Future Hospital Journal 2014 Vol 1, No 2: 112–6

Personal reflections on the inspections of the Defence Medical Services by the Healthcare Commission and Care Quality Commission

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ABSTRACT

The Defence Medical Services (DMS) have been inspected by the Healthcare Commission and by the Care Quality Commission. Both inspections reported a mixed picture: high quality in some areas, particularly those concerned with operational casualties, but room for improvement in other areas, particularly the infrastructure of home-base primary care. The DMS valued the external validation of their own systems of quality assurance, and the findings of the inspectors have supported progress in areas where resource constraints have been difficult to overcome. Other findings have encouraged attention to areas of practice that needed improvement. The benefit of these inspections cannot be realised unless the organisation is prepared to accept adverse observations not as criticism but as opportunities for improvement. The inspections also benefitted the inspectors, providing a different and interesting clinical environment, and some benchmarking for future inspections of civilian general practice.

KEYWORDS: Defence Medical Services, DMS, Care Quality Commission, CQC, Healthcare Commission, inspector general

Introduction

The Defence Medical Services (DMS) have now been inspected twice by external healthcare assurance authorities; by the Healthcare Commission (HcC) in 2008,[1] and by the Care Quality Commission (CQC) in 2011–12.[2] At the time of the inspections, DMS provided healthcare for some 250,000 people, mostly Service personnel and their families, and also entitled civilian personnel (particularly in overseas locations). Primary healthcare was provided by the Royal Navy, the Army and the RAF from medical centres within dockyards, barracks or air bases, as well as on board ships and submarines, and within various operational formations (see Fig 1). (Since 1 April 2014, primary care provision across the Services has been the responsibility of a new joint organisation, Defence Primary Healthcare. This has not substantially changed the arrangements in medical centres, but the introduction of a unified management structure has provided a common system of regionally based clinical governance for all Defence primary healthcare.) DMS primary healthcare is provided by both uniformed and civilian doctors, nurses and other healthcare personnel, providing a full range of general medical services and occupational healthcare.

This article records the author's impressions of these inspections, and their impact on the DMS, based on first-hand experience and on the experiences and opinions of colleagues.

As inspector general for the DMS, the author is responsible to the surgeon general for providing assurance regarding the quality and safety of its healthcare and medical operational capabilities. The surgeon general is responsible to the Defence Board. There are various internal systems in place to assure and drive improvement in the quality of care provided, but in-house governance processes must be supported by an element of external assurance, and that has been provided by the HcC and CQC. They were under no obligation to inspect the DMS. Defence was excluded from statutory responsibilities of the Commissions, and the HcC inspection of 2008 was conducted at the invitation of the then surgeon general. The chair of the HcC at the time, Professor Sir Ian Kennedy, wrote in his forward to the report how the Commission was pleased to accept the invitation. 'All concerned felt it right that [the healthcare of DMS patients] should be subject to the same scrutiny as that of others in England.'

Clinical scope of the Defence Medical Services

Although the DMS patient group is small when compared with NHS England's (less than 0.5%), it is clearly diverse with some unique challenges, in terms of geographical spread, occupational health requirements and its primary task of supporting UK military operations. The DMS offer primary care to the families of Service personnel on larger bases where they have a commitment to GP vocational training, and in remote locations where there is no suitable NHS provision. In most locations Service personnel attend the unit DMS medical centre, while families are registered with a local NHS practice. Dental care for family members is not provided by the DMS, except in overseas locations. In addition to primary

