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

We carried out an announced comprehensive inspection of Cosford Regional Rehabilitation Unit on 29 November 2017.

To get to the heart of patients’ experience of care and treatment, we asked the following five questions, which formed the framework for the areas we looked at during the inspection.

**Our findings were:**

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<th>Question</th>
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<td>Are services safe?</td>
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<td>Are services effective?</td>
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<td>Are services caring?</td>
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Letter from the Chief Inspector of Hospitals

We carried out an announced comprehensive inspection at Cosford Regional Rehabilitation Unit on 29 November 2017. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to patient safety and a system in place for reporting and recording significant events. Risks were assessed and minimised, standards of cleanliness and hygiene were maintained, and staff understood their responsibilities to keep patients safe. Staff were confident to report incidents and lessons were learnt when things went wrong, however patients were not always kept fully informed during the process.
- Patient outcomes were collected using validated measures and demonstrated improvements as a result of treatment.
- Evidence based practice was used to guide treatment and there was a strong culture of continuous improvement. Staff were aware of current evidence based guidance and practice was reviewed through detailed clinical audit and service evaluation.
- Patients were positive about their interactions with staff and said they had been treated with compassion and dignity. The individual needs of patients and the occupational needs of their employment were considered and staff provided explanations to patients and supported them to cope emotionally.
- Information about services and how to make a complaint or a comment was available. Patients were fully informed about their treatment and the unit investigated and acted on complaints received quickly. Patients could provide feedback to the service in multiple ways and this was acted upon.
- Patients who required urgent access to treatment were seen quickly and action was taken to reduce cancellations to treatment. Patients were involved in decisions about the type of treatment they received.
- The unit had good facilities and was equipped to treat patients and meet their needs. Suitable clinical equipment, and fitness and strength equipment for rehabilitation was available and the unit had an arrangement in place to use additional facilities.
- There was a clear leadership structure and staff felt supported by management. Leaders were visible, encouraged and engaged staff to be autonomous.
- The governance framework ensured quality, performance and risks were understood and managed. Action was taken to improve the service which integrated the views of patients and staff.
• The service was focused on continuous improvement and staff engaged with and led on projects at all levels. There was a culture of feedback and openness with staff being confident and engaged in their work.

Recommendations for improvement

We found the following areas where the service could make improvements:

• Systems and processes to keep patients safe were not always embedded at the unit. Not all staff had completed mandatory training to the required level and some equipment was out of date or checks had not taken place.
• Patients sometimes waited longer than they should for treatment and waiting time targets were not always met.

Professor Ted Baker
Chief Inspector of Hospitals
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

Regional Rehabilitation Unit (RRU) Cosford, is a facility provided by the Defence Primary Healthcare (DPHC) Unit delivering intermediate rehabilitation within the Defence Medical Rehabilitation Programme (DMRP). It is located at Royal Air Force (RAF) Cosford, near Wolverhampton in the West Midlands and provides clinical management of moderate musculoskeletal conditions to the military population within a defined geographical area. There are 14 RRUs across the United Kingdom.

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 condition. Courses run for three weeks and are condition specific; 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 a service lead, a clinical physiotherapy lead, physiotherapists, doctors, exercise rehabilitation instructors (ERIs), podiatrist, and administrators.

Facilities include two treatment rooms, a gym and cardiovascular training area, and access to the RAF swimming pool on site.

Our inspection team

The inspection was overseen and attended by CQC Head of Delivery Hospitals. The inspection was led by a Care Quality Commission (CQC) Inspection Manager. The inspection team also included a CQC Inspector, and a CQC Analyst. The team were joined by a Defence Medical Services (DMS) Specialist Advisor in Rehabilitation.

How we carried out this inspection
Before visiting, we reviewed a range of information we hold about the unit. We carried out an announced visit on 29 November 2017. During our visit we:

- Spoke with a range of staff, including physiotherapists, podiatrist, exercise rehabilitation instructors (ERIs), administrators, service lead, doctor. 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?
Detailed findings

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.

