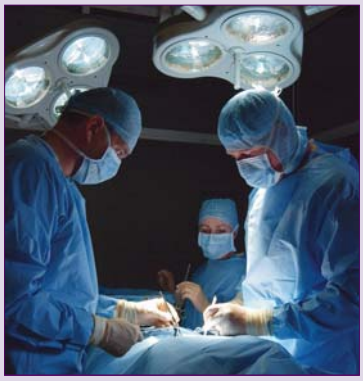
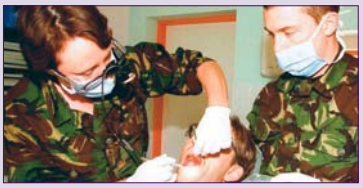
Inspecting Informing Improving

Healthcare Commission

Defence Medical Services

A review of the clinical governance of the Defence Medical Services in the UK and overseas




Service review

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The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.
- Be independent, fair and open in our decision making, and consultative about our processes.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, will take over the Healthcare Commission's work in England. Healthcare Inspectorate Wales will become responsible for carrying out our activities relating to Wales.

Foreword

This report is the product of a fruitful collaboration between the Department of Health and the Ministry of Defence, and between the Healthcare Commission and the Defence Medical Services. It owes much to the leadership and commitment of the Surgeon General, Lieutenant General Louis Lillywhite and his predecessor, the late Surgeon Vice-Admiral Ian Jenkins. They took the view that it would be beneficial to the Defence Medical Services if its services were exposed to the scrutiny that the Healthcare Commission applies to the performance of the NHS. The Healthcare Commission, in line with its primary statutory duty to encourage improvement in the provision of health and healthcare, was pleased to accept the invitation. The Defence Medical Services provides care for about 250,000 people – Service personnel and their families. All concerned felt it right that their healthcare should be subject to the same scrutiny as that of others in England.

In recognising the value of external appraisal, a significant step has been taken. While the Healthcare Commission will cease to operate after 31 March, to be replaced by the Care Quality Commission, the principle of ensuring that the performance and quality of the Defence Medical Services are routinely assessed is now accepted and embedded.

The picture that the report paints of the Defence Medical Services is varied. There are areas of outstanding performance that the NHS could profitably learn from, not least the organisation and operation of trauma services. There are other areas where improvements need to be made, for example, getting universal standards in place across all services, and addressing maintenance and cleanliness at some medical units providing services away from the front line. These needs for improvement are recognised and it is pleasing that actions are already being taken to address them. It is important that progress is monitored and reported on regularly.

Professor Sir Ian Kennedy
Chair

Summary

What the Healthcare Commission was requested to do

In January 2008 the Surgeon General, Ministry of Defence requested the Healthcare Commission to undertake an independent review of the quality of healthcare services provided by the Defence Medical Services (DMS) in the UK and overseas.

We had not assessed the services provided by the DMS before, as they were outside the scope of the Health and Social Care Act (2003), which provides the legal framework within which the Healthcare Commission operates. However, the DMS was very keen to have an independent assessment of its services. The legislation required to bring the DMS within our regulatory remit was laid before Parliament in June 2008.

> "....a key issue is the lack of an external regulator..... the DMS is very small and it can be extremely difficult to keep up with best practice across the whole spectrum of medical care. An external regulator would help us to identify where we are failing to adopt best emerging practice...."
> Lieutenant General L P Lillywhite,
> Surgeon General

The review was based on *Standards for Better Health*, which were set by the Government and are used to assess the performance of the NHS. These standards focus on important patient safety issues, on the quality of healthcare provided and on how well services are focused on the needs of patients. A list of the standards can be found in appendix 1.

Some parts of the DMS had used these standards for internal review of the quality of care, but they had not been consistently applied across the three Services. This review has, therefore, provided the first opportunity to undertake a consistent review process across all areas of DMS healthcare provision within a specific timeframe.

This report provides the findings of our review, which was undertaken during 2008. It will outline the focus of the review, describe the DMS, report our key findings and make conclusions and recommendations for development and improvement. Our findings include areas of excellence and best practice, what we found about the standards of care across the DMS and the views of some of those who use the services.

Appendix 2 gives a list of the key people involved in the planning, management and delivery of the review.

The focus of the review

This was an ambitious and challenging review. The scope of the DMS ranges from routine healthcare to healthcare provided in extraordinary locations and situations. We therefore needed to understand the context in which services were delivered and the particular challenges this presented.

The overall aim of our review was to promote improvement in DMS services by identifying good practice and areas that need to improve. It also aimed to help the DMS to implement more robust governance of the quality of the care and treatment it provides.

The review was based on our current methods for assessing NHS and independent healthcare organisations. DMS units were asked to carry out a self-assessment, which took the form of a declaration against compliance with the Government's *Standards for Better Health*. We analysed their declarations and then visited 53 units in the UK and overseas to check their compliance against their self-assessments.

We selected these units as a representative sample of the services provided. We received 153 declarations, which came from single units – for example, rehabilitation units – and from hospitals or regions representing several medical centres.

We also sought the views of those who use the services, members of the armed forces, their dependants and civilians who are entitled to receive care and treatment from the DMS.

It was agreed that the findings of the review would be made public and that the report would be available on the Healthcare Commission's website.

The Defence Medical Services

The DMS is responsible for providing healthcare to approximately 258,000 people, including Service personnel serving in the UK and overseas, those at sea, and family dependants of Service personnel and entitled civilians.

The DMS encompasses all of the medical, dental, nursing, allied health professional, paramedical and support personnel, including civilian staff, employed by the Royal Navy, the British Army, the Royal Air Force and supporting units. The DMS also provides some aspects of healthcare to other countries' Service and civilian personnel overseas, in both permanent military bases and 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 healthcare and specialist medical care. The DMS also provides healthcare in a range of facilities, including medical and dental centres, regional rehabilitation units and in field hospitals.

"....our patients and their families, whether military or civilian, as well as military commanders, Ministers and the public, expect us to deliver healthcare, both in barracks and on operations, which is of a high and continually improving standard...."
Lieutenant General L P Lillywhite,
Surgeon General

The Royal Naval Medical Service employs 1,522 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 4,958 personnel who provide healthcare. This includes British Forces Germany Healthcare Services, medical regiments and field hospitals, primary and pre-hospital emergency care and Territorial Army field hospitals.

The Royal Air Force Medical Services employs 1,898 personnel who deliver primary, secondary and intermediate care, including the aeromedical evacuation service to the Armed Forces through headquarters Tactical Medical Wing and the Aeromedical Evacuation Control Cell.

The Defence Dental Services employ 783 personnel from the Royal Navy, the Army, the Royal Air Force and the civil service. Military Dental Service personnel are employed and located all over the world and civilian employees work alongside military personnel in the UK, Cyprus and Germany.

"....we have a mixture of professionals from the three Services and a large percentage of civilians who form part of, and are considered a crucial part of our workforce...."
Brigadier Pretsell, Director,
Defence Dental Services

The DMS is responsible for ensuring that Service personnel are ready and medically fit to go where they are required in the UK and throughout the world – generally referred to as being 'fit for task'. This includes being ready to participate in international peacekeeping initiatives, respond to emergency situations – for example, floods, earthquakes or other environmental or natural disasters, both in the UK and overseas – or to go into areas of conflict or war zones.

The following services, not directly provided by the DMS, were not part of this review:

- The five Ministry of Defence hospital units in the UK. They are embedded into NHS acute trusts, and the host trusts provide the care for Service personnel. These units are in Portsmouth, South Tees, Frimley Park, Plymouth and Peterborough.
- The Royal Centre for Defence Medicine (RCDM), which acts as a centre of excellence for military medical research and receives and treats military casualties from around the world. This centre is on the same site as the University Hospitals Birmingham NHS Foundation Trust. We assess all of these services as part of our annual health check of all NHS trusts. They were therefore not part of this review, except for the headquarters element of the RCDM.

Also excluded from this review was care that the DMS commissions from the NHS and the independent healthcare sector – for example, specialist diagnostic care and inpatient mental healthcare – as we already assess these organisations.

At the time of our review, the DMS was commissioning inpatient mental health services from an independent healthcare organisation. However, in November 2008 the Ministry of Defence awarded a contract to a partnership of seven NHS trusts to provide inpatient mental healthcare. The NHS trust leading this partnership is the South Staffordshire and Shropshire Healthcare NHS Foundation Trust. The other six trusts involved in the partnership are Cambridge and Peterborough NHS Foundation Trust, NHS Grampian, Hampshire Partnership NHS Trust, Lincolnshire Partnership NHS Foundation Trust, Somerset NHS Foundation Trust and Tees, and Esk and Wear Valleys NHS Foundation Trust.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust is also taking part in one of a number of pilot schemes in the UK to provide mental healthcare to veterans.

The organisational and governance structures of the DMS are provided in appendix 3.

Key findings

Our review identified some areas of exceptional good practice and expertise. It also found several areas where improvement is needed. Our findings are summarised under the following headings:

- The standards of care across the DMS.
- Views of those who use the services.
- Areas of exemplary practice.
- Areas of good practice in clinical governance.

The standards of care across the DMS

Clinical care

Our review centred on the processes and procedures within the DMS for ensuring the

delivery of safe and effective care and treatment, and whether these were focused on the needs of patients. This is called 'clinical governance'. The review also considered how services continually sought to promote and improve health and wellbeing.

Our review considered the quality of care and treatment provided by the DMS overall and how well services were complying with Government standards for quality of care, the safety of patients, how services are managed, the training of staff and the facilities in which care is delivered. We found that services were provided by highly motivated and caring teams of staff across all three Services. There was a strong focus on patients and an emphasis on providing accessible services in a number of diverse settings.

Following guidance on best practice

Planning and delivering treatment and care should take into account any nationally agreed recommendations for the use of existing or new medicines and treatments and any guidance on clinical procedures. Much of this guidance is produced by the National Institute for Health and Clinical Effectiveness (NICE).

The Defence Dental Services declared 100% compliance with this standard, while services provided by the Royal Navy, the Army and the Royal Air Force (RAF) declared much lower levels of compliance. Half of the Royal Navy units declared non-compliance. Units that complied had clear documented processes and plans for implementing recommendations on best practice with regular monitoring in place.

We found that some staff were confused about the difference between NICE guidance, which evaluates the safety and effectiveness of clinical procedures where they are used for diagnosis or treatment, and NICE technology appraisals, which are recommendations on the use of new and existing medicines and treatments.

Infection control, use of clinical devices and disposal of clinical waste

These standards focus on ensuring that working practices prevent or reduce the risk of harm to patients and have a particular emphasis on hygiene and cleanliness.

Infection control

Nearly 70% of the units' self-assessments declared compliance with standards on infection control, with the exception of the Royal Navy, where over half declared non-compliance. Our review found that although some areas had clear infection control policies and monitoring in place and had identified specific members of staff to take overall responsibility for the management of infection control, this was not the case in half of the units visited in our follow-up visits. Cleaning contracts were also frequently stated to be inadequate.

Medical devices

Over 90% of the units' self-assessments declared compliance with ensuring that all risks associated with obtaining and using medical devices were minimised. We found that there were clear lines of accountability to ensure this in the units visited.

Reuseable medical devices

Nearly 90% of the units' self-assessments declared compliance with ensuring that reusable medical devices were properly decontaminated before being re-used and that risks associated with decontamination facilities and processes were well managed. However, we found that in some areas there was a lack of monitoring to assure that this standard was being complied with.

Disposal of clinical waste
Eighty-four per cent of units' self-assessments declared compliance with ensuring that there are systems in place to minimise risk to patients, staff and the general public by properly managing the segregation, handling, transport and disposal of waste. We found that some of the units visited had insufficient local monitoring of clinical waste and inappropriate segregation and transporting of waste.

Management of medicines

Services should have systems in place to ensure that medicines are handled safely and securely.

Eighty-two per cent of self-assessments declared compliance with ensuring clear lines of accountability for managing medicines, regular review of the medicine stock, adherence to prescribing policy and appropriate management of controlled drugs. In our visits, we found that over half of the units' compliance was impeded by factors such as a lack of monitoring of the policy on the management of medicines, insufficient training for staff in dispensing medicines, and inconsistencies and under-reporting of incidents relating to prescribing and dispensing medicines.

Management of medical records

Services should have a systematic and planned approach to the management of medical records, and all records should be completed appropriately, available when required, maintained confidentially and stored securely at all times.

We found that the management of medical records was an area that needed to improve. While clear policies and practices were in place and staff were aware of the need to maintain the confidentiality of personal information, we observed several breaches of information security. This included not ensuring that patient records were stored securely at all times.

We received some reports about difficulties in the introduction of the electronic medical record system – called the 'Defence Management Information Capability Programme'. This programme is intended to deliver an integrated electronic healthcare record and improve the way the DMS accesses and uses health information. Despite initial difficulties, staff were positive about the roll out of this programme.

Environment and amenities for care

All care and treatment should be provided in environments that promote the wellbeing of patients and staff and are designed for the effective and safe delivery of care.

We found that some services were provided in either purpose-built, well-equipped medical centres, or in suitably adapted older buildings. These units offered clean and appropriate clinical environments. Although a lot of the buildings used to provide medical care were old, these were still well maintained.

However, we also visited a number of medical centres, both in the UK and overseas, where clinical services were provided in what we considered to be unacceptable conditions. These included very poor maintenance of the buildings and inadequate facilities for clinical staff to work in. Our review found that some of the medical centres also had poor levels of cleanliness. It was particularly concerning that some of these centres had been scrutinised through internal environmental audits. The review found internal audit reports highlighting areas of concern in terms of safety and

infection control with clear recommendations. However, there was little evidence of recommendations being taken forward.

One of the reasons given for not maintaining these medical centres was because a 'new build' was either planned or under consideration, but this was often several years away from construction. We found the facilities in these areas to be wholly unacceptable for patients and for the staff providing health services, and reported our concerns to the DMS.

In response, the DMS took immediate action to begin to address these concerns. Actions taken included drawing up detailed programmes of renovation and maintenance, repairing buildings, replacing equipment, upgrading existing facilities, ensuring that radiators had temperature controls, and ensuring that patients' privacy was maintained – especially in changing facilities. The DMS also implemented a programme of deep cleaning for areas where this was identified as a need. Actions were taken straight away in some areas, with completion dates on all actions by the end of March 2009. The DMS stated that all of the issues raised had been taken very seriously and were seen as an opportunity to demonstrate commitment to improving standards for providing healthcare.

We found that in some areas in England, there was a high concentration of medical centres in close proximity to each other. We recommend that the DMS undertake a review of the number, location and standards of accommodation of the medical centres and consider how to ensure the best use of the resources available.

Clinical supervision

Clinical care and treatment should be delivered under appropriate supervision and leadership for all staff.

We found that there was a high level of declared compliance against this standard. Our follow-up visits found that units were aware of where there were good supervisory arrangements in place and where this needed to be improved. The GP training practices that we visited had robust clinical supervision for trainees.

We also found that professionally qualified clinical staff were able to update the clinical skills and techniques that were relevant to their work and considered this to be an area of good practice.

Improving health

Services should be designed to promote, protect and improve the health of the people served.

Keeping Service personnel healthy is a key priority for the DMS. We found some excellent initiatives in place to promote healthy lifestyles and effective joint working with local NHS trusts in England. Health promotion activities focused on DMS policy issues, such as smoking cessation, sexual health and programmes of health screening. Other areas included information on managing specific conditions, such as diabetes and asthma and advice and support on alcohol misuse.

We found an area of particularly good practice when reviewing this standard in Army primary care services. Regular health promotion themes were set by the medical directorates, in partnership with the single Service headquarters, and delivered in local medical centres. However, the themes were not always followed in each medical centre.

Safety of patients

Standards relating to patients' safety are concerned with ensuring that safety is enhanced and maintained and that activities are in place that prevent or reduce the risk of harm to patients.

Child protection and safeguarding training
We reviewed the standard that ensures that medical services have processes in place for identifying, reporting and taking action if there are any actual or potential concerns about the safety of a child. Children are defined as all those under the age of 18, and this includes dependant children of Service personnel, cadets or trainees.

Our review found that some DMS staff were unsure of the process for reporting any child protection or safeguarding issues. Also of particular concern, in some areas, was a lack of recognition that those under the age of 18, particular those between the ages of 16 to 18 should be defined as children. Children from the age of 16 can consent to medical treatment but are still legally defined as children.

While no specific concerns were found regarding the practice of treating and safeguarding children, the lack of child protection training and the realisation of responsibilities for all staff working both directly and indirectly with children was a concern which should be addressed.

Use of ambulances
We found an issue relating to the use of ambulances to transport patients – but in one area only. Staff were concerned about the continued use of ambulances that had been reported in an internal inspection as unsafe and needing urgent replacement. We raised this with senior officers during the review as a matter of concern to the DMS because of the continuing risk to patients.

The DMS has stated that the ambulances, in this one area, had been in use since 2002 and that it was known that these vehicles presented a safety risk to patients. A plan to modify existing vehicles and reduce the risk by mid February 2009 was put in place. New vehicles are planned to be delivered in June or July 2009. The risk in using these vehicles has been known for a considerable time and their continued use prolongs the risk to patients' safety. We consider that this risk remains high and unacceptable.

Management of staff and services

Managerial leadership and accountability focus on ensuring that the culture, systems and working practices that ensure probity, quality improvement and patients' safety are central to all activities concerned with clinical care and treatment.

Raising concerns
We found that DMS staff were generally confident in raising concerns about any aspect of clinical practice and challenging discrimination and equality issues. There was a culture of trying to address and sort out any concerns, incidents or complaints at a local level. This had, however, led to under-reporting of these within many services. Most staff who spoke to our assessors knew how to report issues or incidents through the chain of command or through the incident reporting processes. Some staff told us that there was some reluctance to report concerns due to the culture and command structure, and that it may affect career progression. Most of the units we visited had systems in place for reporting and managing any risk to healthcare delivery, collecting feedback from people who use the health services and reviewing clinical practice.

Training of staff
We found good practice in the access to training given to all levels of staff. In particular, opportunities for clinical staff to update or extend their clinical skills and knowledge were extensive. Other examples included access to health promotion courses for practice nurses. These included programmes to provide support, care and advice for people with asthma or diabetes, or health promotion activities such as weight loss clinics and advice and support on giving up smoking.

