Defence Medical Services

Halton Regional Rehabilitation Unit

Inspection Report

Regional Rehabilitation Unit
Halton,
Aylesbury,
Buckinghamshire
HP22 5PF

Date of inspection visit 23 November 2021
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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 Halton Regional Rehabilitation Unit (RRU) on 23 November 2021.

Defence Medical Service is not subject to the Health and Social Care Act 2008 and is not subject to the CQC's enforcement powers. The CQC undertook this inspection as an independent body. We do not have a legal duty to rate, but we have highlighted good practice and made recommendations on issues which the service could improve.

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 a system for reporting and recording significant events.
- Essential systems, processes and practices were available to ensure patient safety.
- Risks to patients who used services were assessed and their safety monitored and maintained.
- 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.

- Patient's needs were assessed, and care and treatment were delivered in line with current legislation, standards and evidence-based guidance.
- Patients had their needs assessed, their care planned and delivered, and their care goals identified
- 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.
- The information needed to plan and deliver care and treatment was available to most relevant staff in a timely and accessible way through the unit's patient record system and their intranet system.
- Staff sought patients' consent to care and treatment in line with legislation and guidance.

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

- Interactions we observed between staff and patients were friendly and caring. Staff were helpful and courteous and treated patients with respect.
- 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
- Staff communicated with patients in a way that meant they would understand their care and treatment.

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

- The unit uses information about the needs of the Population at Risk (PAR) within the Area of Responsibility (AOR) to inform how services are planned and delivered.
- Patients had timely access to initial assessment, diagnosis or urgent treatment in a way which suited them. Patients had access to care and treatment at a time to suit them.
- The unit had a system for handling concerns and complaints.

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

- There was a clear vision and values set out for the service, with quality and safety the top priority.
- The service had an overarching governance framework, which supported the delivery of the strategy and good quality care.
- The management in the service demonstrated they had the experience, capacity and capability to run the service and ensure high quality care.
- Feedback was collected and used to adapt and develop the way the course ran

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

- We found strong leadership in the unit with staff feeling well supported by the OC. There was an extremely positive culture within the unit and mutual respect between staff at all levels. There was good engagement between staff and leaders.
- Patient’s needs were the focus of all interventions. The MIAC clinic provided a holistic approach and focused on returning patients to fitness for both work and leisure activities.
- Patients gave excellent feedback about their experience and patient feedback was listened to and used to make improvements where possible.
- The unit was responsive to meeting individual needs and patients were fully involved in their care. There was good information and education provided to patients enabling them to make informed choices about their care. Care plans were regularly reviewed with patients and adapted to ensure they were acceptable and appropriate to meeting patient’s treatment objectives.
- There was a strong MDT approach to care with staff working closely together to assess and treat patients to ensure all patient care needs were met.
- Processes and systems were followed well by staff. For example, medicines management and consent processes were robust, and record keeping was of a high standard.

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

- The regional support to the interim leadership was limited. The interim team would benefit from additional support and training and options for this should be explored by the regional team.
- There was not optimum use of outcome or audit data. Although patient outcome information was collected, results were not routinely collated or analysed at a local level. There was no systematic programme of regular audit reviewing quality of clinical care. This meant that the unit was unable to demonstrate that they routinely used information from outcomes and clinical audit to make improvements to the care delivered.
- There was not a clear and robust process for recording of pre-user equipment checks. It was not always easy to see if appropriate pre-user checks had been completed as required.
- There was an inconsistent process for staff supervision / peer review. Some staff group received regular formal peer supervision, but other staff groups did not have a formalised process.
- The known anomaly between performance data held by region and the performance data held locally by the RRU should be explored and addressed.
- The RRU did not have a strategic plan setting out the aims and objectives of the unit for its future development. There was no means of measuring achievement of any plans for improvements in service delivery.
- There was a recognition that the building estates and facilities were not fit for purpose in all areas. Some areas were in need of repair or lacking appropriate facilities but there was no plan for this to be addressed by the DMS as the base was due for closure in the near future. Systems and processes for effective cleaning of all clinical areas and management of environmental and facilities risks should be reviewed and formalised.
- Opportunities for wider inclusion of family members in the rehabilitation process should be explored.

Professor Ted Baker
Chief Inspector of Hospitals

Regional Rehabilitation Unit – Halton

Detailed findings

Why we carried out this inspection

The Care Quality Commission (CQC) carried out this inspection as one of a programme of inspections at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability. Defence Medical Services (DMS) are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently, DMS services are not subject to inspection by CQC and CQC has no powers of enforcement. However, where CQC finds shortfalls in the quality of services during inspection, we will report them by making a recommendation for action to the Surgeon General's office.

Background to the service

Defence Medical Services' (DMS) primary role is to promote, protect and restore the health of the UK armed forces to ensure that they are ready and medically fit to go where they are required in the UK and throughout the world. DMS is made up of the Navy Medical Service, Army Medical Service, the Royal Air Force Medical Service and HQ Defence Medical Services. They operate with a budget of £500million and are staffed by around 12,100 service personnel (8,100 regular and 4,000 reserve) and 2,500 civilian personnel and together provide healthcare to 135,360 UK Armed Forces personnel.

Regional Rehabilitation Unit (RRU) Halton is a 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 Halton near Aylesbury in Buckinghamshire and provides clinical management of moderate musculoskeletal conditions to the military population within a defined geographical area. There are 15 RRUs across the United Kingdom.

The RRU at Halton provides Multi-disciplinary Injury Assessment Clinics (MIAC), Injury Assessment Clinics (IAC), Regional Podiatry Clinics (RPS) and intensive rehabilitation courses to a Population at Risk (PAR) in excess of 20,000. Clinics are run daily and patients receive full time rehabilitation when attending courses which are held throughout the year.

RRU Halton's population at risk (PAR) is service personnel based at the following locations:

- MOD Bicester
- RAF Brize Norton
- MOD Abingdon
- RAF Benson
- RAF High Wycombe
- RAF Halton
- British Forces Cyprus

The population is mixed from ground trades to those of fixed wing and rotary aircrew alongside a percentage of RLC and infantry soldiers. RRU Halton supports tri-service service personnel in varying roles across the units in the PAR. 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 and operational roles.

The military service lead (OC) and Regional Trade Specialist Advisor (RTSA) provide regional sports exercise medicine expertise and a professional point of contact. Staff conduct liaison visits with the satellite physiotherapy departments within region, providing support and guidance on healthcare governance, military processes, and specific equipment care processes. The RTSA 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 personnel and observe course content and MIAC to ensure joined up care between PCRFs and the RRU. All newly graduated ERIs will attend the RRU to complete several objectives in their Post Graduate Mentoring Programme.

Access to the RRU is through referral from other services in the DMRP. Patients receive an initial joint assessment in the Multidisciplinary Injury Assessment Clinic (MIAC). Patients can access one to one treatment and rehabilitation courses to treat their conditions. Courses currently run for 8 days. Patients are expected to attend for the duration of the course and can live on site or off-site at their unit. During courses, patients can access one to one treatment at the same time.

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

Multi-disciplinary Injury Assessment Clinic (MIAC)

Clinical assessment at the RRU is delivered through the MIAC. This is a Consultant led clinical assessment, with a Band 7 physiotherapist (clinical specialist). Both the consultants and the clinical specialist physiotherapist are specialists in sports and exercise medicine. 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.
- An appropriate 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. Some reviews and follow-ups are conducted by a telephone or RVC consultation.

