferences 2011 -- *Defence Medical Rehabilitation Centre, Headley Court*



## Section 5 Regional rehabilitation units

In the regional rehabilitation units, we inspected against the following outcomes:

Outcome 1: Respecting and involving people who use services

Outcome 4: Care and welfare of people who use services

Outcome 6: Cooperating with other providers

Outcome 14: Supporting workers

Outcome 16: Assessing and monitoring the quality of service provision

### Outcome 1: Respecting and involving people who use services

The standard states that people receiving services should:

- Understand the care, treatment and support choices available to them.
- Be able to express their views, so far as they are able to do so, and be involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

#### Regional rehabilitation units - Outcome 1

All of 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 we 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 have their views and experiences taken into account in the way services were provided. The patients interviewed in the regional rehabilitation units were very positive about services meeting their needs and in the provision of information about their current and future healthcare needs

### **Level of compliance**

All of the regional rehabilitation units were judged to be compliant with this standard. One unit had minor concerns.

### **Minor concerns**

Minor concerns related to the age and layout of the building for one of the regional rehabilitation units. This presented infection control risks and the unit could not accommodate the number of patients requiring rehabilitation programmes. Sleeping accommodation attached to the same unit was not adequate for patients attending a treatment programme. There were also minor concerns related to accessing information on the electronic patient record system, inhibiting multidisciplinary working.

### **Services compliant with this standard**

Patients benefitted from a working ethos that promoted their right to be treated with dignity and consideration irrespective of their rank. Patients receiving rehabilitation in the regional rehabilitation units understood the care, treatment and support available to them. They particularly appreciated the information and explanation given to them about their injuries or illness. This helped their understanding of what they needed to do to reach their optimum level of fitness and recovery. Patients were encouraged to give regular feedback about their treatment and the quality of services provided. All patients irrespective of rank were treated with respect.

## **Examples of good practice**

### **Patient respect and involvement**

Patients told us that their individual treatment plans were designed with them by the treating clinicians and rehabilitation staff. This group of staff included sports and exercise medicine consultants, physiotherapists and exercise rehabilitation instructors. Patients reported that they were always able to ask any questions about their treatment plans and explanations were always given - *Regional Rehabilitation Centre, Edinburgh*

Patients expressed their appreciation of the efforts made by staff in order to protect their privacy and maintain their confidentiality. Assessments and consultations with patients took place in private with enough time allocated for their appointment to ensure they had opportunity to have their needs fully addressed - *Regional Rehabilitation Unit, Catterick*

### **Meeting patient needs**

Patients said the information they received at the start of their course of treatment was comprehensive. They said they fully understood their injury, the mechanics of how limbs function and what they had to do as part of their rehabilitation. We saw the individual work programme given to patients with exercises as part of their treatment programme - *Regional Rehabilitation Unit, Aldershot*

Patient information leaflets were also available, which included, for example, information on injection therapy, shockwave therapy, a treatment for tendon related pain or muscular skeletal problems and manipulations -*Regional Rehabilitation Unit, Edinburgh*

### **Making informed choices**

We found patients made an informed decision to be referred to the rehabilitation unit. Patients said they were assessed by the multi-disciplinary injury assessment clinic at the unit before they were accepted for rehabilitation. The assessment also took account of any previous injuries, needs and preferences - *Regional Rehabilitation Unit, Aldershot*

### **Collecting feedback from people who use services**

Staff gave us additional examples of where patients' feedback had led to changes at the unit. These included installing a radio in the physiotherapy treatment bays and adapting course programmes to give more flexibility for patients between exercise and education classes - *Regional Rehabilitation Unit, Catterick*

### **Comparison with individual unit DMS Common Assurance Framework (CAF) reports for regional rehabilitation units:**

Comparison of the CQC inspection reports with the individual unit DMS CAF reports indicated that for Outcome 1: Respecting and involving people who use services, the majority of relevant concerns identified in the CAF reports had been resolved by the time of inspection. There were however, some issues raised in the inspection reports that had been missed in the CAF reports for Outcome 1. These tended to focus on problems with infrastructure constraints and minor problems with accessibility of the electronic recording system inhibiting multidisciplinary working.

## **Outcome 4: Care and welfare of people who use services**

The standard states that people receiving services should expect to experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

### **Regional Rehabilitation Units - Outcome 4**

All of the regional rehabilitation units we inspected were judged as fully compliant with this standard. There were no minor concerns.

In the regional rehabilitation units we inspected, 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 tailor made treatment planned. We found that patients experienced safe, effective and appropriate care and treatment. 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.

### Services compliant with this standard

The regional rehabilitation units we inspected ensured that patients experienced effective, safe and appropriate care, treatment and support that met their needs and protected their rights. Care was based on good practice guidance that was goal orientated, well co-ordinated and tailored to people's individual needs. Patients were assessed through the multi disciplinary injury assessment clinic (MIAC) which provided case management for complex injuries of patients referred with musculoskeletal injury or for patients requiring specialist investigations and/or the fast track surgical service. A major strand of the MIAC was to establish a diagnosis, develop a treatment plan and monitor each patient's progress and outcome. Patients were fully involved in the planning and monitoring of their treatment plans.

### Examples of good and exemplary practice

#### Assessment, planning and delivery of care

The individual exercise programmes were developed by staff and patients and ensured personal objectives were identified. Patients said staff gave them clear instructions about their individual exercise programme. Patients knew their progress was monitored after each session followed by reviews at the midpoint and at the end of the course - *Regional Rehabilitation Unit Aldershot*

The unit provided an extensive educational component in all of the programmes. Patients reported how helpful it was to gain an understanding of the nature of their injuries and information on maintaining their health once their treatment was completed - *Regional Rehabilitation Unit Edinburgh*

Patients reported to us how quickly they received appointments following their initial referral. They said how initial assessments were carried out by the medical officer and a physiotherapist. The plan of care was then developed with the individual by both professionals - *Regional Rehabilitation Unit Catterick*

#### Managing risks

The multi-disciplinary injury assessment clinic made up of a medical officer and clinical specialist physiotherapist. The clinic would assess the complex injuries of patients referred with musculoskeletal injury or for those who required specialist investigations, injections and/or the fast track surgical service or intensive rehabilitation. One of the key roles for the assessment clinic was to establish a diagnosis, develop a treatment plan and monitor each patient's progress and outcome - *Regional Rehabilitation Unit Aldershot*

Patients who attended the regional rehabilitation unit, experienced effective, safe and appropriate care, treatment and support that met their needs. Treatment programmes were delivered by a team of highly motivated and competent rehabilitation specialist staff, who ensured that a patient focus was central to all of the work they undertook - *Regional Rehabilitation Centre Edinburgh*

