

Defence Medical Services

Plymouth Regional Rehabilitation Unit

Inspection Report

Regional Rehabilitation Unit

RRU Plymouth

Old Gymnasium

HMS Drake

Plymouth

Devon

PL2 2BG


Date of inspection visit 07 July 2021

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This report describes our judgement of the quality of care at this service. It is based on a combination of

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

We carried out an announced comprehensive inspection at Plymouth Regional Rehabilitation Unit (RRU) on 7 July 2021.

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 Defence Medical Services.

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

We found that this practice was safe in accordance with CQC's inspection framework

- There was an effective system available for staff to report significant events, incidents, near misses and concerns.
- Risks to patients who used services were assessed and their safety monitored and maintained.
- Staffing levels, skill mix and caseloads were planned and reviewed to ensure people received safe care and treatment at all times, in line with relevant tools and guidance.
- The unit had adequate arrangements to respond to emergencies and major incidents.

We found that this practice was effective in accordance with CQC's inspection framework.

- Patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Relevant and current evidence-based best practice guidance had been identified and developed for defence rehabilitation services. This was used to direct how services, care and treatment was delivered.
- There was a strong team approach to multidisciplinary working within the RRU.
- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis.
- Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Patients were encouraged to be owners of their care and treatment. Additional information and support was available at the RRU to supplement rehabilitation programmes to ensure care and treatment optimised recovery.

We found that this practice was caring in accordance with CQC's inspection framework.

- Patients spoke positively about the care they received from the staff at the unit.
- Staff communicated with patients in a way that they would understand their care and treatment.

We found that this practice was responsive in accordance with CQC's inspection framework.

- The introduction of the trickle feed model had improved the quality of service provided to patients.
- The unit used information about the needs of the Population at Risk (PAR) within the Area of Responsibility (AOR) to inform how services were planned and delivered.
- The RRU had a system for handling concerns and complaints. Action was taken to improve the service as a result of complaints.
- The RRU was performing well against set key performance indicators.

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

- There was a clear vision for the RRU and their priorities to improve the quality of care and treatment at the RRU had been set out and achieved.
- There was evidence across the RRU of strong and passionate leadership, and a commitment to provide high quality services for patients.
- Governance systems were in order and it was clear a large amount of work had been done to facilitate effective implementation of systems and process to ensure clear oversight of the service.
- There was a culture of a strong teamworking ethic across the RRU. The team was cohesive, engaged and involved in all aspects of the running of the RRU.
- Feedback was sought from patients to identify whether improvements could be made to the course. Feedback for both the course and MIAC was very positive.
- However, although not a criticism of RRU Plymouth, we were concerned about the future stability of the unit and the potential loss of the positive changes which had been introduced and developed under the current OC. This was due to the current OC moving to a new post, the previous turnover of staff and the lack of training available for leaders coming into the unit to manage the role.

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

- The introduction of the trickle feed model had been instrumental in the provision of an improved quality of service being provided to patients. It had also provided staff with improved job satisfaction.

Professor Ted Baker

Chief Inspector of Hospitals

Regional Rehabilitation Unit – Plymouth

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 Defence Medical Services.

Background to the service

Regional Rehabilitation Unit (RRU) Plymouth is a rehabilitation facility provided by the Defence Primary Healthcare (DPHC) Unit delivering intermediate rehabilitation within the Defence Medical Rehabilitation Programme (DMRP). The regional rehabilitation unit (RRU) is located at Plymouth in Devon and provides clinical management of moderate musculoskeletal conditions to the military population within a defined geographical area. There are 13 RRUs across the United Kingdom.

Plymouth supports a population of 20,000 and includes 19 Primary Care Rehabilitation Facilities (PCRF), where 10 of these refer into the RRU. This ranges from Royal Marines, Royal Navy, Army and RAF personnel, including Phase 1, 2 and two air stations. This population provides significant challenges for rehabilitation due to the injuries sustained and the requirement to regain the required fitness levels to enable military personnel to carry out their physically demanding military roles. The service does not treat patients with complex psychological conditions and patients are screened for this prior to referral. The service does however provide information and support in the bio-psychological management of pain and can refer onto specialist services if required.

Multi-disciplinary Injury Assessment Clinic (MIAC)

Clinical assessment at the RRU is delivered through the MIAC. This is a combined clinical assessment by a specialist GP trained in Sports and Exercise Medicine (SEM) to diploma level, a physiotherapist (clinical specialist) and an exercise rehabilitation instructor (ERI). The GP should ideally be an experienced military officer. 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. The role of the MIAC is to determine:

- An accurate diagnosis.
- The need for further investigation.
- A treatment plan, agreed with the patient.
- The patient's fitness for group-based exercise therapy.

- The requirement for onward referral.

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.

Injury Assessment Clinic (IAC)

An IAC comprising of a physio and an ERI can be used for the assessment of patients with a confirmed diagnosis or the review of those returning after investigation or outpatient treatment where the management plan has already been agreed at the MIAC.

Onward Referral

The RRU provides the gateway to onward referral to secondary care including:

- Stanford Hall
- Fast Track orthopaedic surgery
- Other secondary care and opinion such as orthopaedic opinion, pain management, etc.

Clinical Investigations

The RRU provides the gateway to rapid access imaging. RRUs also have access to on-site diagnostic ultrasound scanning for immediate clinical guidance.

Residential Therapy

This is for patients whose condition necessitates a period of intensive daily rehabilitation (such as post orthopaedic surgery), whose condition may be exacerbated by travel or who cannot effectively perform their role or find protected time whilst in full time employment. Patients may be admitted for three weeks into homogenous patient groups for rehabilitation of specific conditions (e.g. back pain) or into general groups with a range of differing injuries.

Regional Podiatry Service (RPS)

The aim of the RPS 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, together with the provision of both off-the-shelf and custom-made orthotics from an MOD approved supplier as required. The RPS is commanded by and accommodated at the RRU. It consists of two part time podiatrists (30hrs and 14.5 hrs) who will deliver clinics at either the RRU or regionally through a peripatetic service.

The service lead (OC) and Regional Trade Specialist Advisor (RTSA) provide a regional SME and professional POC, conducting liaison visits with the satellite physio departments within region, providing support and guidance on HG or military processes, specific equipment care processes. The RTSA also provides ERI mentoring in the region to all civilian, military and locum 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 PCRFS and RRU.

Access to the service is through referral from other services in the DMRP and patients 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. Patients can access one to one treatment and rehabilitation courses to treat their conditions. Courses on average run for 2 weeks but this can be adapted to the individual patients

needs three. Patients are expected to attend for the duration of the course and can live on site or off-site locally. During courses, patients can access one to one treatment at the same time.

The RRU is staffed by an OC, a clinical specialist physiotherapy lead, physiotherapists, MIAC doctor, regional trade specialist advisor (RTSA)/ lead exercise rehabilitation instructors (ERIs), a podiatrist and administrators.

We carried out a comprehensive announced inspection of this service. RRU Plymouth had not been inspected by CQC previously.