Injury Assessment Clinic (IAC)

An IAC is conducted by a physio and can be used for the assessment of patients with a confirmed diagnosis or the review of those returning after investigation. IAC is suitable for non-medically complex patients who have been triaged as appropriate. It can also provide outpatient treatment

where the management plan has already been agreed at the MIAC. IAC can be used to create additional capacity when there is limited availability of MIAC clinics.

Onward Referral

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

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

Clinical Investigations

The RRU provides the gateway to rapid access imaging. The RRU also has access to onsite 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), or 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 a compressed eight-day intense course. Usually the RRU runs three simultaneous courses of 15 patients each for three weeks. Due to COVID and adhering to social distancing requirements this has been amended and currently the RRU was running two simultaneous courses of five patients each. The courses currently being held were generals rehabilitation courses suitable for patients with a range of differing conditions.

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 a MOD approved supplier as required. The RPS is commanded by and accommodated at the RRU. It consists of one part-time Band 7 podiatrist who delivers clinics at either the RRU or regionally through a peripatetic service.

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

Our inspection team

Our inspection team was led by a CQC inspector. The team included two inspectors, and one Defence Medical Services (DMS) Specialist Advisor in Rehabilitation.

How we carried out this inspection

Before visiting, we reviewed a range of information about the unit. We carried out an announced inspection on 23 November 2021. During the inspection, we:

- Spoke with eight staff, including physiotherapists, exercise rehabilitation instructors (ERIs), administrators, 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

RRU Halton conducted hot debriefs on the final day of each inpatient rehabilitation course. The information was fed back to staff who led the course immediately to identify any urgent issues or recurring themes. The debrief was conducted by either the Officer Commanding (OC) or the Regional Trade Specialist Advisor (RTSA). The information was shared with unit support staff to improve services such as accommodation and catering.
Patients were asked eight questions to understand if they were satisfied with their care, how they would rate the course and if they would recommend the service. Results collected in September 2021 from 113 patients found that:

- 99% of patients felt that staff would listen to comments, complaints or compliments
- 100% of patients would recommend the facility to colleagues, friends or family members
- 100% were generally satisfied with their Care
- 99% felt that the course met their expectations
- 96% were satisfied with the level of progress they had made
- 100% felt the course had given them the knowledge and confidence to manage their injury/condition
- In regard to the course staff addressing their healthcare and individual needs, 93% rated this as excellent and 7% good.
- In relation to the course staff giving patients clear information, 92% of patients rated this as excellent and 8% good.

As part of our inspection, we also spoke with 6 patients. Patients were consistently positive about their experience at the RRU including attendance at courses and MIAC. Some patients commented that they would have liked the course to be longer, but they recognised the course had been shortened due to the impact of COVID-19. Patients commented that the MIAC offered a responsive and thorough assessment service. Patients told us they were able to access classes easily and without delay and had been included in the development of their goals and treatment

plans. MIAC staff and course instructors were described as approachable, knowledgeable, friendly and supportive.

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

- There was an effective system available for staff to report significant events, incidents, near misses and concerns. The Automated Significant Events Reporting System (ASER) was used to report and record all incidents as well as examples of positive practice. Staff understood their responsibilities to raise concerns and record these. Incidents were reviewed, thoroughly investigated and closed by the service lead.
- A spreadsheet of all incidents was maintained. The incident log was held electronically on the ASER system and provided a brief overview of the incident, when the incident was submitted, and the outcome of the root cause analysis and actions taken as a result. During 2021, seven incidents had been recorded on the ASER system; all had a rating of no harm.
- Once incidents had been identified, lessons were learnt and action was taken to improve safety at the Regional Rehabilitation Unit (RRU). Updates and learning from significant incidents which had occurred was shared with staff at regular team meetings. Staff told us about two incidents where learning had been identified and changes in process had been implemented to prevent recurrence.
- Lessons were learned, shared and communicated across teams and RRUs. There were MIAC working group meetings six-monthly where representatives from each RRU MIAC team shared matters of the moment, including learning from incidents. These meetings were halted due to COVID-19 but had recently restarted as virtual meetings. There were regional rehabilitation officer virtual meetings every two weeks where the OCs from each RRU met to discuss regional safety matters across RRUs). Safety alerts and relevant alerts from gov.uk were emailed out to OC group mailboxes from the regional headquarters. These were distributed to the whole RRU team and recorded on the governance workbook. Discussion about alerts was also recorded in clinical meeting minutes.
- 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. Staff described how a patient who experienced a delay in referral on, had received an explanation about what had happened and an apology.

Overview of safety systems and processes

- Essential systems, processes and practices were available to ensure patient safety. Staff received mandatory training in safety systems, processes and practices. Training compliance was set at 100% for the RRUs. The year to date training information from April to September 2021 showed that there was 100% completion of mandatory training in four out of five staff groups. For the MIAC GP staff group mandatory training compliance was 92%; all staff members in this group were yet to complete 'Automated Electronic Defibrillators (AED)' and 'Anaphylaxis' training. This was since there had been reduced availability of some face to face training sessions due to COVID-19.
- An overview of mandatory training compliance was stored electronically and was held regionally. A member of the administrative team had a designated role to monitor mandatory training compliance at the RRU and update the regional compliance sheet. They prompted staff by email to update any training that was due. Training was usually completed by staff in the allocated governance weeks written into the service delivery plan.
- Arrangements for safeguarding reflected relevant legislation and local requirements.
- Staff understood their responsibilities and adhered to safeguarding policies and procedures. They knew that one of the doctors in the MIAC team was the safeguarding lead. Staff knew the safeguarding lead was the first point of contact for any safeguarding concerns they may have. An example was provided of when a safeguarding concern had been identified when a patient disclosed that they had been self-harming. The patient was referred for specialist support to ensure that they were kept safe.
- Systems, processes and practices kept patients safe. All staff were Disclosure and Barring Service (DBS) checked and their professional registration and expiry date was reviewed. This ensured all staff at the unit were safe and fit to practice at the unit. A mandatory training database (that included this information) was kept with limited access at Regional Headquarters. Information was held electronically, and a check of the professional register or equivalent had been completed for all staff.
- Standards of cleanliness and hygiene were maintained. There was a process for cleaning clinic rooms and gymnasium areas twice a day which was recorded. We found clinical areas to be visibly clean. However, cleaning of the strength and conditioning suite was not to the standard of a clinical environment as the building use was not classified as medical. The unit had recently negotiated with the cleaning contractors for more thorough cleaning and reported it had improved.
- There were reliable systems in place to protect people from infection. The RRU had an infection, prevention and control (IPC) lead who provided appropriate advice and carried out relevant audits. Hand hygiene, cleanliness and PPE audits were carried out regularly. Staff had access to clinical handwashing sinks, and we observed good hand hygiene practice. There were posters in clinic rooms promoting good handwashing techniques. Hand soap and alcohol gel was widely available. Staff used personal protective equipment (PPE) appropriately. All equipment used and touch points in clinic rooms including chairs, plinths and door handles, were wiped down with antibacterial wipes in-between patients. All gym equipment that was used during exercise classes was wiped down by individual patients after use. Information on managing suspected cases of COVID-19 was displayed. The course programme had been restructured to keep people safe during the COVID-19 pandemic. The number of course participants had been reduced to five per course which enabled social distancing. The length of the course had been shortened to eight days and there was more distance learning. This had reduced contact time alongside increased use of telephone and video consultations. All patients completed a COVID-19 screening questionnaire over the telephone before attending for

appointments or classes. There was a lateral flow testing facility at the base. All patients attending courses and all staff completed lateral flow tests twice weekly.

