Defence Medical Services

Northern Ireland Regional Rehabilitation Unit

Inspection Report

Regional Rehabilitation Unit
Aldergrove Barracks
Belfast
Northern Ireland

Date of inspection visit : 14 February 2024
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, and information given to us from the provider and patients.

Ratings

Overall rating for this service	Good
Are services well-led?	Good

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

We carried out an announced follow-up inspection at Northern Ireland Regional Rehabilitation Unit (RRU) on 14 February 2024.

Our key findings across all the areas we re-inspected were as follows:

We found that leadership was good in accordance with CQC's inspection framework.

- There was a clear vision and a mission statement set out for the service, with quality and safety as the top priority.
- The service had an overarching governance framework, which supported the delivery of the strategy and good quality care. Key gapped posts had been filled and lines of accountability had been clarified. Quality, performance and risks were understood and managed.
- Managers within the service worked hard to run the service and to ensure that patients' needs were met. Accountability for healthcare governance had been made clear. All staff prioritised safe, high quality and compassionate care and were working within their terms of reference.
- Staff supervision and peer review arrangements were appropriate. All staff groups now received regular formal peer supervision.
- Staff and patients were encouraged to provide feedback using QR codes and this was acted on to make improvements to the service.
- There was a focus on continuous learning and improvement at all levels within the service.

We identified the following notable practice, which had a positive impact on patient experience:

- Quality improvement work was delivering improvements for patients. We saw a piece of work which aimed to rationalise routine MIAC reviews and was succeeding in reducing waiting times for initial MIAC assessments. We also noted a project around integrated goal setting (across PCRF and RRU teams) which aimed to ensure that the most appropriate goals were being set with and by each patient. The OC had undertaken 'lived experience' service evaluation and had attended a rehabilitation course in order to experience care from a patient's perspective. This has resulted in a number of improvements to the way the course was delivered, including

providing a place for patients to store their belongings, providing a place for patients to sit and engaging with Chain of Command to extend their understanding of the value of rehabilitation.

- Multi-Disciplinary Team (MDT) meetings with PCRFs had been reinstated. This included recorded discussion around individual patients and integrated goal setting. Feedback from PCRF staff had been positive and it was felt that this integrated approach led to the best possible outcomes for rehabilitating patients.
- Risk assessment documentation had been streamlined to allow for more proactive and effective management of risks. This improvement work had been recognised as a purple ASER.

Recommendations for improvement
We found the following areas where the service could make improvements:

- Streamline the process for and clarify responsibility for RRU equipment servicing.

Sean O Kelly
Chief Inspector of Hospitals

Regional Rehabilitation Unit – Northern Ireland

Detailed findings

Why we carried out this inspection

The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare Regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare Regulator for the DMS.

Background to the service

The Regional Rehabilitation Unit (RRU) is a defence regional facility which provides medical opinion and delivers treatment for patients with moderate musculoskeletal injuries. There are 12 RRUs across the UK. RRUs deliver intermediate care and provide the main conduit to secondary care rehabilitation. Each RRU supports a number of identified primary care rehabilitation facilities (PCRFs). This support ranges from the receipt of referrals through to providing advice with regards to clinical governance and delivery.

RRU NI provides coordinated clinical management and intermediate rehabilitation to a tri-service population within a defined geographical region – Northern Ireland.

RRU NI takes its model of care from the Defence Medical Rehabilitation Plan in which clinical factors, service factors and local factors determine whether a patient can best be rehabilitated in a PCRF, RRU or Defence Medical Rehabilitation Centre (DMRC).
The RRU has four main roles:

1. Provision of specialist musculoskeletal opinion delivered by a Multidisciplinary Injury Assessment Clinic (MIAC). This includes a Sports and Exercise Medicine Doctor (SEM) and a physiotherapist and can include an ERI when required. Clinical assessment at the RRU is delivered through the MIAC.
The role of the MIAC is to determine:

- An accurate diagnosis.
- The need for further investigation.
- An appropriate treatment plan agreed with the patient.
- The patient's fitness for group-based exercise therapy.
- The requirement for onward referral.

The treatment plan may allow for patient management to be maintained at local level and preclude the need for secondary care or inpatient rehabilitation.

The MIAC is a critical element of clinical assessment and planning in the defence medical rehabilitation programme (DMRP). The MIAC will identify patient requirements and allocate appropriate early treatment based on clinical need, operational issues and individual circumstances. All patients being referred to the RRU for the first time should be seen in a MIAC. This is to ensure that there is an appropriate clinical plan for the patient and that the patient's case is being actively managed with interaction with relevant agencies. The MIAC clinicians are available to discuss individual cases prior to or after referral to MIAC.