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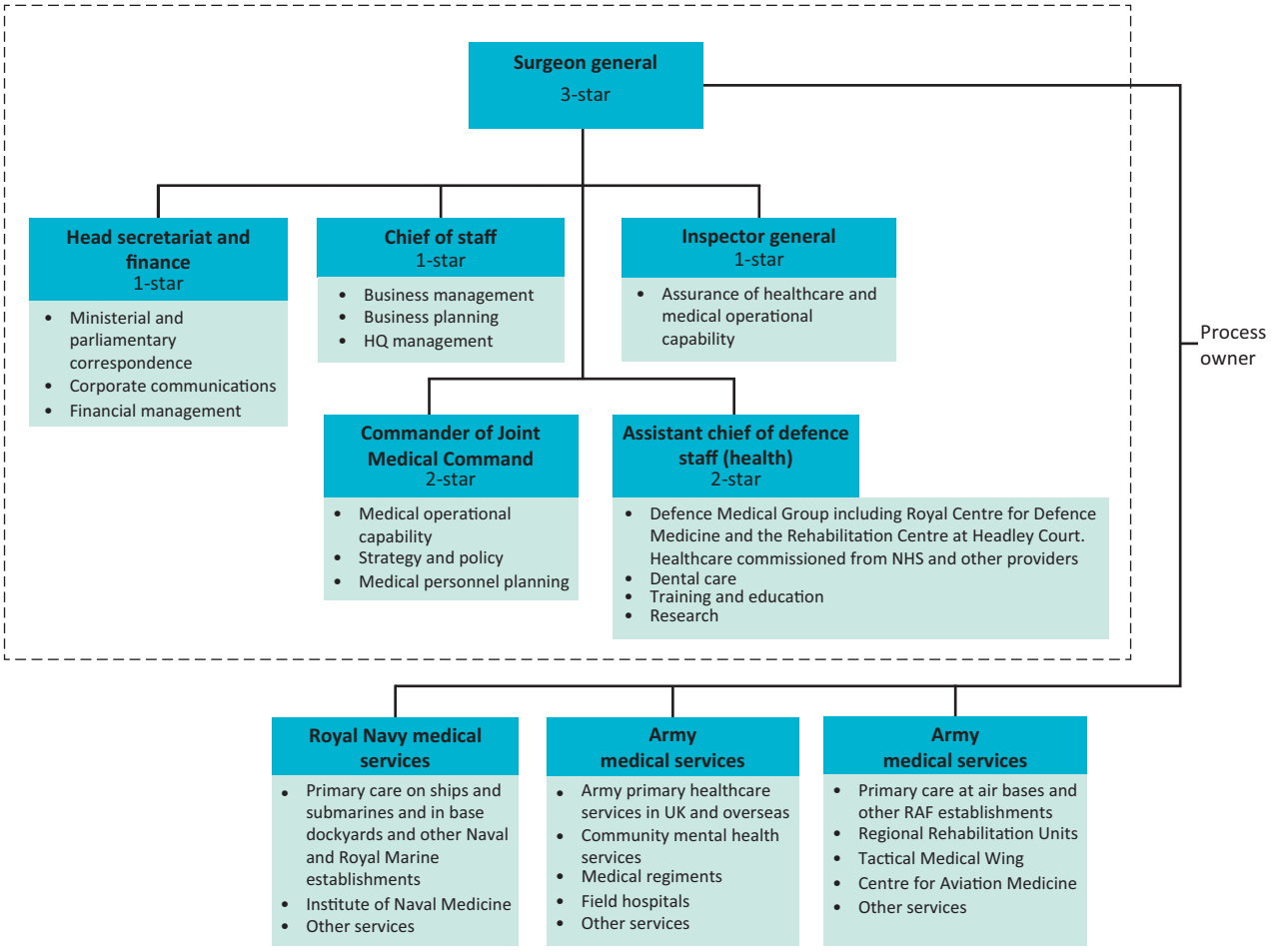

Fig 1. Organisation chart of the Defence Medical Services, June 2012. Dashed box indicates surgeon general's area of direct command responsibility. However, as process owner for healthcare and medical operational capability, the surgeon general sets the policies, standards and rules to be applied in the delivery of these outputs across Defence, including those areas of healthcare delivery that remain RN, Army and RAF responsibilities and thus outside his direct command and budgetary control.