## Results from the survey

Results from the survey found a number of very positive responses about rehabilitation programmes. Comments included:

*“...quality of rehabilitation care is outstanding. The work done by the physiotherapists has alleviated significant problems which would almost certainly otherwise have led to time off, medical downgrade etc, along with the incurred expense (both to myself and the Service).”*

*“...the physios I have seen have been first class.”*

*“...the physio treatment that I have received has been excellent.”*

However, concerns were raised about the accommodation attached to some of the regional rehabilitation units, which impacted on the treatment received. Comments included:

*“The accommodation which I was subjected to was terrible, cold water, no privacy, 15 patients sharing 1 room with TV blaring away and moving up and down the dorm I could not sleep and felt like just leaving the course.”*

## Outcome 6: Co-operating with other providers

The standard states that people receiving services should expect to receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

### Regional Rehabilitation Units - Outcome 6

All of the regional rehabilitation units we inspected were judged as fully compliant with this standard. There were no minor concerns.

We found that patients received safe and co-ordinated care, treatment and support where more than one provider was involved or 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.

### Services compliant with this standard

The regional rehabilitation units worked very closely with other providers including the medical defence hospital units within NHS hospital trusts. Patients were referred to a range of services such as orthopaedics and neurology services, podiatry, elite sports clinics and sports injury specialist clinical staff, rheumatology services and clinics for pain control or brain injury. Staff in the regional units also worked closely with colleagues in the primary healthcare rehabilitation facilities within primary healthcare medical centres, offering advice and training. Staff

across all of the rehabilitation units had access to best practice documents and guidance circulated through the defence medical rehabilitation centre.

### Examples of good practice

Staff said patients that required diagnostic services including scans were referred to the local hospital. Appointments were arranged with the patients' consent and at the time that suited them. Patients reported they received a good service and could contact the hospital directly for test results if these were urgent - *Regional Rehabilitation Unit Aldershot*

Staff described initiatives aimed at developing a wider advice and training role across the region. Staff from the RRU worked in close liaison with colleagues working in the primary healthcare rehabilitation units, offering both advice and training. This included, for example, monthly training sessions held and routine visits undertaken to primary healthcare rehabilitation facilities. Staff also described an on-going project with local orthopaedic services to ensure provision of specialist care for military personnel within NHS settings - *Regional Rehabilitation Unit Edinburgh*

## Outcome 14: Supporting workers:

The standard states that people receiving services should expect to be safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

### Regional rehabilitation units - Outcome 14

All of the regional rehabilitation units we inspected were judged as fully compliant with this standard. There were no minor concerns.

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

### Services compliant with this standard

Patients we spoke with in the regional rehabilitation units told us that they received care, treatment and support from staff that were confident and professional at all times. Staff in the units we inspected had completed induction programmes and had access to training and development programmes. These included, for example, training such as equality and diversity, safeguarding adults, fire and health and safety. Staff understood their role and were committed in providing patient centred treatment. Staff were supervised and had appraisals. The units had regular staff meetings and staff were actively encouraged to contribute to the development of the service. Locum staff were fully integrated with the teams and their personal training and development was constantly monitored. Staff felt very well supported and the teams were well led and managed.

## Examples of good practice

### Staff induction, training and development

Staff we spoke with had completed the induction programme. This programme covered information about the facilities, policies and mandatory training such as equality and diversity, safeguarding adults, fire and health and safety. They understood their role and were committed in providing patient centred treatment. We saw evidence of attendance at the induction programme in staff personal records - *Regional Rehabilitation Unit Aldershot*

We saw specific guidance related to training needs of relevant staff, the subject to be completed, and frequency of this and how staff accessed learning programmes. We also saw training records outlining the mandatory training programme for the current year and next year. This detailed the minimum level of training required, subject matter, frequency, who needed to attend and information on the respective course. An electronic data base recorded training for each staff member - *Regional Rehabilitation Unit Catterick*

### Staff supervision

Staff felt well supported, received appropriate and regular supervision and had a lot of opportunities to meet with colleagues to discuss service provision and how services could improve. This included, as a current development, a system for early identification of the need for referral to other services. This included, for example, the need for surgery or treatment and support for psychological symptoms - *Regional Rehabilitation Centre Edinburgh*

### Staff work environment

There were regular practice meetings where issues could be discussed and informal training could be introduced to support individuals and aid team learning. There was access to policies related to bullying and harassment and staff felt able to raise concerns, should they need to do so. Regular canvassing was done throughout the staff team on how individuals could contribute to making the regular practice meetings more informative and successful - *Regional Rehabilitation Unit Catterick*

Staff said that there were informal weekly meetings and formal unit meetings every two months where issues were discussed. The minutes of the last unit meeting showed these meetings were well attended and staff contributed ideas and feedback to make these effective - *Regional Rehabilitation Unit Aldershot*

## Outcome 16: Assessing and monitoring the quality of service provision

The standard states that people receiving services should expect to benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

### Regional rehabilitation units - Outcome 16

All of the regional rehabilitation units we inspected were judged as fully compliant with this standard. There were no minor concerns.

In the regional rehabilitation units we inspected, we found that patients benefitted from safe care, treatment and support due to effective processes in place to manage risks and monitor the delivery of services. Planned programmes of audit activity were in place, risk registers 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.

### Services compliant with this standard

In the regional rehabilitation units we inspected, patient satisfaction and feedback systems were in place. There were several examples of where this had led to improvements in services provided. Services were regularly monitored and a planned programme of audits was in place. Outcomes from service evaluation, monitoring and audits were used to improve practice. Risk assessments and risk registers were in place and reviewed and updated regularly. Actions taken to reduce or remove risks were clearly documented.

The units had regular staff meetings where staff could discuss treatment plans, service developments or improvements to practice. Staff were aware of their roles and responsibilities and locum staff were monitored and involved in all aspects of the services provided. Systems were in place, and understood by staff for reporting risk, safety issues or significant events.