- Clinical waste and sharps were managed safely. Sharps boxes were used and disposed of in line with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. Clinical waste was disposed of in yellow bags which were placed in a locked clinical waste bin, for which there was a contract for regular removal.
- Chaperone posters were displayed around the RRU. We saw posters on notice boards in the gym and in the clinic room highlighting the opportunity for patients to have a chaperone present for any appointments they attended.
- Premises used by the RRU were not all fit for purpose. Facilities were not purpose built and were housed in old buildings. This was identified as a risk and the risk was owned by the RAF station. There were three gymnasium areas in use – two were used for delivery of classes and one for individual exercise programmes. The gym area in building 100 was sectioned off with boards to enable separate areas for exercise and class lectures to run simultaneously. This meant that it was noisy and it could be difficult for patients to hear and be heard by staff. This was particularly problematic for any patients with a hearing impairment. The area used for individual exercise was the strength and conditioning suite. This was since the RRU were unable to hold strength and conditioning equipment (weights) in their own facility due to a structural defect with the floor. The equipment was needed for use during the rehabilitation courses so had been moved to the strength and conditioning suite. The area was unheated and was exceptionally cold. Although there was a risk assessment for this area it was not detailed enough to show mitigations for risks of lack of cleaning or temperature controls. However, it was well equipped and the RRU had sole use of the area at specific designated times each day. We found the MIAC and podiatry rooms were large, bright and suitable for the intended purpose.
- There were limited changing facilities and a lack of shower facilities available for patient use following exercise. The RRU had adjusted the course timetable to mitigate the risks of this. The timings of the exercise sessions on the course had been moved to be before break times which enabled patients to return to their rooms for a shower. All patients were allocated a room with showering facilities even if they were not staying on the base during the course.
- Arrangements for the maintenance and use of equipment did not always ensure patient safety. Equipment was maintained and serviced in line with manufacturers' instructions, but it was not clear if staff routinely completed pre-user checks of equipment. Fmed 373 logs were not always fully complete; there were missing signatures on some dates for some pieces of equipment such as the ultrasound machine and plinth. It was unclear whether equipment had been used on these days and not checked by staff before use, or if equipment had not been used on these dates.
- An electronic inventory log was maintained and held information as to when maintenance had taken place for the equipment at the RRU. The log was maintained by the unit RTSA and showed servicing was in date.
- 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. Records of equipment items that were faulty and / or out of use were maintained on an electronic spreadsheet managed by the RTSA. We saw that there were several out of use items of equipment in the gym which were clearly labelled whilst awaiting collection for disposal.
- Electrical testing of equipment at the RRU was maintained. Electrical equipment was tested to ensure it was safe for use. Stickers on electrical equipment identified these checks had taken place.
- The RTSA kept of log of when staff had received training on how to use each item of equipment.

- Resuscitation equipment was available in the MIAC room in building 410 and in the gymnasium in building 100. Equipment was checked daily to ensure it was ready for use in an emergency. Equipment consisted of an automated external defibrillator (AED) in both buildings and also oxygen and emergency drugs (adrenaline) in the form of an injectable pen device in the MIAC room. These were stored in accordance with safe medicines management guidance. There was no AED in the strength and conditioning suite; the nearest AED was 30m away in the adjacent gym building which was signposted in the suite. There was, however, a first aid kit and a phone with emergency numbers in the strength and conditioning suite. The course patients were never in the gym facilities unsupervised by RRU staff.
- Arrangements for managing medicines kept people safe. Medicines were held in a locked ambient temperature cabinet with access by named personnel only. Keys were held in a locked cabinet in the admin office and there was a system for signing out the keys meaning staff access to the fridge was recorded and could be monitored. Temperature checks of the medicines fridge were regularly completed and recorded. There was information on what action to take if the temperatures were out of range. We checked records for the past two months and saw that temperatures were all within range. There was a medicines management lead who was one of the consultants. They completed regular stock checks of medicines held. There was a process for recording when medicines had been used in a book where staff documented the dose used, the balance of the medicine remaining in the fridge, and the patient details. Medicines stock checks included monitoring of expiry dates. All medicines we checked in the fridge were within their expiry date. Medication audits were completed to monitor that the remaining stock matched the balances logged in the book.
- There were first aid kits, eye wash kits and blood spill packs in the podiatry room, clinic rooms and all gymnasiums
- 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. However, not all staff had full access to DMICP. The podiatrist could not view entries made on DMICP made by PCRF staff meaning they were not able to see full referral information for patients. This had been raised as a concern on several occasions and escalated to the regional headquarters but remained an ongoing issue.
- Patient records were organised, up to date and shared and stored appropriately. We reviewed eight patient records for patients attending the multidisciplinary injury assessment clinic (MIAC) and rehabilitation courses. Records were clear, comprehensive and structured. Records included referral information, patient assessments, consent and treatment plans which were all complete. All records were stored securely on an electronic system with password protected access.

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.
- RRU Halton reported the following whole time equivalent (WTE) establishment staffing as of September 2021:

Staff group	Planned staff - WTE	Actual staff - WTE	Fill rate (%)
Physiotherapist B7	1	1	100.0%
Physiotherapist B6	2	2	100.0%
Multi-disciplinary Injury Assessment Clinic (MIAC) doctor	1	1	100.0%
Civilian Exercise Rehabilitation Instructor (ERI) B5	1	1	100.0%
Podiatrist B7	0.6	0.6	100.0%
Administrator E1	2	1	50.0%
Administrator E2	1	1	100.0%
Military Exercise Rehabilitation Instructor (ERI) Flight Sergeant (FS)	1	1	100.0%
Military Exercise Rehabilitation Instructor (ERI) Sergeant (Sgt)	1	1	100.0%
Military Exercise Rehabilitation Instructor (ERI) Corporal (Cpl)	1	1	100.0%
Military Physiotherapy Second in Command (2iC)	1	0	0.0%
Military Physiotherapy Officer Commanding (OC)	1	1	100.0%
Total	**13.6**	**11.6**	**85.3%**

- The RRU reported that as of 23 November 2021 they had four vacancies for substantive posts across the service in the following roles; E1 administrator, Civilian ERI, Military 2IC Physiotherapist and Military OC Physiotherapist. The RRU advised that the Military OC Physio was currently deployed, and their role was being temporarily filled by the band 7 clinical specialist physiotherapist. This meant there was an acting OC in post. The ERI and 2IC physiotherapist roles were being filled by locum staff and the ERI administrator post had been recruited to with a due start date of November 2021. The RRU did not have a target vacancy rate.
- For the period from October 2020 to September 2021, the RRU reported no sickness days for the following staffing groups; ERI B5, Cpl ERI, Sgt ERI, FS ERI, and OC RRU. For the same period, the RRU reported a total of 47 sickness days for the staff groups of Administrator E2, Physiotherapist B6, Administrator, B7 Physiotherapist and B7 Podiatrist. The RRU did not have a target sickness rate.
- For the period from October 2020 to September 2021, the RRU reported that there were eight staff leavers from the following roles: E1 admin (2), E2 admin (1), Civilian ERI (1), Military 2iC physio (1), Military OC physio (1), Military ERI FS (1) and Military ERI Cpl (1). This data included military deployment and promotion of staff as well as staff leavers. The RRU did not have a target turnover rate but told us that the high turnover of staff was a concern. Of 13 posts only four had remained unchanged in the last year. This created a risk of loss of corporate knowledge and potential impact on consistency and quality of service delivery. Recruitment to vacant posts was impeded by the slow recruitment process for civilian members of staff.
- Comprehensive risk assessments regarding service provision were carried out using a clear methodical approach and actions to mitigate any risks had been identified. Course delivery had been reviewed due to the COVID-19 pandemic and adjustments had been made. These included reduced numbers of participants, social distancing measures, one-way systems, Covid screening assessments and regular lateral flow tests.