medical and dental care, community-based mental health, rehabilitation and occupational health services serve regions comprising 10 to 15 primary care units. Secondary healthcare for the Defence population in the UK is no longer provided in military hospitals. Rather, service health professionals work in NHS hospitals (the MOD Hospital Units [MDHUs] at Northallerton, Peterborough, Frimley Park, Portsmouth and Derriford, and the Royal Centre for Defence Medicine [RCDM] within University Hospitals Birmingham Foundation Trust), and DMS patients receive NHS hospital care. Such hospitals were already included in both the HcC and CQC remits as NHS Trusts, so they were outside the scope of the DMS inspections. The remaining UK location where DMS patients receive inpatient care in a military establishment is the Defence Medical Rehabilitation Centre at Headley Court in Surrey, which was inspected by both the HcC and CQC.

Overseas, the UK maintains substantial garrisons in the Falkland Islands, Gibraltar and Cyprus, where primary care is provided for Service personnel, civilian workers and their families. Hospital care for DMS patients in Germany is procured via a commercial partner from German hospitals, and in Gibraltar and the Falklands by relatively small local hospitals backed up by evacuation systems to transfer patients to more advanced care facilities when required. Overseas 'host nation' hospitals lay outside the scope of the inspections, but at that time Cyprus was the location of the last remaining peacetime British military hospital, The Princess Mary Hospital (TPMH), Akrotiri, and this was visited by the HcC. (TPMH closed in October 2012, with secondary care now provided through a contract with a Cypriot independent sector provider.)

Clearly, the principal role of the DMS is to provide medical support to military operations, currently mainly centred in Afghanistan. Here there is a 'Role 1 matrix' to provide primary care, pre-hospital emergency care and medical evacuation across a vast area of hostile (in every sense of the word) countryside. The Field Hospital at Camp Bastion (Fig 2), manned by DMS personnel from all three Services, is supported by members of the Reserves, NHS colleagues and coalition partners. Afghanistan was visited by both the HcC and the CQC.

Fig 2. The Defence Medical Services in action.
(a) Transfer of a casualty from helicopter to field hospital by field ambulance at Camp Bastion, Afghanistan.
(b) Field surgical team (exercising).

Pre-inspection period

The author was attached to the surgeon general's staff in the MOD when the HcC was invited to inspect the DMS, and engaged in drafting a new governance and assurance policy. Although committed to openness and transparency, and with strong clinical governance processes already established in much of the organisation, DMS were well aware of areas of weakness. There were concerns that there would be little opportunity to resolve problems before the inspection, and uneasiness about exposure to external scrutiny and public reporting of known areas that required improvement; in other words having the car MOT-ed before it had been serviced! In retrospect such reservations about the wisdom of this course of action reflected the fact that the organisation was still some way short of achieving the necessary cultural change of an improving organisation, from defensiveness in the face of criticism to enthusiasm for opportunities to improve. The surgeon general's approach proved to be correct in initiating not incremental improvement, but a cathartic exposure to maximise benefit to the organisation and to its patients.

The HcC inspection programme that was agreed between DMS and the HcC involved primary care medical and dental centres from all three Services, rehabilitation units, departments of community mental health and the hospitals in Afghanistan and Cyprus. There were no 'no-notice' inspections, and teams were accompanied by a liaison officer to ensure that things ran smoothly and that all security considerations were addressed.

The Healthcare Commission inspection and report[1]

The inspectors were made to feel welcome, and staff were pre-briefed to be open and willing to expose any areas of concern. Those inspected seemed to feel the inspections could add weight to the case for improvement, and appeared to share in the objective of improving patient care. The HcC made laudatory comments about the exemplary care of casualties in Afghanistan, with recommendations that the NHS could learn from military practice, especially the high quality of rehabilitation services. High levels of patient satisfaction were reported with primary medical and dental services, with most

negative comments concerning non-clinical aspects of activity.