### Examples of good practice

#### Assessing and monitoring the quality of service provision

Staff told us that patients were asked to complete an evaluation form at the end of the course. Patients we spoke with were aware that they would be required to complete an evaluation form at the end of the course. Evaluation forms were analysed by senior staff for trends or concerns and courses modified. For example, more lower limb rehabilitation courses were held to meet the referrals demands - *Regional Rehabilitation Unit Aldershot*

Staff monitored the unit's activity by scrutiny of statistical returns regarding access to appointments, rehabilitation courses and the number of missed appointments - *Regional Rehabilitation Unit Edinburgh*



### **Risk management**

There was a comprehensive log of general risk assessments in place that had been signed by all staff to acknowledge they were aware of identified risks. New staff were required to do this as part of their induction. The review of risk assessments was ongoing and minutes of practice meetings demonstrated how new risks were added and brought to the attention of all staff. Risk assessments were included in the document review calendar that staff were undertaking on a monthly basis. In addition there were specific risk assessments in place to manage hazardous substances, manual handling, display screen equipment and personal protective equipment - *Regional Rehabilitation Unit Catterick*

The RRU had a risk management policy and risk register was in place. The risk register was available and seen on the IT system. There was evidence that the risk register was updated regularly, daily if required, and that risks were discussed, assessed and escalated as necessary. In addition, there were documented risk assessments covering all RRU activity - *Regional Rehabilitation Centre Edinburgh*

### **Continuous improvement**

A programme of audits had been undertaken including a detailed analysis of patient referrals and the appropriateness of these referrals to the relevant treatment courses. This had identified that the patients that were brought back on a number of courses was appropriate due to the clinical need of the patient. Practice meeting minutes dated October 2011 reported that the audit had shown no inappropriate re-admissions - *Regional Rehabilitation Unit Catterick*

Staff demonstrated they understood the purpose of the audits. The outcomes and actions required from these were captured on the unit's risk register and monitored by the officer in charge. For example, audit outcomes had resulted in splash backs being fitted behind the sinks and a review of the cleaning contract being undertaken - *Regional Rehabilitation Unit Aldershot*

## Section 6 Defence dental services

In the Defence Dental Services, we inspected against the following outcomes:

Outcome 4 Care and welfare of people who use services

Outcome 8: Cleanliness and infection control

Outcome 10: Safety and suitability of premises

Outcome 16: Assessing and monitoring the quality of service provision

### Outcome 4: Care and welfare of people who use services

The standard states that people receiving services should expect to experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

#### Defence Dental Services - Outcome 4

All of the 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. We found that patients experienced safe, effective and appropriate care, treatment and support. Patients had access to a lot of information about oral health and hygiene and general health issues. Patients we spoke with in the dental centres inspected were very confident in the competence of dental staff.

A number of comments were made about the dental services in the survey. Clinical care and staff were stated to be good or excellent. However, there were a considerable number of comments about the lack of dental staff and the distance Service personnel had to travel to access the dental services.

#### Minor concerns

This concern related to the lack of a risk assessment for emergency medication.

#### Services compliant with this standard

Patients were fully assessed and involved in their treatment plans. They were given information about treatment and risks and about their general health in addition to their oral health. We found that patients experienced safe, effective and

appropriate care, treatment and support. Patients we spoke with in the dental centres inspected were very confident in the competence of dental staff.

Across the dental services we found that medical records were well managed, detailed and stored securely. Information about assessment and treatment plans were clearly and appropriately documented.

We found a significant amount of evidence to confirm that guidance for best practice from the National Institute for Health and Clinical Excellence (NICE) was being used to ensure the most up-to-date dental treatments were in place. We also found a lot of health promotion information available to patients on oral health and hygiene and on general health issues.

### Examples of good practice

#### Assessment, planning and delivery of care

Patients were aware of what their treatment plan entailed and said that staff explained the treatment they needed and why it was needed. They told us that appointments were on time so there was no waiting around. The records we looked at were detailed and provided a clear picture of the patient's dental history and current treatment plan. Documented assessments were thorough and included periodontal and carcinoma risk assessments. Oral health promotion was evident from the records. Where possible, patients were treated by the same clinician in order to provide continuity of care once treatment plans had been formalised - *Dental Centre, Catterick Scotton Road*

Patients who gave consent to speak with us found the dental briefings informative. They received an oral health promotion pack, which contained a toothbrush, toothpaste and information about dental care. Patients said they were offered health and dental promotion advice. They said staff answered their questions and concerns without any judgments and offered them the opportunity to speak in private. Risks associated with the treatment were also outlined and patients had the opportunity to opt out of the treatment if they were unsure. Post treatment follow-up was planned to fit around their training schedule - *Dental Centre, Catterick Helles Barrack*

Patients we spoke with told us that they found the services offered to be excellent. They gave a number of very positive comments about the staff, which included the level of kindness and how respectful staff were when providing treatment. We were told that great care was taken by staff to ensure all options were explained fully prior to treatment. Patients said that staff also offered a variety of dental health promotion advice. Patients described to us how dressings and written information was given to them following treatment such as extractions. The information included precautions to be taken following the treatment and how to obtain assistance and information in an emergency - *Dental Centre, Marchwood*

#### Managing risks

Dental staff had access to best practice guidance, including how to manage a medical emergency and General Dental Council standards. The practice had a policies and standards document in place to ensure that treatment was compliant

with NICE guidance. Staff told us that they took a proactive approach to third molar management and that extractions were being monitored by the Defence Dental Services public health department to ensure that they were managed in accordance with NICE guidance - *Dental Centre, HMS Culdrose*

The dental centre ran a morning sick parade daily, supported by a structured triage system. As patients presented for sick parade they had a brief consultation with the dental nurse, who recorded the nature and duration of their problem. This enabled dental staff to prioritise and prepare for inspection and treatment, by setting out the correct instruments and planning the intervention - *Dental Centre, Cranwell*

### Results from the survey

The results from the survey included a lot of comments on the dental services. These were generally very positive about the clinical care and the staff providing dental services. The main concerns expressed related to the distance people had to travel to see a dentist and not enough dental staff. Comments included:

*"No dental service provided for St Mawgan or Portreath, so a visit to the dentist means a 1hr 30 minute round trip for a five minute check up - totally ridiculous!!"*

*"For dental services I have to travel to Brize Norton which means a 3-4 hour evolution. Additionally, everyone travelling to Brize Norton does so independently. Therefore there is a huge waste of working time and of travel costs."*

*"There are approx 1,600 military personnel at Abbey Wood, Bristol but yet there is no dental facility. We are obliged to travel to Innsworth (for Army personnel - 40 miles each way) or Brize Norton (for RN and RAF staff - 61 miles each way)."*

*"Not enough dental staff - long waiting list. Direct affect on primary duty."*

*"Poor service, appointments constantly cancelled due to lack of dentist or hygienist."*

*"I have no complaints about the service I received from the Dental Centre in Hohne. Although they were very short staffed (no reception staff), they were extremely efficient and I didn't have to wait too long for an appointment."*

## Outcome 8: Cleanliness and infection control

The standard states that people receiving services should expect to receive care in healthcare premises that are compliant with The Code of Practice for health and audit social care on the prevention and control of infections and related guidance.