- When patients were identified as suitable for injection therapy or acupuncture, part of the consent process included a checklist to ensure there were no contraindications to the procedure. Oxygen and Adrenaline were kept in the MIAC room for use in the event of an allergic reaction to injection therapy.
- When patients were exercising in the gym areas there were first aid kits and emergency equipment (AED) for use in the event that a patient required urgent medical attention. All staff were trained and knowledgeable in first aid and basic life support.
- The staff to patient ratio on the courses was determined to ensure the safety of patients. Since course numbers had been reduced due to COVID-19, the ratio of staff to patients was one staff for a maximum of five 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.
- All patients were assessed in MIAC for suitability for the course - at that point if there are any concerns regarding mobility for example, adjustments/mitigations can be made. All patients attending a course were assessed by the physiotherapist prior to starting any exercises. The ERI would plan individual exercise programmes following this assessment. Patients were regularly reviewed by the physiotherapist, dependent on their changing needs.

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 RRU had a local business continuity plan (BCP) dated 27 September 2021 which all staff had signed to confirm they had read. The plan was reviewed and updated annually. The purpose of the BCP was to provide a means of ensuring the continuation of RRU outputs in the event of a loss of facilities or resources due to peacetime disaster. The BCP detailed the contingencies, including the required replacement plans, to ensure continuity of service either in the short, medium or long term. The plan used a Red, Amber, Green rating system to identify the impact of the loss of critical resources and facilities on the RRU's critical outputs. The plan included a Communicable Disease Control (CDC) Plan specific to RRU Halton.
- The unit carried out six-monthly workplace health and safety inspections This was to ensure legal compliance with the Health and Safety at Work etc Act 1974 (HASAWA), Regulatory Reform (Fire Safety) 2005 and other related Regulations. The latest inspection had been completed on 27 September 2021. Following the inspection an action plan documented any problems or issues and set out remedial actions with target dates for completion.
- The RRU had a current fire risk assessment. All alarms and fire equipment were checked weekly. Annual fire drills were completed in both buildings. All staff completed online fire briefs as part of their mandatory training.

Are services effective?

Good

(for example, treatment is effective)

Our findings

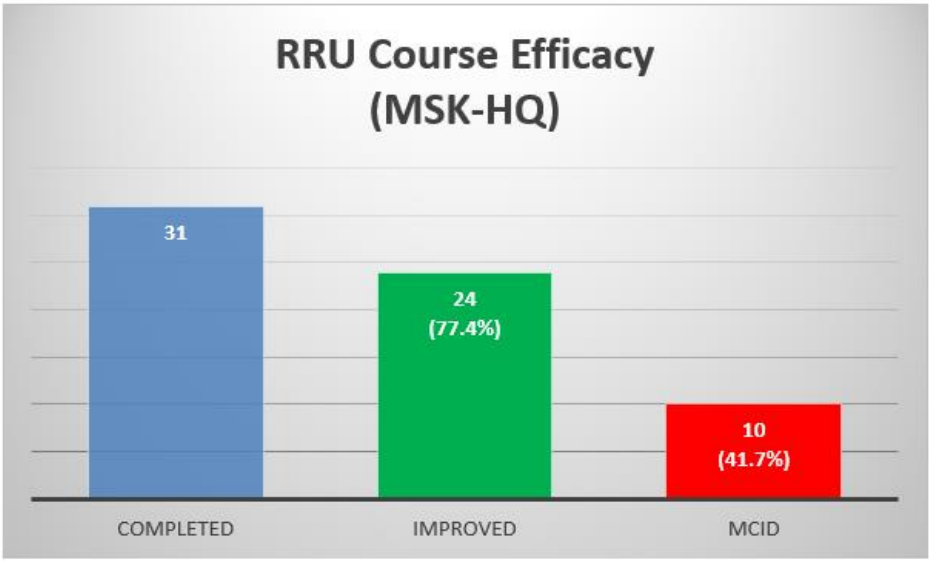
Effective needs assessment

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

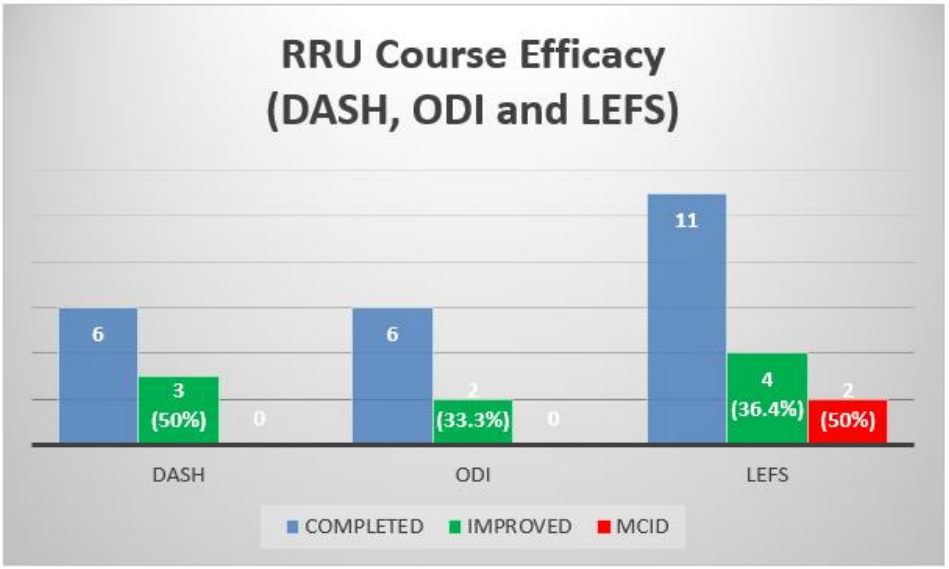
- Patient's needs were assessed and care and treatment were delivered in line with current legislation, standards and evidence-based guidance. Relevant and current evidence-based guidance had been identified and developed for defence rehabilitation services and was used to direct how services, care and treatment were delivered. These guidelines determined the necessary assessments and treatments required for specific conditions. Podiatry and physiotherapy staff followed professional standards of practice and followed national guidelines for care and treatment such as NICE guidelines.
- Rehabilitation was delivered in line with evidence-based practice guidance on treating musculoskeletal conditions and provided a holistic approach to rehabilitation. Courses provided exercise and education sessions which included health promotion and wellbeing information. The rehabilitation courses were based on best practice guidance and had been written centrally. The courses were standardised across DPHC with specified mandatory elements although the delivery of these elements could be modified in each unit to suit the resources available. For example, RRU Halton did not have access to a swimming pool so hydrotherapy sessions were replaced with alternative exercise sessions.
- At RRU Halton there was a quarterly review of course content which was carried out through an MDT team course development meeting. The meeting reviewed issues and suggestions raised through patient feedback forms. The team discussed the concerns and considered available options to make changes and improvements.
- Staff had access to DPHC 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 clinic, for example, the management of ankle, knee and hip pain and the management of lower back pain. The document contained flow charts identifying specific care pathways. Each document identified specific clinical features which may be found for different presenting conditions and identified the approach to management of the condition which needed to be taken by the RRU. The document also identified red flag (serious pathology) which would need immediate attention and escalation if identified. References to the guidelines and evidence which had been used to develop the documents was also identified within the document.
- 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 ten which could be used to rate their level of pain). Pain was scored when patients were assessed and in response to treatments so staff could monitor the effect of these on pain. We heard from patients that staff would adapt their exercise programme if they were experiencing pain.