Where areas of concern were identified that necessitated immediate action, this was implemented without question and as quickly as could be achieved. The most common issues raised concerned inadequate infrastructure. Military personnel have a tendency to carry out their duties irrespective of surroundings, and in some locations physical facilities had incrementally deteriorated to the point where they fell woefully short of what should have been considered acceptable. A beneficial effect of the HcC inspection was to force a recalibration of these expectations, and in some locations the weight of the CQC report assisted in securing funding for long-delayed rebuilding or renovation work.

The HcC report commended the surgeon general for his openness and willingness to commission an independent, published review, and for taking swift action on issues that arose during the course of its execution, and recommended that action be taken to enable further external inspection in the future. However, shortly after the DMS inspection, the HcC stood down in favour of the CQC. Although DMS were still excluded from the statutory requirements for inspection, in 2011 the new surgeon general invited the CQC to conduct a follow-up inspection, in line with the HcC recommendation. The purpose was again to provide external scrutiny of DMS healthcare so that patients would benefit from the national quality assurance process, to validate internal governance and assurance processes and observe progress on implementation of the recommendations of the HcC.

The Care Quality Commission inspection and report[2]

The CQC inspection differed in some ways from that of the HcC, in that the inspection framework was now focussed on 'outcomes', rather than upon the pillars of clinical governance used by the HcC, and described in the Department of Health's 2004 document *Standards for Better Health*,[3] which are largely process-driven. The outcomes are laid down in legislation – the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – and described in Essential Standards of Quality and Safety in Health and Social Care (CQC, March 2010).[4] Nevertheless, the basic process employed was similar, with small teams of inspectors accompanied by a military liaison officer visiting a variety of units in the UK and overseas, again including those in Afghanistan and Cyprus.

By this time the post of inspector general for the DMS was well established, and internal governance and assurance processes were becoming embedded. The CQC also made positive comments, observing: 'The inspector general's office was in a much better position to be able to accurately identify many of the most pressing issues with service provision, and thereby target improvement actions, than it had been in 2008.' The DMS Common Assurance Framework, derived from 'Standards for Better Health' (as used by the HcC), nevertheless produced results that generally aligned well with the CQC findings based on 'Essential Standards'.

The CQC findings were similar to those of HcC, identifying excellent practice in operational trauma care and rehabilitation, and good practice in all areas inspected.[2] However, primary care again presented a more mixed picture, with 60% of units inspected failing to meet at least one satisfactory outcome standard. Strong compliance was reported in dental care, community mental health and deployed primary care. The overall conclusion was that substantial progress had been made in all areas since the HcC visit, particularly in governance and assurance systems, but there were still areas requiring significant attention. The main area of concern was again physical infrastructure. Although some progress had been made since the HcC visit, sub-standard facilities remained. Safeguarding protocols and training was a further deficiency, as was monitoring of the effectiveness of treatment through primary care audit.

The DMS reaction to the CQC report was to accept the recommendations, and to prioritise the areas of concern. It was essential not to limit attention to the units that happened to have been included in the CQC visit programme, and infrastructure was subjected to a pan-DMS audit to identify priorities. One outcome of this exercise was to establish that the sample of medical and dental treatment facilities seen by the CQC was approximately typical. It will take some years to get to the point where the DMS medical estate is completely satisfactory, but better processes are in place to ensure that these requirements are properly championed so as to compete effectively for resources with other areas of Defence.

Secondly, it was encouraging to see recognition of progress made, albeit with the caveat that there was more to do. The organisational culture must be open to criticism as an enabler for improvement, in keeping with the 'just culture' to which we aspire. By 'just culture' I mean that we aim to be open and honest in all aspects of activity, including at times when things have gone wrong, so that we can learn from mistakes and near misses, and avoiding a 'blame culture', where people become reluctant to report error for fear of adverse consequences. However, this is not the same as a 'no-blame' culture; healthcare professionals cannot abdicate responsibility, and adverse events arising from neglectful of otherwise culpable action or inaction attract the appropriate investigation and holding to account, in line with NHS practice.