2.Provision of specialist podiatry assessment. Currently the service hosts a Band 7 Podiatrist who provides services both within the RRU and to patients referred from surrounding PCRF's. The aim of the specialist podiatry service is to provide a clinical biomechanical podiatry service to all entitled service personnel within the RRU catchment area. The majority of patients with biomechanical problems are managed effectively within Primary Healthcare (PHC) at the PCRFs. Where this management is unsuccessful or a Podiatrist/Biomechanical specialist opinion is required, the RPS will provide a highly skilled and specialist lower limb biomechanical assessment and treatment.

3. Provision of intensive residential rehabilitation courses. This is for patients whose condition necessitates a period of intensive daily rehabilitation (such as post orthopaedic surgery). Patients may be referred for three weeks for rehabilitation on a 'trickle feed' course with other patients who have a range of differing injuries to the lower limb or spine. Rehabilitation sessions run in the mornings allowing patients who can to return to their units in the afternoon or to be accommodated on site at Aldergrove where travel is not possible.

4. Specialist outpatient injury assessment clinics (IACs) where treatment such as Extracorporeal Shockwave Therapy (ESWT) can be carried out.

Onward referral to other specialised centres can be arranged after MIAC, for example for MRI scan, ultrasound diagnostic scan, or orthopaedic opinion via the electronic referral system (eRS). This list is not exhaustive and can also include referral to DMRC for specialist advice and treatment of tendon injuries. There are links with local hospitals to access orthopaedic care, including private hospitals, both surgically and for MRI delivery.

The Regional Trade Specialist Advisor (RTSA) provides a regional, professional point of contact, conducting liaison visits with the PCRFs within region, and providing support and guidance. The RTSA also provides exercise rehabilitation instructor (ERI) mentoring in the region to all ERIs. All new joiners in the region are invited to attend a day at RRU to meet personalities, be provided training on DMICP, shadow course and MIAC in order to ensure joined up care between PCRF and RRU.

Access to the service is through referral from medical centres and PCRFs.
Most patients referred to the RRU will have already received rehabilitation at their local PCRF, and following rehabilitation at the RRU, will be discharged back to the PCRF.
All patients referred receive an initial joint assessment by a doctor (a specialist GP trained in sports and exercise medicine) and a clinical specialist physiotherapist, in the Multidisciplinary Injury Assessment Clinic (MIAC) located at the RRU.

Rehabilitation Referral Guidelines

Clinical Factors	• Moderate Injury • Requires intensive rehabilitation (daily) • Failure to respond to rehabilitation at PCRF level • Additional level of expertise
Service Factors	• Unable to continue to work in any capacity • Unable to continue work in specialist role (infantry, aircrew, PTI). • Temporary MES awarded
Local Factors	• No facility for local Rx available • Requires protected time for rehabilitation

The RRU is staffed by a service lead (permanent OC is now in post), clinical specialist physiotherapy lead (Band 7 is now in post), physiotherapists, a MIAC doctor (8 hours per week), regional trade specialist advisor (RTSA), exercise rehabilitation instructors (ERIs), a podiatrist and administrators.

Our inspection team

The re-inspection was undertaken by a CQC inspection manager.

How we carried out this inspection

We carried out an announced inspection on 14th February 2024. During the inspection, we:

- Spoke with staff, including physiotherapists, exercise rehabilitation instructors (ERIs), administrators, the OC and the RTSA.
- Asked patients to complete comments cards to tell us about their experience of the service.

- Looked at information the service used to deliver care and treatment.
- Reviewed patient notes.
- Reviewed policies and management information.

What people who use the unit say

There was a board in reception clearly stating the positive changes made to the RRU following patient requests and concerns. There were visible QR codes in both buildings for patients to report any building faults or defective medical/gym equipment. Numerous places in the RRU exist for patients to provide feedback to the RTSA through QR codes and email. Patient satisfaction information was collated on an ongoing basis and discussed at each healthcare governance meeting. We saw that 102 patients had submitted feedback following attendance on a course between January 2022 and October 2023. 100% said that they were satisfied with their care and stated that they would recommend the service to their family and friends. We noted that where patients had made suggestions, these had been considered and where possible implemented.

Ahead of our inspection, we sent comments cards to the service and asked staff to prompt patients to give their feedback. Thirty-two patients had filled these out and all were positive and reflected caring compassionate staff who went the extra mile to support patients' recovery. Seven patients commented that they had received good explanations around their treatment options so that they could make informed decisions about their care. Several patients commented on the cleanliness of the premises being good and a number stated that they had been able to access the service promptly.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Good 

Our findings

We found that this practice was well-led in accordance with CQC's inspection framework

Staff responsibilities were clear. Quality, performance and risks were understood and managed.