### Defence Dental Services - Outcome 8

The Defence Dental Services were compliant with this standard. 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 the services had a designated lead for overseeing the management of infection control. Staff were aware of relevant policies 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.

### Minor concerns

The concern related to the removal of clinical waste not being fully assessed.

### Services compliant with this standard

In the dental services we inspected, premises were clean, with systems in place to manage infection prevention and control. The services had a designated lead for overseeing the management of infection control. Staff were aware of relevant policies 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.

### Examples of good practice

Staff told us they were comfortable peer reviewing each other's practice in relation to infection control, offering guidance and feedback when needed. This happened informally on a day to day basis. Assessments were carried out formally on a quarterly basis. Staff knew how to escalate concerns about staff practice, via the principle dental officer and the Defence Dental Services, using the raising concerns policy. Staff referred to their codes of practice and to the British Dental Association guidance when speaking about hygiene and infection control. In addition IPC processes were reviewed as part of the clinical quality assurance methods in place - *Dental Centre Dartmouth*

Infection control guidance, such as the management of sharps injuries, was displayed within the centre for reference. This service had a designated lead responsible for infection prevention and control and for overseeing decontamination. They were also a lead for implementation of Defence Dental Services Standard Operating Procedures Chapter 13 and Health Technical Memorandum (HTM) 01-05. In the surgery, staff demonstrated how surfaces and instruments were cleaned, which included the use of appropriate personal protective equipment during decontamination processes. Sterilisation cycle numbers on all instruments used were recorded in the patients' records and a process was in place to validate sterilisation cycles - *Dental Centre Cranwell*

Staff outlined the decontamination cycle for us, highlighting that instruments used for routine procedures were sterilised using a non-vacuum cycle and bagged for 21 days. All instruments for oral surgery were sterilised using the vacuum cycle and were labelled and bagged for 60 days. To avoid confusion, oral surgery kits were only located in the treatment room used by the oral surgery specialist. All equipment requiring decontamination was checked and validation records maintained for each sterilisation cycle - *Dental Centre Catterick Scotton Road*

We saw that appropriate hand washing facilities, paper towels, foot operated bins and alcohol gels were available throughout the dental centre. All surgeries sinks were fitted with elbow taps and hand washing guidance was displayed. We saw personal protective equipment was available and used correctly. A spillage kit for the management of body fluids was available in all surgeries along with a protocol on how it should be used. Dental nurses gave a clear and detailed description about how they managed spillages and body fluids. Arrangements were in place for the maintenance of equipment decontaminated prior to repair - *Dental Centre Catterick Helles Barrack*

During the inspection we found all areas of the dental practice to be exceptionally clean and hygienic. We observed staff complying with guidance and wearing personal protective clothing and equipment when dealing with patients and equipment. Cleaning routines and requirements were displayed throughout the centre relating to both the environment and individual items including dental chairs. These schedules detailed the standard of cleaning required, the frequency of checks and staff roles and responsibilities - *Dental Centre Minley*

### Outcome 10: Safety and suitability of premises

The standard states that people receiving services and people who work in or visit the premises should expect to be in safe, accessible surroundings that promote their wellbeing.

#### Defence Dental Services - Outcome 10

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 centre judged as not 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 inclement weather 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 a considerable number of 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. Patients were treated in adequate facilities and not at risk from unsafe equipment or facilities.

### **Level of compliance**

All but one of the dental services were compliant with this standard. However minor concerns were indentified in over 60% of the services inspected.

### **Minor concerns**

Although compliant, there were a number of concerns relating to the infrastructure of the premises and included maintenance requirements not being met, poor access for patients with limited mobility and inadequate toilet facilities.

### **Services not compliant with this standard**

One of the practices inspected was not compliant as 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 inclement weather caused the roof to bow. The internal temperature could not be maintained in these surgeries.

### **Services compliant with this standard**

In the dental services inspected, that were compliant with this standard, we found that premises provided appropriate accommodation to meet the needs of patients and staff who provided dental care and treatment. Despite a considerable number of maintenance issues, premises were kept clean and hygienic. Risk assessments for all of the Control of Substances Hazardous to Health (COSHH) items were in place and dated. Hazardous substances were stored safely and securely. Health and safety information was displayed in the waiting area for patients. The centres had business continuity plans in place in the event of a major incident, for example the loss of power. The centres had risk management processes in place and spillage kits available in surgeries. Radiography was well managed and Ionising Radiation (Medical Exposure) Regulations 2000 protocols were displayed

## Examples of good practice

### Design and layout of practice/service area

The environment was designed with a waiting area, reception desk and treatment facilities for patients, as well as separate areas for staff to undertake administrative duties. We saw information displayed pertaining to the building hazards regulations, which included the identified risk and method for minimising this, such as risks related slips, trips and falls. Emergency procedures were displayed for events such as fires, medical situations and incident reporting. Safety precautions for x-ray exposure were also visible on the notice board. We saw that a workplace health and safety inspection had taken place in June 2011 and that there were no issues raised from this - *Dental Centre Marchwood*

### Managing risk

Risk assessments had been undertaken and were reviewed regularly by the practice staff. We found the systems for identifying, reporting, recording and learning from incidents to be firmly embedded into practice. There was a nominated radiation protection supervisor who could demonstrate that the appropriate training had been undertaken and updated. All staff had attended relevant training and were confident in describing how they managed radiation and radiography equipment in line with the practice policy - *Dental Centre Minley*

There were nominated leads for resuscitation and first aid and associated guidance was displayed about managing medical emergencies. Appropriate emergency equipment was located in the dental corridor directly outside the surgeries. All emergency drugs were in date and a record of expiry dates was available. A log was available showing details of the emergency exercises that had taken place. Daily checks were carried out on the oxygen cylinder. Emergency eye wash was available in the staff room, in all three surgeries and in the dental laboratory - *Dental Centre HMS Culdrose*

## Outcome 16: Assessing and monitoring the quality of service provision

The standard states that people receiving services should expect to benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

### Defence Dental Services - Outcome 16

All of the dental services inspected were compliant with this standard. However, minor concerns were identified in over 40% of practices inspected. These related to services where not all environmental risks had been risk-assessed or not all actions had been taken as a result of concerns raised in environmental audits. Although there was clinical audit activity, this was not part of a planned programme of clinical audit.