"....the training that we are giving our clinicians keeps them up to speed and has seen our service improved over the years ... the commitment that these people give provides an excellent service...."
Colonel Pat John, Deputy Chief of Staff Medical at Permanent Joint HQ

Attendance at mandatory training was generally good although not all areas declared 100% compliance with this standard. DMS staff in some areas reported that their high turnover of staff made it more difficult to release staff for essential training.

Medical assistants
The DMS employs medical assistants within each of the three Services, who have no primary clinical qualification, but are trained in basic medical care – for example, hearing or sight testing, first aid and basic or advanced life support skills. There is no exact equivalent role in the NHS, although some of the RAF medical assistants had undergone state registered paramedic training through the NHS training scheme. The role of the medical assistant is invaluable and variable. It includes extensive administrative and military duties, as well as providing support to medical teams – for example, on ships, in medical centres and rehabilitation units and in field hospitals. Medical assistants are often the first responder in emergency medical situations.

"....our medical assistants are the 'bedrocks' at sea...our challenge is to support them more...."
Surgeon Commodore Tim Douglas-Riley, Director, Royal Naval Medical Service

Our assessment teams met many medical assistants throughout the three Services and found this extremely committed group of staff to be very enthusiastic about their roles, flexible, positive and motivated. They were appreciative of, and valued access to, regular training and development of skills, but raised concerns about a lack of clear pathways for career progression. They were particularly concerned that their skills and competence, gained through training and experience, were not leading to formal qualifications, which would assist their careers, both within the DMS and at the end of their military contract or on retirement from the Services.

The role of medical assistants and their access to qualifications needs to be reviewed and developed. The skills of these personnel could be harnessed in the health service, when they leave the DMS. It would be appropriate for the DMS to liaise with bodies such as NHS Employers to see how the skills and experience acquired by medical assistants can be transferred when they leave the Services.

"....we recognise the need for our medics to be more qualified and we are endeavouring to provide our medical assistants with more formal education...."
Air Vice-Marshal Paul Evans, Director General Royal Air Force Medical Services

Monitoring performance
Performance requirements are set out in the Defence Health Programme and the complementary single Service plans and strategies. Services are required to monitor and achieve these within specific timeframes. Defence Dental Services declared low levels of compliance on this, as did the Joint Medical Command, which is responsible for the management of all joint clinical care, medical education and commissioning specialist care and treatment.

We found that the role of regional and service-specific headquarters was not always clear to staff working in the clinical services. This affected what was being reported between the headquarters and clinical units.

Regular monitoring of how individual staff were performing and what development and training needs were required, known as staff appraisals, was clearly evident.

Collecting information and health statistics

In managing services, the DMS collects health statistics and information in areas of healthcare delivery. Regular internal reviews and audits across services have also taken place. However, these were planned, implemented and processed differently by the Royal Navy, the Army, the Royal Air Force and the Defence Dental Services. This has led to:

- A lack of a comprehensive approach to managing and reviewing services.
- A lack of learning lessons between Services.
- The inability to capture and provide a clear corporate overview of how well the DMS, as a whole, was achieving standards or meeting required levels of performance.

It had not been possible for the DMS to make comparisons between areas of provision as information is not collected, analysed and stored centrally to obtain a full and detailed picture of the performance of the DMS as a whole.

The Defence Medical Information Capability Programme, which is currently being rolled out is planned to provide electronic patient records and a central database with comprehensive health information. The DMS anticipates that this will bring about a consistent approach to information gathering and will be used as part of the governance of healthcare delivery.

Views of those who use the services

A key part of our review was to ask for comments from Service personnel, members of their families and civilians who work for the Ministry of Defence and are entitled, under their contract of employment, to some aspects of medical treatment and care. The review received comments from 300 people.

Seventy per cent of respondents, who gave a relevant comment, had a positive opinion of primary care services, stating that services were accessible and that staff were professional and competent. Negative comments were mainly about administration processes, including loss of medical records, poor communication and lack of continuity of care – for example, changes in doctors and use of locum medical staff.

Over 80% of respondents, who gave a relevant comment, had a positive opinion of dental services, but concerns were raised about long waiting times for appointments. A quarter of the people who responded stated that there was a difference between treatment given to Service personnel and treatment given to their

dependants. A particular concern was that some dependants felt they were not treated as well as Service personnel and, at times, had difficulty getting dental care. The DMS has stated that dependants are not, however, entitled to defence dental care in the UK.

Seventy-nine per cent of the 47 relevant comments gave a positive opinion of hospital care, although waiting times were considered too long. Concern was raised about the closure of military hospitals in favour of NHS and independent acute healthcare providers, stating a preference for military hospitals.

All the comments we received about rehabilitation services were positive. Services were described as "excellent" and "first class", with praise for professional and supportive staff.

The DMS provides community mental health services and, although the number of respondents commenting on these services was low by comparison with other services, experiences were positive or satisfactory – including good access to services. We received no negative comments.

Areas of exemplary practice

Our review found a number of areas of very good practice throughout the DMS. We identified good practice based on standards, clinical opinion and feedback from those who use the services. The following were considered to be examples of areas where practice was exemplary.

Trauma management in military operations overseas in war zones

An area of great importance for the armed services and their dependants is how injuries in areas of conflict and in war zones, or 'hostile areas', are managed. Our review found exceptional practice in this area. The management of major injuries encompasses a range of issues:

- **Preparation**

There are two major protocols covering all aspects of trauma management in areas of conflict or war zones. These are setting up a field hospital and the management of casualties. We found that these protocols were comprehensive and detailed. They are valued by staff and are used extensively to prepare for deployment. Our assessment team observed part of a medical preparatory exercise.

- **Training**

All members of the DMS, who have been nominated to be deployed to areas of conflict, participate in exercises, such as learning and practicing trauma care and management. During the month's training, staff fully rehearse the setting up and use of a field hospital. Training includes two three-day intensive modules on the management of major battle injuries, in accordance with DMS protocols, which are observed and audited. Although the composition of the medical teams change during a tour of duty, the fact that all have rehearsed and have a sound understanding of their roles maintains the integrity and quality of the service delivered.

We found that staff in front line units understood their role in relation to trauma. The training reinforced and confirmed their core roles: to save life, stabilise the condition of casualties and to transport them for further treatment.

- **Medical Emergency Response /Immediate Response Teams**

Emergency medical care in hostile areas is provided by teams of dedicated, highly efficient and extremely competent teams of clinical and clinical-support staff. The Medical Emergency Response Teams (MERT) and the Immediate Response Teams (IRT), led by the Royal Air Force, provide an emergency response service to support medical teams in the care, treatment and evacuation of personnel injured on the battlefield. We found the commitment to ensuring responsive, well-trained and well-equipped staff to provide emergency care and treatment to members of the armed forces in hostile situations to be excellent and exemplary practice. The MERT and IRT are doctors, paramedics, nurses and medical assistants, who are normally flown to the site of the injured by helicopter. All staff have undergone specialist emergency response training appropriate to their role and provide immediate, often lifesaving, treatment on the battlefield under the protection of a combat guard. Pre-hospital care is delivered on the ground and in-flight on board the helicopter.

Helicopters are equipped to carry and treat casualties who are on stretchers or who are able to walk. The time from receiving a call to the team being airborne and on the way to the casualty is a matter of minutes. Team working from the moment a call is received is of the highest level. Casualties can be assessed and treated very quickly, which may be critical to their recovery. We found the standards of response and care and treatment from the medical and immediate response teams, in extremely challenging situations, to be exemplary.

"....we have the difficulty of operating in austere environments and in remote locations... this is a traditional feature of what we do and we are doing this very well. All the indicators show we are achieving an enviable record of success, especially with trauma..."
Major General Alan Hawley,
Director General Army Medical Services

- **Hospital care**

Casualties admitted to hospital take a journey of care that starts in the emergency department, where their condition is stabilised and their care planned. The policies, protocols and guidelines necessary to manage the different pathways of care, X-ray, intensive or high-dependency care or repatriation, are in place. Staff were well informed and trained in their use.

Staff make a rigorous check of equipment every 24 hours. All equipment was checked to be in good working order. Staff in the emergency department and intensive and high dependency care areas worked closely together.

"....the results achieved in the management of the injured soldier in the current conflicts are the best ever reported... this is a truly remarkable achievement...."
Mr John Black, President,
The Royal College of Surgeons of England

- **Aeromedical evacuation**

A unit known as the Tactical Medical Wing, based at RAF Lyneham, is responsible for providing teams for the RAF's aeromedical evacuation service. The teams work in various conditions, recovering ill or wounded personnel from across the world. RAF aeromedical personnel also provide in-flight care to wounded and ill personnel who require transport to and between

medical facilities, such as field hospitals. The unit has a number of staff on stand-by, who are ready to leave their homes or places of work and go anywhere they are required, at short notice. The Critical Care Air Support Teams provide worldwide repatriation of the most critically ill and injured members of the armed forces.

"....a major achievement is establishing an aeromedical evacuation system that delivers the critically injured patient from the point of wounding to hospital care in the UK, often in less than 24 hours...."
Major General von Bertele,
Commander, Joint Medical Command

Patients' diaries

We found a very innovative programme that involved all staff recording events in diaries for individual patients. We were told that recovering patients have found the patients' diaries very helpful, as they can fill in the time lost from their memories, which can be so disruptive to recovery. This initiative has also helped grieving relatives to identify better with the last days of their loved one's life. It can also reassure them as to the quality and intensity of the care which was given.

Diary entries tended to focus on significant events or milestones in a patient's care and recovery, such as improvements in wounds or sitting out of bed for the first time. Colleagues who were visiting patients were also encouraged to write entries and to include news from the patients' parent unit, or anything the patient might have an interest in. We think that this initiative could be shared widely with NHS and independent healthcare intensive care and high dependency units.

Major Trauma Audit for Clinical Effectiveness (MACE)

The Royal Centre for Defence Medicine, located in Birmingham, leads the Major Trauma Audit for Clinical Effectiveness, or MACE audit. This is a systematic review of standards and processes of care, which examines all aspects of trauma assessment, immediate and ongoing treatment and care and clinical outcomes. Clinical feedback is conducted on a weekly basis through teleconference meetings between the UK and the field hospitals in areas of conflict and war zones. This is known as the Joint Theatre Clinical Case Conference. Standards and clinical procedures were examined carefully, and all aspects of the treatment were carefully recorded. All clinical data from when a person is wounded, through to rehabilitation is collected on the Joint Theatre Trauma Registry. This uses standard codes for injuries so that performance can be compared internationally.

There was close scrutiny of this systematic review of standards from Birmingham so that all the required information was completed accurately. The audit had 68 key performance indicators and was used to review, develop and continuously improve trauma care.

"....The College is very impressed with the high level of research being carried out by the DMS, which contributes directly to the very good service our troops are receiving...."
Mr John Black, President,
The Royal College of Surgeons of England

We found the Major Trauma Audit for Clinical Effectiveness to be excellent, but consider that it would benefit from an electronic upgrade to improve recording.

We believe that the management of injured Service personnel is worthy of publicising, as there is much that could be learned by the trauma services within the NHS. All aspects of the management of the journey of care have been made as efficient as possible, including:

- The design and set-up of the field hospital, with logical and quick access to all services as and when they are required.
- Attention to training, with all aspects covered, including clear roles and practice sessions, which are recorded and analysed.
- Training of all personnel, but led by the medical assistants, in immediate treatment of life threatening injuries, using tourniquets and haemostatic packs (to reduce blood loss) and morphine.
- Immediate transportation of casualties from the front line to the hospital, with patients being stabilised on the way by specialist staff.
- Stabilisation in hospital, with immediate surgery to save life. This is supported by state of the art techniques, including liberal use of haemostatic factors and drugs.
- Transfer to intensive care and quick repatriation to the UK.
- Comprehensive audit, using in-house information systems coupled with robust data.

Rehabilitation services

The DMS provides intensive rehabilitation support to Service personnel on both an inpatient basis and a regional outpatient basis. Inpatient care is provided at Headley Court rehabilitation centre, where Service personnel with musculoskeletal, neurological or complex trauma injuries are treated. Patients can be transferred directly from hospital care, or referred to Headley Court as part of the rehabilitation programme. Accommodation is available to families of patients. Headley Court is staffed by Service and civilian personnel. Facilities and services include hydrotherapy, a gym, a social work department, physiotherapy, occupational therapy, remedial therapy and a prosthetic department.

The service provides a number of regional rehabilitation units across the UK and in Germany. Our review found that the care and treatment in regional rehabilitation units was excellent, and was provided by highly motivated and dedicated staff.

Areas of good practice in clinical governance

Our review found a number of specific and effective systems in place for ensuring the delivery of safe and effective care and treatment within the units we visited. The following are examples of good practice in clinical governance relating to specific standards:

Acting on safety alerts

Systems should be in place to ensure that notices relating to safe care of patients, alerts and other communications concerning safety which require action, are acted upon within required timescales in order to protect patients. These were evident throughout the DMS. The review found a high level of compliance with this standard in the units visited in follow-up assessment visits. Evidence for compliance included policy, processes and systems for acting on safety notices and alerts, were well embedded. There were clear lines of accountability and responsibility for designated staff and effective monitoring systems in place.

Use of medical devices

All of the units providing healthcare need to keep patients, staff and visitors safe by having systems to ensure that all risks associated with obtaining and using medical devices are minimised. Compliance with this standard was assessed by us in six units, which were assessed as complying both in their self-declaration and on our follow-up. Good practice included clear policies and processes being in place to make sure that equipment was ready for use when required. We also found clear lines of accountability for procurement and competency-based training for staff in these units.

Continuous learning for clinical staff

Professionally qualified staff who are providing clinical care should continuously update relevant skills and techniques. We made follow-up assessments on this standard in 14 units. We found that appraisals of staff were well embedded and linked to programmes for training and development. We also found that staff received good access to training and some units worked in partnership with NHS trusts to develop clinical skills.

Participating in clinical audit

Clinical staff should participate in regular clinical audits and reviews of clinical services. We found a number of clinical audits with subsequent action plans, and examples of resulting changes and improvements in practice. Some of the units we visited had a designated person to take the lead in audit, and training, developing, managing and learning from audits was in place.

Main conclusions

The DMS is responsible for providing routine healthcare, as well as care and treatment delivered in a range of different and challenging environments in the UK and abroad, and on land, at sea and on board aircraft. The challenges that this breadth of services presents are met by teams of committed and dedicated staff. Our review found areas of excellence and areas where improvements need to be made to ensure that Service personnel, their dependants and civilians continue to receive safe healthcare.

Our review found a number of examples of exemplary healthcare provision in the areas of trauma care and rehabilitation. The training processes leading to excellent trauma management are an area that the NHS could learn from in the delivery of emergency care.

We found many examples of very good practice in individual units across the Royal Navy, the Army and the Royal Air Force. There were, however, variations across the DMS in the way that health services were monitored and reviewed. The way that information was reported and statistics collected made it difficult for the DMS to get a corporate picture of how services were achieving standards or meeting required levels of performance. This highlighted the need for a clear governance structure and system for the whole of the DMS.

During the course of the review however, the DMS reviewed its governance arrangements and has now published a healthcare governance and assurance policy directive. This is aimed at developing common healthcare governance and assurance processes throughout the DMS.

Our review found that staff working in clinical services did not always understand the role of regional and service-specific headquarters, and there is a need for this to be clarified.

Our review highlighted areas that are in need of attention, as well as areas in need of development. The DMS responded immediately to areas of concern raised during the course of the review, primarily about buildings and the infrastructure within medical centres, and took immediate action to begin to address these. There is still work to do, however, to ensure that services are safe and that all clinical environments are suitable and 'fit for purpose'.

Despite being a relatively small sample of people who use the DMS, those people who gave us comments or concerns on their experiences of care and treatment were generally positive and satisfied about healthcare services. One issue raised, however, is a perceived difference in the level of service provided to different groups of people covered by DMS – particularly Service personnel versus dependants and other workers. It would be beneficial for the DMS to be clear about entitlement to care and provision, including where entitlement is limited to specific groups of people.

The information from our review, its recommendations and conclusions should inform clinical governance structures and processes for the whole of the DMS, enable areas already identified as good practice to develop further, and focus work on areas for improvement and development.

The Healthcare Commission recommends that the DMS reflects on this experience of external review and consider how to ensure independent review of its services in the future.

Recommendations

Clinical care

National guidance and best practice

The DMS should:

- Base all its care and treatment on best practice guidance and available directives.
- Review all relevant NICE technology appraisals on new and existing medicines and treatments, and guidance on clinical procedures to ensure that these are reflected in DMS policy and guidance where relevant.
- More importantly, ensure that its current policy and directives, which are already based on best practice, are implemented and monitored to ensure compliance.

Infection control, decontamination and clinical waste

The DMS should:

- Ensure that they have effective infection control and management plans and processes in place and that they have a named person to lead all aspects of the management of infection control. This should include detailed cleaning schedules and standards on hygiene to be maintained.
- Adhere to decontamination policy, procedures and processes for the safe and effective segregation, handling and disposal of all clinical waste, as part of an infection control governance plan.

Management of medicines

The DMS should:

- Review all its policies, processes and practices on the management of medicines, due to the comparatively high level of assessed non-

compliance that we found with all parts of this standard across all three Services.

Management of medical records

The DMS should:

- Keep all personal and confidential medical information securely, whether in paper or electronic form, to avoid unauthorised or inappropriate access, in line with DMS policy and government legislation. Although effective information governance is in place within some units, this is not the case across the DMS.
- Give all staff advice and training on information management and governance, as part of their induction programmes.

Clinical environments

The DMS should:

- In partnership with those responsible for infrastructure including Defence Estates and the single Services, carry out a review of DMS facilities in the UK and overseas to ensure that they are all 'fit for purpose' for clinical care and for the safety of patients and staff.
- Set minimum standards for all healthcare facilities, which can be used for regular monitoring through environmental and infection control audits. Action plans for all audits should specify named individuals accountable for ensuring that actions are undertaken in a timely and appropriate manner.
- Ensure that clear lines of accountability for the maintenance and infrastructure of all clinical environments are included in local governance plans.
- Undertake a review of the number, location and standards of accommodation of all medical centres and consider how to ensure the best use of the resources available.

Clinical supervision

The DMS should:

- Provide all staff involved in the delivery of care and treatment with appropriate levels of clinical supervision and clinical leadership. There are already a number of effective clinical supervisory frameworks and practices, and this good practice should be developed to cover the DMS.