The bilateral benefit of inspection

The DMS benefited substantially from the inspections carried out by both the HcC and CQC. In applying the same quality yardstick to defence and civilian healthcare, the organisations provided encouragement and assistance in the prioritisation of limited resources, and benefited the patients we care for. In some cases the inspections served as a 'wake-up call', particularly alerting health professionals and the chain of command that healthcare facilities that are not fit for task should not be tolerated, and thereby reinforcing requirements for improvement that had been agreed but not implemented because of resource constraints.

Conversely, I suggest that the HcC and CQC benefited in turn from inspecting the DMS, a task that they undertook without additional resource when under no obligation to do so. Conversations with the inspectors and managers, particularly in the light of the post-inspection 'wash-up' meeting following the CQC inspection, suggest the leadership of both Commissions felt that inspecting the DMS was the right thing to do. There is now a Military Covenant,[5] with direction that Government ministries and departments should take steps to see that military personnel are not disadvantaged by their status as serving members of the Armed Forces, and these inspections could be taken as an example of such equality.

Moreover, enthusiasm from middle management within the Commissions and from the inspectors involved was evident

and provided a different perspective to their usual routine; opportunities to see ships at sea, Army barracks and air bases are intrinsically interesting, whether in the UK, Germany, Cyprus or Afghanistan. The CQC inspectors valued the opportunity that the DMS inspections provided to work in stable teams for a period of time, in contrast to their more usual *ad hoc* teams coming together for individual inspections. Third, inspection teams were generally welcomed, and enthusiasm for exposing our practices, 'warts and all', by staff who saw the inspectors as allies in the quest for improved services to patients was a positive aspect of the process. Finally, at the time the CQC had not inspected primary care facilities, and the DMS inspections therefore served to inform the development of the process now being implemented across NHS England.

Conclusions

Thus expectations were met. The leadership of the DMS was right to voluntarily subject the organisation to external scrutiny. The leadership expected criticism, but it was constructive and provided assistance in prioritising attention and investment in the most appropriate areas. It was gratifying to have recognition of areas of good or excellent practice, and to note that the areas of strength tended to be those in support of operational casualties. On the other hand, there was appropriate concern at the exposure of some areas that needed improvement, not all of which had already been identified, emphasising the importance of implementation of our internal governance and assurance processes. All the improvement actions recommended by the HcC and CQC have been important, and benefitted both patients and staff. However, possibly the biggest advance was acceptance of the principle of actively seeking constructive criticism, not avoiding it, and genuinely welcoming such opportunities in order to serve our patients better. ■

Disclaimer

Dr Gaffney is a RAF medical officer serving in the Surgeon General's HQ. This article reflects the views of the author and should not be taken as representing the views or policy of the Ministry of Defence.

References

1 Healthcare Commission. *Defence Medical Services: A review of the clinical governance of the Defence Medical Services in the UK and overseas.* Healthcare Commission, 2009. Available online at www.nhs.uk/nhsengland/militaryhealthcare/documents/defence_medical_services_review[1].pdf [Accessed 3 July 2014].

2 Care Quality Commission. *Defence Medical Services: a review of compliance with the essential standards of quality and safety. Summary report.* CQC, 2012. Available online at www.gov.uk/government/uploads/system/uploads/attachment_data/file/33723/cqc_summary_report_20120621.pdf [Accessed 3 July 2014].

3 Department of Health. *Standards for Better Health.* DoH, 2004. Available online at www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4086665 [Accessed 3 July 2014].

4 Care Quality Commission. *Essential standards of quality and safety in health and social care.* CQC, March 2010. Available online at www.cqc.org.uk/file/4471 [Accessed 3 July 2014].

5 Ministry of Defence. Fulfilling the commitments of the armed forces covenant. MoD, 2014. Available online at www.gov.uk/government/policies/fulfilling-the-commitments-of-the-armed-forces-covenant/supporting-pages/armed-forces-covenant [Accessed 3 July 2014].

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