We found that the dental services inspected had effective and efficient processes in place to monitor the safety and quality of services provided. These included programme 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 policies and procedures for the safe practice and governance of dental services. Staff felt confident to raise or report any concerns. The dental services ensured that patients benefitted from safe quality care, treatment and support, due to effective management of risks to their health, welfare and safety.

### **Level of compliance**

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

### **Minor concerns**

Concerns identified related to services where not all environmental risks had been risk-assessed or not all actions had been taken as a result of concerns raised in environmental audits. , although there was clinical audit activity, this was not part of a planned programme of clinical audit.

### **Services compliant with this standard**

We found that the dental services inspected had effective and efficient processes in place to monitor the safety and quality of services provided. These included programme 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 policies and procedures for the safe practice and governance of dental services. Staff felt confident to raise or report any concerns.

### **Examples of good practice**

#### **Assessing and monitoring the quality of service provision**

Staff monitored attendance rates and initially found that clinical time was not being used effectively as patients failed to attend 16% of appointments. To reduce this number, staff worked with the unit commanding officers and implemented a system of arranging appointments around training schedules. They also introduced a method of reminding people of appointments at morning drills and then any failures to attend were reported to the unit. The impact of these measures has seen the number of patients failing to attend appointments fall from 16% to between 3 and 4% - *Dental Centre Minley*

#### **Risk management**

The service had a designated radiation protection supervisor. Staff demonstrated an excellent understanding of the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER), and associated good practice. One member of staff was about to undergo training as a radiation protection supervisor - *Dental Centre Dartmouth*

There were arrangements in place to manage laboratory processes and stock within the dental centre. There were local rules in place to govern the use of dental radiation. All radiographs were quality assured and graded in accordance with Faculty of General Dental Practice standards. The number of x-rays was recorded on a laminated sheet and totals were transcribed into a log that was monitored. The date when chemicals required changing was recorded and clinical waste was logged. All lab work was contracted out and there was a tracking system in place to monitor this activity. There was also a log of expiry dates of all dental materials in each consulting room - *Dental Centre HMS Culdrose*

All medical equipment in the dental centre was checked by Medical Dental Servicing Section technicians on a six monthly basis. A hazardous waste log was in place and spillage kits were available in every surgery. Medical gases were stored in a locked cage at the rear of the medical centre, with the exception of a small oxygen cylinder kept on the emergency trolley. A first aid sign was in place, identifying the medical centre as the first point of contact for first aid - *Dental Centre Cranwell*

Personal protective equipment for staff was available in each treatment room. An equipment care training policy was in place supported by a standard operating procedure. As part of the induction process, all staff were required to complete one day of infection prevention and control (IPC) training which included familiarising themselves with the IPC policy. Staff provided a signature as confirmation that they understood their responsibilities. In addition staff were required to undertake 3-6 monthly update IPC training - *Dental Centre Catterick Scotton Road*

### **Continuous improvement**

We reviewed the programme of audit which was planned and managed by the practice manager. We looked at audits including audits for infection control, risk management, waste management and hand hygiene. When we spoke with staff it was clear they were very aware of the importance of audit within the practice. They told us of the process of recording and reporting the outcome of each audit, together with managing any improvement action plans - *Dental Centre Minley*

Practice meetings were held monthly and minuted. There were set agenda items which included health and safety, staff training, infection prevention and control infrastructure, maintenance and patient safety. Staff told us they could add items to the agenda that they wished to raise. The minutes of the meetings for November 2011 and December 2011 were comprehensive and showed progress on action points raised at the previous meeting. The dental centre held brief meetings each Wednesday morning so issues that could not wait until the next practice meeting could be addressed - *Dental Centre Catterick Helles Barracks*

The service had a designated radiation protection supervisor. Staff demonstrated an excellent understanding of the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER), and associated good practice. One member of staff was about to undergo training as a radiation protection supervisor - *Dental Centre Dartmouth*

## Comparison of CQC inspection reports with DMS Common Assurance Framework (CAF) reports for individual units

Comparing the CQC inspection reports with the analysis of CAF reports for the individual units showed that for all outcomes the vast majority of concerns identified in the CAF assessments had been resolved by the time of the CQC inspections. There were however, some issues not identified in the CAF assessments that were found during the inspections. The identification of missed concerns was most apparent for Outcome 10: safety and suitability of premises and Outcome 16: assessing and monitoring the quality of service provision. However, the concerns were missed were all minor issues with no major problems missed in the CAF reports. For Outcome 10 the concerns missed largely related to unit size and minor maintenance issues, while for Outcome 16 the issues missed tended to be around deficiencies with the services audit programme.

## Comparison with CAF assurance spreadsheet: CQC inspection report analysis – summary of dental centre inspections

In total, we inspected seven dental services as part of the DMS review although, due to changes in methodology, only five locations were assessed against Outcome 4.

**Table 1**

Outcome	Compliant		Minor concerns		Moderate concerns	
	No.	%	No.	%	No.	%
4	4	80%	1	20%	0	0%
8	6	86%	1	14%	0	0%
10	2	29%	4	57%	1	14%
16	4	57%	3	43%	0	0%

As can be seen from Table 1 above, Outcome 10 was clearly the poorest performing area with the lowest proportion of fully compliant units and the only outcome for which any units were found to be non-compliant. Outcome 16 was the next poorest performer with nearly half of the seven locations found to have minor concerns with governance. Meanwhile outcomes 4 and 8 performed well with only one location found to have minor concerns for each of these outcomes.

Comparing table 2 below, the results for 91 dental unit CAF assessments, with table 1 shows some similarities, with outcome 10 performing the worst under both assessment methodologies. However, Outcome 16 performed better in the CAF assessments than Outcome 8, while in the CQC inspections Outcome 8 performed noticeably better than outcome 16. Overall levels of compliance were higher for all four outcomes in the CQC inspections, although this was for a much smaller sample of services inspected than the CAF assessments.

Table 2

Outcome	% Green	% Red
	DDS (n=91)	DDS (n=91)
4: Care and welfare of people who use services	52.16%	13.77%
8: Cleanliness and infection control	32.23%	47.62%
10: Safety and suitability of premises	8.24%	87.36%
16: Assessing and monitoring the quality of service provision	35.89%	43.56%

Note: 'n' refers to the number of CAF reports for each service type: the n is not a denominator as there were different numbers of CAF serials for each outcome.

## Conclusion

Comparisons of the results from the DMS CAF assessments with results from the CQC inspections for dental units indicated that the CAF methodology was able to identify the outcomes at highest risk of non-compliance with the essential standards of quality and safety. There were, however, some discrepancies – particularly in relation to CAF judgements around governance standards.