Management, monitoring and improving outcomes for people

- A range of validated patient reported outcome measures (PROM) were used for all patients attending the RRU such as Disabilities of the Arm, Shoulder and Hand (DASH), STarT back screening tool and the MSK-HQ. Outcome measures were collected relevant to the patient's presenting condition. These were used as a metric during assessment and were available to the PCRFs through DMICP when patients were discharged from the RRU.
- There was not a clear approach to using patient outcome measures for monitoring and benchmarking the quality of the service. Objective measures were collected during assessment but not always after treatment. Measures were used at the point of assessment and were patient specific to provide an objective measure associated with the patient's injury. However, measures were not routinely repeated following treatment at the RRU as there was insufficient time to expect to see a change in the measures. Rehabilitation often continued at the PCRFs; time spent at the RRU was only a part of the patient's rehabilitation journey. This meant that outcome measure data was not routinely collated for use to identify if treatments were effective. RRU Halton was one of the trial sites for a new system of collecting outcome measures over 12 weeks across the patient's whole rehabilitation journey (Redcap). This was a research project which was planned to be rolled out across DPHC services. The roll out of Redcap would enable tracking of patient's change in outcome measure scores across the rehabilitation pathway.
- 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. During this session short, medium and long-term goals would be set in conjunction with what the patient wanted to achieve. Goals set were specific, achievable, measurable and had at timeframe for completion. This enabled a treatment programme to be designed specifically to meet the individual needs of the patient. Progress with achievement of goals was regularly reviewed during the course.
- The RRU had collected some outcome measures before and after treatment as part of a one-off audit. However, objective measures were not routinely used pre and post treatment to identify improvements which had been made to the individual patient's condition following the course of treatment.
- The RRU used the Musculoskeletal Health Questionnaire (MSK-HQ) to evidence course efficacy. Data was collected retrospectively as part of an audit for 13 completed "Generals" courses (involving 31 patients) between September and December 2020 (this was the latest available data). This found that overall, 77% of patient's MSK-HQ scores improved and 42% recorded a minimally clinically important difference (MCID).



- The RRU provided data of outcomes broken down by pathology specific outcomes which had been gathered during a one-off audit (Patient Reported Outcome Measures – An Audit to Assess RRU Halton Course Efficacy). The audit found that:
  - For the Disability of the Arm and Hand (DASH) 50% (three of six patients) of scores were improved.
  - For the 33% of Oswestry Disability Index (ODI) 33% (two out of six patients) scores were improved.
  - For the Lower Extremity Functional Scale (LEFS) for Lower Limbs 36% (four out of eleven patients) of scores were improved, although 50% (two of the four patients who had improved scores) recorded a minimally clinically important difference (MCID).



Effective staffing

- 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 (JSP 950 leaflet 5-1-5). 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.

- Registered professionals were supported to meet the requirements of their professional registration. A register of staff professional registration was held which included HCPC and GMC PIN numbers. All registered professionals had current registration. Staff undertook a number of work-based activities including training and peer review. This ensured they met the requirements of their continuing professional development.
- RRU Halton actively supported CPD through several methods, including a regional in-service training programme, local in-service training and peer review. There was a 12-month programme of local in-service training for all staff at the RRU. Regional in-service training also took place four times a year. The podiatrist attended quarterly meetings with other RRU podiatrists which included profession specific training updates. In addition, there were discussion forums online and on closed social media groups for shared learning. There was a band 7 regional peer group for physiotherapists which included teaching sessions and sharing of professional information and updates.
- Peer review took place for some, but not all staff. There was no formal supervision programme but there were formal (mandated) and informal peer review sessions for physiotherapists and ERIs. This provided an opportunity for staff to have their practice critically appraised to identify any areas which they needed to develop to ensure high quality care and treatment was provided for patients. However, locum physiotherapy staff had not all received a peer review. There was no requirement for the podiatrist to receive regular peer supervision although they reported they had completed a one-off peer review session with the clinical specialist physiotherapist. There was a plan to set up regional peer review sessions for podiatrists.
- The learning needs of staff were identified through an appraisal system. The RRU reported that as of September 2021 all required staff had completed an appraisal. This was in line with the RRU appraisal target rate of 100%.
- Newly appointed staff were part of a mandatory induction programme. This included locum staff. The induction was overseen by the RTSA and ensured staff were familiar with the environment and their role and responsibilities on starting work at the unit. New staff were required to complete a suite of mandatory training sessions as part of their induction.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to most 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. There was also a joint clinic with the physiotherapist, doctor and podiatrist held at the unit. There were regular MDT clinical meetings where any complex cases could be discussed by the whole team to ensure there was a joint working approach to rehabilitation.
- Most staff had the information they needed to deliver effective care and treatment to patients. Most staff had access to the electronic records system which held a contemporaneous, multidisciplinary records of the care and treatment of individual

patients at the unit. However, the podiatrist and ERIs were unable to see entries made by medical staff at the PCRFs. This meant that these staff were unable to see all referral information about patients. This issue had been escalated as it was unable to be resolved at RRU level.

- Patients received clear information prior the course to fully inform them about the treatment they would receive and what was expected. On the course joining instructions sent to all patients attending a course there was a link to the Defence Connect page with pre learning information and surveys/questionnaires to complete before starting the course.
- All discharge information when patients had completed a course was held on DMICP so staff at the PCRFs could access this. The discharge information included patient's individual exercise programmes so the PCRF teams could monitor and progress these as required. Follow up appointments were arranged with staff in the PCRFs when patients were discharged. Patients received a follow up call, or face to face appointment if necessary, with the MIAC doctor or physiotherapist four to six weeks after discharge to monitor their progress and ensure they had been able to access any appropriate follow on care.
- Following appointments, staff completed an outcomes sheet for each patient which identified the outcome of their assessment and whether any follow up appointments or referral on was required. Outcome sheets were processed by the administration team who recorded the outcome of the appointment and ensured any required actions were completed.

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 clinical areas of 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. Patients arriving for MIAC appointments were given a laminated sheet to read at the admin desk which explained the consent to treatment process. Compliance with the consent policy was audited as part of the record keeping audits.
- Verbal consent was sought from patients at the start of each assessment and treatment session. There were written consent processes for some treatments involving a higher level of risk such as injection therapy, acupuncture and shockwave therapy. Patients were given information sheets with information about possible risks and benefits of these treatments to help them make informed choices. Patients had time to ask questions about their treatment options and medical staff provided clear explanations in response. There were consent forms for each relevant procedure with statements of consent which were required to be signed and dated by patients before procedures were performed. The MIAC doctor explained that they liked to bring patients back for a second appointment to receive injections rather than doing the injection on the day of assessment. This gave patients time to consider the information about their treatment options before they made decisions.
- When overseas patients were emailed with their remote video call appointment details this included the option not to consent to using video consultation. If this was the case, consultation by telephone appointment was offered in the first instance.

Supporting patients towards optimal function

The service identified patients who may be in need of extra support and signposted them to relevant services. There were helpline and welfare phone numbers on display for patients in the waiting room. Staff talked to patients during appointments about other services, they could access to help them manage their condition and improve the outcome of rehabilitation.

- 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. Goals for rehabilitation were displayed in the gymnasium areas and promoted a 'growth mindset' approach. 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 goal.
- Rehabilitation courses included education and information sessions to support patients in developing skills to help manage their own condition. 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.
- Patient goals were specific so they could achieve what was required from their treatment. Goals were often focused on work-based activities to make sure patients were physically fit to return to the high demands of their operational duties following their rehabilitation. However, staff had a holistic approach to rehabilitation and also considered patient's leisure interests when setting goals with them.
- Information was available to support patients to manage their own health and wellbeing. Information was displayed on boards to provide advice and signpost patients to other mechanisms of support. There was information on stress awareness, heat illness, cold injury awareness, and nutrition.