Vision and strategy

- The vision for RRU NI was to achieve excellence in patient care, targeted rehabilitation and so support patients to return to their work role. The strategy is to do this was through good communication with PCRFS and Units.
- The overarching mission statement for the RRU was 'To sustain and improve the operational effectiveness of service personnel by provision of high-quality targeted rehabilitation, accelerating the return of injured personnel to their optimal physical capacity, while influencing their psychological and social health.' It was clear from speaking to staff that they had a clear understanding of the importance of providing high quality, personalised rehabilitation to patients.
- There was a specific strategy and operational guidance for the defence medical rehabilitation programme (DMRP), which had been developed centrally. This contained detail on how the local services fitted into the overall strategy and operational framework. The document provided a detailed account of how services ran, what services were included, care pathways, all treatment referral clinical guidelines and facilities.
- The overall strategy of the DMRP was to maximise the number of service personnel who were medically fit for role.

Governance arrangements

The service had an overarching governance framework, which supported the delivery of the strategy and good quality care. This outlined structures and procedures to be followed. With increased leadership capacity since the previous inspection, responsibilities were now clear. Quality improvement work was being undertaken and risks were captured and managed.

- There was an effective governance framework to ensure quality, performance and risk were understood and managed. There was an overarching ministry of defence (MOD) corporate governance policy (JSP 525). This covered the structure of MOD governance, governance principle, roles and responsibilities, governance control processes and risk management

processes. The policy was not specific to the RRU but provided context and guidance about how MOD governance processes worked.

- Governance arrangements at RRU NI were systematic and reflected best practice. We saw the unit had a governance documentation and oversight system, which was referred to as the workbook. All staff could access the workbook and all staff were aware of the governance system through weekly team meetings and monthly governance meetings.
- We reviewed the governance workbook which included the risk register, quality improvement programme actions and progress, mandatory training compliance, professional registrations, complaints, incidents, standard operating procedures and meeting minutes.
- There was a healthcare assurance framework (HAF) assessment which was a live document used to support the delivery of good quality care. It was based on the five CQC domains of safe, effective, caring, responsive and well led. We reviewed the information held within this and were able to directly tie the evidence held there with our own key lines of enquiry.
- There were systems and processes to identify, manage and mitigate risks associated with the unit. RRU NI maintained a comprehensive register of risks that could affect the RRU and its staff and patients. The risk register was reviewed regularly by the unit leads. The risk was rated for likelihood of impact and probability it would occur. Management plans and mitigating actions had been identified to manage the risk. A responsible person had also been designated to oversee and manage the risks. A decision was recorded as to whether a reach risk should be Treated, Tolerated, Terminated or Transferred. Staff we spoke with were engaged with the risk management process, the risk register and told us they were involved in discussions about solutions. This was in line with the RRU's risk management standard operating procedure.
- All active risks identified on the RRU risk register had a description of the identified risk, a risk rating, actions to mitigate the risk, timeframe and date in which the risk required a review. Each risk was RAG rated to give a severity score and an associated risk control approach. We saw that there risks had been escalated to Commander DPHC via DHRG, including the closure of the rehabilitation pool. Since our last inspection Hepatitis B status records for staff working the RRU had been obtained, an area affording privacy in the RRU gym had been created and all consultation rooms now had sinks. Some additional infrastructure improvements were outstanding but statements of need had been submitted and sat with Headquarters for mitigation. A business case had also been submitted to increase the hours of the doctor from 8 hours to 16 hours per week to allow time for mandatory training, administration, sick and annual leave. Risks that were no longer applicable were retired from the risk register.
- There was a programme of clinical and internal audit used to monitor quality and identify areas for improvement. An audit log was maintained which identified which audits were to be completed, how often, when they needed to be reviewed and who was responsible for the audit. We saw a piece of work which aimed to rationalise routine MIAC reviews with the aim of reducing waiting times for initial MIAC assessments. We also noted a project around integrated goal setting (across PCRF and RRU teams) which aimed to ensure that the most appropriate goals were being set with and by each patient. The OC had undertaken 'lived experience' service evaluation and had attended a rehabilitation course in order to experience care from a patient's perspective. This has resulted in a number of improvements to the way the course was delivered, including providing a place for patients

to store their belongings, providing a place for patients to sit and engaging with Chain of Command to extend their understanding of the value of rehabilitation.