## Section 7 Departments of community mental health

In the Departments of community mental health, we inspected against the following outcomes:

Outcome 1: Respecting and involving people who use services

Outcome 4: Care and welfare of people who use services

Outcome 16: Assessing and monitoring the quality of service provision

### Outcome 1: Respecting and involving people who use services

The standard states that people receiving services should:

- Understand the care, treatment and support choices available to them.
- Be able to express their views, so far as they are able to do so, and be involved in making decisions about their care, treatment and support.
- Have their privacy, dignity and independence respected.
- Have their views and experiences taken into account in the way the service is provided and delivered.

#### Departments of community mental health - Outcome 1

We inspected two services that provided community mental health care services. Both were fully compliant with this standard. There were no minor concerns.

Staff working in the community mental health teams ensured that patients understood the care, treatment and support available to them. Patients expressed their views, which were taken into account in the way the services were provided. 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.

#### Examples of good practice

##### Patient respect and involvement

Patients told us that they always felt welcomed when they attended the centre, and staff treated them respectfully. They complimented the administration staff on their ability to make them feel at ease on arrival, and their attentiveness to their needs - *Department of community mental health, Leuchars*

Patients gave us other examples of how their privacy, dignity and confidentiality were maintained. For example, appointments had been made at times that would help the patient avoid seeing colleagues, and civilian dress could be worn for appointments, which helped the patient to be seen as an individual - *Department of community mental health, Leuchars*

### **Meeting patient needs**

Patients reported to us how quickly they received appointments following their initial referral. They said how important information was shared between health professionals to reduce repetition, which often increased their anxiety. For further appointments and treatment, patients told us they were offered options and were able to make choices regarding their treatment. Family members were involved when patients felt it was appropriate. Information was provided to patients for out-of-hours access and we saw that the service was provided 365 days a year - *Department of community mental health, Portsmouth*

### **Collecting feedback from people who use services**

During our visit we saw evidence that the quality of the services provided for patients was continuously monitored through a range of methods. Patients could give feedback through the completion of response forms, which were located in the waiting area. There was also a generic feedback/suggestion process available. We noted that the results of the September 2011 audit of patient responses were displayed in the waiting area. Staff told us of recent changes implemented as a result of feedback received from patients. This included the provision of a radio system in the waiting area. We were told that a drinking water dispenser had been requested and was due to be installed early in December - *Department of community mental health, Portsmouth*

## **Outcome 4: Care and welfare of people who use services**

The standard states that people receiving services should expect to experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

### **Departments of community mental health - Outcome 4**

We inspected two services that provided community mental health care services and both were compliant with this standard. There were minor concerns within one of the services, which related to the limited access and delay in getting assessment and treatment from the psychology services.

Patients received effective, safe and appropriate care from the community mental health services. Patients were fully involved in the assessment of their mental health needs and in planning support and treatment from choices available. They were supported by committed, knowledgeable well-trained and up-to-date staff, who understood their roles and responsibilities.

### **Services compliant with this standard**

Patients benefitted from effective, safe and appropriate care from the community mental health services, which met their needs and expectations. They were supported by committed, knowledgeable well trained and up to date staff, who understood their roles and responsibilities.

### **Examples of good practice**

#### **Assessment, planning and delivery of care**

Staff told us that all consultations included listening to patients to get an understanding of their medical issues and how these impacted on their health and wellbeing. Patients' that spoke with us felt that the assessment process was detailed and thorough but in particular, that the staff facilitated a process of drawing out information, enabling them to identify the most appropriate support - *Department of community mental health, Portsmouth*

Patients felt that staff were confident in their roles and knowledgeable about the care and treatment they provided. They said that staff told them about research based evidence for therapies they offered, and signposted them to things like relevant websites and articles in journals for further information. Staff spoke knowledgeably about specific therapies, such as those used to support behaviour changes and alcohol detoxification programmes - *Department of community mental health, Leuchars*

We spoke with patients attending the Military Behavioural Activation and Rehabilitation Course. This therapy was said to be particularly helpful in treating depression. Patients told us how their programme of treatment was totally patient-centred, which meant it was respectful and responsive to individual preferences, needs and values. Patients also said that staff delivering this course were sensitive and highly supportive to their individual needs. In our discussions, it was evident that patients felt their individual needs were fully respected and that staff went to great lengths to ensure that the support processes used were appropriate to meeting these needs - *Department of community mental health, Portsmouth*

#### **Managing risks**

Patient records were very detailed. We saw comprehensive assessments of needs, which included social and family history, health beliefs, current diagnosis, employment status and the patient's expectations of treatment. Patients and staff told us that they developed a care plan together based on this information. We saw that care plans included details about the type of treatment being used, any medication prescribed and treatment review arrangements. Care plans also included crisis support arrangements, and set out clear advice about where the patient could get help when the centre was closed. Records included clear risk assessments and management plans for areas of risk such as suicide self-harm, substance misuse and vulnerability - *Department of community mental health, Leuchars*

### Extract from an interview with a member of the Armed Forces

*We spoke to a person who was admitted to the Sir William Gower Centre in Chalfont initially for a week but stayed seven weeks. He had a full medical and tests, and was then told he had non-epileptic attack disorder as a result of post traumatic stress disorder. He was then taken off all medication and had 20 sessions of Cognitive Behavioural Therapy, which helped. He feels early diagnosis and intervention is critical: "I said I was fine and clearly I was not fine... I can now see if someone has PTSD by their expressions and behaviours - having been there myself. The condition is very real and sometimes not taken seriously... I would not want anyone to go through what I went through." He is now getting the right treatment. Senior rank: Royal Air Force*

### Outcome 16: Assessing and monitoring the quality of service provision

The standard states that people receiving services should expect to benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

#### Departments of community mental health - Outcome 16

Both of the services we inspected were fully compliant with this standard. There were no minor concerns.

The departments of community mental health had effective and efficient processes in place to monitor the safety and quality of services provided. These included programme for audits, risk assessments and monitoring and implementing relevant clinical guidelines. Patients received safe care, treatment and support, due to effective management of risks to their health, welfare and safety.