Improving health

The DMS should:

- Develop a systematic and targeted approach to health promotion and disease prevention, building on current good initiatives and partnerships with local NHS trusts. This should include assessments of local health needs and an evaluation of the impact of initiatives.
- Collate and analyse information on health promotion and disease prevention centrally to promote sharing and learning across all of the DMS.

Safety of patients

Child protection and safeguarding training

The DMS should:

- Implement a programme of training in child protection and safeguarding. The level of training should be proportionate and appropriate to the position of staff, but must include all clinical and non-clinical staff, and contracted staff working in areas where children are treated.
- Ensure that all its staff recognise that Service personnel who are under 18 years of age are legally still children. Healthcare staff need to treat them appropriately in relation to child protection and safeguarding.

Use of ambulances

The DMS should:

- Maintain all its vehicles used for transporting patients within agreed standards of safety. Where risks to the safety of patients are known, these should be addressed immediately. Where examination shows that vehicles should be replaced as a matter of urgency – or immediately, this needs to be acted upon.

Management of staff and services

Care and treatment available to non-Service personnel

The DMS should:

- Make information available on all services in the UK and overseas that makes it clear which specific care and treatment is available to Service personnel, and which is available to their dependants and entitled civilians.

Experiences of the dependants of Service personnel

The DMS should:

- Explore the concerns of those using services, especially dependants, about the difficulties experienced with the administration and bureaucracy of services.

Processes and structures relating to clinical governance

The DMS should:

- Monitor the implementation of the new governance structure and arrangements and the accountability and responsibilities for personnel with leading clinical governance roles and responsibilities.
- Describe the responsibilities of headquarters, clinical units and individual staff so that there are clear definitions of their roles and responsibilities for ensuring effective clinical governance.
- Agree a governance plan that describes how and what information will be collected, analysed and used to assist development and innovation.

The DMS has already recognised that this is an area for improvement and is in the process of effecting changes to the clinical governance processes and structures.

Mandatory training

The DMS should:

- Address the inconsistencies in attendance at mandatory training programmes to ensure that all staff, military and civilian personnel, including students, attend mandatory training that is relevant to their position and to the service in which they are working.
- Ensure that it has monitoring systems in place to record attendance at all required activities for training and development, either before placement, posting or deployment or within an acceptable timeframe within the service to which individuals are assigned.

The role of medical assistants

The DMS should:

- Review the role of medical assistants working in the Royal Navy, the Army and the Royal Air Force, with a particular emphasis on their role in assisting the delivery of healthcare and treatment.

- Consider identifying appropriate qualifications for the role of medical assistant in all three Services. This would help to ensure that the underpinning knowledge, as well as the practical application of clinical skills, is understood and competence formally assessed and recognised.

Independent assessment and review

The DMS should:

- Reflect on the experience of our external review and consider how to find a way to ensure independent review of its services on a regular basis in the future.

The Healthcare Commission would like to commend the Surgeon General for being open and willing to have an independent review of the DMS and also for taking swift action on issues that arose during the course of the review. The Commission believes that this has shown the value of independent assessment both for the management of the services and for the delivery of clinical care.

The DMS has already engaged in early discussions about ongoing external review and regulation with the new regulator for health, mental health and adult social care, the Care Quality Commission, which will take over the work of the Healthcare Commission, which ceases to exist after 31 March 2009. The Care Quality Commission will become operational from 1 April 2009.

Next steps

This was a one-off review of the quality of the DMS undertaken by the Healthcare Commission. We have no jurisdiction to require any actions to be taken. However, the findings of this review should inform the development of care and treatment provided by the DMS, influence future planning of services and provide a focus on the areas that need improvement.

The DMS has seen the report of the review and has accepted its recommendations and begun to take action where needed.

We strongly recommend that the DMS draws up a clear action plan to address all of the recommendations from this review. This needs to include a timetable for action, what outcomes are required, and to identify key personnel who will be accountable for implementing, monitoring, reporting and ensuring that actions are undertaken in a timely and effective way.

1. Introduction

The Healthcare Commission had not assessed Defence Medical Services (DMS) before, as it was outside the scope of the Health and Social Care Act (2003), which provides the legal framework we operate in. However, following the request from the Surgeon General for the Healthcare Commission to review the DMS, regulations were laid before Parliament to bring the DMS within our regulatory remit in June 2008. We then adapted and applied the methodologies that we use to assess English healthcare providers to assess the DMS.

The aims of our review were:

- To examine the clinical governance processes of the DMS by undertaking an independent assessment of the services provided to Service personnel, their dependants and entitled civilians.
- To align the DMS with best practice in healthcare assessment and regulation processes.
- To promote improvement in DMS provision by identifying good practice and areas for improvement.

2. Methodology

Approach

The Healthcare Commission adopted a similar approach to that used used for the assessment of NHS trusts' performance against the *Standards for Better Health*, produced by the Department of Health in 2004.

This involved developing criteria for assessing each standard. These criteria were presented as elements. The elements provided further detail on the standard and provided some direction on how compliance with the standard may be demonstrated. Each element included the key items of legislation and the Ministry of Defence or DMS policy that described the underlying requirements. These have been used to underpin the review. We developed these criteria with representatives from the Royal Navy, the Army and the Royal Air Force.

In addition, we reviewed how applicable each of the standards was to each type of service – such as community mental health and primary care. We identified some standards as not being applicable – for example standards relating to the provision of food, which only apply to inpatient settings or services which have overnight bedding down facilities.

We asked members of the armed forces, their dependants and entitled civilians, who use the services, for their comments on the quality of the healthcare services provided.

We also invited organisations that work with the DMS to submit comments. This was in line with current methods of seeking commentaries from third parties in the assessment of NHS trusts in England.

We sought feedback in three distinct ways:

- Requesting comments from members of the armed forces and their dependants, and also civilians who work for the Ministry of Defence on a contractual basis or were entitled to emergency treatment in areas of conflict or war zones.
- Requesting comments from organisations in the voluntary sector who work with current and ex-Service personnel, for example, welfare services.
- Requesting comments from organisations that provide professional regulation, advice and support to the DMS, for example, the Royal Colleges.

We received just fewer than 500 comments about the healthcare provided by the DMS, primarily from members of the armed forces.

The overall aims of obtaining information from those who use the service and related organisations were to identify:

- Areas of good or excellent practice.
- Areas of concern.

Self-assessment

The first stage of the review involved a self-assessment by the DMS against the standards, based on the criteria developed. Although it has been DMS policy for some time to comply with the *Standards for Better Health*, each of the three Services had previously chosen to do this independently and had their own systems for clinical governance. Most were using self-assessment questionnaires, followed up by internal inspections. This was, however, the first time that all three Services had been asked to complete the same self-assessment.

We requested self-assessments of declarations of compliance with the standards at unit level – for example, military hospitals and rehabilitation centres – rather than a single declaration for the whole of the DMS. Within Army provision and for dental services, declarations were made on a regional basis to cover several health centres. This was for pragmatic reasons, recognising the lack of a common assurance system throughout the DMS. We received 153 declarations in total.

One key difference from the assessment of standards in the NHS was that we asked DMS units for evidence to support the declarations for each standard. This was to address, in part, the lack of external sources of information available about performance in the DMS on which to cross-check and risk-assess declarations.

When NHS trusts submit their self-assessment declarations of compliance against the *Standards for Better Health*, we can compare and analyse them against a considerable amount of information. This allows us to target follow-up assessment visits to those trusts that are actually or potentially non-compliant. This information is drawn from the various sources that trusts are required to submit information to on their performance against targets and standards. The DMS does not submit health information to external bodies in the same way as the NHS. There was therefore no information on which to cross-check the individual units' self-declarations.

Each unit or region submitted their completed self-assessment to us electronically, or on paper if internet access was not available or not practicable.

Follow-up assessment visits

The second stage of our review consisted of a series of assessment visits carried out by Healthcare Commission assessors, to check the accuracy of the self-assessments.

The overarching aims of these follow-up assessment visits were to:

- Provide a more detailed picture of performance than could have been obtained by self-assessment alone.
- Assess the accuracy of the self-assessments.
- Compare effectiveness of clinical governance processes across the DMS to identify areas of excellence as well as those areas where improvement is necessary.

We visited 53 units, which we selected on the basis of a stratified sample, representative of the different service types. Therefore, the largest number of visits was to primary care services, as these formed the majority of services provided by the DMS. We made fewer visits to community mental health and dental services, as there were fewer of these. A list of the DMS units visited is provided in appendix 4.

A team of assessors from the Healthcare Commission undertook these visits during October and November 2008. Teams consisted of three to four experienced assessors and senior clinical advisors. Each member of the assessment team went through a briefing and training programme to familiarise themselves with DMS policies and procedures, gain an understanding of the context in which healthcare is provided by the DMS and understand the scope and diversity of service provision. Training and written guidance was also given on the methodology and assessment tools to be used in the follow-up visits.

Although all of the standards have been assessed during our review, we did not assess every standard on our visits. We chose the standards for the follow-up assessment visits in partnership with the DMS. They included all the safety and clinical effectiveness standards, as well as a number of standards on governance, patient focused services and public health.

We selected five standards for assessment on each visit, according to the relevance for the service being provided – for example, standards relating to health promotion were only chosen for follow-up in primary care. Other considerations were to provide as broad as possible an assessment of standards across provision to allow comparisons between the three Services.

Our approach for the assessment visits was to test compliance with the standards. This was different from our approach in the NHS where inspections are used to test assurance systems. NHS trusts are required to continually provide health statistics and information to national organisations and central government. This information is used to cross-check declarations, risk-assess those at risk of non-compliance and target follow-up assessment. However, the DMS does not provide the same information and therefore it was felt to be more appropriate and meaningful to check compliance.

We selected the standards for assessment randomly, and therefore there was a mixture of standards where units had declared that they were compliant and some where they had declared that they were non-compliant. Again, this differed from our assessment of the NHS where inspection teams only follow-up standards where a trust has declared to be compliant, but we have evidence to suggest they were non-compliant.

We developed inspection guides for each of the standards being assessed during our visits. We also developed questions for each of the elements being assessed. This ensured consistency between the various assessment teams in the questions they asked and the judgements that they made.

Our assessors had to establish whether any assurance mechanism that was in place could be supported by evidence, through speaking to the people in charge of the unit as well as their staff. In addition, we developed an observation tool. This enabled our assessment teams to check compliance with standards through observations within the different units and service types.

As well as looking for evidence of compliance and non-compliance with the standards, our assessors also looked for examples of good or excellent practice.

3. Details of findings

The findings of the review are divided into two categories:

- The comments we received from people using the services and comments from organisations working with the Defence Medical Services (DMS).
- Information from units' self-assessment declarations and our follow-up visits to clinical areas.

Comments from people using the services and organisations working with the DMS

The comments from people using the services and organisations working with the DMS are reported in two ways. Firstly, comments on specific services as follows:

- Primary care
- Dental services
- Secondary care (hospital services)
- Rehabilitation services
- Community mental health services.

Secondly, key issues by role of respondents who submitted comment as follows:

- Members of the armed forces.
- Entitled civilians.
- Family dependants.
- Professional bodies.

We received 485 pieces of feedback about the healthcare services provided by the DMS.

Number of commentaries by healthcare types	
Primary care	213
Dental services	128
Secondary care (hospital care)	81
Rehabilitation services	33
Community mental health services	10
Other	20
Total	**485**

We received comments from 215 members of the armed forces, 52 dependants, 20 entitled civilians and 13 professional bodies.

Number of respondents by role	
Member of the armed forces	215
Entitled civilians	20
Family dependants	52
Professional bodies	13
Total	**300**

Note: respondents could comment on more than one area of healthcare.

We invited feedback from members of the armed forces, their dependants and entitled civilians about their experiences of care provided by the DMS. We also sought comments from voluntary organisations that work with current or ex-Service personnel and from organisations that provide professional regulation, advice and support to the DMS on clinical issues. There were a number of options available for providing comments on the services – by completing an on-line feedback form, writing to or emailing the Healthcare Commission, or by telephoning our helpline. We used the Ministry of Defence internal communication systems to publicise this.

We received a total of 485 pieces of feedback in response to our appeal. Of these, the largest proportion of responses (215) was from members of the armed forces, with 52 from dependants, 20 from entitled civilians and 13 from professional bodies.

Commentary analysis by healthcare type

Primary care

We heard from 145 respondents who had an opinion on primary care services. Of these, more than 70% were positive, with less than a third expressing a negative (23%) or satisfactory (6%) view.

Comments from members of the armed forces were 65% positive, from dependants 84% positive, from entitled civilians 89% positive and from professional bodies 60% positive.

"In general terms I have found that access to primary health has been either very good or excellent. I have been able to get appointments in a timely manner and contact with health professionals and support staff has been a positive experience."
Member of the armed forces

Attitudes of staff were reflected upon favourably by 68% of the 38 respondents who commented on this issue.

"The care I have received from the RN sick bays have been excellent, delivered by helpful cheerful staff. What a contrast to my NHS experiences!"
Member of the armed forces

"The service I received was excellent, I really felt listened to and cared for and that all procedures were followed up and that everything was explained to me."
Family member

"Sometimes I feel as though I am not being treated as a 'patient' in the sense that I would be in the NHS environment, and just seen as a soldier, when in fact the doctor-patient relationship should supersede that of officer-soldier in these situations."
Member of the armed forces

Access to appointments drew a mixed response from 62 respondents, with 53% of those who commented on access being positive, and 47% being negative. It would appear this is an issue that varies significantly by service and by location.

Administration and bureaucracy drew a consistently negative response. Of the respondents who commented on it, 97% described negative experiences, although the number who commented was small overall – only 32 out of the 485 comments received.

"The care given by primary healthcare services has been excellent. This is undermined, however, by the amount of repetitive administration and bureaucracy that hinders clinical staff from providing even better care. The introduction of a new IT programme has helped but this is being hampered by the continued use of paper based records, etc."
Member of the armed forces

Communication and continuity of primary care both received a number of negative comments. Sixty-two per cent of the 26 respondents who mentioned communication described it as poor, and 88% of the 24 who reflected on continuity of primary care felt it was poor.

"Usually pretty good. However, tends to be a large turnover of locums and, sometimes give some staff more time off than is sometimes necessary. This turnover of staff also affects my wife who gets into a position of trust with

a doctor to find out that they have then moved on and so forth."
Member of the armed forces

"I have not been able to see the same doctor and have had different opinions to the same ailment. There does not appear to be enough time to see patients if you have more than one problem. I was asked if my second issue was going to take long because there was a queue outside. I felt I was being rushed when my healthcare is important to me."
Member of the armed forces

"Having just retired after 37 years service I was, in essence, thrown in the streets medically speaking. I was under treatment on my last day of service but was cut off immediately. The NHS still do not have any documentation on me. As a veteran the Service and government are not interested."
Veteran

"The healthcare that I have received has been first class. All staff have been informative, helpful and friendly. Every time I have had an appointment I have felt comfortable and extremely well looked after."
Entitled civilian

Dental services

More than 80% of the 77 comments that stated an opinion on defence dental care service were positive, with the remainder being negative. Comments expressing an opinion on the DMS dental care service from members of the armed forces were 89% positive, from dependants 60% positive and from entitled civilians 75% positive.

"I have completed 26 years service and would like to say that I've had excellent treatment throughout this time and look forward to another nine years."
Member of the armed forces

"I have no complaints as the service I have received has always been excellent and seems to have improved over the last few years."
Member of the armed forces

Access to appointments and dental care were considered a problem for 32% of the 37 respondents who commented on this issue.

"Good service but long waits for appointments (dentist and hygienist) to carry out annual inspections and you keep getting reminders to tell you that you're overdue!"
Member of the armed forces

Differences in care for Service personnel and dependents were raised in 18% of respondents commenting on dental services, declaring that the dental services did not recognise dependants at all.

"Once again my treatment over the years for dental treatment has been second to none. It was disappointing though when treatment for my family members ceased a number of years ago and was dependent on the area you are serving...the difficulty it is to find a NHS dentist to treat family members."
Member of the armed forces

Hospital care

Seventy-nine per cent of the 47 comments on the opinion of DMS hospital care were positive, with the remainder either fair (4%) or negative (17%).

The major source of negative comment was the closure of military hospitals in favour of NHS and independent healthcare providers. This was raised by 17% of the people who commented on hospital care.

"The service provided for members of the armed forces on return is inadequate, bring back a military hospital with nurses, doctors and allied health practitioners who understand the military ethos."
Entitled civilian

Waiting times and booking an appointment was commented on by 20 out of 81 (25%) respondents who submitted feedback regarding hospital care. Of these 20 comments, 12 (60%) were negative.

Rehabilitation services

All of the 19 respondents (100%) who submitted views on DMS rehabilitation services provided positive feedback.

Comments from members of the armed forces were 100% positive, there were no responses from dependants, 100% positive from entitled civilians and no responses from professional bodies.

"Post surgery (knee reconstruction), I'm now under the care of Cranwell regional rehabilitation unit and although it's early days yet (two weeks post operation) I'm really happy with the service that I'm receiving."
Member of the armed forces

"Headley Court provides outstanding rehabilitation facilities that use intensive methods to produce outstanding results. After six months of almost no progress after breaking a shoulder, I was delighted with a startling breakthrough achieved at Headley Court. More please."
Member of the armed forces

"I was referred to the regional rehabilitation unit and received excellent care throughout the care pathway."
Member of the armed forces

"My rehabilitation was first class. I was given all the support to ensure that my muscles were built up around my knee to support healing and I am now able to fully participate in all sports."
Member of the armed forces

"I had cause to utilise the Princess Mary hospital rehabilitation services and have received a first class service. The staff had a great deal of understanding of rehabilitation techniques to deal with complicated injuries."
Member of the armed forces

Community mental health services

Seven respondents expressed an opinion on the community mental health services provided by the DMS and of those 86% were positive and 14% were fair. Comments expressing an opinion on the DMS hospital care service from members of the armed forces were 80% positive and 100% positive from dependants. There were no comments from entitled civilians or the professional bodies.

"Mental health care is very effective within this area. They are quick to respond to patients' needs."
Family member

Other feedback

An open feedback element was provided in the feedback form, and of the seven people who chose to use it, 71% expressed a positive opinion of DMS services, with the remainder expressing a negative view.

"Deployed primary and secondary healthcare are the best in the world! What a shame that we can't give our soldiers, sailors, airmen and their families treatment this efficiently and enthusiastically at home!"
Member of the armed forces

Information from unit self-assessments and follow-up visits

The following summarises the key findings from the self-assessment declarations and information from the follow-up visits.