Our inspection team

Our inspection team was led by a CQC inspector. The team included three inspectors.

How we carried out this inspection

Before visiting, we reviewed a range of information about the unit. We carried out an announced inspection on 7 July 2021. During the inspection, we:

Spoke with 12 staff, including physiotherapists, exercise rehabilitation instructors (ERIs), administrators, MIAC doctor and the service lead. We were able to speak with patients who were on courses or receiving treatment on the day of the inspection.

Looked at information the service used to deliver care and treatment.

Reviewed patient notes, complaints and incident information.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

What people who use the unit say

Patient survey results were collected and reviewed following each course. Results from March to June 2021 showed that the majority of respondents, felt all elements of the course from joining, through to specific aspects of course delivery were with good or excellent. 100% of patients said they felt staff attended to their individual needs and felt the delivery of the course and individual programme sessions were either good or excellent.

Comments provided included 'the course exceeded my expectations,' 'fantastic course,' 'I feel more confident,' and 'staff were helpful supportive and knowledgeable.'

Comments were equally as positive about the MIAC clinic. All of the respondents to the questionnaire between April and June 2021 were 100% satisfied with their appointment, the access they had to healthcare advice and the feeling that their needs were addressed. All of the respondents were satisfied with their care and treatment and would recommend the service to a friend or colleague.

As part of our inspection, we also spoke with eight patients. Patients were consistently positive about their experience at the RRU which reflected the outcomes of the patient satisfaction questionnaires completed by patients after finishing their rehabilitation at the RRU.

Good



Are services safe?

Our findings

We found that this practice was safe in accordance with CQC's inspection framework

Safe track record and learning

There was a system for reporting and recording significant events. Action and learning was taken as a result of incidents which had occurred.

- There was a system available for staff to report significant events, incidents, near misses and concerns and mechanisms for maintaining patient safety, through online tools, such as the ASER (Automated Significant Event Reporting) toolkit to report. A spreadsheet of all incidents was maintained.
- Staff understood their responsibilities to raise concerns and record these. Incidents were reviewed, thoroughly investigated and closed by the service lead. If the incident occurred in the RRU, these would be reported to the Navy Safety Occurrence Report (NSOR) and DPHC. If incidents occurred outside on the base, they would only be reported to NSOR, even if RRU staff were involved. There had been one incident where an RRU staff member tripped outside in the base in a pothole. This was reported to NSOR and action was taken and repairs were carried out to make the area safe.
- The Automated Significant Event Reporting system (ASER) also identified a further 13 incidents between June 2020 and June 2021. Of these incidents, the most commonly reported incidents related to administration issues and medical device and environmental issues.
- Once incidents had been identified, lessons were learnt, and action was taken to improve safety. We saw evidence that incidents and the outcomes were discussed between all staff at the healthcare governance meetings.
- The duty of candour relates to openness and transparency. It requires staff to be open, transparent and candid with patients when things go wrong and offer an apology to the patient as soon as the incident had been identified, irrespective of who was to blame. No reported incidents at the RRU had required the application of the duty of candour.

Overview of safety systems and processes

Essential systems, processes and practices were available to ensure patient safety.

- Systems, processes and practices to ensure patient safety supported all aspects of care and treatment provided by RRU Plymouth. Staff received mandatory training in safety

systems, processes and practices. Staff at the RRU were 100% compliant with mandatory training.

- An overview of mandatory training compliance was stored electronically. A lead member of staff had a designated role to monitor mandatory training compliance at the RRU. Training was usually completed by staff in the allocated governance weeks and the move to the trickle feed model meant there was greater flexibility for staff to attend courses.
- Arrangements for safeguarding reflected relevant legislation and local requirements. Staff received safeguarding training to level two in line with national guidance. All staff at the RRU were compliant with safeguarding training. The doctor at the RRU held level three safeguarding training. Staff understood their responsibilities and adhered to safeguarding policies and procedures. There had been no safeguarding issues raised by staff at RRU Plymouth.
- Systems, processes and practices kept patients safe. All staff were Disclosure and Barring Service (DBS) checked. This ensured all staff at the RRU were safe and fit to practice. All staff working for the RRU had an up to date DBS check.
- Chaperone posters were displayed around the RRU. These highlighted the opportunity for patients to have a chaperone present for any appointments they attended. Some staff at the RRU had also received training to be chaperones.
- The environment provided a challenge to ensure confidentiality was maintained for patients. This had been identified on the risk register, and there was an acute awareness of this risk by all staff. This was due to the open plan layout of the facility. A number of actions had been taken to manage the risk this created. These included use of the annex facility, trying where possible to ensure clinics did not cross over, provision and the option of a confidential space for patients if they so wished and information was also provided to patients to make them aware of this issue and the options available to them. Patients we spoke with felt that this had not been a problem for them. There had been no complaints logged as a result of this issue.
- A proactive approach to the longer-term management of the confidentiality issue was ongoing at the time of our inspection. A statement of need for change to the facility had been raised to secure building works for a specific clinic room. This was raised in May 2021 and the unit was awaiting the final outcome.
- Infrastructure challenges also included the disjointed administration provision from a geographical perspective. Working practices had changed to ensure that the RRU was able to meet COVID-19 guidance and requirements within the environment they had. This meant that the outpatient service has moved to the annex. One member of the admin team had also moved to the annex as a result of the change to the service delivery. New ways of working had been developed and driven by the administration team to overcome the challenges and improve communication. Administration staff felt heard and had been supported by the OC to make the required changes to mitigate the risks of this change.
- The service had suitable premises and equipment and looked after them well to ensure the safety of staff and patients. There was a wide range of equipment to aid patients recovery and rehabilitation. Equipment was stored tidily with some on designated racks and off the floor to assist adequate cleaning of the facilities.
- Arrangements for the maintenance and use of equipment ensured patient safety. Equipment was used, maintained and serviced in line with manufacturers' instructions. An electronic inventory log was maintained and held information as to when maintenance had taken place for the equipment at the RRU. The log showed servicing was in date.
- There was a clear process to manage faulty equipment in a timely way. Issues with equipment were reported verbally to the RTSA on site. This resulted in the equipment being put out of use and a request for a repair was booked.