### Examples of good practice

#### Assessing and monitoring the quality of service provision

Patients could give feedback through the completion of response forms, which were located in the waiting area. There was also a generic feedback/suggestion process available. We noted that the results of the September 2011 audit of patient responses were displayed in the waiting area. Staff told us of recent changes implemented as a result of feedback received from patients. This included the provision of a radio system in the waiting area. We were told that a drinking water dispenser had been requested and was due to be installed early in December- *Department of community mental health, Portsmouth*



Audit topics were based on requirements identified from the internal assurance process, the Common Assurance Framework (CAF). Other areas audited were triggered by issues arising within the centre. These included, for example, audits of patient records, infection control, non attendance for appointments, and the implementation of NICE guidance regarding anxiety management. Staff also told us about audits they had carried out for topics such as post traumatic stress disorder the use of anti-depressant medication and prescribing protocols. The patient records audit highlighted, for example, that the recording of mental health diagnosis codes was variable. We saw that the issue was discussed at a team meeting, action taken and would be re audited - *Department of community mental health Leuchars*

### **Managing risks**

There was a requirement to update the risk register as an ongoing process. The risk register showed that each risk was outlined, dated, identified an owner and recorded the required action. We discussed examples of risks recently identified and managed and the processes gone through to bring the matter to resolution. One example was related to an alarm facility fitted in the building. This had been installed without any provision for maintenance or training of personnel in its use. As a result of escalation, a new contract had been negotiated, including service and ongoing maintenance of the equipment and staff training. Funding had been approved and a date for fitting had been identified - *Department of community mental health, Portsmouth*

Records showed that staff had carried out, and regularly reviewed, risk assessments for all aspects of the service provided. For example, we saw risk assessments for the infrastructure, staff on sick leave, psychology services and staff training. Actions to mitigate the risks were detailed in the assessment documentation. We saw that the risk register was reported to the regional governance lead every three months. Policies and procedures were in place for reducing wider risks to the service such as fire safety, lone working for staff, and business continuity in the event of a disaster - *Department of community mental health, Leuchars*



## Summary of patient responses to the survey

We received a total of 554 responses from the survey, which asked Service personnel, dependants and entitled civilians to share their experiences about the services provided by the DMS. Over 85% of respondents were members of the Armed Forces. Just over 7.5% of respondents were dependants (45 comments) and just over 6.5% of respondents were entitled civilians (40 comments).

In terms of overall tone, there was a mixture of positive and negative comments in the responses received. However, due to the fact that this was an unstructured survey collecting only free text comments, it was not considered appropriate to compare overall numbers of positive and negative comments. Instead, the data returned was analysed in terms of themes and triangulated with other evidence gathered to illustrate findings against the essential standards inspected.

Breaking the responses down into outcome groups showed that, while negative responses indicated specific areas of concern, the positive comments tended to be more general responses. A large proportion of the positive responses simply stated “the dental service is excellent” or “it is very good”, which were less useful when trying to determine problems or strengths.

### Conclusions from survey

Although the format of an open survey enabled the respondent to include more information, it provided less structured responses, making it difficult to establish themes or to perform specific quantitative analysis. Since there was no question to identify the respondent’s location, it was difficult to assess comments referring to the state of premises. It also resulted in a number of conflicting views on areas such as waiting times, with no way to match the responses and establish if the issues were limited to specific services or problematic across an entire service.

Primary medical healthcare services and defence dental services dominated the responses. No conclusions can be drawn about mental health services, rehabilitation services or hospital care.

The majority of positive feedback was very broad, with almost all the responses falling into Outcome 1: Respecting and involving people who use services, Outcome 4: Care and welfare of people who use services, or the general category. Negative feedback was more precise but as expected, the majority fell under the same outcome areas.

What we can establish was that the main concerns among patients were administrative problems, understaffing, lack of respect for minor injuries and having to travel long distances for care.

On the whole, the responses showed that the quality of clinical care was good, with an emphasis on physiotherapy being especially good.



## Comparison with findings from the 2008 Healthcare Commission review

As part of this review, we assessed the impact of the previous review undertaken by the Healthcare Commission in 2008, which was published in March 2009, and how its recommendations had been addressed. We looked at the main issues found in the previous review and compared them with the findings from this CQC review.

### **Dignity and respect**

Patients' dignity and respect was a key concern in the 2008 review, as privacy and confidentiality were compromised during confidential discussions and consultations by the layout of rooms in some facilities, cramped receptions and waiting areas and poorly sited pharmacy hatches.

While the CQC inspections did indicate a greater awareness of the need to maintain privacy and confidentiality, and measures were being put in place by DMS staff, similar infrastructure constraints were still apparent in several services. However, the CQC inspections showed extremely high compliance with the outcome on respecting and involving people who used services, including making sure they were treated with dignity and were involved in their care.

### **Care and welfare of people who use services**

In the 2008 review, there was little evidence to demonstrate monitoring of compliance with NICE technology appraisals and a lack of systems to ensure that staff had read NICE guidance. There was also a lack of formal audit undertaken regarding compliance with NICE guidance. There was little local health needs analysis, few local health promotion plans, no evaluation of health promotional initiatives and little sharing of information.

The CQC inspections showed that many units now had evidence to show compliance with NICE technology and processes in place, including audits of adherence to NICE guidance. There was also evidence of increased health promotion activity and analysis of the health needs of the local population. However, there were still several services where clinical audit systems were deficient, for example a lack of formal audit programmes. A number of services had significant health promotion programmes and information in place but population health needs analysis were either in development or lacked evidence. This included for example, a lack of a chronic disease register. Although some services undertook a considerable amount of planned audit activity, using findings to improve and develop services, we also found a lack of a planned and systematic audit process in place. There was no national or regional audit system in place to collate the results of audits for individual units, with the CAF visits being the only check that units are performing audits.

## **Safeguarding vulnerable adults and children**

In the 2008 review, a key concern was staff being unaware of safeguarding policy and procedures, a lack of a designated safeguarding lead for safeguarding issues and little or no evidence of working with civilian partner agencies who had a lead responsibility for local safeguarding issues. Concerns included a lack of audit of child protection and safeguarding processes and a lack of systems in place to ensure and record that all staff had the relevant pre-employment checks.

Outcomes from the CQC inspections showed that many services now had a dedicated safeguarding lead and that a considerable amount of training had been undertaken by staff about child protection and child safeguarding issues. There were also improvements in terms of most services having clear recording processes in place to check that all relevant pre-employment checks had been undertaken and that staff who were required to be registered with a professional body had renewed their registration. However, in some services there were no effective systems in place for recording this information in staff files, not all staff had attended safeguarding training and there was a considerable lack of local processes in place to advise staff on the action to be taken if or when they had safeguarding concerns. There were also deficiencies in the establishment of effective joint working arrangements in place with local civilian lead safeguarding agencies.