- At service level, safety performance was not compared to other RRU services and there was no overall way to view this. Staff told us that overall safety performance was monitored centrally and that they would be alerted through monthly reports if there were areas of concerns. Locally the service monitored aspects of safety including numbers of incidents and complaints. This information was then submitted centrally so comparisons could be made. A governance and risk review was produced by the central team and returned to the service, this was available to view and so comparisons between other services could be made but there was no requirement to do this. There were plans to improve the reporting in the near future so clear comparisons could be made between sites.

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. An electronic incident reporting system was used to report incidents. Staff we spoke with knew how to report incidents using the electronic system and were confident to do so. Once reported the incident would be reviewed by the service lead who had responsibility for investigating and responding to the incident.

- During the reporting period December 2016 to November 2017, three incidents were reported. All three were incidents that had not happened at the RRU but were concerned with the impact that another clinical service was having on patients. On reviewing these incidents a theme had been identified and this had been escalated to senior staff to review. At the time of the inspection the incidents were being reviewed by senior staff to then decide on actions to minimise further occurrences.

- Between December 2016 and November 2017, the service had not reported any never events. Never events are serious incidents that are entirely preventable as guidance, or safe recommendations providing strong systemic protective barriers, are available at national level, and should have been implemented by all healthcare providers.

- Reliable systems, processes and practices were in place to ensure all care and treatment was carried out safely. Staff were clear on the process for raising concerns associated with
safeguarding, equipment, other staff, and if they had a whistleblowing concern. There were specific people identified as a point of contact for each of these areas and in addition, staff knew about other people or parts of the organisation that would also be suitable to report to, such as the human resources team.

- Lessons were learned and improvements made when things went wrong. We reviewed four incident files at the time of the inspection. These included a delay in treatment caused by the service, a delay in treatment due to the patient accessing an alternative service, an injury to a patient during hydrotherapy, and an incident during a strength exercise in the gym. In all cases, incidents were investigated and the cause identified together with actions to reduce further risk.

- Staff were all aware of the clinical incidents that had occurred in the service and improvements made in response to them. There was a thorough understanding of the balance between safety and challenging patients to progress their rehabilitation, this meant that treatments were delivered safely while not limiting the opportunity for patients to progress.

- People involved in incidents were not always kept fully informed during the incident review process. For example, an incident that resulted in a change in practice during gym sessions had not been fed back to the individual involved. This meant they were not aware of the changes made as a result of the incident. In addition, it was not always clear if the principles of duty of candour had been followed including being open, honest and offering an apology to the patient as soon as the incident had been identified; irrespective of who is to blame. In some incidents we reviewed, an apology had been given but in some, it had not.

- Lessons were learned and shared, and action taken as a result of investigations. Staff told us how their practice had changed as a result of an incident and how the team had worked together to learn, take action and reduce the risk in the future. Other changes to practice had happened as a result of the incident as staff felt there may be a risk it could happen in other situations. Updates and learning from significant incidents which had happened at other RRUs was available to staff on the intranet update page and staff told us about learning that had been shared from other units.

- Incident themes were identified for the service and when appropriate these themes were escalated to more senior staff to review and undertake action. We reviewed an example of an incident theme associated with the delay in treatment when accessing an alternative service, this had been escalated to senior staff to review.

- Incidents, investigations, actions and learning were discussed at team meetings. Staff told us if an incident had happened, it was discussed as a team and no blame was placed on the individual. The team reviewed actions and learning to reduce the likelihood of the incident happening again, and provided support to each other to achieve this.

**Overview of safety systems and processes**

The unit had clearly defined and embedded systems, processes and units in place to minimise risks to patient safety.

- Systems, processes and practices were in place to keep people safe. All staff were Disclosure and Barring Service (DBS) checked and their professional registration and expiry date was reviewed. Information on checks was stored on the governance spreadsheet, which the service lead had access too, with a clear indication of what date a review was required on staff checks and registration. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent
Safeguarding Authority (ISA).

- Locum staff had a number of checks carried out before working in the service. These included: security checks, proof of qualification, registration and previous registration conditions. All information was kept on file by the service lead and locum staff were supported to complete revalidation for their registration while working in the service.