- Resuscitation equipment was available in the gym area and was checked daily to ensure it was ready for use in an emergency. An automated external defibrillator was available in the main rehabilitation area.
- A member of staff at the RRU was the infection prevention and control (IPC) link for the unit. Staff could discuss any issues around infection prevention and control with them. Staff were aware of who held this role.
- Changes to IPC systems, processes and practices had changed at the RRU due to COVID-19 to ensure the safety of patients and staff. Patient flow was now in operation round the building and staff wore full personal protective equipment when they directly interacted with patients. We saw additional signage and guidance about COVID-19 IPC practices which had been implemented at the RRU. For example guidance about hand washing was available and there was an IPC notice board in the reception area to provide clear information for all attending the RRU to ensure safety.
- COVID-19 had influenced a change in the model to which RRU course delivery was provided and infection control practices were managed. These were outlined in the RRU Plymouth COVID-19 working practices document. Training was provided to staff as part of a wider training programme which included DONNING and DOFFING of personal protective equipment, cleaning of high risk areas, how to manage a suspected COVID-19 patient in the RRU and cleaning expectations for the patients using the service. All risk assessments had been updated to include COVID-19.
- The unit had reliable systems which protected patients from healthcare associated infections. The RRU was cleaned daily by a team from the military base. Additional cleaning, as a result of COVID-19 was also being carried out by the staff at the unit around touch points. Equipment was cleaned twice a day, and there was a cleaning schedule identifying high risk areas and how often they need to be cleaned and also detailed the most appropriate cleaning product to use.
- There were signs and posters around the unit reminding staff to wash their hands and how to take personal protective equipment on and off. There was also the availability of PPE and hand gel and access to sinks to ensure standards of cleanliness and hygiene were maintained.
- Infection prevention and control audits were carried out every eight weeks. At the time of the inspection one was underway. Actions from the most recently completed audit included purchasing new plastic noticeboards to improve IPC and new clinician chairs which enabled more effective cleaning. Regular handwashing audits were carried out which looked at a small sample of staff at the RRU and staff received annual handwashing training.
- The service used the defence medical information capability programme (DMICP) to store and access electronic patient records. This allowed staff to access patient records, in line with their role and the level of access they would require to view the information needed to treat the patient.
- Patient records were organised, up to date and shared and stored appropriately. We reviewed 10 patient records for patients attending the multidisciplinary injury assessment clinic (MIAC) and rehabilitation courses. Records included referral information, patient assessments, consent and treatment plans and were all complete.
- There was a medicines management policy JSP 950 9-2-1 available detailing the obtaining, storing, handling, prescribing, supplying and disposing of medicines. A standard operating procedure for medicines management, including injection therapy written by the doctor was also available specifically for RRU Plymouth and due for review in 2022. This covered emergency equipment requirements, storage, checking and recording of information in patient notes.
- We saw that staff followed this policy and medicines were stored safely and securely. Systems were followed for prescribing, supplying and managing medicines stock using an

electronic recording method. Medicines were checked to be in date and fridge temperatures were checked and recorded in line with the policy at each clinic.

- Staff could identify and respond appropriately to patients whose health was at risk of deteriorating and managed changing risks to patients who used services. Staff had access to and automated external defibrillator at the unit.

Monitoring risks to patients

Risks to patients who used services were assessed and their safety monitored and maintained. Staffing levels, skill mix and caseloads were planned and reviewed to ensure people received safe care and treatment at all times in line with relevant tools and guidance.

- Comprehensive risk assessments regarding service provision were carried out using a clear methodical approach and actions to mitigate any risks had been identified. Risk assessments completed for the service included the group sessions, aquatic therapy and injection therapy. Other risk assessments had been completed for all other aspects of service delivery at the RRU. These documents were held electronically. We reviewed three risk assessments. Each 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.
- As of June 2021, RRU Plymouth had a 98% staff fill rate. The unit was down 0.25 WTE for a band six physiotherapist and 0.15 WTE for a GP in Sports & Exercise Medicine. There was one vacancy for an administration post. The ERI posts had, until recently, been filled by locums. However, at the time of our inspection, one of the ERI posts had been filled with a substantive member of staff who had commenced their role the week prior to our inspection. The other ERI post had been recruited to and the substantive post holder was due to start in September 2021. Funding to maintain locum cover in this role until September 2021 had been secured so there were no gaps that could impact on service delivery.
- Workforce issues were also a challenge at the RRU as the current workforce did not reflect the size of the population at risk (PAR) served by the RRU. This was also reflected in the workforce numbers of other RRUs who served a similar size PAR. A business case had been put forward to increase the number of doctor hours provided at the RRU. The RRU, at the time of the inspection, had 32 hours of doctor cover. However, this was lower than other RRUs that serviced the same size PAR. The RRU was also waiting to finalise an increase in band six physiotherapist hours and that of a further band seven physiotherapist role.
- For the period from June 2020 to June 2021, the RRU reported that there were no sickness days for the operational commander, the doctor, podiatrist or exercise rehabilitation instructors (ERI). For the same period, the RRU reported that there were 51 sickness days for the admin staff and the physio team had a total of two sickness days.
- The staff to patient ratio on the courses was determined to ensure the safety of patients. The ratio of staff to patients was two staff for 15 patients. Different components of the course were delivered by either the ERI or physiotherapist individually, or as a pair when required. Approach to treatment was based on the skills of staff and this also allowed time for staff to treat patients on a one to one basis when necessary. Changes to service provision as a result of COVID 19 mean that the course was limited to 15 patients, each with their own stations.

Arrangements to deal with emergencies and major incidents

The unit had adequate arrangements to respond to emergencies and major incidents.

- Potential risks for the service were anticipated and planned for in advance. The business continuity and resilience plan was specific to RRU Plymouth. The plan identified major threats to all aspects of service delivery, such as MIAC, IAC and podiatry services and the course and mitigation and management if an emergency or major incident occurred. The document provided guidance on alternative locations and outlined how the service would continue to run in an emergency situation.
- The COVID 19 pandemic posed a major risk for all business and services. The RRU had to make adjustments to enable service continuity. The RRU Plymouth COVID 19 working practices document was developed and a training programme to support the staff had also been implemented to introduce, implement and embed the changes to practice which were needed at the RRU. Training included course admission processes, IPC, equipment management, and basic life support in the COVID 19 environment to name a few.

Are services effective? (for example, treatment is effective)

Good



Our findings

We found that this practice was effective in accordance with CQC's inspection framework

Effective needs assessment

- Patient's needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Relevant and current evidence-based guidance had been identified and developed for defence rehabilitation services and was used to direct how services, care and treatment were delivered. These guidelines determined the necessary assessments and treatments required for specific conditions.
- Staff had access to best practice guidelines to inform the care and treatment they provided to patients. Specific guidelines had been produced to cover a range of conditions seen at the RRU. Common guidelines and pathways documents were available for staff and patients to reference in the gym.
- Rehabilitation was delivered in line with evidence-based practice guidance on treating musculoskeletal conditions and provided a holistic approach to rehabilitation. The education sessions for the course were based on best practice guidance and had been written centrally and had to cover a range of information to accommodate for different levels of baseline knowledge and understanding between the patients. Patients spoke very highly of the education sessions provided by the RRU and had found them a supportive part of their rehabilitation.
- Pain was assessed and managed according to each individual patient and patients felt their pain was managed well. Pain was assessed using a visual analogue scale (a straight-line scale from one to 10 which could be used to rate their level of pain) when patients were assessed and in response to treatments so staff could monitor the effect of these on pain. Patients spoke positively of how their pain had been managed and adjustment which had been made to enable them to continue with their rehabilitation without making their pain worse.

Management, monitoring and improving outcomes for people

Validated patient reported outcome measures (PROM) were used for all patients attending the RRU.