The DMS submitted 153 individual self-assessment declarations stating whether their area of healthcare services was compliant or non-compliant with the standard. The units were asked to provide evidence used to assess compliance. In the follow-up assessment visits to a sample of services, we looked at evidence of compliance and whether there was agreement with the service's declaration.

Service provision was categorised into the following:

- Primary care/occupational medicine.
- Secondary care/hospital services.
- Regional rehabilitation units.
- Inpatient rehabilitation.
- Departments of community mental health.
- Defence dental services.
- Medical directorates within the single Service headquarters.
- Regional medical headquarters.

The number of self-assessments submitted to us consisted of:

- 50 from Royal Navy units including the Royal Fleet Auxiliary.
- 26 from the British Army. These represented the regions which the British Army serve and contain a number of different healthcare units within each region. Also included were field army medical formations and headquarters and the Territorial Army.
- 43 from Royal Air Force units including the Royal Auxiliary Air Force.
- 12 from Defence Dental Service (DDS) units which included the DDS headquarters and the DDS regions where each region has several dental centres.
- 19 from Permanent Joint Headquarters (UK) units. These included units deployed to operations and the Permanent Joint Operating Bases.
- 3 from Joint Medical Command units.

Standards and level of declared compliance

The following identifies the aims of each of the standards and reports the percentage of declared compliance and non-compliance. This is followed by evidence collected from the follow-up assessment visits to selected units.

The standards were grouped under the following areas:

- Patient safety
- Clinical and cost effectiveness
- Governance
- Patient focus
- Accessible and responsive care
- Care environment and amenities
- Public health.

Patient safety

Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Standard C01a – incident reporting

Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.

- 138 out of 151 (91%) self-assessments that were applicable to complying with incident reporting declared compliance.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
88%	96%	91%	100%	94%	100%

Note: Self-assessments that selected commissioning as the type of healthcare provided were not applicable for this standard (1%).

- Declared compliance on incident reporting was high across all the services ranging from 88% of the Royal Navy units to 100% of Defence Dental Services and Joint Medical Commands.

This standard was assessed in 16 out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in eight out of the 16 (50%) units' declarations of compliance being overturned to non-compliance.

Standard C01a	DMS unit declaration	Healthcare Commission assessment
Royal Navy Dept community mental health	Compliant	Compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant
Army department community mental health	Compliant	Not compliant
RAF primary care	Compliant	Not compliant
RAF primary care	Compliant	Not compliant
RAF Tactical Medical Wing	Compliant	Compliant
RAF community mental health	Compliant	Not compliant
RAF primary care	Compliant	Not compliant
RAF headquarters	Compliant	Compliant
Dental services headquarters	Compliant	Compliant
Joint Medical Command	Compliant	Compliant
Secondary care permanent base	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Clear overarching policy and processes in place.
- Positive incident reporting culture with staff actively encouraged and supported.
- Systems in place for the counting, aggregation and analysis for patterns and trends in incidents reported.
- Links with established clinical governance arrangements providing a platform for timely action planning and implementation upon findings.
- Feedback mechanisms reaching all staff.

Key reasons for non-compliance included the following:

- High threshold for incident reporting excluding minor incidents and near misses.
- Cultural barriers to incident reporting, concern stated about rank.
- Cumbersome process stated by staff.
- Limited counting, aggregation and analysis of incident reports.
- Incident reports not constructively used to drive improvements in practice and services.
- Limited feedback mechanisms.

Comments and issues:

- Even in the presence of a clear overarching policy and associated processes the threshold for incident reporting is variable. This can lead to inaccuracies in counting, aggregation and analysis for emerging patterns and trends and lost opportunities for driving improvements in practice and services.

Standard C01b – acting on safety alerts

Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.

- 133 out of 151 (88%) self-assessments that were applicable to complying with acting on safety alerts declared compliance.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
76%	100%	91%	100%	94%	100%

Note: Self-assessments that selected commissioning as the type of healthcare provided were not applicable for this standard (1%).

- All the British Army regions, Defence Dental Services, and the three Joint Medical Command units declared they were compliant with acting on safety alerts.

This standard was assessed in 15 out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in upholding 13 out of the 15 units' (87%) declarations of compliance.

- This is a significant finding indicating an area of good practice.

Standard C01b	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Compliant	Compliant
Royal Navy primary care	Compliant	Compliant
Royal Navy headquarters	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
Army regional rehabilitation unit	Compliant	Not compliant
Army headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant
RAF primary care	Compliant	Compliant
RAF primary care	Compliant	Compliant
Joint primary care	Compliant	Compliant
Joint Medical Command	Compliant	Not compliant

Key evidence presented by the DMS units for compliance included the following:

- Policy, processes and systems for following patient safety notices and alerts from receipt to action.
- Named designated staff with clear lines of responsibility and accountability.
- Monitoring systems in place for ensuring compliance with policy, process and actions taken.

Standard C02 – safeguarding children

Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.

- 111 out of 153 (73%) self-assessments declared compliance with safeguarding children standards.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
66%	88%	70%	83%	68%	100%

- Declared compliance with safeguarding children standards was lower across the services compared to other standards:
  - Three British Army regions declared non-compliance with safeguarding children standards.
  - 17 Royal Navy units (34%) declared non-compliance with safeguarding children standards.
  - 13 Royal Air Force units (30%) declared non-compliance with safeguarding children standards.

This standard was assessed in 8 out of 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in five out of the eight (62%) units' declarations of compliance being overturned to non-compliance. One declared non-compliance and the assessment agreed with this. Therefore across the eight units there was a total of six out of eight (75%) assessed as non-compliant.

- This is a significant finding and the evidence used to declare compliance with this standard should be reviewed.

Standard C02	DMS unit declaration	Healthcare Commission assessment
Royal Navy Primary Care	Compliant	Not compliant
Army headquarters	Compliant	Compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Not compliant	Not compliant
RAF primary care	Compliant	Not compliant
RAF primary care	Compliant	Not compliant
RAF primary care	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Arrangements in place for safeguarding children supported by current policy and processes.
- Named designated safeguarding lead person with appropriate levels of training and experience.
- Up-to-date safeguarding training provided for all staff.
- Good links with civilian partner organisations.
- Criminal Records Bureau checks up to date for all staff with a programme of periodic revalidation.

Key reasons for non-compliance included the following:

- Staff unaware of safeguarding policy and processes.
- Lack of designated safeguarding lead person.
- Lack of systems of audit or periodic review of child safeguarding processes.
- Limited or no evidence of joint working with civilian partner agencies.
- Not all staff had current Criminal Records Bureau checks and no system for periodic updates.

Comments and issues:

- There was a lack of recognition, in some areas, that all those under 18 years old, including recruits, are defined as children under current legislation.
- Safeguarding issues identified during the review about clinical environment were addressed immediately by the DMS.

Standard C03 – NICE interventional procedures guidance

Healthcare organisations protect patients by following National Institute for Health and Clinical Excellence (NICE) interventional procedures guidance.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
1 unit	5 regions	1 unit	12 units	3 units	1 unit
100%	100%	100%	100%	67%	100%

Note: Standard only applicable to the self-assessments that selected Defence Dental Services, secondary care and the tactical medical wing as the type of healthcare they provide.

One out of the 22 healthcare services declared itself non-compliant with following NICE interventional procedures guidance.

This standard was not assessed on follow-up visits – assessed in self-declarations only.

Standard C04a – infection control

Healthcare organisations protect patients through systems that ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA).

- 106 out of 153 (69%) self-assessments declared compliance with infection control.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
48%	81%	77%	92%	84%	67%

- Over half of the Royal Navy units declared non-compliance with infection control.

This standard was assessed in 13 out of 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in five out of the 10 (50%) units' declarations of compliance being overturned to non-compliance. Three units declared non-compliance and the Healthcare Commission's assessment agreed with this. The total number of units that were non-compliant was therefore eight out of 13 (62%).

- This is a significant finding and the evidence used to declare compliance with this standard should be reviewed.

Standard C04a – Infection control systems	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Not compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Compliant
RAF Tactical Wing	Compliant	Compliant
RAF primary care	Not compliant	Not compliant
Dental services	Compliant	Compliant
Dental services	Compliant	Not compliant
Dental services	Compliant	Not compliant
Dental services	Compliant	Not compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Not compliant
Secondary care operations	Compliant	Compliant
Inpatient Rehabilitation Unit	Not compliant	Not compliant

Key evidence presented by the DMS units for compliance included the following:

- Clear infection control policy and associated processes in place readily available to all staff.
- Local and regional designated lead for infection control with clear roles and responsibilities.
- Competent infection control advice available to staff both locally and regionally.
- Monitoring of compliance with the infection control policy.
- Infection control training provided to all clinical staff with a programme of update training.
- Ongoing infection control environmental risk assessments undertaken with evidence of timely actions taken upon findings.
- Systematic infection control audits undertaken and reported through clinical governance arrangements with actions planned and taken upon findings in a timely fashion.

Key reasons for non-compliance included the following:

- Lack of awareness by staff of the infection control policies and practices.
- No infection control designated lead.
- Lack of competent infection control advisory sources.
- Insufficient provision of infection control training.
- Lack of monitoring for compliance with the infection control policy.
- Lack of systematic audit to inform improvements in policy and practice.

Comments and issues:

- There were repeated issues reported about the scope of external cleaning contracts being insufficient to ensure adequate environmental cleaning standards on a day-to-day basis.

Standard C04b – medical devices

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.

- 134 out of 144 (93%) self-assessments declared compliance with ensuring that all risks associated with the acquisition and use of medical devices are minimised.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
89%	100%	92%	100%	94%	100%

Note: Self-assessments that selected commissioning and mental health as the types of healthcare provided were not applicable for this standard (6%).

- All the British Army regions, Defence Dental Services, and the three Joint Medical Command units declared they were compliant with ensuring that all risks associated with the acquisition and use of medical devices are minimised.

This standard was assessed in six out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment agreed with all the units' declaration of compliance.
- This is a significant finding and indicates an area of good practice.

Key evidence presented by the DMS units for compliance included the following:

- Clearly stated policy and processes in place covering all of the activities required to achieve optimum equipment readiness.
- Clear lines of named accountability and responsibility for the procurement and optimum integrity of all equipment requirements.
- Comprehensive competency-based training provided to ensure the highest proficiency in using and handing all equipment.
- Thorough training records maintained for all staff.

Comments and issues:

- Complete compliance was achieved by all units assessed to a high standard.

Standard C04b	DMS unit declaration	Healthcare Commission assessment
Royal Navy regional rehabilitation unit	Compliant	Compliant
Army regional rehabilitation unit	Compliant	Compliant
Army regional rehabilitation unit	Compliant	Compliant
RAF regional rehabilitation unit	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Secondary care operations	Compliant	Compliant

Standard C04c – decontamination

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.

- 133 out of 153 (87%) self-assessments declared compliance with ensuring reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
84%	88%	93%	100%	79%	67%

- Declared compliance ranged from 67% of Joint Medical Commands to 100% of Defence Dental Services.

This standard was assessed in five out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in three out of the five (60%) units' declarations of compliance being overturned to non-compliance.
- This is a significant finding for the dental services and the evidence used to declare compliance with this standard should be reviewed.

Key evidence presented by the DMS units for compliance included the following:

- Designated accountable and responsible person in place for decontamination with appropriate training and experience.
- Competency-based training available to all staff reflecting current national guidance.
- Clear policies and processes for decontamination with strict adherence by all relevant staff.

Key reasons for non-compliance included the following:

- Lack of designated leadership and accountability for guiding decontamination activities in line with national guidance and local policy.
- Lack of local monitoring for compliance against decontamination policies.
- Lack of systematic audit mechanisms or linking arrangements in place to ensure that timely actions are planned and taken upon findings and disseminated to all relevant staff.
- Inadequate provision and routine use of fit-for-purpose protective equipment and clothing.

Standard C04c	DMS unit declaration	Healthcare Commission assessment
Dental services	Compliant	Compliant
Dental services	Compliant	Not compliant
Dental services	Compliant	Not compliant
Dental services	Compliant	Not compliant
Royal Navy primary care	Compliant	Compliant

Standard C04d – medicines management

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely.

- 112 out of 136 (82%) self-assessments declared compliance with ensuring that medicines are handled safely and securely.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
76%	86%	84%	100%	94%	0%

Note: Self-assessments that selected commissioning, headquarters and mental health as the types of healthcare provided were not applicable for this standard (11%).

This standard was assessed in 13 out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in seven out of the 13 (54%) units' declarations of compliance being overturned to non-compliance.
- This is a significant finding and the evidence used to declare compliance with this standard should be reviewed.

Key evidence presented by the DMS units for compliance included the following:

- Clear lines of accountability covering all medicines management activities.
- Reporting of incidents and near misses involving medicines with timely actions planned and taken upon findings.
- Monitoring against the medicines management policy with actions planned and taken in a timely fashion upon findings.
- Systematic audit mechanisms in place that feed into clinical governance arrangements so that actions can be planned and taken in a timely fashion and disseminated to all relevant staff.
- Established drugs formulary used to inform stock control and prescribing activities.
- Systems in place for procuring medicines for exceptional prescribing.
- Competency-based medicines management training with programmed updates for relevant staff.
- Appropriate management of controlled drugs activities under the guidance of a designated accountable officer.

Standard C04d	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
RAF primary care	Compliant	Not compliant
RAF Tactical Medical Wing	Compliant	Compliant
Secondary care permanent base	Compliant	Not compliant
Secondary care operations	Compliant	Compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Not compliant

Key reasons for non-compliance included the following:

- Lack of monitoring against the medicines management policy to ensure consistencies in practice and safety.
- Lack of a systematic approach to local and regional audits of all medicine management activities and linking appropriate changes in practice requirements through clinical governance arrangements.
- Insufficient competency-based medicines management training opportunities for all relevant staff.
- Inadequate systems in place for checking for expired medications.
- Inconsistencies and under-reporting of incidents and near misses involving medicines. This can compromise the potential for learning and the accuracy of counting and aggregating, and analysing the emerging patterns and trend analysis that should be used to inform evidence-based changes in policy and practice.
- Service specific or Joint Service Formulary not routinely used to inform stock control or prescribing activities.

Comments and issues:

- Comparatively high levels of assessed non-compliance with all elements for this standard across all three Services would indicate the need for a review of all medicines management policies, processes and practices to ensure the safety of patients and staff.

Standard C04e – waste management

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

- 128 out of 153 (84%) self-assessments declared compliance with ensuring that waste management systems were in place.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
74%	88%	88%	100%	84%	67%

This standard was assessed in five out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in three out of the five (60%) units' declarations of compliance being overturned to non-compliance.
- This is a significant finding and the evidence used to declare compliance with this standard should be reviewed.

Key evidence presented by the DMS units for compliance included the following:

- Periodic audit systems in place.
- Good levels of training provided for some clinical staff.

Key reasons for non-compliance included the following:

- Insufficient local monitoring for compliance with the clinical waste policy.
- Insufficient local audit mechanisms in place to ensure that clinical waste activities are linked to clinical governance arrangements.
- Insufficient arrangements in place to ensure that appropriate actions are planned and taken in a timely fashion as a result of audit findings.
- Inappropriate segregation of clinical and general waste.
- Insufficient training provided to all staff covering all clinical waste activities.
- Serious clinical waste disposal concerns not cited on the risk register.

Standard C04e – Waste management systems	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Not compliant	Not compliant
Royal Navy headquarters	Compliant	Compliant
Secondary care operations	Compliant	Not compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Not compliant

Percentage of declared compliance with the safety standards overall						
	Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
Incident reporting	88%	96%	91%	100%	94%	100%
Acting on safety alerts	76%	100%	91%	100%	94%	100%
Safeguarding children	66%	88%	70%	83%	68%	100%
Infection control	48%	81%	77%	92%	84%	67%
Medical devices	89%	100%	92%	100%	94%	100%
Decontamination	84%	88%	93%	100%	79%	67%
Medicines management	76%	86%	84%	100%	94%	0%
Waste management	74%	88%	88%	100%	84%	67%

Clinical and cost effectiveness

Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes.

Standard C05a – NICE technology appraisals

Healthcare organisations ensure that they conform to National Institute for Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

- 109 out of 153 (79%) self-assessments declared compliance with taking into account nationally agreed guidance when planning and delivering treatment and care.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
50%	77%	77%	100%	84%	100%

- Half of Royal Navy units declared non-compliance with taking account of nationally agreed guidance when planning and delivering treatment and care.

This standard was assessed in seven out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in one out of the five (60%) units' declarations of compliance being overturned to non-compliance. Assessment agreed with two declarations of non-compliance. The total number of units assessed as non-compliant was therefore three out of seven (43%).

Standard C05a – NICE technology appraisals	DMS unit declaration	Healthcare Commission assessment
Royal Navy Dept of community mental health	Not compliant	Not compliant
Army Dept of community mental health	Not compliant	Not compliant
RAF Dept of community mental health	Compliant	Compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Joint Medical Command headquarters	Compliant	Not compliant

Key evidence presented by the DMS units for compliance included the following:

- Mechanisms for deciding whether a NICE technology appraisal (TA) is relevant to its services and, where appropriate, for making an assessment of current local practice against the appraisal.
- Policy – Department of Community Mental Health Standing Orders via Chain of Command, Surgeon General Policy Letters
- Documented process for implementation.
- Plans for the implementation of each relevant TA.
- Relevant staff/teams notified about the actions required to implement the TA.
- Monthly business and team meetings.
- Examples given of implementation of technology appraisals.
- Audit activity and recent TAs affecting annual audit programme.
- Quarterly reports.
- Monitoring through appraisals and one-to-one clinical supervision.

Key reasons for non-compliance included the following:

- No evidence to demonstrate monitoring of compliance with NICE technology appraisals.
- No formal audit or regional/national request to undertake audit of compliance with NICE technology appraisals.
- No systems to ensure that staff had read NICE guidance and technology appraisals.

Comments and issues:

- Some confusion regarding the difference between NICE guidance and NICE technology appraisals.

Standard C05b – clinical supervision

Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership.

- 130 out of 153 (85%) self-assessments declared compliance with ensuring that clinical care and treatment are carried out under supervision and leadership.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
76%	81%	88%	100%	89%	67%

- All Defence Dental Services declared compliance with ensuring that clinical care and treatment are carried out under supervision and leadership.

This standard was assessed in 17 out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in five out of the 15 (33%) units' declarations of compliance being overturned to non-compliance. Two units declared non-compliance which was agreed on assessment. The total number of units that were non-compliant was seven out of 17 (41%).