- Staff had a programme of mandatory training in the safety systems, processes and practices. Compliance with training was not always at the required level. We saw records, which showed the mandatory training programme for staff. The compliance level for the service was set at 100%. Compliance for the following training was 100% for Caldicott training, equality and diversity, environmental awareness, office safety, safeguarding level one and two, defence information passport, and data protection. Training at 90% compliance was basic life support, display screen equipment, and unconscious bias. Training at 80% compliance was fire safety, health and safety, infection prevention and control, responsible for information, military computer system user stage one and two. The lowest compliance for the team was 70% for manual handling and 50% for business continuity and Defence Medical Information Capability Programme (DMICP). However, all staff with training compliance under 100% had been booked to attend necessary training before January 2018. The service lead had to complete equality and diversity advisor training; this was booked for January 2018.

- Levels of compliance were recorded on an electronic system and some staff also kept their own records so they could keep track of their own compliance. Compliance was reviewed every three months and staff were informed if they needed to complete courses. Staff were given time to complete mandatory training during time between courses and there was an expectation that staff would use this time to complete this training. However, compliance remained low in some cases.

- Some staff received training certified by the Royal Lifesaving Society UK to gain the National Pool Lifeguards Qualification. This allowed them to lifeguard at the swimming pool when patients were receiving treatment. At all sessions a member of staff who was lifeguard trained was present so patients and staff were protected. We observed an additional member of staff who was lifeguard trained at the pool on the day of inspection, as one member of the team was unable to carry out these duties.

- There were arrangements in place to safeguard adults and children from abuse but not all levels of training reflected relevant legislation and local requirements. Staff were trained in safeguarding adults and children. Staff were trained to safeguarding level two level, this was in line with the national guidance (intercollegiate document, 2014) which recommends staff should be trained to one of five levels of competency, depending upon role and interaction with adults and children. Staff told us that previously some safeguarding mandatory training had been out of date and additional training had been arranged in the form of an external course to make sure staff were trained.

- Staff who required a higher level of safeguarding training at level three had training that had expired. This included the safeguarding lead for the service and was due to a lack of local courses running. This had been identified on the service’s risk register. At the time of inspection, an appropriate training course had not been identified. However, actions had been taken to mitigate the risk, staff had access to an appropriately trained staff member in medical department in the adjacent department. This allowed staff direct access to an appropriate member of staff while patients were in the department being treated.

- Staff understood their responsibilities and adhered to safeguarding policies and procedures. Staff were clear how they would manage a safeguarding concern and who they would get advice from, they would discuss issues with their service lead and the local safeguarding lead. Staff demonstrated an understanding of what types of issues might alert them to make a
safeguarding referral and the process to follow.

- Chaperone posters were visible in the patient waiting area and all clinical treatment rooms including the Multidisciplinary Injury Assessment Clinic (MIAC) and the Podiatry clinic room. This informed patients they could request a chaperone for their assessment or treatment.

- Standards of cleanliness and hygiene were maintained. The environment was visibly clean and tidy. We saw evidence cleaning took place on a daily basis. The department had a contract with an external cleaning company who used cleaning schedules which outlined how and when cleaning should take place. Staff told us a deep clean of clinical areas took place once a week with all movable furniture and equipment being removed so difficult to reach places could be cleaned. Two items were looked at had a layer of superficial dust. This was the bottom shelf of the resus trolley, and the shoulder press machine. All other equipment was dust free and appeared clean and tidy.

- There was safe management of clinical waste. Throughout the department there were colour coded waste bins, which clearly stated what type of waste, should be disposed of in them. We looked at a general waste bin and a clinical waste bin, both contained appropriate waste and were not overfilled. Sharps were disposed of in sharps boxes with colour-coded lids. We reviewed two sharps boxes in the treatment room, which were correctly labelled, not overfilled and contained sharps items only. However, both box lids were fully open, rather than partially shut which meant there was a risk of the contents spilling out if the box was knocked over.