- Objective measures were routinely used pre and post treatment to identify improvements which had been made to the individual patient's condition following the course of treatment. These measures were patient specific to provide an objective measure associated with the patient's injury. Objective measures used included the single leg bridge, straight leg raise, single leg seated press and the multistage walking test.

- There had been a drive to look to introduce more functional outcome measures to better support the PCRFS and the occupational health team in making decisions about navy personnel returning to work. In November 2020, the unit introduced the Functional Assessment Simulating Ships Tasks outcome measure. This measure was carried out at a point in time, decided by the clinicians and the patient to see whether the patient would be ready to cope with the demand of returning to operational work on board a ship. At the time of the inspection, work was ongoing to implement the use of this tool more regularly at the RRU and the linked PCRFS. We saw evidence that the OC had escalated this to make this mandatory and to ensure there was a way to understand the effectiveness of its use via use of an audit tool.
- Patients had their needs assessed, their care planned and delivered, and their care goals identified when they started treatment at the RRU. Prior to starting the course, the patient would be assessed by the physio and ERI to identify their individual needs. On starting the course, patients would set short, medium and long-term goals in conjunction with what they wanted to achieve. Goals set were specific, achievable, measurable and had a timeframe for completion. Education sessions and information was provided to patients in goal setting to enable them to get the most out of their rehabilitation at the RRU. This enabled a treatment programme to be designed specifically to meet the individual needs of each patient.

Effective staffing

Staff had the competencies and experience to carry out their role, which enabled them to optimise care and treatment for patients.

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis. A policy was in place for the statutory professional registration of healthcare professionals in the defence medical services. This covered the requirement for professional registration, confirmation of registration on and during appointment, and a list of registered healthcare professionals who could be employed by the Ministry of Defence.
- A peer review took place between exercise rehabilitation instructors (ERI) and physiotherapy staff including staff of different grades and disciplines. This provided an opportunity for staff to have their practice critically appraised to identify any areas which needed to develop to ensure high quality care and treatment was provided for patients. This was a new initiative as the physiotherapists and ERIs were new in post. Staff told us there were plans to embed sessions further to ensure they were documenting learning for professional development.
- Staff received in-service training to develop their knowledge and skills to optimise care and treatment for patients. The RRU was part of a regional in-service training and also part of the local in-service training programme run by PCRFS Drake. The training was provided by staff from the RRU and external speakers, depending upon the topic being covered and the best placed person to provide the training. The first face to face session was due to be held in December 2021 with a focus on functional outcome measures, in particular the Functional Assessment Simulating Ships Tasks which had recently been introduced at the RRU.
- The learning needs of staff were identified through an appraisal system. At the time of the inspection, all staff who required an appraisal had received one. Staff were responsible for arranging their own appraisals. This was due to the different requirements for military and civilian staff regarding specific times of the year when these needed to be completed.

- Newly appointed staff, locum staff and students were part of a mandatory induction programme. The induction programme had been introduced one year ago, following the start of the OC and RTSA coming into post and their not being a formal induction programme specific to the RRU. The induction booklet included a comprehensive document including all essential information new staff needed to be aware of and have access to. This ensured staff were familiar with the environment and their role and responsibilities on starting work at the unit.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the unit's patient record system and their intranet system.

- All staff at the RRU, including those from different services were involved in assessing, planning and delivering patients care and treatment. Joint assessments allowed care and treatment to be optimised for patients due to the provision of a more co-ordinated approach to management of the patient's condition. For example, physiotherapists and ERIs jointly carried out initial patient assessments developing treatment plans for patients attending the course, and the doctor and clinical lead physiotherapist held a joint MIAC clinic.
- Staff had the information they needed to deliver effective care and treatment to patients. Each member of staff had access to the electronic records system which held a contemporaneous, multidisciplinary record of the care and treatment of individual patients at the unit.
- Weekly multi-disciplinary team meetings attended by staff at the RRU ensured that all patients were discussed and where required, signposted to other services to manage their ongoing physical rehabilitation and mental health needs. Staff also had access to a shared diary which included information about when audits needed to be completed and other information which enabled the seamless running of the service of the RRU.
- Patients received clear information prior the course to fully inform them about the treatment they would receive and what was expected. Patients told us this information had been useful and informative.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood relevant consent requirements and sought patients' consent to care and treatment in line with legislation and guidance.
- The consent policy was displayed on the wall in the RRU. The policy included the consenting process and staff responsibilities regarding consent processes. The policy also displayed the rights of the patient in the consent process. Consent forms were sent to patients prior to them starting on the course and ongoing implied consent was taken when patients attended the course programme on a daily basis.
- Written consent was obtained for treatments which involved a high level of risk. Patient records for patients who had undergone either shockwave therapy (electrotherapy treatment for soft tissue and bone conditions), acupuncture or injection therapy contained a consent form identifying benefits, risks and contraindications of treatment. All consent forms were signed and dated by the individual receiving the treatment and then scanned onto the electronic record system.

- We reviewed 10 sets of patient records and found that verbal consent had been recorded in all but one treatment episode.

Supporting patients towards optimal function

Patients were encouraged to be owners of their care and treatment. Additional information and support was available at the RRU to supplement rehabilitation programmes to ensure care and treatment optimised recovery.

- Patients were encouraged from the start to take ownership of their rehabilitation and promoted self-management from an early stage in the course. The course was designed to directly involve patients in setting short and long-term goals. Patients were supported to take responsibility for their rehabilitation with the view to ongoing self-management on completion of their course at the RRU in order to achieve their longer-term goals. Patient goals were specific so they could achieve what was required from their treatment.
- Rehabilitation courses included education and information sessions to support patients in developing skills to help manage their own conditions. For example, education about pain and pacing activities was delivered so patients could use these principles for their ongoing rehabilitation once they had left the course. Patients spoke highly of the education sessions provided as part of their programme.
- Information was available to support patients to manage their own health and wellbeing. In the reception area there were information leaflets that provided advice and signposted patients to other mechanisms of support with issues such as mental health problems and the gym had noticeboards containing useful information, for example around the importance of nutrition.

Good



Are services caring?

Our findings

We found that this practice was caring in accordance with CQC's inspection framework.

Kindness, dignity, respect and compassion

Interactions we observed between staff and patients were respectful. Staff treated patients with compassion. Staff were helpful and courteous and treated patients with respect.

- Patients were treated with compassion, staff discussed treatments with patients and were able to adapt individual treatments in response to patient feedback. Staff were supportive in their approach to patients and motivated and empowered them to fully participate in activities to their own ability and drive their own rehabilitation.
- Patient's personal, cultural, social and religious needs were understood and respected. Individual needs of patients and the occupational needs of their employment were considered when devising treatment plans.
- All interactions between staff and patients were appropriate and respectful. Staff built up a rapport with patients quickly and we observed friendly communication with them engaging in day to day conversation.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time to ask questions and get support on a one to one basis.