- In April 2023, RRU NI hosted an 'mTBI/Vestibular Roadshow 'which aimed to support clinicians in the early identification and effective management of vertigo, dizziness, and imbalance following concussion.
- With a Band 7 physiotherapist now in post, it had been possible to reinstate the Multi-Disciplinary Team (MDT) meetings with PCRFs. This included discussion around individual patients and integrated goal setting.
- Following the previous inspection, work had been undertaken around Apollo patient outcomes. (Project Apollo is a performance tool used to measure the progress of patients against set indicators). Indicator DHIR032 measures the percentage of care pathways at the RRU which showed improvement in validated outcome scores within the year. It was identified that data around the MSK-HQ score had not been accurately captured in Apollo and a manual check was undertaken – this showed that 98% of patients had completed the outcome score for MSK-HQ. For RRU NI, 67% of patients had an improved FAA score in the past 12 months and 19% were shown to have an improved MSK-HQ score in the last 12 months.
- There were clear arrangements providing good oversight of safety, quality and risk at the RRU. There was a monthly team meeting at which all aspects of areas related to governance were discussed, which included safety and quality issues such as incidents, training, risks, infection prevention control, equipment updates staffing and patient feedback. We saw minutes of meetings which indicated this was occurring regularly. Staff told us they felt these meetings were a whole team affair and everyone was engaged and participated in discussions.
- The RTSA, OC and administrator often met informally on a daily basis to discuss and address any pertinent issues. Discussions with gym staff took place on most afternoons. Any decisions were then discussed at staff meetings and recorded.
- We reviewed the terms of reference and job descriptions for key staff within the service and noted that lines of accountability were appropriate and in line with the skills and experience of the individual staff member. Staff with allocated time and training were leading on healthcare governance.

Leadership and culture

The management in the service demonstrated they had the experience, capacity and capability to run the service and ensure high quality care. They told us they prioritised safe, high quality and compassionate care.

- Leadership capacity at this RRU had increased since our last visit with the fulfilment of key staff roles. A band 7 physiotherapist had joined the team and a permanent OC was in post. A second administrator had also joined the team. The doctor continued to work an 8 hour week, which did not allow sufficient time for mandatory training and administration and meant that the staff member sometimes worked evenings to cover requirements.
- Safe, high quality and compassionate care was prioritised at all times. Line management responsibilities had been reviewed since the previous inspection. Staff had the skills, knowledge and experience to carry out their roles effectively and terms of reference reflected this. The return to post of the OC had brought a positive management approach to the team.

- Since the last inspection, the support arrangements available to the RRU in Northern Ireland had changed and was now provided by Operations Rehabilitation DHRG. We spoke with two individuals working within DHRG and discussed their input with staff working in the RRU - their contribution and professional knowledge was appreciated and valued.
- There was a patient-centred culture at the unit. Staff described how the leadership team promoted an inclusive and open-door culture with everyone having an equal voice, regardless of rank or grade. Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. Staff were given the opportunity to express their views at meetings.
- Staff supported each other on a daily basis and worked together to provide high quality care for patients. Staff told us of the supportive relationships in the RRU and of the opportunities they had as a team to review the care and treatment being provided to individual patients.
- Staff felt respected and valued and leaders encouraged supportive relationships between staff. Staff felt they could raise any worries or concerns and that these were always listened to and acted on. All staff at the unit, along with the service lead spoke of an open-door policy. Staff felt confident and safe to speak openly about any concerns they had. There was a whole team ethos of 'equal voice' regardless of rank.

Seeking and acting on feedback from patients and staff

- Patient satisfaction information was collated on an ongoing basis and discussed at each healthcare governance meeting. We saw that 102 patients had submitted feedback following attendance on a course between January 2022 and October 2023. The latest results showed high levels of satisfaction. Feedback collected was used to adapt and develop the way services were delivered. The service was able to provide examples of when they had acted on patient feedback to make improvements.
- Staff were encouraged to give feedback and discuss any concerns or issues with colleagues and management. There was an open-door policy and staff felt comfortable to raise any issues or concerns with the service lead. They felt they were always listened to and well supported. Staff raised feedback points on a daily basis and these were formally recorded in the next weekly staff meeting. Examples of improvement following staff feedback included the gym staff suggesting that new flooring was required and a recent order for more gym equipment including rowers, calf raise machine and ski ergos.
- The culture at the unit was developed around providing a personalised patient focussed service to meet the needs of each individual, in a timeframe which met their military operational requirements.

Continuous improvement

- Issues around cleaning standards had been tackled and direct liaison with the contractor has ensured that improvements were delivered.
- There were visible QR codes in both buildings for patients to report any building faults or defective medical/gym equipment. Numerous places in the RRU existed for patients to provide feedback to the RTSA through QR codes and email. Patients gave excellent feedback about their experience and were fully involved in their care. We also noted that any patient or staff feedback was listened to and used to make improvements where possible.
- Multi-Disciplinary Team (MDT) meetings with PCRFs had been reinstated. This included recorded discussion around individual patients and integrated goal setting. Feedback from

PCRF staff had been positive and it was felt that this integrated approach led to the best possible outcomes for rehabilitating patients.

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