- There were reliable systems in place to prevent and protect people from healthcare-associated infections. Hand hygiene audits were completed to monitor practice. The audit completed in June 2017 reviewed practice during a RRU course. The five moments of hand hygiene were used to inform the audit, however it was noted that moment two (before aseptic technique) and moment three (after body fluid exposure risk) were not applicable in the course setting. The results showed that the overall compliance was 92%. Actions from the audit were identified and there was a plan to disseminate the findings to staff during a meeting and re-audit in 12 months.

- There was a local lead for infection prevention and control. This was an exercise rehabilitation instructor (ERI), who was based in the department full time. Staff could approach them to discuss any issues around infection prevention and control.

- All staff we observed in clinic undertook the five moments of hand hygiene, their arms were bare below the elbows, and cleaned equipment before and after patient use. Staff uniforms appeared clean and tidy. Equipment covers and chairs in the department were covered in wipeable fabric to allow them to be cleaned between patient uses. All chairs and most equipment were in good condition however, there was a small rip in the cover on the bench of the Smith machine, which could pose an infection risk.

- The maintenance and use of equipment did not always keep people safe. A policy was in place for equipment care and staff knew where to find it and what it contained. Staff were clear on the frequency that equipment should be reviewed and serviced and a system was in place to check equipment using a 373 form. We reviewed the file of 373 forms, which showed that not all checks had been completed on all equipment. We raised this with staff who agreed the forms were not completed as per policy and so they could not be assured checks had taken place for all equipment.

- Gym equipment had stickers attached, which identified the date when it had last been serviced. This allowed staff to visually check equipment before use to make sure it was safe to use. Most equipment had completed stickers however, four cardiovascular machines did not have a sticker so we could not be assured the equipment had been serviced. This was raised at the time of the inspection and appropriate action taken. The equipment was put out of service until the checks had taken place.
• Overall gym equipment was in good condition and working order throughout the department. When not in use equipment was stored away and off the floor in suitable storage shelving.

• Staff told us that issues with equipment were sometimes reported verbally to the appropriate person on site. This resulted in the equipment labelled out of use and a service or repair was booked. Staff felt equipment was repaired and made fit for use quickly however; this process was not always documented clearly in the appropriate spreadsheet.

• The resuscitation trolley included the necessary equipment to deliver basic life support. Records confirmed checks on the equipment took place each day the clinic was open, however the checks did not always identify problems with the equipment. For example, the automated external defibrillator (AED) and pads, oxygen, and two out of three airways were all within check or expiry date. The oxygen mask and bag did not include expiry dates and one airway was out of its packaging. We raised these issues with the provider at the time of the inspection and prompt action was taken to improve the checking process and change the equipment.

• The resuscitation trolley was located in the treatment room, which had a keypad lock on the door but was left unlocked during clinic hours. The trolley included a drawer to store equipment, which did not have a tamper proof seal. This meant you could not tell if the drawer had been opened between checks. Therefore, if the trolley needed to be used staff could not be confident all equipment required would be in the drawer.

• Resuscitation equipment was available at the swimming pool. Pocket masks and an AED were easily located and within check and expiry date. Evacuation boards were available to recover people from the pool who had a suspected spinal injury. Rescue grab bags were available to recover people from the pool who were in distress and required assistance.

• There were not always effective systems in place regarding the storage of clinical items. A number of items in the clinic room were out of date. This included disposable cleaning cloths, syringes, dressings, massage lotion, the saline and bandage in the eye wash kit and the disinfectant in the blood spill kit. In addition, items such as the cleaning cloths and massage lotion did not include date of opening so it was not clear how long these items had been used for. This was raised at the time of the inspection and action was taken to replace these items and identify a process to ensure a record was kept when items had been opened in the future.

• The swimming pool used by the service was checked daily to make sure temperature, levels of chlorine, and the PH balance was correct. Staff from the RRU were not responsible for these checks but told us they visually checked the test register to make sure levels were correct and that the pool manager would contact them if there were any issues. We reviewed the test register, which showed results between March and November 2017. Over these eight months of testing one set of results were not signed by the tester, two tests were not documented as the battery on the test equipment was low, and three tests had not been reported completely.

• Fire evacuation information was on display around the department with detailed information available on the health and safety notice board in the waiting room. Fire exits were clearly marked and fire doors were kept shut and locked with easy open mechanisms should people need to exit the building quickly. Areas around fire doors and along fire exit routes were free from obstruction and fire extinguishers were available and marked checked and in date.