- Staff were able to form close professional relationships with the patients due to the nature of their work. Over the course duration, they were able to spend time talking to patients about their care, treatments goals and progress. Staff demonstrated a passion for their role and an encouraging, and supportive attitude towards patients.
- Patients were encouraged to be active partners in their care.
- Staff communicated with patients to make sure they understood why they were doing specific exercises. Patients told us they received one to one care from the course instructors to ensure patients were using the correct the technique and they took the time to explain things and modify treatment programmes when required to ensure rehabilitation and recovery chances were optimised.
- Patients told us there were opportunities for them to ask questions and be involved in their care and treatment. This helped to facilitate patients to take control and manage their rehabilitation independently with guidance from the staff.

Patient and family support to cope emotionally with care and treatment

Staff communicated with patients in a way that they would understand their care and treatment.

- It was evident staff clearly understood the impact which patients care, treatment or condition had on their wellbeing.
- Patients were encouraged to link with other course participants while they were completing their rehabilitation. Patients had the opportunity to stay in RRU accommodation on site, which provided them with the opportunity to socialise together during the course, during mealtimes, and in the evening.
- Patients gave us examples of how course staff had effectively managed their pain to enable them to continue to participate in their rehabilitation in a modified way which did not make their pain worse.

Are services responsive to people's needs?

Good



Our findings

We found that this practice was responsive in accordance with CQC's inspection framework

Responding to and meeting patients' needs

The RRU had recently changed its model of care provision to ensure that patients received rehabilitation in a more timely way. Information about the needs of the Population at Risk (PAR) within the Area of Responsibility (AOR) were used to inform how services were planned and delivered. The new model had demonstrated an improved quality of care was being provided to patients.

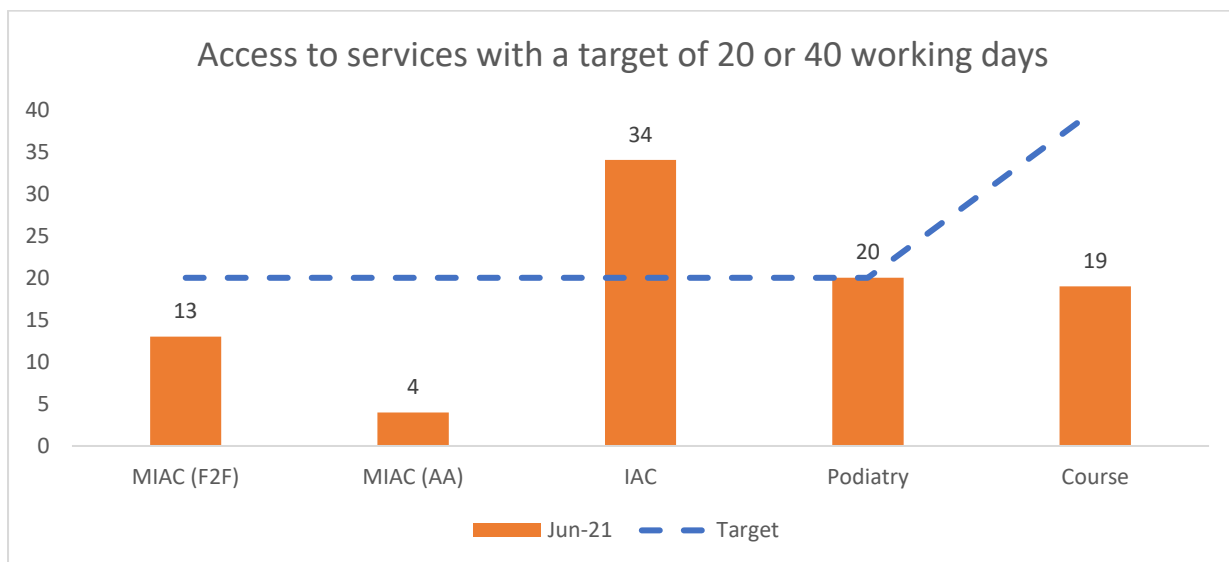
- The model of care provided at RRU Plymouth had changed in September 2020 to a trickle feed model (this model allowed patients to start the courses when they needed it rather than at a specific designated point in time). Delivery of the trickle feed service improved access, flexibility and timely rehabilitation at an earlier stage to enable patients to return to operational duties in a more timely way.
- The model had positively impacted the unit and the ability for patients to access timely care and treatment. The previous model had seen challenges around filling the courses and the length of time patients would wait to start a course following a MIAC assessment. The trickle feed model was introduced to enable an improved patient focus, based around the principle of right patient, right time, right rehab, ensuring key performance indicators were met enabling patients to access the course in a timely way. Prior to this new model being introduced, patients were waiting over 40 days (over KPI) to access the course. Following the introduction of the model in September 2020, 100% of patients had been able to access their required course within 40 days.
- One 'generals' course was being held at the RRU using the trickle feed model. These included lower limbs, spines and upper limbs patients with a range of injuries for a period of rehabilitation. This could range between one and seven weeks depending on the individual patient's needs, enabling greater flexibility to return to operational duties when they were ready. The trickle feed model enabled a more flexible approach to care and treatment rather than the rigidity of the specific courses which were three weeks in duration where patients would remain on the course when they may have not been a rehabilitating need for them to do so.
- The adoption of a system wide approach and involvement of local PCRFS was integral to how services were planned and delivered and had been recently developed by the RRU. This enabled joined up working to meet the needs of individual patients in a timely way. The OC had worked hard to build and maintain working relationships and to support the PCRFS

virtually during COVID-19. This had been hugely challenging due to the vast geographical spread of the PCRFs across the South West region which the RRU served.

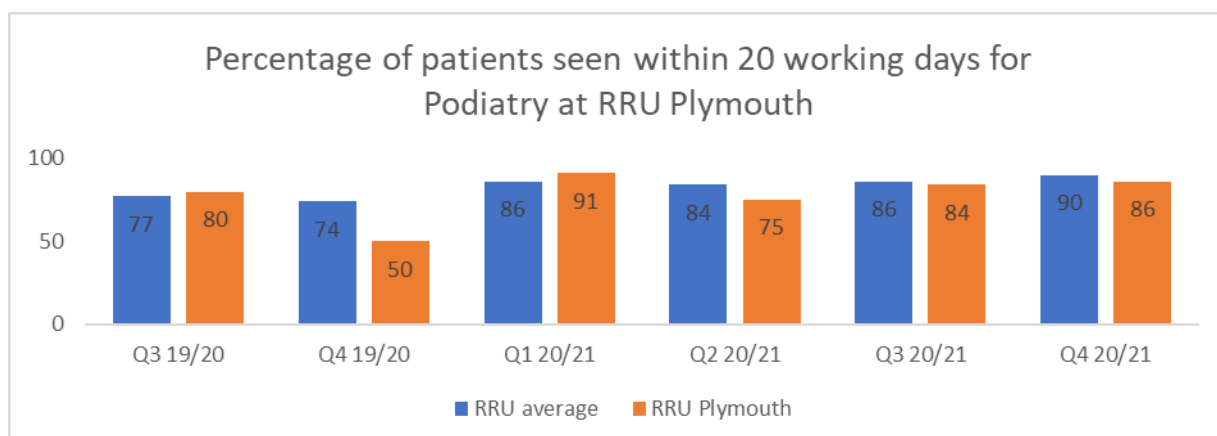
Access to the service

The unit provided assessment and treatment services between 9am and 5pm from Monday to Friday. On the whole the RRU was performing well against set KPIs.