Standard C05b	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Compliant	Not compliant
Royal Navy primary care	Compliant	Compliant
Royal Navy primary care	Compliant	Compliant
Royal Navy primary care	Compliant	Compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
RAF primary care	Compliant	Compliant
RAF primary care	Compliant	Compliant
RAF primary care	Not compliant	Not compliant
Dental services	Compliant	Not compliant
Dental services	Compliant	Compliant
Army headquarters	Compliant	Compliant
Dental services headquarters	Compliant	Compliant
Army regional rehab unit	Compliant	Not compliant
Royal Navy headquarters	Not compliant	Not compliant
Secondary care operations	Compliant	Compliant
Tactical Medical Wing	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Clinical supervision policy and clear supervisory arrangements and frameworks in place.
- Supervisory structures and systems and mechanisms for review and feedback.
- Actions following feedback.
- GP training practices with robust clinical supervision for trainees.
- Job descriptions including clinical supervision responsibilities.
- Protected time for training (trade training).
- Systems in place to ensure continuity of professional registration.

Key reasons for non-compliance included the following:

- Lack of understanding of what constitutes 'clinical' supervision.
- Lack of clinical supervision framework.
- Not all clinical staff receiving supervision.
- There were no 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.

Standard C05c – continuous learning

Healthcare organisations ensure that clinicians (professionally qualified staff providing clinical care or defence medical services to patients) continuously update skills and techniques relevant to their clinical work.

- 133 out of 153 (87%) self-assessments declared compliance with ensuring that clinicians continuously update skills and techniques relevant to their clinical work.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
74%	92%	91%	92%	100%	100%

- All headquarters and joint medical commands declared compliance with ensuring that clinicians continuously update skills and techniques relevant to their clinical work.

This standard was assessed in 15 out of 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment agreed with 14 out of the 15 units' (93%) declaration of compliance.

- This is a significant finding and indicates an area of good practice.

Standard C05c	DMS unit declaration	Healthcare Commission assessment
Army primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
RAF primary care	Compliant	Compliant
RAF primary care	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Secondary care permanent base	Compliant	Not compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Compliant
Dental services	Compliant	Compliant
Dental services	Compliant	Compliant
Army headquarters	Compliant	Compliant
Joint medical command headquarters	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Embedded formal appraisal systems linked to training programmes.
- Funding available for training.
- Developmental training and induction programmes.
- Audits in place, evidence of shared learning, feedback and evaluation provided.
- Training needs or gap analysis undertaken.

Key reasons for non-compliance included the following:

- Unclear as to percentage of staff who had received appraisals and whether these were documented.
- Shortages of staff impacted on time for staff to be released for training.
- Inequalities in clinical training available and funding for civilian staff.
- Peer appraisal not well set up.

Comments:

- Examples of joint working with NHS partners to update clinical skills.

Standard C05d – participating in clinical audit

Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.

- 120 out of 153 (78%) self-assessments declared compliance with participating in clinical audit.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
64%	73%	88%	100%	84%	100%

- All Defence Dental Services and the Joint Medical Commands declared compliance with participating in clinical audit.

This standard was assessed in 13 out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in two out of the 13 (15%) units' declarations of compliance being overturned to non-compliance and one unit's declaration of non-compliance being overturned to be compliant.

- This is a significant finding and indicates an area of good practice.

Standard C05d	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Compliant	Compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
RAF primary care	Compliant	Compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Compliant
RAF regional rehab unit	Not compliant	Compliant
Royal Navy regional rehab unit	Compliant	Compliant
Army regional rehab unit	Compliant	Compliant
RAF headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant
Secondary care operations	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Clinical audit programmes with subsequent action plans.
- Patient feedback.
- Staff able to cite examples of practice change as a result of audit and feedback.
- Clinical audit featured as a standing agenda item in meetings.
- Staff training in audit.
- Designated audit leads.
- Contributions to national data collections.

Key reasons for non-compliance included the following:

- Incomplete audit plan.
- Limited evidence to demonstrate learning from audit activity to improve services.
- Limited evidence to demonstrate the effectiveness of clinical services through evaluation, audit or research.

Standard C06 – partnership working

Healthcare organisations cooperate with each other and social care organisations to ensure those patients' individual needs are properly managed and met.

- 142 out of 153 (93%) self-assessments declared compliance with partnership working.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
88%	92%	93%	92%	95%	100%

- Nine self-assessments declared non-compliance with partnership working.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Although this standard was not assessed in follow-up visits, a number of effective partnership arrangements were noted during the review. These included the DMS working with local NHS primary care trusts in providing joint training opportunities to develop clinical skills and health promotion activities. The DMS also has an effective working relationship with Guy's and St Thomas' NHS Foundation Trust which commissions secondary care in the German healthcare system on behalf of the DMS.

Percentage of declared compliance by the DMS with standards in clinical and cost effectiveness						
	Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
NICE technology appraisals	50%	77%	77%	100%	84%	100%
Clinical supervision	76%	81%	88%	100%	89%	67%
Continuous learning	74%	92%	91%	92%	100%	100%
Participating in clinical audit	64%	73%	88%	100%	84%	100%
Partnership working	88%	92%	93%	92%	95%	100%

Governance

Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.

Standard C07ac – clinical and corporate governance

Healthcare organisations apply the principles of sound clinical and corporate governance and undertake systematic risk assessment and risk management.

- 139 out of 153 (91%) self-assessments declared compliance with applying the principles of sound clinical and corporate governance and undertake systematic risk assessment and risk management.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
88%	96%	84%	100%	100%	100%

- All Defence Dental Services, headquarters and Joint Medical Commands declared compliance with applying the principles of sound clinical and corporate governance and undertaking systematic risk assessment and risk management.

This standard was assessed in 18 out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in one out of the 18 (5%) units' declarations of compliance being overturned to non-compliance and one out of the 18 (5%) unit's declarations of not compliant being overturned to compliant.

Standard C07ac	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Not compliant	Not compliant
Royal Navy primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
Army headquarters	Compliant	Compliant
RAF primary care	Compliant	Not compliant
RAF primary care	Not compliant	Not compliant
Dental services headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant
RAF headquarters	Not compliant	Compliant
Army regional rehab unit	Compliant	Compliant
Inpatient rehab unit	Compliant	Compliant
RAF Tactical Medical Wing	Compliant	Compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Secondary care operations	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Allocated lead(s) for clinical governance.
- Clinical governance plans in place – regular monitoring and updating.
- Clinical governance boards/committees/ meetings in place.
- Regular clinical governance reporting.
- Processes in place – for example, audit programmes, risk registers and risk incident reporting, patient satisfaction and feedback systems, and training.
- Clear clinical governance reporting structures and specific responsibilities for individuals in lead roles.
- Staff awareness of responsibilities for clinical governance.
- Evidence of improvements from risk assessment and management and incident reporting.

Key reasons for non-compliance included the following:

- Clinical governance plans embryonic – being planned but not yet implemented.
- Systems in place for implementing clinical governance – not yet actioned.
- Little evidence of risk assessment, reporting or monitoring.

Standard C07b – openness and honesty

Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.

- 143 out of 153 (93%) self-assessments declared compliance with actively supporting all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
88%	96%	91%	100%	100%	100%

- All Defence Dental Services, headquarters and Joint Medical Commands declared compliance with actively supporting all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Standard C07e – promoting equality

Healthcare organisations challenge discrimination, promote equality and respect human rights.

- 144 out of 153 (94%) self-assessments declared compliance with challenging discrimination, promoting equality and respecting human rights.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
92%	92%	93%	92%	100%	100%

- Nine self-assessments (6%) declared non-compliance with promoting equality. All Joint Medical Commands and headquarters declared compliance with challenging discrimination, promoting equality and respecting human rights.

This standard was assessed in nine out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in one out of the nine (11%) units' declarations of compliance being overturned to non-compliance and one out of the nine (11%) units' declarations of not compliant being overturned to compliant.

- This is a significant finding and indicates an area of good practice.

Standard C07e	DMS unit declaration	Healthcare Commission assessment
RAF primary care	Compliant	Compliant
Army primary care	Compliant	Not compliant
Royal Navy Dept of Community Mental Health	Not compliant	Compliant
Army Dept of Community Mental Health	Compliant	Compliant
RAF Dept of Community Mental Health	Compliant	Compliant
Royal Navy headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant
RAF headquarters	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Awareness of equality and diversity scheme and policies.
- Information given to staff which included standards for equality and diversity.
- Specific equality and diversity officers and advisors.
- Examples given of actions taken to promote equality.
- Examples given of policy changes to promote equality.
- Awareness of how to report issues relating to equality and diversity.
- Some statistical reporting.

Key reasons for non-compliance included the following:

- Low awareness of equality and diversity policies and issues.
- No equality and diversity monitoring in place.

Comments and issues:

- Some clinical facilities were not DDA compliant (Disability Discrimination Act – legislation to promote civil rights for disabled people and protect disabled people from discrimination).
- Statistical reporting tended to be on age, gender and rank – little evidence of statistics on ethnicity and religion.

Standard C07f – existing performance requirements

Healthcare organisations meet the existing performance requirements as set out in the Defence Health Programme and complementary single Service plans.

- 119 out of 153 (78%) self-assessments declared compliance with meeting the existing performance requirements as set out in the Defence Health Programme and complementary single Service plans.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
80%	81%	86%	33%	94%	33%

- Four out of 12 Defence Dental Services declared compliance with meeting the existing performance requirements as set out in the Defence Health Programme and complementary single Service plans.

- A fifth of Royal Navy units declared non-compliance with meeting the existing performance requirements as set out in the Defence Health Programme and complementary single Service plans. One out of three declarations from Joint Medical Command declared compliance with meeting existing performance requirements.

This standard was not assessed on follow-up visits – it was only assessed in self-declarations.

Standard C08a – whistle blowing

Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.

- 130 out of 149 (87%) self-assessments declared compliance with supporting their staff through having access to processes which permit them to raise concerns.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
74%	96%	91%	100%	100%	100%

Note: Self-assessments that selected commissioning as the type of healthcare provided were not applicable for this standard (1%).

- A quarter of the Royal Navy units declared non-compliance with supporting their staff through having access to processes which permit them to raise concerns.

This standard was assessed in nine out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in one out of the nine (11%) units' declarations of compliance being overturned to non-compliance and one out of the nine (11%) units' declarations of not compliant being overturned to compliant.

Standard C08a	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Compliant	Compliant
Royal Navy primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Compliant
RAF primary care	Not compliant	Compliant
Joint primary care	Compliant	Compliant
Joint medical command headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Staff awareness of relevant policies and processes.
- Staff stated confidence in raising concerns.
- Examples of change resulting from reporting concerns.
- Examples of reported concerns being well managed.
- Army complaints commissioner.

Key reasons for non-compliance included the following:

- Lack of awareness of relevant policy and reporting processes.
- Stated under-reporting of concerns.

Comments and issues:

- 'Rank' was reported to be an actual or potential barrier to reporting concerns.

Standard C08b – personal development programmes

Healthcare organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.

- 131 out of 149 (88%) self-assessments declared compliance with having personal development programmes.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
78%	84%	95%	92%	100%	100%

Note: Self-assessments that selected commissioning as the type of healthcare provided were not applicable for this standard (1%).

- All headquarters and Joint Medical Command self-assessments declared compliance with having personal development programmes.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Standard C09 – records management

Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

- 137 out of 153 (90%) self-assessments declared compliance with having an effective records management system.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
80%	92%	93%	100%	95%	100%

- A fifth of Royal Navy units declared non-compliance with having an effective records management system.

This standard was assessed in 15 out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in nine out of the 15 (64%) units' declarations of compliance being overturned to non-compliance.

- This is a significant finding and evidence used to declare compliance with this standard should be reviewed.

Standard C09	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Not compliant
RAF primary care	Compliant	Not compliant
RAF primary care	Compliant	Not compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Compliant
Defence Dental Services	Compliant	Not compliant
Secondary care operations	Compliant	Not compliant
Secondary care operations	Compliant	Not compliant
Secondary care operations	Compliant	Not compliant
Royal Navy regional rehab unit	Compliant	Not compliant
Army regional rehab unit	Compliant	Not compliant
RAF regional rehab unit	Not compliant	Not compliant
Army headquarters	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Records management policy in place – staff aware and following policy.
- Lead for records management.
- Information for patients on access to records and data protection – for example, in patient information leaflets.
- Training on records management and information governance.
- Caldicott Guardian identified (Caldicott Guardians are senior members of staff who have responsibility for protecting the confidentiality of patients' information and enabling appropriate information sharing).
- Audit of records undertaken and subsequent actions.

Key reasons for non-compliance included the following:

- No Caldicott Guardian identified.
- No records management or information governance training.
- No clear systems in place for disposal of records.
- No awareness of records management policies.
- Patient information potentially accessible to unauthorised staff – breaches of information confidentiality security, for example, notes not being stored securely.

Comments and issues:

- Some units providing secondary care felt unable to provide evidence against element 2 – 'records are completed appropriately and are available when required and disposed of in line with single Service policies' – as in barracks and not on operations. As all elements are required to be met the overall assessment was therefore not compliant.
- Some difficulties reported with the new electronic patient record system, the Defence Management Information Capability Programme, but generally positive about the roll-out of programme.

Standard C10a – employment checks

Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.

- 136 out of 153 (89%) self-assessments declared compliance with employment checks.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
82%	85%	95%	83%	95%	100%

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Standard C10b – professional codes of practice

Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice.

- 141 out of 148 (95%) self-assessments declared compliance with the requirement that all employed professionals abide by relevant published codes of professional practice.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
92%	92%	98%	92%	100%	100%

Note: Self-assessments that selected commissioning as the type of healthcare provided were not applicable for this standard (1%).

- Seven (5%) self-assessments declared non-compliance with the requirement that all employed professionals abide by relevant published codes of professional practice.

This standard was not assessed on follow-up visits – it was only assessed in self-declarations.

Standard C11a – provision of training

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
70%	95%	95%	92%	100%	100%

- 36 self-assessments (24%) declared that this standard was not applicable to their service or not applicable to their type of healthcare provided.

- Of the 117 self-assessments that declared it was applicable, 103 (88%) self-assessments declared they were compliant and 14 (12%) assessments declared they were non-compliant.

This standard was assessed in five out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in one out of the five (20%) units' declarations of non-compliance being overturned to compliance.

Standard C11a	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Not compliant	Compliant
Army headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant
RAF headquarters	Compliant	Compliant
Inpatient rehab unit	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Clear recruitment processes in place.
- Commissioning policy in place for recruitment through agencies.
- Selected and limited recruitment agencies used.
- Recruitment and training records in place.
- Registration and qualifications checked by agency and rechecked locally.

Comments and issues:

- Some concerns were raised around the number of agency staff used. This was considered a risk and on risk register – mitigation actions included using limited number of agencies.
- Reasons given for the use of agency staff included permanent staff being deployed.

Standard C11b – participation in mandatory training programmes

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes.

- 118 out of 141 (84%) self-assessments declared compliance with participation in mandatory training programmes.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
73%	95%	83%	92%	88%	100%

Note: Self-assessments that selected commissioning and headquarters as the types of healthcare provided were not applicable for this standard (8%).

This standard was assessed in seven out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in one out of the seven (14%) units' declarations of compliance being overturned to non-compliance.

Key evidence presented by the DMS units for compliance included the following:

- Induction programmes in place – areas included infection control, patient handling, information management, equipment care and clinically focused areas such as basic life support.
- Training records held and attendance monitoring in place.
- Responsibilities for training in job descriptions.

Key reasons for non-compliance included the following:

- High staff turnover and shortages of staff causing difficulty to release staff for training cited as reasons for low mandatory training uptake.
- No monitoring of attendance in place.

Standard C11b	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Compliant	Compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Not compliant
Inpatient rehab unit	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Secondary care operations	Compliant	Compliant
Secondary care operations	Compliant	Compliant

Standard C11c – professional development

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives.

- 128 out of 149 (86%) self-assessments declared compliance with professional development with staff.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
76%	84%	95%	100%	89%	67%

Note: Self-assessments that selected commissioning as the type of healthcare provided were not applicable for this standard (1%).

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Standard C12 – research governance

Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.

- 42 out of 48 (88%) self-assessments declared compliance with having systems in place to ensure that the principles and requirements of the research governance framework are consistently applied. 105 (69%) self-assessments declared this standard as not applicable.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Percentage of declared compliance by the DMS with standards on governance						
	Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
Clinical and corporate governance	88%	96%	84%	100%	100%	100%
Openness and honesty	88%	96%	91%	100%	100%	100%
Promoting equality	92%	92%	93%	92%	100%	100%
Existing performance requirements	80%	81%	86%	33%	94%	33%
Whistle blowing	74%	96%	91%	100%	100%	100%
Personal development programmes	78%	84%	95%	92%	100%	100%
Records management	80%	92%	93%	100%	95%	100%
Employment checks	82%	85%	95%	83%	95%	100%
Professional codes of practice	92%	92%	98%	92%	100%	100%
Provision of training	70%	95%	95%	92%	100%	100%
Participation in mandatory training programmes	73%	95%	83%	92%	88%	100%
Professional development	76%	84%	95%	100%	89%	67%

Patient focus

Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.

Standard C13a – dignity and respect

Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.

- 147 out of 153 (96%) self-assessments declared compliance with ensuring that staff treat patients, their relatives and carers with dignity and respect.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
95%	100%	95%	100%	100%	100%

- Declaring compliance with ensuring that staff treat patients, their relatives and carers with dignity and respect was high across all the services. Four out of the six services all declared 100% compliance.

This standard was assessed in 9 out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in two out of the nine (22%) units' declarations of compliance being overturned to non-compliance.

Standard C13a	DMS unit declaration	Healthcare Commission assessment
Army primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Not compliant
Capital Ship	Compliant	Compliant
Regional rehab unit	Compliant	Not compliant
Regional rehab unit	Compliant	Compliant
Regional rehab unit	Compliant	Compliant
Regional rehab unit	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Clear signage.
- Chaperone policy.
- Documented codes of conduct.
- Suggestion boxes, patient satisfaction questionnaires.
- Induction training included expected standards of behaviour.
- Staff training.
- Complaints monitoring.
- Carers' group meetings.
- Suitably designed environments.