Are services caring?

Good

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 friendly and caring. 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. There was information displayed about how patients and staff could access padres and world faith chaplains for support. Patients and staff had access to a multi faith prayer room.
- 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. The consultant had a good rapport with patients which made them clinic feel relaxed and reassured.
- Staff demonstrated a helpful supportive attitude towards patients. We observed staff supervising patients to ensure safety and providing encouragement and motivation during the sessions. Patients reported that ERIs checked their understanding of exercises and explained how they would help their condition. Staff were described as flexible and understanding and explained how individual exercise programmes were adapted if patients were seen to be struggling or in pain.

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 during initial assessment and ongoing consultations to make an informed decision about the choice of treatment available to them. We also saw that care plans were personalised.

- Staff were able to form close professional relationships with the patients due to the nature of their work. Over the course duration of eight days, they were able to spend time talking to patients about their care, treatments goals and progress. Staff showed an encouraging, and supportive attitude towards patients.
- Patients were encouraged to be active partners in their care. Treatment goals were agreed between staff and patients and were regularly reviewed and updated as required. Patients on the course told us that they could discuss their treatment on a one to one basis with the course instructors at any time.
- Staff communicated with patients to make sure they understood why they were doing specific exercises. We observed staff clearly demonstrate exercises to patients and take the time to explain the relevance of the exercise and how this would benefit the patient. Staff took the time to correct the technique used by patients to ensure that the exercises would have an optimum impact on the patient's rehabilitation. We saw that staff also demonstrated equipment to patients to make sure they fully understood how to use it safely.
- There were opportunities for patients to ask questions and be involved in their care and treatment. There were positive interactions between staff and patients, and we saw that staff were all approachable and explained everything well. Staff answered questions appropriately when patients asked them. This helped to facilitate patients to take control of managing their rehabilitation independently with appropriate guidance from the staff.

- Each patient group had an identified physiotherapist and ERI for the duration of the course. These clinicians were their first point of contact during the course although every patient could talk with the RTSA at any time.

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. Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. We saw staff talking to patients about their care and made time to ensure they understood what they were saying. However, there was no evidence that families were actively involved in the rehabilitation process.

- It was evident staff clearly understood the impact which patients care, treatment or condition had on their wellbeing. Staff recognised how problems with physical health and fitness could affect patient's mental health. Staff gave examples of when they had signposted individuals to additional support services to support their full recovery.
- Staff supported patients to manage their emotional needs and understood how working in a high-pressured environment could affect engagement with rehabilitation and jeopardise their ability to make a full recovery from injury. There were limited systems in place to support families of injured personnel who were receiving rehabilitation.
- Patients were encouraged to link with other course participants for peer support 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 meal times, and in the evening.
- Staff responded to patients who were experiencing pain quickly and effectively. Exercise programmes were adapted when patients were in pain and staff demonstrated empathy and understanding of the impact of pain on patients.

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 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. We

found they had a plan, which enabled them to meet the needs of the PAR, particularly those with complex needs, long-term or career-limiting conditions.

- The unit usually provided lower limb, upper quadrant, and upper limb speciality courses which patients attended for a period of three weeks for rehabilitation. During COVID-19 these had been adapted to include the essential components of the speciality courses, but in a blended 'Generals' course held over 8 days. These 'Generals' courses were suitable for patients with a range of differing conditions. This helped as many patients as possible access the course whilst capacity was reduced.
- The RRU at Halton provided Multi-disciplinary Injury Assessment Clinics (MIAC), Injury Assessment Clinics (IAC), Regional Podiatry Clinics (RPS) and RRU rehabilitation courses to a Population at Risk (PAR) in excess of 20,000. Courses were provided for patients whose condition necessitated a period of intensive daily rehabilitation. Usually up to 45 patients attended the course receiving full time rehabilitation at any one time. This was delivered as three courses of 15 patients each for three weeks. Currently due to COVID-19 there was a maximum of 10 patients on the courses. The courses were being delivered as two courses of five patients each over eight days. Patients were expected to attend for the duration of the course and could live on site or off-site at their unit. During courses, patients could also access one to one treatment if required.
- The podiatry clinic provided lower limb biomechanical assessment, assessment for and provision of custom-made orthoses, gait analysis, expert footwear/boot recommendations and prescription for custom boots when indicated. In addition, there was an extra corporeal ShockWave therapy (ESWT) clinic for foot/ankle specific pathology. Before COVID-19 a peripatetic podiatry clinic was offered at Brize Norton to improve patient access to care. The clinic had temporarily been halted due to COVID-19 as there was a limitation on clinical space available for the clinic.
- The MIAC was a multidisciplinary clinic delivered by an experienced physiotherapist and sports exercise medicine (SEM) Consultant. The clinic offered assessment, point of contact ultrasound scanning, injection therapy, and onward referral to specialist services e.g. pain clinic, pressure testing, imaging, orthopaedic referral. The clinic also acted as a point of contact for referrers in the region for clinical advice.
- The RRU also had the option of delivering an IAC (Injury Assessment Clinic) where needed. This was delivered by a B7 physiotherapist only. This was used where there was limited availability of MIAC clinics and the patient was triaged as appropriate. IACs were suitable for non-medically complex patients who did not require surgical or imaging referral.
- The RRU provided care pathway planning and management of patients with complex needs. For example, a patient stationed in Turkey who required a post traumatic ruptured hamstring surgical repair was offered a consultation via remote video call. The RRU team liaised with the overseas medical cell for medical management and with an external agency to meet the patient's therapy needs post operatively. The unit worked closely with the consultant team at DMRC to provide further advice on management due to the complexity.
- There had been a foot and ankle orthopaedic clinic delivered at the RRU by a military foot and ankle surgeon and B7 physiotherapist. Referrals to the clinic were accepted from MIAC and podiatry for complex foot and ankle issues requiring a specialist review and possible surgical referral. This clinic was halted in 2021 as the consultant was deployed overseas but was planned to restart in January 2022.
- MIAC records and recommendations contributed to occupational health review clinics where patients were facing career limiting conditions. MIAC clinicians liaised with patient's medical officers at the Medical Centre to discuss and recommend appropriate medical gradings.

- Patients had access to fast track diagnostic imaging and some surgical procedures if required at a local private hospital. Referrals could be made from doctors in MIAC and these were tracked by the administration team to ensure they were actioned in line with key performance indicators.
- Staff at the RRU could make recommendations to patient's medical officers at the PCRFs for referral to other appropriate services such as smoking cessation and mental health support. They could also refer to DMRC for specialist opinions including rheumatology, peripheral nerve injury, compartment pressure testing, gait laboratory, Orthotist, pain clinic and specialist in-patient courses such as chronic regional pain syndrome.
- There were alternative assessment and treatment options available for when usual care could not be delivered for any reason. If there was no availability for a rehabilitation course, the RRU could refer to other local RRUs. For patients limited by COVID-19 travel restrictions there was the option of appointments at a remote video consultation clinic. For a period of 12 months in 2020 when there was limited access to ultrasound qualified clinicians in MIAC, an ultrasound scan clinic was established at another local RRU for Halton patients to enable continued diagnostic capability.
- Services were planned to take account of the needs of different patients. All reasonable efforts and adjustments were made to enable patients to receive their care or treatment. The unit was fully accessible for all patients. Where facilities were located on the first floor there was lift access. There was an equality and diversity policy which outlined the requirements to treat all job applicants, staff, patients, or any other person fairly. The policy covered the requirements based on protected characteristics (race, age, sex, sexual orientation, marital status, disability) and any other characteristic defined. All staff at the RRU had completed equality and diversity training.
- Action was taken to remove barriers to treatment when patients found information difficult to understand. The RRU gave an example of when they had provided additional one to one support during a course to help a patient with limited understanding of the English language. This included using drawings and google translate to help them understand the information provided in lectures so they could fully participate in their rehabilitation programme.