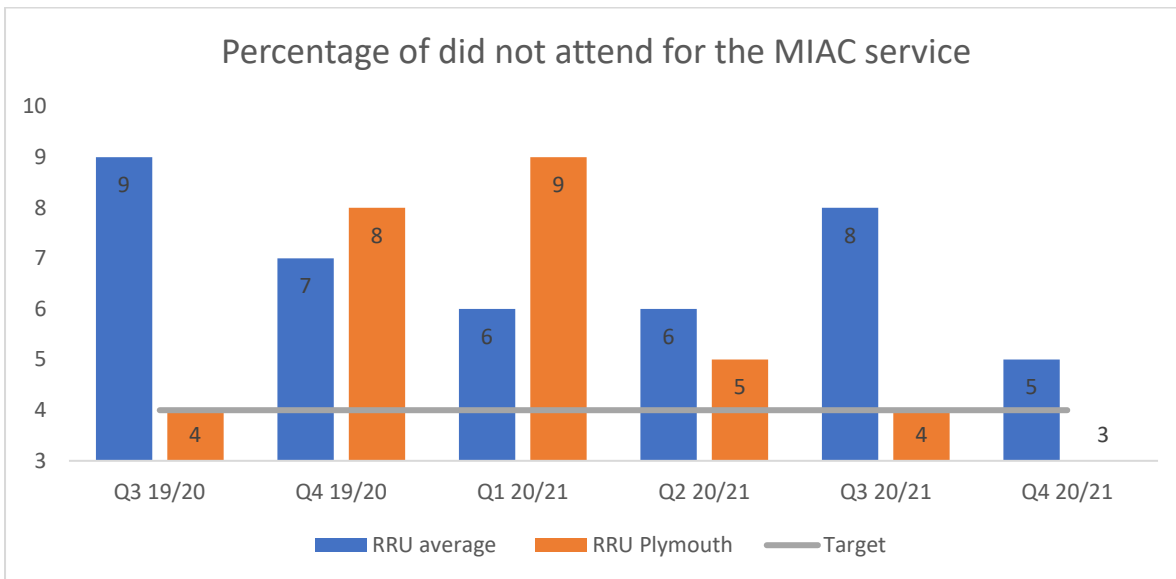
- The introduction of the trickle feed model ensured patients had timely access to initial assessment, diagnosis or urgent treatment in a way that suited them. Data showed that 100% of patients were able to access their required course within 40 days.
- The target for undertaking new patient assessments was set for initial assessments to be offered within 20 working days of referral. Data provided by the RRU for June 2021 showed all services had a lower referral to treatment than the target except for IAC services.



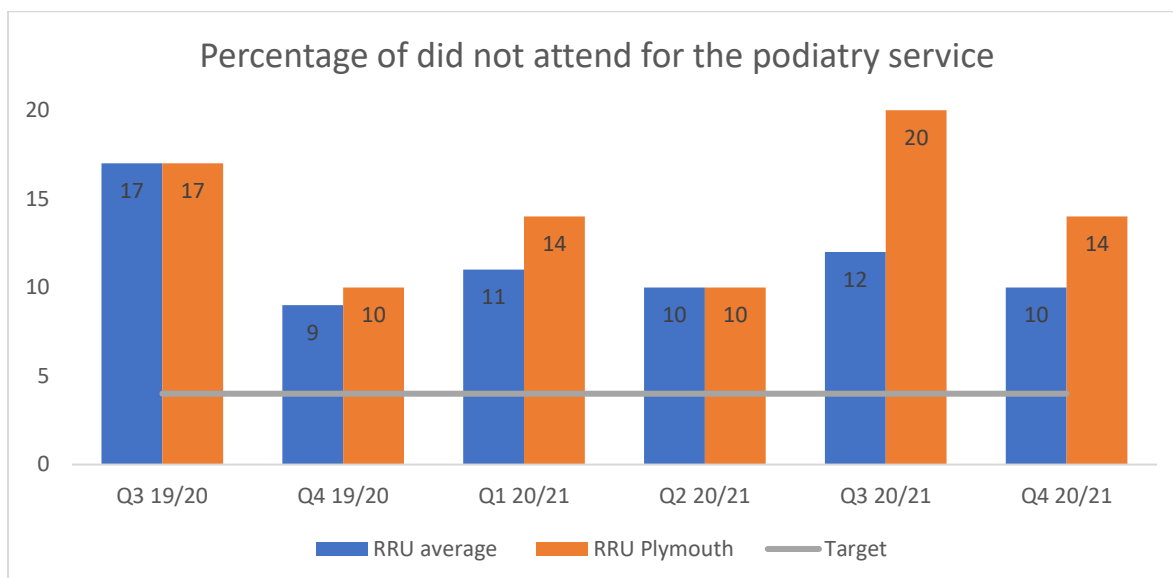
- Performance against different indicators was collected across all of the RRU's which enabled benchmarking to occur, to demonstrate how well each individual RRU was performing.
- Performance at RRU Plymouth has been similar to the RRU average for the percentage of patients seen within 20 working days for the podiatry service.



- Performance against DNA (did not attend) was collected for each of the RRUs, which demonstrated RRU Plymouth's own performance compared to the average performance across the RRUs between October 2019 and March 2021. Performance at RRU Plymouth for patients not attending the MIAC clinic had been better than the RRU average until quarter four 19/20. However, since then, the performance had picked up again in quarter three 20/21 when performance was better than the RRU average.
- Patients at any time could not attend an appointment for a variety of reasons. If this occurred data would be captured to reflect this, meaning that it would be represented as a failure to meet the KPI, despite this not being the responsibility of the RRU.



- RRU Plymouth for the percentage of patients who did not attend their appointments for the podiatry service for the whole period from October 2019 to March 2021, was on the whole, in line with the RRU average. The target for DNA rates at RRU Plymouth was 4%. However, the reason for the lack of compliance with the KPI was not in the control of the RRU. Patients at any time could not attend an appointment for a variety of reasons. If this occurred data would be captured to reflect this, meaning that it would be represented as a failure to meet the KPI, despite his not being the responsibility of the RRU.
- Despite this being outside of the control of the RRU, a member of the administration team who looked after the podiatry service had done an audit of the data available, and as a result, the service had introduced sending letters to patients to remind them of their podiatry appointments. Despite this, improvements had not been made. This was on the agenda for August 2021 at the healthcare governance meeting. Staff told us there had been discussion of an electronic text message service being implemented as another opportunity to remind patients about their appointment. This was in the early stages of discussion at the time of our inspection.