Key reasons for non-compliance included the following:

- Concerns raised from patient feedback relating to the absence of separate dedicated changing facilities had not been adequately addressed.
- Patient dignity and respect was not being preserved during confidential discussions about individual examinations and consultations.
- The sharing of changing facilities with visiting school children presented a potential safeguarding risk that had not been fully recognised or addressed appropriately (subsequently addressed by the DMS when raised by the Healthcare Commission).
- Patient privacy, dignity and confidentiality were compromised by the layout of rooms in some facilities.

Comments and issues:

- A number of poorly designed and poorly maintained buildings often compromised this standard.

Standard C13b – consent

Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information.

- 139 out of 144 (97%) self-assessments declared compliance with ensuring that appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
96%	100%	90%	100%	100%	100%

Note: Self-assessments that selected headquarters as the type of healthcare provided were not applicable for this standard (6%).

- Declaring compliance with ensuring that appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information was high across all the services. Ninety-seven per cent declared compliance was the highest percentage of compliance across all the standards assessed.

This standard was assessed in three out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment agreed with all the units' declaration of compliance.
- This is a significant finding and indicates an area of good practice in departments of community mental health.

Key evidence presented by the DMS units for compliance included the following:

- Staff awareness of the need for consent to be obtained and of consent policies and Surgeon General Policy Letters.
- Standing orders being followed.
- Patient information available and given to patients.
- Consent records.

Standard C13b	DMS unit declaration	Healthcare Commission assessment
Royal Navy Dept community mental health	Compliant	Compliant
Army Dept community mental health	Compliant	Compliant
RAF Dept community mental health	Compliant	Compliant

Standard C13c – handling confidential information

Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary.

- 133 out 153 (87%) self-assessments declared compliance with ensuring that staff treat patient information confidentially, except where authorised by legislation to the contrary.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
82%	96%	79%	100%	100%	67%

This standard was assessed in three out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in one out of the three (33%) units' declaration of compliant being overturned to not compliant.

Key evidence presented by the DMS units for compliance included the following:

- Caldicott Guardians in place.
- Standard operating procedures in place and followed.
- Secure management of records.
- Staff awareness.
- Training records of staff attending relevant information management programmes.

Key reasons for non-compliance included the following:

- No nominated Caldicott Guardian.

Standard C13c	DMS unit declaration	Healthcare Commission assessment
Joint primary care	Compliant	Not compliant
RAF primary care	Compliant	Compliant
Regional rehab unit	Compliant	Compliant

Standard C14a – complaints system

Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services.

- 145 out of 153 (95%) self-assessments declared compliance with ensuring that complaints systems are in place.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
90%	100%	98%	92%	95%	100%

- All the Army regions that submitted self-assessments declared that they had systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services.

This standard was assessed in 11 out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in five out of the 11 (45%) units' declarations of compliance being overturned to non-compliance.

Standard C14a	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Compliant	Not compliant
Royal Navy primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
RAF primary care	Compliant	Compliant
RAF primary care	Compliant	Not compliant
Dental services	Compliant	Not compliant
Dental services	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Complaints policies in place and staff aware of these.
- Patient information in various formats relevant to need patient population.
- Staff training on management of complaints.
- Complaints audit and evaluation and complaints database.
- Complaints discussed as standing agenda items at meetings.
- Staff able to report changes to practice as a result of complaints.
- Advocacy services contacted and available as required.

Key reasons for non-compliance included the following:

- Staff were not aware of any complaints policy or process or the arrangements for handling or investigating formal complaints.
- Little evidence of ongoing monitoring or audit of complaints or issues raised.
- Little evidence of information for patients on how to make a complaint, raise issues or give positive feedback about the services or facilities.
- No independent advocacy arrangements in place to assist patients, carers and relatives to access the complaints procedure.
- Verbal complaints were not generally recorded so that recurring issues aggregation and trend analysis were not completed.
- Information in different languages was not available in places where many patients', relatives' and carers' first language was not English.
- Complaints training not provided to staff at any level.

Standard C14b – discrimination against complainants

Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made.

- 142 out of 153 (93%) declared compliance with having systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
84%	96%	95%	100%	100%	100%

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Standard C14c – acting on complaints

Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

- 140 out of 153 (92%) declared compliance with acting on complaints.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
90%	88%	93%	100%	95%	67%

This standard was assessed in eight out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in one out of the eight (13%) units' declarations of compliance being overturned to non-compliance and one out of the eight (13%) units' declarations of not compliant being overturned to compliant.

Standard C14c	DMS unit declaration	Healthcare Commission assessment
Royal Navy Dept community mental health	Compliant	Compliant
Army Dept community mental health	Not compliant	Compliant
RAF Dept community mental health	Compliant	Compliant
Army headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant
Army headquarters	Compliant	Compliant
Dental services headquarters	Compliant	Not compliant
RAF headquarters	Compliant	Compliant

Key evidence presented by the DMS units for compliance included the following:

- Complaints policies known and in place.
- Designated lead personnel for complaints.
- Timescales for responses met.
- Themed analysis of complaints.
- Examples of learning from complaints.
- Complaints included on risk registers.
- Staff able to give examples of changes to practice as a consequence of complaints.

Key reasons for non-compliance included the following:

- Headquarters not always informed of complaints.

Comments and issues:

- There was variation between different headquarters' role and function in the management of complaints.

Standard C15a – choice of food

Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet.

- 35 DMS units declared this standard as applicable.
- 32 self-assessments declared compliance (91%).
- Three self-assessments (9%) (two Army primary care, one Royal Navy primary care) declared non-compliance.
- Standard not applicable to 118 self-assessments.
- Of the three self-assessments that declared non-compliance, commentary included that they declared non-compliant due to ongoing surveys in each facility highlighting issues with dietary services, no water provision and difficulties for patients who require a vegetarian or soft diet. It was stated that these issues had been raised through the chain of command.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Standard C15b – meeting patients' dietary requirements

Where food is provided, healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.

- 35 Defence Medical Services units declared this standard as applicable.
- 31 units declared compliance (89%).
- 4 units (11%) (one Army primary care service, one Royal Navy primary care service, one Royal Air Force primary care service, and one HQ primary care) declared non-compliance.
- Standard not applicable to 118 self-assessments.
- Of the four self-assessments that declared non-compliance, commentary included that they declared non-compliant because:
  - There was no provision to supply food at a unit due to the pay as you dine system, but fluids were offered as required.
  - There was no water provision facilities for patient use.
  - There were no arrangements for 24-hour food provision.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Standard C16 – information for patients

Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care.

- 123 out of 143 (86%) self-assessments declared compliance with making information available to patients.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
71%	100%	81%	100%	100%	100%

Note: Self-assessments that selected headquarters as the type of healthcare provided were not applicable for this standard (6%).

- All self-assessments from the British Army, Defence Dental Services, headquarters and Joint Medical Commands declared compliance with making information available to patients.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Percentage of declared compliance by the DMS with standards on patient focus						
	Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
Dignity and respect	95%	100%	95%	100%	100%	100%
Consent	96%	100%	90%	100%	100%	100%
Handling confidential information	82%	96%	79%	100%	100%	67%
Complaints system	90%	100%	98%	92%	95%	100%
Discrimination against complainants	84%	96%	95%	100%	100%	100%
Acting on complaints	90%	88%	93%	100%	95%	67%
Information for patients	71%	100%	81%	100%	100%	100%

Accessible and responsive care

Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway.

Standard C17 – listening to views of patients

The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

- 145 out of 153 (95%) self-assessments declared compliance with listening to views of patients, carers and others.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
92%	92%	95%	100%	100%	100%

- Nearly all self-assessments declared compliance with listening to views of patients, their carers and others.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Standard C18 – access to services

Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

- 132 out of 153 (86%) self-assessments declared compliance with enabling all members of the population to access services equally and offer choice in access to services and treatment equitably.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
82%	85%	86%	100%	89%	100%

- Compared with the two other standards in the patient focus domain, declarations of compliance with enabling all members of the population to access services equally and offer choice in access to services and treatment equitably was lower.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Standard C19 – access in an emergency

Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.

- 145 out of 153 (95%) self-assessments declared compliance with ensuring that patients with emergency health needs are able to access care promptly and within agreed timescales, and all patients are able to access services within national expectations on access to services.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
90%	96%	95%	100%	100%	100%

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Percentage of declared compliance by the DMS with standards for accessible and responsive care						
	Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
Listening to views of patients	92%	92%	95%	100%	100%	100%
Access to services	82%	85%	86%	100%	89%	100%
Access in an emergency	90%	96%	95%	100%	100%	100%

Care environment and amenities

Care is provided in environments that promote patient and staff wellbeing and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

Core standard 20a – safe and secure environment

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation.

- 135 out of 148 (91%) self-assessments declared compliance with providing effective care in a safe and secure environment.(This standard was applicable to all types of healthcare service but five units did not declare).

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
83%	92%	98%	100%	95%	67%

- Declared compliance on providing effective care in a safe and secure environment was lower across all the services compared with declared compliance on other standards. It ranged from 67% of the Joint Medical Commands to 100% of Defence Dental Services.

This standard was assessed in **all** clinical units (except headquarters) on follow-up visits by a review assessment team using a specifically designed observation tool which looked at the facilities and clinical environment.

Key evidence presented by the DMS units for compliance included the following:

- Relevant protocols in place and staff aware of contents.
- Designated lead for risk management.
- Fire safety training.
- Fire fighting equipment checks.
- Risk register regularly updated.
- Health and safety training.

Core standard 20b – private and confidential environment

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.

- 122 out of 153 (80%) self-assessments declared compliance with providing effective care in a safe and secure environment. Notably a fifth of self-assessments declared non-compliance.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
76%	69%	86%	83%	89%	67%

- Approximately a quarter of Royal Navy units and a third of British Army regions declared non-compliance with providing effective care in a safe and secure environment.

This standard was assessed in all clinical units (except headquarters) on follow-up visits by a review assessment team using a specifically designed observation tool which looked at the facilities and clinical environment.

Key evidence presented by the DMS units for compliance included the following:

- Well designed waiting and reception areas.
- Individual consulting rooms with lockable doors and appropriate signage.
- Single sex washroom and toilet facilities.
- Single sex bedding down facilities where appropriate.
- Designated areas for audiometry, ECG and optometry.
- Health and safety audits.
- Quiet spaces available for confidential conversations.
- Chaperone policy.

Key reasons for non-compliance included the following:

- Poor layout, cramped reception/waiting areas, poorly sited pharmacy hatches.
- Location of treatment and consultation facilities did not promote confidentiality and privacy.

Comments and issues:

- In some units, risk assessments had been undertaken with action plans to redesign and improve the environment in terms of privacy and confidentiality.

Standard C21 – environment promotes effective care

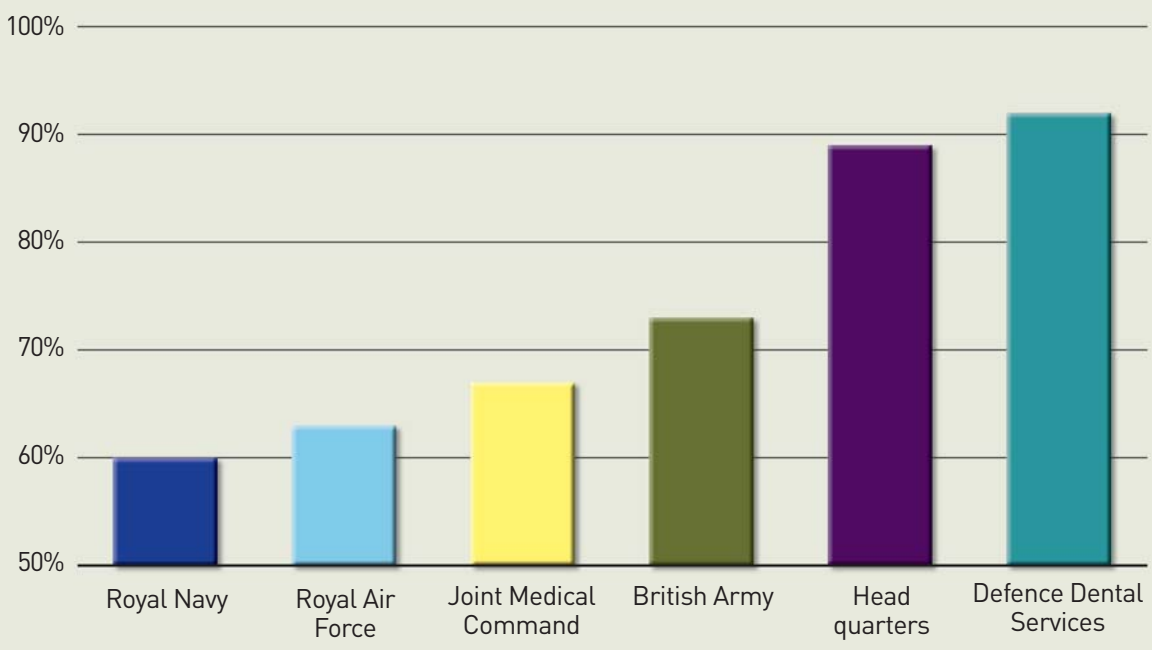
Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

- 105 out of 153 (69%) self-assessments declared compliance with providing services in environments which promote effective care and optimise health outcomes by being well designed and well maintained premises.
- Providing services in environments that promote effective care was the standard with least declared compliance as a whole and across the services.
- 60% of the Royal Navy self-assessments declared compliance, which was the lowest amount of compliance. The Defence Dental Services declared the most amount of compliance with 92% of their self-assessments.
- Commentary from self-assessments that declared non-compliance included the following:

Percentage of declared compliance

Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
60%	73%	63%	92%	89%	67%

Figure 1: Declared compliance with healthcare services providing an environment that promotes effective care



"Our building is old but functional. It is not well designed for its purpose and maintenance is poor as there are plans to build a new medical centre in 2012. We hope many issues will be addressed at that time. The building is cleaned daily by contract cleaners and kept tidy by the duty MA. We do not formally assess cleaning standards."
Royal Navy, Primary Care

"....buildings that were not designed for purpose and are in excess of 50 years old."
British Army, Primary Care

"The building is cleaned daily for two hours. The building is due to undergo a major refurbishment in the autumn to bring the building up to standard. Once these works have been completed, a new cleaning contract will be in force and the building will have two full-time domestic staff who will ensure the building is cleaned thoroughly twice a day and complies with infection control policy."
Royal Air Force, Primary Care

This standard was assessed in 19 out of the 53 units on follow-up visits by a review assessment team.

Standard C21	DMS unit declaration	Healthcare Commission assessment
Royal Navy primary care	Compliant	Compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
RAF primary care	Not compliant	Not compliant
RAF primary care	Not compliant	Compliant
Joint primary care	Compliant	Compliant
Joint primary care	Compliant	Compliant
Army regional rehab unit	Compliant	Not compliant
Royal Navy regional rehab unit	Not compliant	Not compliant
RAF regional rehab unit	Not compliant	Not compliant
Dental services	Compliant	Compliant
Dental services	Compliant	Not compliant
Defence dental services	Compliant	Not compliant
Dental services headquarters	Compliant	Not compliant
Secondary care permanent base	Compliant	Not compliant

- The Healthcare Commission's assessment resulted in nine out of the 15 (60%) units' declarations of compliance being overturned to non-compliance. Three units declared non-compliance which the Healthcare Commission agreed with. The total of non-compliance overall was therefore 12 out of 19 (63%). One declaration of non-compliance was overturned to compliance.
- This is a significant finding and the evidence used to declare compliance with this standard should be reviewed.

Key evidence presented by the DMS units for compliance included the following:

- Clean environment and fit-for-purpose facilities.
- Appropriate cleaning specification and contract monitoring.
- Deep clean and on-call cleaning arrangements available.
- Quality monitoring of maintenance.
- Infection control training.
- Infection control audits.
- Disabled access and facilities (for example, toilets, lifts).
- Infection control, single use equipment and decontamination policies.

Key reasons for non-compliance included the following:

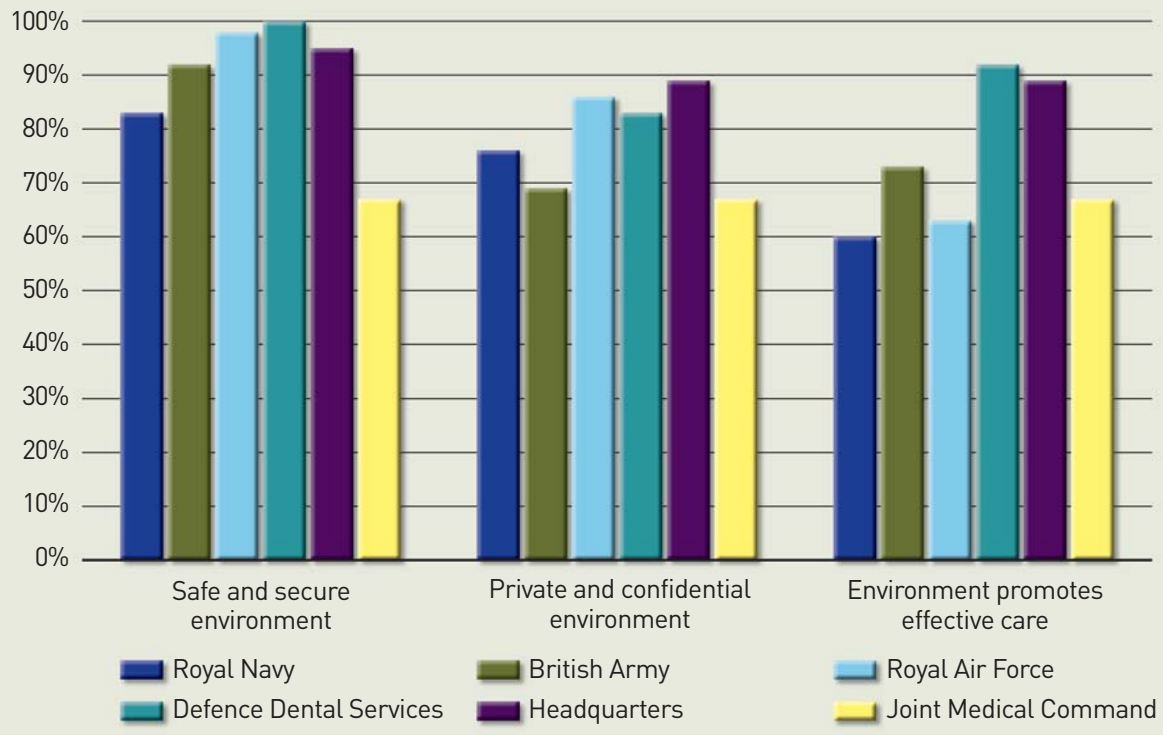
- No local environmental risk assessments or environmental audit or monitoring.
- Poor standards of decoration.
- Remedial works not undertaken in a timely manner.
- Poor standards of cleanliness.
- External maintenance and cleaning contracts poorly monitored.
- Units not DDA compliant (Disability Discrimination Act – legislation to promote civil rights for disabled people and protect disabled people from discrimination).
- No hand wash sinks in clinical areas.
- No alcohol hand rubs in clinical areas.
- Non-adherence to COSHH principles (Control of Substances Hazardous to Health Regulations – intended to protect people from ill health caused by exposure to hazardous substances – for example chemicals, biological agents such as bacteria or parasites, gas).
- Poorly designed facilities compromising patient confidentiality.
- No dedicated sluice facilities.
- Condemned central heating boiler.
- Limited infection control training.
- Poor hand hygiene observed.
- Facilities not fit for purpose.
- No standards for environmental cleanliness.
- No risk register.