• Arrangements for managing medicines and medical gases did not always keep people safe. A policy was in place for management of medicines (JSP 950 Leaflet 9-2-1). This covered the classification of medicines, the procurement and receipt of medicines, security, storage, stock management, prescribing, supply and administration, dispensing, and training and education for staff.

• A medicines management audit was completed in September 2017 and re-audit was due to take place in January 2018. Compliance was reviewed in the following areas: daily fridge
temperature monitoring, monthly stick balance checks, and prescription management. These target score for compliance was 100%. Results for fridge temperature monitoring was 43% for July 2017, 29% for August 2017, 47% for September 2017 on days when only MIAC clinics took place. On days when the MIAC and medical officer (MO) clinics took place, these results were 56% for July, 100% for August, and 75% for September 2017.

- Stock balance check results demonstrated compliance was 75% overall for monthly checks in 2016, and 11% compliance for month checks in 2017. Additional checks took place every quarter, which demonstrated 75% compliance for 2016 and 33% compliance for 2017. Previous actions were taken to reduce low compliance including an additional free clinical slot every month to allow time for checks to take place, and a twice yearly inspection review to be completed by the service lead. This had not led to an improvement in results between 2016 and 2017, however the service knew about the poor compliance and additional actions were being taken.

- Medicines were only prescribed by doctors. There were no prescribing physiotherapists in the service. Prescription management results indicated that 100% of prescriptions were signed by the doctor in both 2016 and 2017. The batch number and expiry date record was completed in 87% of records in 2016, and 100% or records in 2017.

- During the inspection, we reviewed medicines required to be stored in the fridge. We observed the fridge temperature was within range and minimum and maximum temperature range had been recorded every day the clinic was open. All medicines in the fridge were in date. The fridge was lockable and located in the treatment room, which had a code lock on the door. However the fridge and clinic door were not always locked when the room was unattended, this meant medicines were not always securely stored. No other medicines were stored in the department.

- In the reporting period, November 2016 to October 2017 there had been no medicines incidents reported by staff.

- Staff were not always clear on the correct procedure for safe disposal or medicines. Staff told us they would dispose of medicines in different ways. Only some staff were clear on the correct way to dispose of medicines, which was to take them to the medical centre next door where they could be disposed of safely.

- Individual care records were written and managed in a way that kept people safe. Patient records were electronic and were accessed on computers around the department. Records were password protected with access limited to those staff with the right to access them. The system provided an audit trail of all staff that had looked at or amended the record.

- Processes were in place to maintain patient’s confidentiality and to safely maintain records and this complied with the notes management handbook. Staff told us how they would manage patient records from creation to destruction however, staff were unable to identify a policy for the management of individual patient records from creation to destruction.

- A policy was in place that detailed the Caldicott principles and how staff should apply them. The Caldicott principles are seven confidentiality principles, which outline how personal confidential data should be handled. There was an overall Caldicott guardian for the Ministry of Defence (MOD): the Head of Medical Strategy and Policy, together with a Caldicott guardian with specific responsibility for DMS. A Caldicott audit took place in November 2017, which reviewed five random areas in the department over five days. The results showed 100% compliance in all areas, this was an improvement compared to audits completed in July 2016 and May 2017 where some computers had been found left unattended and unlocked, and office door unlocked, and there had been an unattended patient issue.

- Staff were able to tell us how they managed personal data in line with the policy, for example a
physiotherapist and a podiatrist told us that they could view therapy information for the patient but they would not be able to directly view information on the electronic record by the mental health team as this may not be appropriate.

- We reviewed 10 records and overall saw they were organised, eligible, up to date and stored and shared appropriately. Records included information on assessment of the patient, clinical pathways, risk assessments, outcome measures and patient specific goals and in all 10 records, these were completed. In eight records, there was no evidence of an emotional assessment or psychological screening being documented, for these eight patients more complete documentation of this would have been beneficial. In two out of seven records no assessment of pain was documented which would have been beneficial.