Access to the service

The unit provided assessment and treatment services between 9am and 5pm from Monday to Friday but not each weekday.

- MIAC clinics were held four days a week and podiatry clinics were held three days a week. IAC was held as demand required.
- Patients had timely access to initial assessment, diagnosis or urgent treatment in a way which suited them. Patients had access to care and treatment at a time to suit them. The RRU assessment and treatment services were available from 0800 to 1700 Monday to Thursday and from 0800 to 1300 on Fridays. The administration team oversaw the appointment system. 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 were sent to the physiotherapist or doctor in the MIAC for triage. Following triage, the clinician returned the referral to the administrator to book in the appropriate appointment. There was a template with appointment slots with allocated timings to ensure sufficient time was allocated for new assessment appointments, injection appointments and review appointments. There were two protected new patient assessment appointment slots with the doctor in MIAC each day.

- Patients were allocated an initial appointment and information would be sent to the patient and referring unit. Patients were offered the first available clinic appointment.
- There was flexibility in appointment times and appointments could be altered to suit the needs of the patient. For example, consideration was given for travel time from other stations such as Brize Norton and patients may be offered later appointment times if they were more convenient. For overseas patients consideration was given to different time zones, and appointments were always offered within the patient's working hours. Assessment appointments allowed the MIAC team to make a decision on whether the patient needed to be seen face to face, and to clinically prioritise their care.
- The service prioritised care and treatment for patients with the most urgent need. Referrals were classed as urgent and routine and were triaged by the MIAC doctor or physiotherapist. Urgent referrals could be seen at the first available clinic within five working days whilst routine referrals were seen within 20 days. Referrals were allocated according to clinical and/or military needs. Referrals would be classed as urgent of the information identified red flags (symptoms indicating a more serious pathology) or if the patient was due to be deployed. The referrer would be informed of the outcome of the triage decision. All patients referred for the rehabilitation courses required assessment in the MIAC clinic before starting the course to ensure they were suitable.
- If there were no new patient appointment slots in MIAC, there was a contingency plan to make an urgent appointment slot available if required by creating an IAC slot, or taking an hour out of allocated administration time for MIAC doctors.
- The target for accessing services from the first referral for the Multi-disciplinary Injury Assessment Clinic and Podiatry clinic was 20 working days for 85% of patients. The target for course admission was 40 days from the date of referral for 90% of patients. Performance data against these targets was held on a regional database which the RRU had access to. Data showed that targets for wait times were generally not being met for MIAC assessment, podiatry assessment or course admission:

Clinic type	**Q1 Apr – Jun 20**	**Q2 Jul -Sept 20**	**Q3 Oct – Dec 20**	**Q4 Jan – Mar 21**
Multi-disciplinary Injury Assessment Clinic (MIAC).	67%	21%	16%	68%
Podiatry (POD)	88%	94%	100%	75%
COURSE	56%	53%	N/A	N/A

- However, the acting OC told us that they were meeting target assessment times. There was a known anomaly with the regional database which was being investigated. Local data collected by the RRU showed that from February to September 2021, MIAC access times were between 10 and 24 working days, with an average of 19 days. In November 2021, the average wait for MIAC was reported as 14 working days, for podiatry clinic it was 9 working days, and for access to the course it was 18 days. This data was shared in clinical meetings and documented in the minutes.
- The target for urgent referrals to be seen in MIAC was five working days and the RRU told us they achieved this.
- There was a new aeromedical standard operating procedure (SOP) which had begun at the end of April 2021.This required aeromedical patients to be seen within five working days. Five aeromedical patients had been seen by the RRU since April 2021 and all had been seen within the five working day target.
- No records of cancelled appointments were kept by RRU Halton but the administrative team entered all appointments and appointment changes in to the patient tracking system

(DASA) where stats were monitored centrally. No data on cancellation rates was provided by the RRU.

- The RRU had a target Did Not Attend (DNA) rate of 5%. Performance overall for all clinic/course types ranged from 0% to 14%. The target performance for DNAs was not consistently met for any of the services offered:

Clinic type	Q1 Apr – Jun 20	Q2 Jul -Sept 20	Q3 Oct – Dec 20	Q4 Jan – Mar 21
Multi-disciplinary Injury Assessment Clinic (MIAC).	3%	6%	3%	5%
Podiatry (POD)	0%	14%	4%	0%
COURSE	1%	5%	8%	4%

- There was a clear process for patients who did not attend appointments. Any patient DNAs were documented in a patient's record on DMICP. The administration team would attempt to call any patient who did not attend to check they were aware of their appointment and would book a second appointment if required. If a patient wasn't made aware of their appointment, this was followed up with the PCRF to investigate.
- If patients did not attend three consecutive appointments, they could be discharged back to their referrer, but this decision was made on a case-by-case basis.
- Staff worked to improve access to services for patients who may not be able to freely travel to the RRU for appointments. A remote video call clinic had been established between the MIAC team in the UK and the B7 physiotherapist in Cyprus. This enabled the physiotherapist to carry out the objective examination whilst the MIAC UK team verbally directed the assessment. This clinic was still in a trial phase, but it allowed a good option for assessment and MDT working with ongoing challenges to travel. There had been a podiatry clinic held at the military base in Brunei before COVID19 limited travel. The podiatrist would visit the base for one week every quarter to hold podiatry clinics for assessment, advice and treatment. This improved access for overseas personnel who may not be able to easily travel to the UK RRU to be seen.
- Feedback from patients resulted in changes to how the service was planned, developed and delivered. There were 'you said, we did' boards displaying information about how the delivery of courses had been adapted in response to comments made by patients.

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.

- Concerns and complaints were listened and 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. The policy stated informal verbal complaints would be dealt with locally by the end of the next working day.
- The OC told us that all concerns raised were investigated by the OC and RTSA. Initially a conversation was held to gain more information about the concerns raised and to attempt to reach a local resolution where possible. Where local resolution was not possible,

concerns were progressed to written complaints which were handled in line with the complaints policy.

- RRU Halton reported that they had received no complaints during the reporting period of October 2020 to September 2021. However, a complaint had been received on 3 November 2021 relating to the quality of the food received by patients during the course. This concern had been investigated and actions had been identified, in line with the complaints policy.
- Complaints and compliments were routinely shared with staff at the monthly clinical meetings.
- Information was available to support patients in making a complaint if they felt the need to do so. We saw that compliments, concerns, and complaints posters were widely displayed across the unit. Posters detailed the procedure for patients to make a complaint in the RRU and provided the contact details for the OC.

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 and set of values identified for the service, with quality and safety as the top priority. The vision for the RRU was 'to deliver excellent patient focused care to keep our workforce fit for delivery of operations and fit for life.' The values supporting the delivery of the vision were 'PROUD'; Patient-centred, Respect, Open, Unity, Development. Staff were aware of the vision and values and had been involved in agreeing these.
- There was a centrally developed specific strategy and operational guidance for the defence medical rehabilitation programme. 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 RRU did not have a local developmental business plan to support achievement of the central strategy or RRU vision. However, the acting OC said that patient feedback and outcomes from treatment, which were being collated using Redcap, would be used to measure achievement of the vision going forwards.