Comments and issues:

- There were several units that failed to comply with this standard. The main reasons were that buildings and estates were unfit for purpose, poor standards of cleanliness were observed and there was a lack of environmental risk assessment and contract monitoring. In some cases, where risks and shortfalls in service had been identified, little had been done by way of resolution.

Percentage of declared compliance by the DMS with standards for accessible and responsive care						
	Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
Safe and secure environment	83%	92%	98%	100%	95%	67%
Private and confidential environment	76%	69%	86%	83%	89%	67%
Environment promotes effective care	60%	73%	63%	92%	89%	67%

Figure 2: Percentage of declared compliance with the standards in the care environment and amenities domain across the services



Public health

Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Standard C22a – local partnerships

Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by cooperating with each other, with local authorities and other organisations and by making an appropriate and effective contribution to local partnership arrangements, including local strategic partnerships and crime and disorder reduction partnerships.

- 135 out of 153 (88%) self-assessments declared compliance with this standard.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
82%	96%	86%	100%	89%	100%

- Declared compliance with having local partnerships was varied. The majority of self-assessments declared compliance ranging from 82% of Royal Navy assessments to 100% of all three of the Joint Medical Command self-assessments.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Standard C22b – using the annual report of the local director of public health

Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by ensuring that the local director of public health's annual report informs their policies and practices.

- 104 out of 145 (72%) self-assessments declared compliance with using the annual report of the local director of public health.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
47%	96%	70%	100%	84%	100%

Note: Eight self-assessments declared this standard as not applicable. These were three Royal Navy self-assessments, three Royal Air Force self-assessments, one British Army self-assessment and one Defence Dental Service self-assessment.

- Declared compliance with using the annual report of the local director of public health was low compared to declared compliance with other standards. Half of Royal Navy self-assessments declared non-compliance and just over a third of Royal Air Force self-assessments declared non-compliance. Only the Defence Dental Services and the Joint Medical Command declared all their services as compliant with using the annual report of the local Director of Public Health.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Standard C23 – promotion of public health programmes and national service frameworks

Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

- 137 out of 148 (93%) self-assessments declared compliance with the promotion of public health programmes and NSF.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
84%	100%	70%	100%	89%	100%

Note: Self-assessments that selected regional rehabilitation units and tactical medical wing as the type of healthcare provided were not applicable for this standard (3%).

- Over a third of the Royal Air Force self-assessments declared non-compliance with the promotion of public health programmes and NSFs. The British Army, Defence Dental Services and Joint Medical Command declared all their services as compliant with promotion of public health programmes and NSFs.

This standard was assessed in 13 out of the 53 units on follow-up visits by a review assessment team.

- The Healthcare Commission's assessment resulted in eight out of the 13 (62%) units' declarations of compliance being overturned to non-compliance.
- This is a significant finding and the evidence used to declare compliance with this standard should be reviewed.

Standard C23	DMS unit declaration	Healthcare Commission assessment
Army primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
Army primary care	Compliant	Not compliant
RAF primary care	Compliant	Compliant
RAF primary care	Compliant	Not compliant
Dental services headquarters	Compliant	Compliant
Army headquarters	Compliant	Not compliant

Key evidence presented by the DMS units for compliance included the following:

- Themed health promotion plan developed and implemented.
- Health needs assessment undertaken.
- Joint initiatives and shared learning with local NHS trusts.
- Patients' information available – for example, lifestyle issues, disease management, health screening – information fairs and road shows.
- Individual and group sessions and clinics – for example, weight control, smoking cessation, sexual health and alcohol misuse – programmes developed in line with DMS policy.

Key reasons for non-compliance included the following:

- No local health needs analysis.
- Little evidence of health promotion programmes.
- No local health promotion plans.
- No evaluation of health promotion initiatives.
- Little or no sharing of information.

Comments and issues:

- Good practice – regular health promotion themes set by Army primary care headquarters that reflected national determinations, suggesting a strong emphasis on health promotion and preventative medicine – themes not always followed through in local services.

Standard C24 – emergency planning

Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services.

- 130 out of 149 (87%) self-assessments declared compliance with this standard.

Percentage of declared compliance					
Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
79%	85%	95%	92%	95%	67%

Note: Self-assessments that selected regional rehabilitation units as the type of healthcare provided were not applicable for this standard (3%).

- No area declared all their self-assessments as compliant with emergency planning. Declared compliance ranged from 38 out of 48 Royal Navy self-assessments to 39 out of 41 Royal Air Force self-assessments.

This standard was not assessed on follow-up visits – it was assessed in self-declarations only.

Percentage of declared compliance by the DMS with standards in public health and health promotion						
	Royal Navy	British Army	Royal Air Force	Defence Dental Services	Head-quarters	Joint Medical Command
Local partnerships	82%	96%	86%	100%	89%	100%
Using the annual report of the local director of public health	47%	96%	70%	100%	84%	100%
Promotion of public health programmes and NSFs	84%	100%	70%	100%	89%	100%
Emergency planning	79%	85%	95%	92%	95%	67%

4. Conclusions

In inviting the Healthcare Commission to undertake an independent review of the quality of care within the Defence Medical Services (DMS), it can be concluded that there was a desire for external scrutiny of the standards of care and treatment provided, to improve services and to identify areas of good clinical practice.

This has been a challenging and rewarding review for the Healthcare Commission in undertaking healthcare assessment in an area not previously assessed by us. We needed to understand the context in which the DMS operated, the challenges it faced, and the diversity of the services it provided. The breadth and scope of these services provide a combination of routine healthcare services and the delivery of healthcare in extraordinary and very different locations and situations.

Our review found a number of examples of exemplary healthcare provision in the areas of trauma care and rehabilitation. The training processes leading to excellent trauma management are an area that the NHS could learn from in the delivery of emergency care.

Although the number of Service personnel, dependants and entitled civilians commenting on their experiences of DMS was comparatively low compared with the population served, there was a high level of satisfaction expressed overall. Opinion of the primary care services and hospital care provided was high, particularly among Service personnel. Just over half of respondents stated that appointments were easily made or waiting times were short within primary care. Feedback was very positive about the rehabilitation and community mental health services, with no negative opinions submitted. Most respondents had a positive opinion of dental care but waiting times were considered too long.

The feedback we received suggests that administration and bureaucracy are negative factors in the DMS, with 97% of respondents who mentioned them experiencing problems. Comments regarding both poor communication and a lack of continuity of care outweighed the number of positive comments in these areas. We also received negative comments about the closure of military hospitals in favour of NHS and independent healthcare providers. Some respondents stated that there was a distinct difference between the services provided to Service personnel and those available to dependants.

Our review focused on the *Standards for Better Health* implemented in the NHS in 2004. These standards have also been used by the DMS for internally reviewing the quality of care. The standards, however, had not been consistently applied across the DMS and this review has provided the first opportunity to implement the same review process across all areas of DMS healthcare provision. This should be a starting point from which to work on the areas identified for development and improvement and to further develop, share and learn from existing good practice.

The DMS submitted 153 individual self-assessment declarations stating whether their area of healthcare services was compliant or non-compliant with the *Standards for Better Health*. Some declarations covered regional groups of healthcare provision, for example, a number of medical centres. In our follow-up assessment visits to some of the services, we looked at evidence of compliance. The DMS needs to consider how to collect data and information and how this can be used to influence and contribute to effective assessment in the future.

A high proportion of self-assessments declared compliance with standards relating directly to clinical care, such as taking account of nationally agreed guidance when planning and delivering treatment and care. Our review found that the DMS had mechanisms in place for deciding on the relevance of national advice, and documented processes for implementation, monitoring and review. We also found, in some areas, little or no evidence of national guidance being taken into account, or systems being in place to monitor best practice guidance.

There were high levels of compliance declared with ensuring that clinical care and treatment was carried out under supervision and leadership. Particularly good examples of clinical supervision for trainees were found in GP training practices. There were a number of services where there was a lack of evidence of clear supervisory frameworks and practices.

Our review found that formal staff appraisal systems were well embedded across all services and staff had good access to development and training. Professional clinical staff were able to access opportunities to continuously update skills and techniques relevant to their clinical work. The number of clinicians participating in regular audits and reviews of clinical services was variable. Three-quarters of the units declared compliance in their self-assessment of this standard, and some of the units we visited had detailed clinical audit programmes, were able to cite examples of practice change as a result of audits and had designated audit leads. Information from audits in some areas contributed to national data collections.

All Defence Dental Services, headquarters and Joint Medical Command units declared compliance with applying the principles of sound clinical and corporate governance and undertaking systematic risk assessment and risk management. There was a high level of declared compliance from the three Services. Evidence to support this from follow-up assessment visits included audit programmes, risk registers and risk incident reporting, patient satisfaction and feedback systems. The review also found areas with clear clinical governance reporting structures and specific responsibilities for individuals in lead roles.

We found that DMS staff were generally confident to raise concerns about any aspect of clinical practice and to challenge discrimination and equality issues. There was a culture of trying to address and sort out any concerns, incidents or complaints at a local level. This had, however, led to under-reporting within many services.

Nine declarations out of the 153 submitted self-declared to be non-compliant with the standard relating to promoting equality. Evidence from follow-up visits supporting compliance included awareness of equality and diversity schemes and policies among staff, specific equality and diversity officers and advisors and examples of actions taken to promote equality. Our review found that some services were not compliant with requirements of the Disability Discrimination Act.

Although 90% of self-assessments declared compliance with having effective records management systems, in follow-up visits it was found that this was an area which needed to be improved. Some records were not stored securely and some units did not have a Caldicott Guardian appointed. A further area for attention was the management of medicines where a review of policy and practice is recommended.

Declared compliance with ensuring that staff treat patients, their relatives and carers with dignity and respect was high across all the services. Four out of the six services declared 100% compliance. Ensuring that appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information was high across all the services. The percentage of declared compliance on this was the highest across all the standards assessed. Follow-up visits found that staff were aware of the policy for, and process of, obtaining consent to treatment.

All the Army regions that submitted self-assessments declared that they had systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services. All other areas declared over 90% compliance.

Thirty-five units declared that the standard regarding providing food was applicable to their units. The standard states that where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet. Three of the self-assessments declared non-compliance, stating that this was due to ongoing surveys in each facility highlighting issues with dietary services, no water provision and difficulties for patients requiring a vegetarian diet or staff and individuals with problems chewing or swallowing, who require a soft diet. It was stated that these issues had been raised through the chain of command.

All self-assessments from the Army, Defence Dental Services, headquarters and Joint Medical Commands declared compliance with making information available to patients.
Sixty-nine per cent of self-assessments declared compliance with providing services in environments which promote effective care and optimise health outcomes by having well-designed and well-maintained premises. Providing services in environments which promote effective care was the standard with the least declared compliance as a whole and across the services. Sixty per cent of the Royal Navy self-assessments declared compliance, which was the lowest amount of compliance. The Defence Dental Services declared the highest amount of compliance with 92% of their self-assessments compliant.

Our review found units providing services in purpose built, well-equipped medical centres or in older buildings that had been suitably adapted. These medical centres offered clean and appropriate clinical environments. Although a lot of the buildings used to provide medical care were old, these were still well maintained. The review also visited some medical centres both in the UK and overseas where clinical services were provided in what the Healthcare Commission considered to be unacceptable conditions. These conditions included poor maintenance of the buildings and inadequate working facilities for clinical staff. We found that some of the medical centres also had poor levels of cleanliness. We have been formally advised of the immediate actions that have been taken and the plans put in place to address these urgent issues.

Eighty-eight per cent of self-assessments declared compliance with promoting, protecting and demonstrably improving the health of the community served, and narrowing health inequalities by cooperating with each other and with local authorities and other organisations.

Declared compliance with having local partnerships was varied. The majority of self-assessments declared compliance ranging from 82% of Royal Navy assessments to 100% of all three of the Joint Medical Command self-assessments. Good practice in improving health included themed health promotion plans being developed and implemented, health needs assessment being undertaken, joint initiatives and shared learning with local NHS trusts, patient information being available – for example, lifestyle issues, disease management and health screening. Other areas of good practice included individual and group sessions and clinics being provided on issues such as weight control, smoking cessation, sexual health, and alcohol misuse, and these were developed in line with DMS policy.

The information from our review, its recommendations and conclusions should inform clinical governance structures and processes for the whole of the DMS, enable areas already identified as good practice to develop further, and focus work on areas for improvement and development.

The Healthcare Commission recommends that the DMS reflects on this experience of external review and considers how to ensure independent review of its services in the future.

Appendix 1

Standards for Better Health

First domain: safety

Domain outcome: patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Core standard C1

Healthcare organisations protect patients through systems that:

a) Identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.

b) Ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.

Core standard C2

Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.

Core standard C3

Healthcare organisations protect patients by following National Institute for Clinical Excellence (NICE) interventional procedures guidance.

Core standard C4

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that:

a) The risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA).

b) All risks associated with the acquisition and use of medical devices are minimised.

c) All reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.

d) Medicines are handled safely and securely.

e) The prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

Second domain: clinical and cost effectiveness

Domain outcome: patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes.

Core standard C5

Healthcare organisations ensure that:

a) They conform to National Institute for Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

b) Clinical care and treatment are carried out under supervision and leadership.

c) Clinicians* continuously update skills and techniques relevant to their clinical work.

d) Clinicians participate in regular clinical audit and reviews of clinical services.

* Professionally qualified staff providing clinical care or defence medical services to patients.

Core standard C6

Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

Third domain: governance

Domain outcome: managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.

Core standard C7

Healthcare organisations:

a) Apply the principles of sound clinical and corporate governance.

b) Undertake systematic risk assessment and risk management.

c) Actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.

d) Ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources.

e) Challenge discrimination, promote equality and respect human rights.

f) Meet the existing performance requirements.

Third domain: governance (continued)

Core standard C8

Healthcare organisations support their staff through:

a) Having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.

b) Organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.

Core standard C9

Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

Core standard C10

Healthcare organisations:

a) Undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.

b) Require that all employed professionals abide by relevant published codes of professional practice.

Core standard C11

Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare:

a) Are appropriately recruited, trained and qualified for the work they undertake.

b) Participate in mandatory training programmes.

c) Participate in further professional and occupational development commensurate with their work throughout their working lives.

Core standard C12

Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.

Fourth domain: patient focus

Domain outcome: healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.

Core standard C13

Healthcare organisations have systems in place to ensure that:

a) Staff treat patients, their relatives and carers with dignity and respect.

b) Appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information.

c) Staff treat patient information confidentially, except where authorised by legislation to the contrary.

Core standard C14

Healthcare organisations have systems in place to ensure that patients, their relatives and carers:

a) Have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services.

b) Are not discriminated against when complaints are made.

c) Are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

Core standard C15

Note: this standard is applicable only to healthcare organisations that routinely provide patients with food.

Where food is provided, healthcare organisations have systems in place to ensure that:

a) Patients are provided with a choice and that it is prepared safely and provides a balanced diet.

b) Patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.

Core standard C16

Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care.

Fifth domain: accessible and responsive care

Domain outcome: patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway.

Core standard C17

The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

Core standard C18

Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

Core standard C19

Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.

Sixth domain: care environment and amenities

Domain outcome: care is provided in environments that promote patient and staff wellbeing and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

Core standard C20

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being:

a) A safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation.

b) Supportive of patient privacy and confidentiality.

Core standard C21

Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

Seventh domain: public health

Domain outcome: programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Core standard C22

Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:

a) Cooperating with each other and with local authorities and other organisations.

b) Ensuring that the local Director of Public Health's annual report informs their policies and practices.

c) Making an appropriate and effective contribution to local partnership arrangement including local strategic partnerships and crime and disorder reduction partnerships.

Core standard C23

Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

Preface:
The elements are driven by the health improvement and health promotion requirements set out in NSFs and national plans with a particular focus on the following priority areas:

- Encouraging sensible drinking of alcohol.
- Encouraging people to stop smoking and providing a smoke free environment.
- Promoting opportunities for healthy eating.
- Increasing physical activity.
- Reducing drug misuse.
- Promoting sexual health.
- Preventing unintentional injury.

Core standard C24

Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services.

Appendix 2

Contributors to this review

A number of individuals have contributed to the research, development, management and implementation of this review. In recognition of their particular contribution, the Healthcare Commission would like to thank the following people.