- Referrals were received electronically using the specified pathway initiated by the primary care unit. Electronic referrals were monitored throughout the day by the administration team and the clinical lead. The service prioritised care and treatment for patients with the most urgent need.
- Patients had access to care and treatment at a time to suit them. The RRU operated between normal working hours Monday to Friday. The administration team oversaw the appointment system and patients were given a choice of times they could attend.
- There was standard operating procedure set out for patients who did not attend (DNA) appointments. For patients who did not attend, the appropriate professionals were informed at the RRU. Follow up would conclude why the patient did not attend and a decision was made on an individual patient basis as how to manage the DNA, whether they would be discharged back to their PCRF or provided with a further appointment.
- Plymouth RRU had a standard operating procedure (SOP) to take into account the needs of different patients. All reasonable efforts and adjustments could be made to enable patients to receive their care or treatment. The SOP included guidance and mitigation for patients who were to attend the unit in a wheelchair, or if they had visual or hearing impairments. All staff at the RRU had completed an inclusion and diversity fundamentals course as part of their annual mandatory training.
- A disability self-assessment audit had been carried out by the RRU in January 2020, with a further review carried out in June 2021. This assessment highlighted some issues which the unit had escalated to rectify. For example, instillation of induction hearing loops and visual alarms to alert hearing impaired patients to an emergency. The minutes of the April 2021 healthcare governance identified that the RRU was finding it challenging to rectify some of these issues. We saw evidence of how the RRU had tried via various channels to escalate the issues and identify how the recommendations could be fulfilled, with little success. The RRU was now planning to draft a statement of need for the equipment they needed to address the outcome of the disability self-assessment which had been a requirement to complete by their senior command.

Listening and learning from concerns and complaints

The unit had a system for handling concerns and complaints.

There was a designated responsible person who handled all complaints in the unit. The complaints policy and procedures were in line with recognised guidance and DMS processes. Action was taken as a result of complaints being raised.

- Concerns and complaints were listened to, responded to and used to improve the quality of care. There was a policy available to provide guidance for staff about complaints made about healthcare services provided by the defence (JSP 950 leaflet 1-2-10). This covered how the complaint was to be dealt with, including the stage of communication and investigation.
- There had been three complaints since December 2019, however, only one of these related to the RRU. The complaint raised issues about secondary care referrals and the management of these. As a result of the complaint, the RRU produced a patient leaflet about who was responsible for the patient across the different pathways of care. The aim of this was to ensure the patient understood this at every stage of their journey.
- Any compliments received by the RRU were shared with the team. Between January 2020 and May 2021, the unit received nine compliments. The content included comments about the staff, the efficiency and effectiveness of the care and treatment provided and general positive feedback regarding their experiences either attending or dealing with the RRU.

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

Vision and strategy

There was a clear vision for the RRU and their priorities to improve the quality of care and treatment at the RRU had been set out and achieved.

- There was a clear vision and mission statement set out for the service, with quality and safety the top priority. The mission statement for the RRU was 'to sustain and improve the training and operational effectiveness of injured service personnel by provision of high-quality targeted rehabilitation, accelerating their return to optimal physical capability, whilst influencing their psychological and social health.' The vision and team ethos identified 'a combined approach from the whole RRU team, supporting positive attitude, and striving always to improve quality with the consistent aim to progress service delivery for patients. Through fostering and valuing our team spirit, there will be trust in each other to deliver for the team and the patient. Respect for staff and patients, the maintenance of the highest professional standards and safe, caring delivery.'
- The strategy for all defence medical services detailed in the defence rehabilitation concept of operations document had been developed centrally. The drive to develop an individual strategy came from there being no strategy for RRU Plymouth on the OCs arrival into post 18 months ago. The RRU developed its own version of a strategy in January 2020, which set out its priorities for the year ahead. To develop this, the OC met with all staff to better understand the issues they faced at the RRU. what worked well, what didn't and what change they would like to see. This information was then discussed amongst all staff to set the priorities for 2021.

Governance arrangements

The service had an overarching governance framework, which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured responsibilities were clear and that quality, performance and risks were understood and managed.

- There was an effective governance framework to ensure quality, performance and risk were understood and managed. Governance systems were in order and it was clear a large amount of work had been completed to ensure effective implementation of systems and process to enable clear oversight of the service. The governance arrangement at the RRU had significantly changed in the last 18 months following the OC at the time of the inspection joining the team and their not being an effective governance structure already in place.
- 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.
- There were clear arrangements which provided good oversight of safety, quality and risk for all staff at the RRU. There was a range of meetings held at the RRU which provided good oversight as to how the services provided by the RRU were running and to keep staff informed. Meetings included the healthcare governance meeting, meetings relating to the trickle feed model of care, podiatry meetings, MIAC meetings and weekly staff meetings which covered; workforce, equipment, training and sustainment. All meetings were minuted and could be accessed by staff.
- Healthcare governance meetings were held bi-monthly and were attended by all staff at the RRU. We saw minutes from the meetings held in April and June 2021. Set agendas were used which covered a range of topics. These included, but were not limited to; complaints and compliments, incidents, audit, quality improvement plans, ECAF data, RRU benchmarking data, infection control and safeguarding. Minutes included an overview of the discussions under each section and actions were clearly highlighted in red. There was also evidence that actions identified from the previous meeting were reviewed at the next meeting to ensure these had been acted upon.
- Staff at the RRU had a good understanding of performance, quality and safety. Real time data around performance, quality and safety were discussed monthly at the governance meeting. Staff were able to clearly articulate incidents that had occurred at the RRU and the action which had been taken following these.
- There was a systematic 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. There was an audit plan for the year which set out a timetable for audits such as record keeping and infection prevention control. Other audits local to the RRU were also recorded on the programme. The shared staff diary was also used a tool to remind staff when audits needed to be carried out. Each staff member had an area of responsibility and was responsible for the audit in that area.
- A common assurance framework (e-CAF) assessment was a live document used to support the delivery of good quality care. The self-assessment e-CAF framework was based on eight domains. These included; safety, clinical and cost effectiveness, governance, patient experience, accessible and responsive care, care environment and amenities, public health, and occupational health. The RRU had completed the self-assessment and had identified nine areas where 'minor' improvements were required. For example, document links not working and need fixing. The actions were being monitored as part of the healthcare governance meetings where a domain and its associated actions were discussed in detail at each meeting.
- There were systems and processes to identify, manage and mitigate risks associated with the RRU. A risk register was maintained, and management plans and mitigating actions had been identified. Key risks included issues around the workforce and training and infrastructure risks which included patient confidentiality and the disjointed administration

team set up due to COVID 19. Other risks included the transfer of ultrasound scan records from the machine currently in use to a new machine. The OC was able to talk clearly through all of the risks and identified the mitigation and action that had been taken and which was ongoing to manage the key risks.