Governance arrangements

The service had an overarching governance framework, which supported the delivery of the vision 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. 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.
- A common assurance framework (e-CAF) assessment was a live electronic document used to support the delivery of good quality care. This framework was used by all regional RRUs. 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.
- Governance arrangements at RRU Halton were systematic and reflected best practice. We saw the unit had a comprehensive governance documentation and oversight system known as their governance workbook. The workbook had links to the risk register, quality improvement programme actions and progress, mandatory training compliance, professional registrations, complaints, incidents, standard operating procedures and meeting minutes. All staff could access the workbook and were aware of the governance system through regular clinical meetings and healthcare governance meetings.
- There were systems and processes to identify, manage and mitigate risks associated with the unit. Risks were recorded on an RRU risk register which was held centrally by region. The register was reviewed monthly by the RTSA and OC to ensure it remained a current document. All risks were scored, and RAG rated and there were identified risk owners for each risk along with mitigations and planned actions.
- The RRU identified their top risks as staffing, infrastructure, COVID-19 and climactic injury. There was engagement of staff with risk issues through discussion at healthcare governance meetings.
- There was a limited programme of clinical and internal audit used to monitor quality and identify areas for improvement. Although there was an annual audit cycle with named audit leads and target completion dates, the audits focused on process issues rather than quality of clinical care. Audits included record keeping, medicines management, cleanliness and infection prevention and control. Feedback on findings of these audits was discussed in clinical meetings and areas for improvement were identified and shared with staff. There was no routine audit of clinical outcomes following care and treatment provided by the RRU.
- The service was provided with a quarterly dashboard, which detailed performance information on a number of key performance indicators. The data for the dashboards was taken directly from the DASA system where the RRU inputted data for every patient contact. There was collation of data from the system and reporting done centrally at HQ level in order to produce the RRU dashboards.
- The dashboard included data on referral numbers, time taken to offer an appointment, numbers of patients who failed to attend or cancelled appointments, waiting times, and clinical outcomes. 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. The OC sent dashboard results out to the team for information via email. There was discussion in clinical meetings when the unit was failing to meet KPIs to understand why and what contingency plans could be put in place to improve things. Staff were encouraged to contribute ideas and suggestions for improving performance. KPIs were also discussed in management meetings and by Rehabilitation HQ in the Regional Rehabilitation Officer (RRO) Meetings.

Leadership and culture

There were interim leadership arrangements in place at the time of our inspection due to the deployment of the substantive OC. The interim leaders demonstrated they had the capacity and capability to run the service and ensure high quality care. They prioritised safe, high quality and compassionate care. However, it was difficult to ascertain if the level of support the interim team received from the region was adequate.

- The interim leadership had the skills and knowledge to carry out their roles effectively. Staff spoke very highly of the leadership from the service lead and how they were supported and empowered to develop their knowledge and skills. The acting OC and RTSA worked closely together to deliver management responsibilities.
- The acting OC had not had specific leadership training for the role, but this had been requested through an appraisal. They had been booked onto a leadership course, but this was cancelled due to COVID-19. The acting OC did have experience of working at a senior level and had good operational knowledge of the RRU.
- Staff spoke very highly of the leadership from both the OC and acting OC who were the service leads, and of the RTSA who also undertook some management responsibilities. RRU staff described how they were well supported by the local senior team and empowered to develop their knowledge and skills. Leaders were visible and approachable. Staff felt respected and valued and leaders encouraged supportive relationships between staff. However, there was limited visibility and support offered to the RRU leadership from the regional team.
- Leadership and culture at the unit reflected the vision and values of the DMS and were driving a wider systems approach to improve the quality of care for patients in the area. Leaders and staff demonstrated they were committed to working to improve the quality of care by developing the knowledge and skills of the local PCRFs and supporting them to evolve. There was a regional in-service training programme which had a named lead who had set up a 12-month programme of learning and development sessions. This enabled staff to get support from their peers and the clinical lead at the RRU. This supported all staff across the region to optimise care and treatment for patients.
- There was a culture of strong team working both internally between RRU staff and externally with other organisations to ensure the best care and treatment was provided for patients. Staff supported each other on a daily basis and worked together to provide high quality care for patients. The RTSA described having good support from other RTSAs and the TSA at HQ. Their regional role involved advisory visits done to meet with ERIs in local PCRFs. There were monthly virtual meetings held with all regional ERIs and a social media group to provide information and advice.
- The acting OC told us how the team had visited RAF Benson to observe the challenges faced by staff when working in helicopters. This provided RRU staff with a better

understanding of their job roles so they could focus on and meet their specific rehabilitation needs.

- Staff told us of the supportive relationships in the RRU and of the opportunities they had as a multi-disciplinary team to review the care and treatment being provided to individual patients.
- Staff also worked closely with external providers of care for military staff, including consultants and radiologists from a local hospital. This enabled better team working across the system due to all clinicians having a better understanding of the expectations of military requirements for fitness to enable personnel to get back to full operational activity following medical or surgical intervention
- Patients we spoke with told us that all staff were approachable and supportive. They commented that the RTSA who oversaw the course delivery, was very visible and checked in with course participants regularly. Patients told us they were able to approach the RTSA with any concerns.
- Staff told us about social events and team buildings events, which were well attended and facilitated the supportive working relationships they had with each other.

Seeking and acting on feedback from patients and staff

- RRU Halton had its own patient feedback form which was collected at the end of each course to gather views and experiences of patients following their rehabilitation. This asked a variety of questions around the course administration, course content, facilities and staff attitudes and behaviours. It incorporated the Friends and Family test and the mandated DPHC variants around satisfaction with services provided and likelihood of recommending services. Feedback was used to adapt and develop the way services were delivered through discussion at quarterly course review meetings which involved the whole team.
- Staff were encouraged to give feedback and make suggestions for service delivery and improvements. They reported feeling engaged in service development and felt their views were reflected in the planning and delivery of the service.
- Staff were confident to speak up and raise concerns if required. The service had a military hierarchy of staff who delivered the services, but the hierarchy did not deter staff from speaking up. Most staff felt confident and safe to speak openly about any concerns they had. Staff said when they raised any worries or concerns these were listened to and acted on.

Continuous improvement

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

- There was a commitment to quality improvement. The RRU kept a log of quality improvement projects (QIPs) that had been completed. All QIPs were documented on the DPHC Strategic QIP template. The template enabled staff to set out the background to the project, the aims and objectives, how it was completed, key findings and how it had changed practice. Further actions and the process for ongoing review of the quality improvement were also identified.
- The RRU began a quality improvement initiative in 2019 although the work did not get finalised into a quality improvement document. The RRU did not have a documented

strategy or business plan for quality improvement as it was held at HQ level and then ‘fed down’. This enabled a standardised approach.

- The service carried out regional assurance visits. There was a regional advisory visit timetable led by the RTSA where the RTSA and OC visited other sites to offer advice. There was a programme of peer review to ERIs that worked alone in other rehabilitation facilities across the region. This maintained a focus on continuous learning and improvement at all levels within the service.
- There was a commitment to ongoing learning by all staff. All staff were encouraged to attend the local and regional in-service training sessions which were both held regularly. RRU Halton organised quarterly regional in-service training sessions for all clinical staff. There were examples of staff completing additional learning appropriate to their specialist roles to enhance their clinical knowledge and skills. Staff kept up to date with their professional registration requirements by attending professional body meetings, participating in online forums and reading professional journals.