## **Cleanliness and infection control**

Key concerns from the 2008 review included a lack of awareness by staff of the infection control policies and practices and no infection control designated lead. There was also insufficient provision of infection control training, a lack of monitoring for compliance with the infection control policy and a lack of systematic audit to inform improvements in policy and practice. There was also a lack of accountability for guiding decontamination activities in line with national guidance and local policy, a lack of local monitoring for compliance against decontamination policies and a lack of adequate provision and routine use of fit-for-purpose protective equipment and clothing. In terms of waste management, there were insufficient local monitoring systems in place for assessing compliance with the clinical waste policy. There were serious clinical waste disposal concerns not cited on the risk register and poor standards of cleanliness. External maintenance and cleaning contracts were poorly monitored, no hand washing facilities in some clinical areas, no alcohol rubs in clinical areas, limited infection control training and no standards for environmental cleanliness.

Outcomes from the CQC inspections showed that although we only inspected the specific outcome relating to infection control at a small number of services, the findings from the inspection reports indicated that many of the concerns from the 2008 review had been resolved. In general, standards of cleanliness were observed to be high with infection control leads present, good staff understanding of infection control policies and systems in place to monitor compliance with standards. Infection control and management was generally part of the induction training programmes. However, in some primary healthcare medical services we saw evidence of poor infrastructure issues causing difficulties with maintaining infection control standards, which we identified when inspecting against ensuring the safety and suitability of premises.

## Management of medicines

Key concerns from the 2008 review included a lack of monitoring against the medicines management policy to ensure consistencies in practice and safety and a lack of a systematic approach to local and regional audits of medicine management and linking practice requirements through clinical governance systems. There was also insufficient competency-based medicines management training opportunities for all relevant staff, inadequate systems in place for checking expired medications and inconsistencies and under-reporting of incidents and near misses involving medicines.

Outcomes from the CQC inspections showed that there was now greater training in place around medicines management, more consistent use of appropriate formularies and checking of stock. There was also more consistent reporting of incidents and more reliable systems in place for checking expired medicines. There were some ongoing deficiencies identified in relation to monitoring against policy and taking a systematic approach to audits, although there did also appear to have been improvements in these areas since 2009.

## Safety and suitability of premises

Key concerns from the 2008 review included the lack of local environmental risk assessments or environmental audit or monitoring, poor standards of decoration, remedial works not undertaken in a timely manner, units not DDA compliant, non-adherence to COSHH principles, facilities not fit for purpose and no risk registers in place.

Outcomes from the CQC inspections showed that in terms of the concerns identified in 2008, there were improvements in some areas, such as greater use of risk assessments and environmental auditing and adherence to COSHH principles. Most units were accessible for people with limited mobility. However, there were still some premises that were not fit for purpose, maintenance systems in some areas were slow, not all services were appropriately accessible and some premises were very run-down with a poor state of maintenance and decoration. In the CQC inspections, the safety and suitability of premises was the worst performing area in compliance with the relevant essential standard.

## Supporting staff

The 2008 review highlighted a lack of understanding of what constitutes 'clinical' supervision and a lack of clinical supervision frameworks. There was also a lack of systems in place to ensure the medical practitioners were provided with clinical supervision and appraisal through their NHS contracts. There were no recording systems in place to ensure that all clinical staff held current registrations with their respective professional bodies. It was also unclear as to the percentage of staff who had received appraisals and whether these were documented and there were inequalities in clinical training available for civilian staff. The review also identified a high staff turnover and shortages of staff, causing difficulty to release staff for training. These were cited as reasons for low mandatory training uptake and inadequate monitoring of attendance at mandatory training. There was a low awareness of equality and diversity policies and issues, and no equality and diversity monitoring in place.

Outcomes from the CQC inspections showed that considerable improvements had been made in many of the areas of concern identified in 2008. For example, most staff now had regular staff appraisals, most services had systems to monitor training completion and ensure uptake, and there were checks in place to ensure staff had appropriate professional registration. Most services had appropriate supervision arrangements. However, there were ongoing issues at some units, particularly with training arrangements where not all staff undertook mandatory training or records of attendance were not being kept and not all staff groups received regular supervision.

### **Assessing and monitoring the quality of service provision**

Key concerns from the 2008 review included a high threshold for incident reporting that excluded minor incidents and near misses; cultural barriers to incident reporting, and cumbersome reporting processes stated by staff. There was limited counting, aggregation and analysis of incident reports and incident reports were not constructively used to drive improvements in practices and services. Many services had incomplete audit plans, limited evidence to demonstrate learning from audit activity to improve services or limited evidence to demonstrate the effectiveness of clinical services through evaluation, audit or research. Many clinical governance plans were embryonic and systems in place for implementing clinical governance had not been actioned. There was a lack of awareness of relevant policy and reporting processes and staff stated under-reporting of concerns. Rank was reported to be an actual or potential barrier to reporting concerns.

Outcomes from the CQC inspections showed an overall vast improvement in governance arrangements, which in 2008 appeared to be largely absent or embryonic. This was true for both for the individual units as well as the DMS as a whole. The CAF assurance system and incident reporting arrangements that have been introduced since 2009 have clearly had a marked impact in improving the ability of the DMS to monitor performance, target improvements and identify and manage risks to service delivery. However, ongoing deficiencies were identified with governance systems such as lack of audit plans, lack of actions following audits and incomplete or inadequate risk registers.

### **Conclusions**

The comparisons with the findings from the 2008 Healthcare Commission review indicate that there have been significant improvements in practice across the DMS since 2009. This included the significant changes to governance and assurance systems. 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 DMS internal governance structure. Overall, the Inspector General's office was better able to accurately identify many of the most pressing issues with service provision and thereby target improvement actions.

Although these comparisons demonstrated significant improvements across the DMS, there were still ongoing issues that need 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 was still in need of improvement with the problems associated with the DMiCP infrastructure having contributed to shortfalls in patient care. 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 that the CAF methodology has had in assessing units against the Standards for Better Health, 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 rather than on the systems and processes in place.

## Appendix A: Defence Medical 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	Helensburgh, Argyll
HMS Victorious	Helensburgh, 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 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.

© Care Quality Commission 2012

Published June 2012

This publication may be reproduced in whole or in part in any format or medium for non-commercial purposes, provided that it is reproduced accurately and not used in a derogatory manner or in a misleading context. The source should be acknowledged, by showing the publication title and © Care Quality Commission 2012.

### How to contact us

Phone us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at:

**Care Quality Commission**

**Citygate**

**Gallowgate**

**Newcastle upon Tyne**

**NE1 4PA**

Please contact us if you would like a summary of this document in another language or format (for example, in large print, in Braille or on audio CD).

Registered office:

Care Quality Commission

Finsbury Tower

103-105 Bunhill Row

London

EC1Y 8TG