- The service was provided with a quarterly dashboard, which detailed performance information on a number of key performance indicators. This included, time taken to offer an appointment, numbers of patients who failed to attend or cancelled appointments and waiting times for services such as podiatry and MIAC. Each indicator was shown next to the average performance across the other RRU's. This meant an overall comparison could be made to benchmark how well the unit was performing. See the responsive section of the report for further detail.
- However, we did have concerns regarding the future of RRU Plymouth and the stability of the RRU. There had been a number of positive changes made at the RRU since the OC had come into post. The potential loss of the positive changes which had been introduced and developed under the current OC, was a risk as the current OC was moving to a new post in September 2021. Also, the turnover of staff and the lack of training available for leaders coming into the unit to be able to manage the role.

Leadership and culture

The managers in the service demonstrated strong leadership and they had the capacity and capability to run the service and ensure high quality care. It was clear they were passionate about their role.

- There was evidence across the RRU of strong and passionate leadership, and a commitment to provide high quality services for patients. It was clear patients' needs were at the centre of the services delivered at the RRU.
- Leaders at the RRU carried out their role effectively. The OC had been at the RRU for 18 months. Although they had held managerial posts prior to arriving at the RRU, the size of the patch they were covering was new. The OC spoke of the positive support they had received from their seniors when coming into the role and felt they had learned a lot from this posting. The RTSA was also new into post at the same time as the OC. It was clear from the evidence we saw during the inspection that leaders were passionate about their work and the challenges posed by the RRU had been embraced and proactively managed and mitigated during this period. It was clear safety and quality had been prioritised. The OC was due to move on and be replaced by another OC in September 2021.
- Despite being well supported, leadership development had been a challenge. On starting their roles, the OC and RTSA had limited access to any training to support them to carry out the responsibilities required of them by their role. There were no training courses around healthcare governance and other courses had been stopped due to COVID 19. The OC had been proactive in seeking support from colleagues and their seniors and the RTSA had accessed some support from health and safety teams to support with aspects of their role.

- There was an acute awareness of challenges to service delivery and a proactive approach to the management of these. Workforce issues including resource, training and infrastructure challenges which included patient confidentiality issues and the disjointed administration team were seen as the biggest challenges. The OC and RTSA were clearly able to articulate the challenges and the actions which had been taken to manage the issues. We saw evidence of proactive management of the concerns which were ongoing at the time of our inspection.
- There had been a structured and inclusive approach by leaders to introduce the trickle feed model of care into the RRU. The OC had sought advice from other units who had successfully implemented a similar model. Staff from across the RRU had also been involved with its development and implementation, including administration staff. Staff told us that the trickle feed model had improved the quality of care provided to patients and had improved their morale and sense of job satisfaction, in relation to using their time in the most effective and efficient way to benefit patients.
- The OC for RRU Plymouth had sought to develop as a leader within the RRU by asking for feedback from the team. On the whole, feedback was positive recognising the OCs ability to communicate, engage staff and their personal nature. One small area raised as an area for improvement was around improved visibility. However, it was recognised that this had been a challenge with being able to meet face to face due to the COVID 19 pandemic and that the remote contact which had been provided had been well achieved.
- The OC was continuing with ongoing preparation to ensure a seamless transition to the new OC who was starting in September 2021. The OC worked closely with the RTSA who was the consistent link at the RRU and had good oversight of systems and processes, so would be able to support a seamless transition of leadership. The governance documents were up to date and handover documents were being drafted to aid the transition. Further support was ongoing to give the clinical teams more support during the transition period and staff were being kept up to date at staff meetings and governance meetings.
- There was a culture of strong team working to ensure the best care and treatment was provided to patients. 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 be part of the care and treatment being provided to individual patients. The RRU staff were cohesive and engaged and told us they felt involved and included.
- 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 listened to. For example, the administration staff told us how they had felt listened to and empowered to make changes to working processes following a change to their department and ways of working, and how they had received the support to do this.

Seeking and acting on feedback from patients and staff

Feedback was sought from patients to identify whether improvements could be made to the course. Feedback for both the course and MIAC was very positive.

- An electronic questionnaire was used to gather views and experiences from patients following their treatment. Results were gathered centrally and then sent to the RRU to analyse. One member of staff had the responsibility of reviewing the data. We saw evidence of this being fed-back and discussed at healthcare governance meetings. At the time of the inspection there were no actions required from the positive results of the questionnaire, for improvements to either the course or MIAC to be made.
- We saw patient experience data related to the course collected between, March and June 2021, 100% of responses from patients had rated their satisfaction with the booking

process and joining instructions either good or excellent. The RRU had also achieved 100% of either good or excellent scores for; their facilities, equipment, staff managing their individual needs and providing clear information, kindness and compassion, privacy and dignity and the delivery of their individual programme sessions. Less than 5% of patients felt that the individual programme, the group sessions or the hydrotherapy was not beneficial to their recovery. No further written information had been provided to support these comments to enable the RRU to understand how improvements could be made.

- Comments were equally as positive from the patient questionnaire about the MIAC clinic. All of the respondents to the questionnaire between April and June 2021 were 100% satisfied with their appointment, the access they had to healthcare advice and the feeling that their needs were addressed. All of the respondents were satisfied with their care and treatment and would recommend the service to a friend or colleague.

Continuous improvement

There was a focus on continuous learning and improvement within the service.

- Quality improvement was high on the agenda at the RRU to ensure care and treatment was optimised for patients. There were a number of completed and ongoing projects. For example the trickle feed model which had enabled the RRU to meet their KPI around patient access to the courses, better met the needs of the PAR served by the RRU and provided greater flexibility for patients to fit the course in around their clinical needs.
- Other quality improvement work included improved access to scan results. The RRU now had a radiographer who supported the RRU by uploading scan results to the electronic system. This enabled more efficient clinic appointments due to having the required information to hand. No other RRU had this system.
- Quality improvement initiatives came as a result of incidents being reported by the ASER system. There had been challenges in podiatry to access prescribed footwear to aid rehabilitation. The RRU had been instrumental in leading on the 'boots' policy work to improve access to alternative boots should patients require it. As a result of this quality improvement work, there was due to be a change in national policy, accompanied by additional training for stores staff to enable them to better support the needs of the patients and support physiotherapist or podiatrist advice and offer alternative footwear.
- Better communication pathways and working relationships had been developed to improve the quality of care and support provided to patients across the patch. Much work had been done to improve communications with staff in the east of the patch, along with the 19 PCRF's. Working relationships were not well established when the OC and RTSA commenced their role at Plymouth RRU. The OC and RTSA had led on this work. Improved lines of communication meant that support could be provided, and issues could be raised in a more controlled and structured way to ensure concerns were managed and rectified via the correct channels.
- As a result of the COVID 19 pandemic, the DMS needed to develop ways of working to enable continuous provision of services. An electronic platform had been developed called 'attend anywhere' which assisted in remote clinics and enrolling patients on courses. For example, if patients were operational on-board ships, their IAC assessment could take place before they reached port. This meant that care and treatment was provided in a more timely way to optimise recovery.