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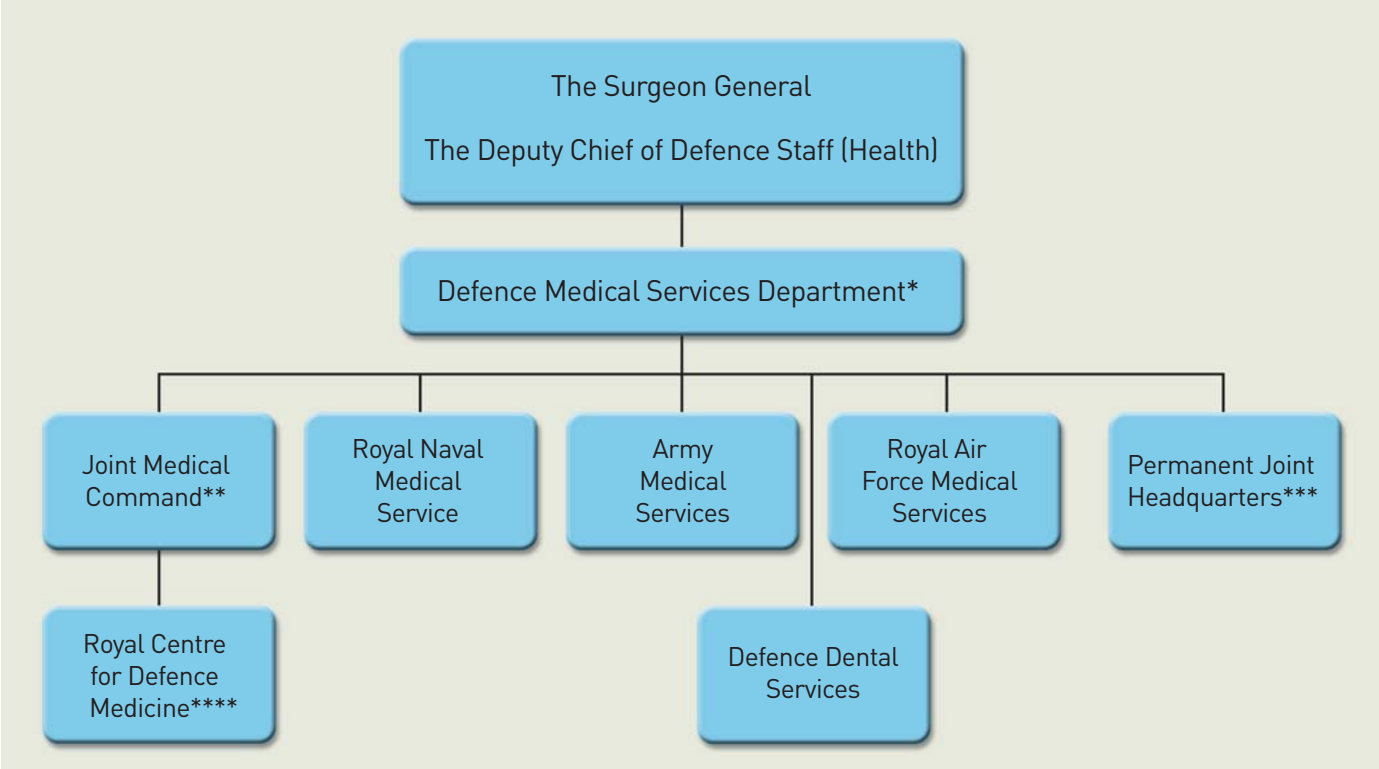
Appendix 3

Defence Medical Services organisational structure



* Defence Medical Services Department is the headquarters of the DMS under the combined leadership of the Surgeon General and the Deputy Chief of Defence Staff (Health).

** Joint Medical Command is responsible for the management and delivery of all joint clinical care, medical education and training and commissioning specialist hospital diagnostic, care and treatment including inpatient mental health care.

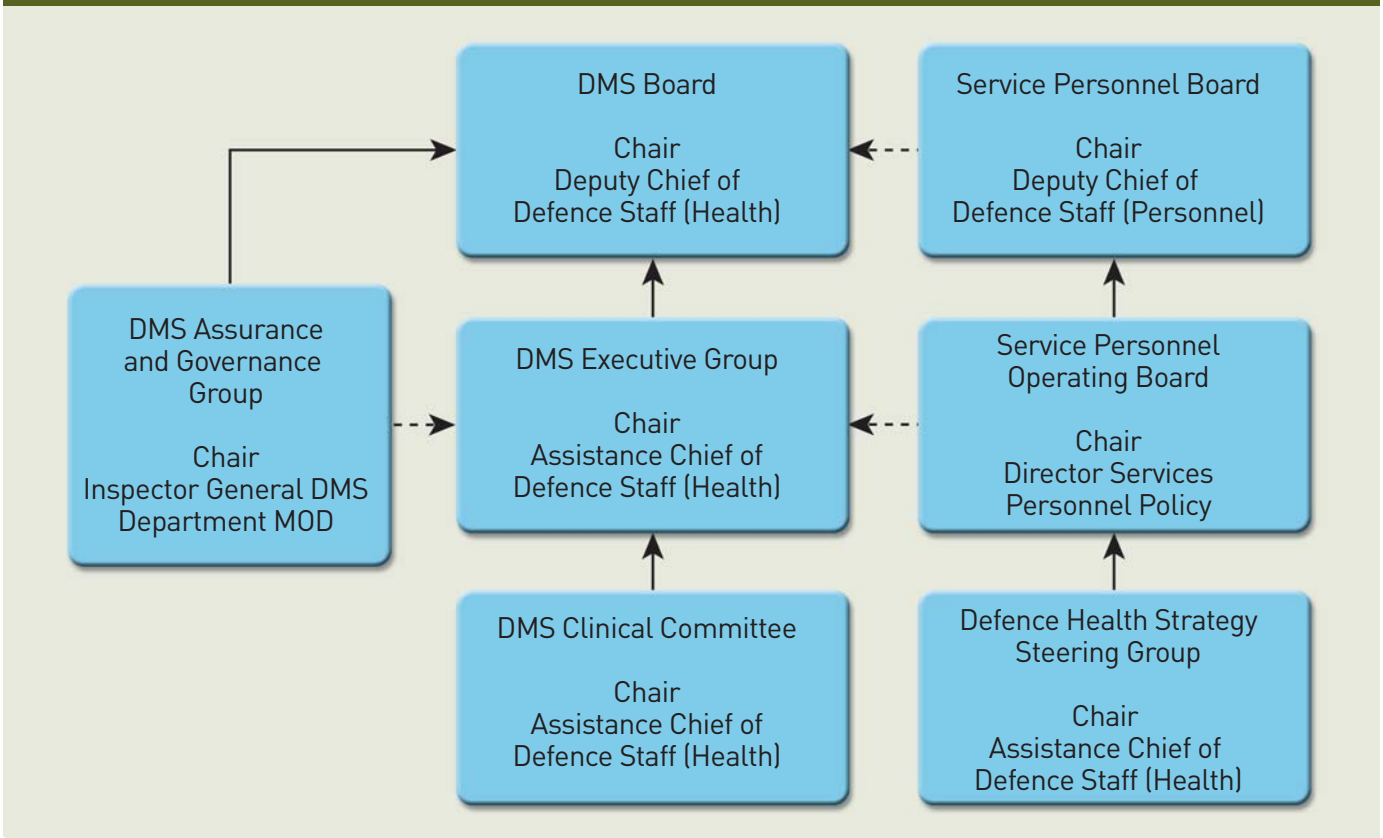
*** The Permanent Joint Headquarters is responsible for healthcare provided in Gibraltar, Cyprus, the Falkland Islands, Diego Garcia and Ascension Island and for healthcare provided in locations where the military services are deployed throughout the world. Responsibility for healthcare standards in these locations is exercised through the Surgeon General.

**** Royal Centre for Defence Medicine based in Birmingham is a dedicated training centre for defence personnel with a focus on medical research. It also provides medical support in secondary and specialist care for members of the armed forces and medical support to military operational deployments.

DMS personnel provide healthcare in the following roles:

- Medical officers (primary and secondary healthcare)
- Dental officers
- Medical support officers
- Nurses (primary and secondary healthcare)
- Allied health professionals
- Medical assistants.

Defence Medical Services governance structure



Royal Naval Medical Service

The Royal Naval Medical Service is responsible for providing comprehensive healthcare on ships, submarines and medical care to the Royal Marines. It employs 1,522 personnel who provide healthcare in the following areas.

Ashore

- 21 medical centres.

Afloat

- Capital ships
- Frigates and destroyers
- Submarines
- Minor war vessels
- Royal fleet auxiliary
- Headquarters.

Operations

- First aid posts
- Combat forward surgical groups
- Primary Casualty Receiving Facility – RFA Argus.

Army Medical Services

The Army Medical Services employs 4,958 personnel who provide healthcare in the following locations:

Primary healthcare:

- Army UK primary healthcare services:
  - 7 regions
  - 66 medical centres
  - 15 medical reception stations
  - 70 primary care rehabilitation facilities
  - 7 regional rehabilitation facilities
  - 8 departments of community mental health.
- British Forces Germany Healthcare Services – Germany.

Army operational healthcare is provided through the following:

- Medical regiments, primary and pre-hospital emergency care
- Field hospitals
- Territorial Army field hospitals.

Royal Air Force Medical Services

The Royal Air Force employs 1,898 personnel who deliver primary, secondary and intermediate care in the following locations:

- 31 medical centres
- 4 departments of community mental health
- 3 regional rehabilitation units
- 3 regional occupational medicine departments.

In addition, the RAF provides an aeromedical evacuation service to the Armed Forces through headquarters Tactical Medical Wing and the Aeromedical Evacuation Control Cell.

Defence Dental Services

The Defence Dental Services employ 783 personnel from the Royal Navy, the Army, the Royal Air Force and the civil service (clinical and non-clinical civilian personnel employed by the Ministry of Defence or the three Services). These personnel are trained dentists, therapists, hygienists, technicians and dental nurses. Military Dental Service personnel are employed and located all over the world and civilian employees work alongside military personnel in the UK, Cyprus and Germany.

There are eleven principal dental officers working from regional delivery headquarters and there are 163 dental centres in total.

Appendix 4

List of DMS units visited by the Healthcare Commission

Service type	Unit	Location	Country
Primary care			
Primary care	HMS Ark Royal Aircraft Carrier	Portsmouth, Hampshire	England
Primary care	HMS Gloucester (Type 42 Destroyer)	Portsmouth, Hampshire	England
Primary care	Royal Navy Medical Centre	Portsmouth, Hampshire	England
Primary care	Royal Navy Medical Centre	Faslane, Dunbartonshire	Scotland
Primary care	Commando Training Centre Royal Marines	Lympstone, Devon	England
Primary care	Army Medical Centre	York, Yorkshire	England
Primary care	Army Medical Centre	Dishforth, North Yorkshire	England
Primary care	Army Medical Centre	Wilton, Wiltshire	England
Primary care	Army Medical Centre	Bulford, Wiltshire	England
Primary care	Army Medical Reception Station	Catterick, North Yorkshire	England
Primary care	Army Medical Reception Station	Tidworth, Wiltshire	England
Primary care	Army Medical Centre	Rheindalen	Germany
Primary care	Army Medical Centre	Elmpt	Germany
Primary care	Army Medical Centre	Bielefeld	Germany
Primary care	Army Medical Centre	Princess Royal Barracks, Gutersloh	Germany
Primary care	PJHQ Medical Centre	Sovereign Base Area, Akrotiri	Cyprus
Primary care	PJHQ Medical Reception Station	Sovereign Base Area, Dhekelia	Cyprus
Primary care	Medical Centre (satellite unit)	Sovereign Base Area, Ayios Nikolaos	Cyprus
Primary care	Medical Centre	Contingency Operating Base, Basra	Iraq
Primary care	Military Transition Team	Contingency Operating Base, Basra	Iraq
Primary care	Royal Air Force Medical Centre	Aldergrove	Northern Ireland
Primary care	Royal Air Force Medical Centre	Benson, Oxon	England
Primary care	Royal Air Force Medical Centre	Lyneham, Wiltshire	England
Primary care	Royal Air Force Medical Centre	High Wycombe, Buckinghamshire	England
Primary care	Royal Air Force Medical Centre	Halton, Buckinghamshire	England
Primary care	Royal Air Force Medical Centre	Kinloss, Forres	Scotland

Service type	Unit	Location	Country
Dental care			
Dental care	Baird Dental Centre	St Thomas' Hospital, London	England
Dental care	Northwood Dental Centre	Northwood, London	England
Dental care	Royal Air Force Dental Centre	St Athan, Cardiff	Wales
Dental care	Royal Air Force Dental Centre	Cosford, Shropshire	England
Secondary/ hospital care			
Secondary/ hospital care	No 34 Field Hospital Army Regular Unit	York, Yorkshire	England
Secondary/ hospital care	Territorial Army 203 (V) Field Hospital	Cardiff	Wales
Secondary/ hospital care	No 4 Medical Regiment Army Regular Unit	Aldershot, Hampshire	England
Secondary/ hospital care	The Princess Mary Hospital	Akrotiri	Cyprus
Secondary/ hospital care	Field Hospital – from various units	Contingency Operating Base, Basra	Iraq
Rehabilitation			
Rehabilitation	Inpatient Rehabilitation Unit	Headley Court, Epsom, Surrey	England
Rehabilitation	Royal Navy Regional Rehabilitation Unit	HMS Nelson, Portsmouth, Wiltshire	England
Rehabilitation	Army Regional Rehabilitation Unit	Aldershot, Hampshire	England
Rehabilitation	Army Regional Rehabilitation Unit	Gütersloh	Germany
Rehabilitation	Royal Air Force Regional Rehabilitation Unit	Cranwell, Lincolnshire	England
Community mental health			
Community Mental Health	Royal Navy Department of Community Mental Health	Plymouth, Devon	England
Community Mental Health	Army Department of Community Mental Health	Lisburn, Belfast	Northern Ireland
Community Mental Health	Royal Air Force Department of Community Mental Health	Cranwell, Lincolnshire	England

Service type	Unit	Location	Country
Headquarters			
Headquarters	Navy Command Medical HQ	Portsmouth, Hampshire	England
Headquarters	British Forces Germany Health Service HQ	Wegberg Rheindalen	Germany
Headquarters	Army Primary Health Care Service	Camberley, Surrey	England
Headquarters	Army Medical Directorate	Camberley, Surrey	England
Headquarters	Army Primary Health Care Service Regional Headquarters	Tidworth Wiltshire	England
Headquarters	HQ 2 Medical Brigade, Army	Strensall, Yorkshire	England
Headquarters	Joint Medical Command Headquarters	Gosport, Hampshire	England
Headquarters	Directorate General RAF Medical Services Air Command	High Wycombe, Buckinghamshire	England
Headquarters	Defence Dental Services Headquarters	Halton, Buckinghamshire	England
Medical headquarters	Headquarters Tactical Medical Wing	Lyneham, Wiltshire	England
Additional visits	**Observation and educational visits**		
Secondary/ acute care	Gilead Hospital	Bielefeld	Germany
Medical training exercise	Army Medical Services Training Centre	Strensall, York	England
Academic Department of Emergency Medicine	Royal Centre for Defence Medicine	Birmingham	England
Submariner medical care	Royal Navy Base	Dunbartonshire	Scotland

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- Surgeon Rear Admiral Lionel Jarvis – Assistant Chief of Defence Staff(Health), Defence Medical Services Department, MOD
- Surgeon Rear Admiral Philip Raffaelli – Director Strategic Change and Inspector General, Defence Medical Services Department, MOD
- Major General Mike von Bertele – Commander Joint Medical Command
- Major General Alan Hawley – Director General Army Medical Services
- Air Vice-Marshal Paul Evans – Director General Royal Air Force Medical Services
- Surgeon Commodore Tim Douglas-Riley – Director Royal Naval Medical Service
- Brigadier Ian Pretsell – Director Defence Dental Services
- Captain Helen Allkins – Director Navy Nursing Services
- Surgeon Captain Paul Hughes – Healthcare Governance, Fleet Medical Division, Royal Navy
- Surgeon Captain Richard Johnston – Assistant Director Performance Management, MOD
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- Group Captain John Gaffney – Assistant Director Performance Management, Defence Medical Services Department, MOD
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- Surgeon Commander Martin Randle – Healthcare Governance, Fleet Medical Division, Royal Navy
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- Lieutenant Colonel Ross McCulloch – Healthcare and Audit, Army Medical Directorate

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- Squadron Leader Trevor Hopper – Assessment and Audit, Directorate of Healthcare MOD
- Squadron Leader Andy Raper – Medical Operations, Permanent Joint Headquarters
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- Miss Caroline Fox – Assistant Director External Development, Defence Medical Services Department, MOD
- Mr Jim Wilson – Senior Auditor, Defence Internal Audit, MOD

Bibliography

Data Protection Act 1998

Human Rights Act 1998

Human Rights Act Scheme for Ministry of Defence 2008-11

Joint Services Publication (JSP) 315 Services Accommodation Code Edition 3 July 1999

JSP 340 D/AMD/113/9 Joint Service Regulations for the management of medical, dental and veterinary materiel and equipment 2000

JSP 375 Health and safety handbook 4th Edition October 2001

JSP 536 Ethical conduct and scrutiny in MOD research involving human participants

Ministry of Defence, Defence Medical Services Department (2008), DMSD/32/14/11, *Defence Medical Services Top Structures – Next Steps (TS-NS) Project Report, 16 January 2008*

MOD Factsheet, 23 March 2007, *Medical Support to Personnel Injured or Sick on Operation: A defence Policy and Business news article*

Surgeon General's policy letter (SGPL) 01/03 dated 7 January 2003 Ref D/SG/370/12/1, Clinical Governance in the Defence Medical Services

SGPL 02/04 dated 20 January 2004 Ref D/DMSD/360/4 Smoking cessation guidelines for use by health professionals in the Defence Medical Services

SGPL 18/04 dated 20 December 2004 Ref DMSD/5/3 Quality assurance of clinical governance on deployed operations

SGPL 05/05 dated 8 March 2005 Ref DMSD/366/1 Minimum training standards for primary care doctors working in the DMS

SGPL 10/05 dated 28 July 2005 Ref 276/2 Clinical supervision for nurses

SGPL 12/05 dated 23 August 2005 Ref DMSD/5/1/2 State regulation of allied health professionals regulated by the Health Professionals Council

SGPL15/05 dated 20 September 2005 Ref DMSD/5/1/1 Clinical governance policy for Departments of Community Mental Health

SGPL 26/05 dated 13 February 2006 Ref DMSD/5/1/1 The Defence Medical Services patient consent policy

SGPL 05/06 dated 24 February 2006 Ref DMSD/13/5/2 Strategy for improving the sexual health of the Armed Forces

SGPL 14/06 dated 15 June 2006 Ref DMSD/5/2 Defence Medical Services resuscitation standards and training policy

SGPL 01/08 dated 29 February 2008 Ref DMSD/20/10 The management of poorly performing doctors and dentists within the Defence Medical Services

SGPL 11/08 dated 18 April 2008 Ref DMSD/02/09/01 The role of Defence consultant advisers and Defence professors

Statutory Instruments, 2008 No. 1181 Public Health, *The Commission for Healthcare Audit and Inspection (Defence Medical Services) Regulations 2008*

www.mod.uk/DefenceInternet

www.mod.uk/DefenceInternet/microsite/dms

www.opsi.gov.uk/

www.uhb.nhs.uk/Services/Rcdm/Home.aspx

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