- Processes were completed to review patients’ records and take any necessary actions to ensure medical records were fully completed and compliant with the law and policy. Audits were completed on records annually and included 10 sets of notes per clinician. Each audit had seven headings covering mandatory compliance, subjective assessment, objective assessment, analysis, treatment planning, treatment implementation/ intervention, and transfer of care/ discharge. We reviewed results from an audit undertaken in June 2017, which demonstrated 100% compliance for all relevant headings.

**Monitoring risks to patients**

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- Risks to people who use services were assessed and their safety monitored and maintained. Staffing levels, skill mix and caseloads were planned and reviewed so that people receive safe care and treatment at all times, in line with relevant tools and guidance. Actual staffing levels met the planned staffing levels for the service. Staffing levels for the service were set at 11 whole time equivalent (WTE) staff to include four clinical civilian staff, two administrators, two military Sergeants, one military Warrant Officer, one military Captain, and one military Major. Between the reporting period December 2016 and November 2017, the actual staffing level for the service was above 99%. One vacancy for a military captain between December 2016 and July 2017 had been back-filled by a locum member of staff. One vacancy for an administrator who left the service in December 2016 was unfilled until May 2017.

- Comprehensive risk assessments were carried out and most risks were managed positively. Risk assessments were listed on a register and included 27 separate risk assessments for the service. 24 of the 27 of the risks listed had a review date. Some of the risks were task specific such as the risk assessment for work experience staff. However, three of the risk assessments did not have an identified review date and one risk assessment was due for review in June 2017 but it had not been marked as completed. Staff told us risks were actively managed and reviewed and this made staff feel it was a safe place to work.

- We reviewed two risk assessments in detail, one for class therapy and one for walking between different areas on the military site. Both included comprehensive details of the risk, hazard, control measures, risk rating, a decision if the risk was adequately controlled and when it should be reviewed.

- Staff could identify and respond appropriately to changing risks to people who used services, including deteriorating health and wellbeing or medical emergencies. Emergency policy (no 13) included an emergency action plan for responding to a patient who became ill and required basic life support (BLS). The policy covered the steps to be taken and how to escalate so further assistance could be called, this was by calling 999 to request an emergency ambulance. The policy was in date and next for review in May 2018.
• Staff on site were trained to use a crash trolley to deliver BLS. An annual resus review took place for the service with the last review being completed in January 2017. This included providing basic life support, automated external defibrillator (AED) and anaphylaxis training, a review of resuscitation equipment, and completion of a resuscitation scenario. Action points were identified from the review including soon expiring medication, daily checks, and the mobility of the resus trolley.

Arrangements to deal with emergencies and major incidents

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

• Potential risks to the service were anticipated and planned for in advance. The service had arrangements in place to respond to emergencies and major incidents and these were practised and reviewed. An up to date and verified emergency policy (no 13) was in place, which included an emergency action plan for fire evacuation. Fire drills were carried out at random times to practice evacuation and follow up feedback was received from the fire brigade to ensure drills and procedures were carried out to the highest standard. We reviewed the record for practice of fire drills, which stated the last drills took place in February and August 2017.
Our findings

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

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines or best practice guidelines for musculoskeletal conditions.

- People’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, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. Best practice guidelines were used to guide assessment and treatment. The National Institute for Health and Care Excellence (NICE) guideline NG59 was used to guide treatment for low back pain and the service included the recommendation to use evidence based screening tools, the STaRT Back, during initial assessment. This tool provided screening information to assist the clinician and patient in making the best decision on what pathway of treatment the patient should receive.

- In some cases, treatment was delivered, which did not directly comply with NICE guidance, for example acupuncture for low back pain. This only took place if there was a clear rational for treatment based on the clinician’s assessment and the needs of the patient. Staff spoke confidently about the use of best practice guidance as a way to guide their practice, rather than dictate it, so the best care could be delivered.

- Rehabilitation courses included exercise rehabilitation, education sessions, psychological wellbeing sessions such as relaxation, and individual treatment sessions. This was in line with evidence based practice guidance on treating musculoskeletal conditions and provided a holistic approach to rehabilitation. Patients valued this approach, however some patients commented that the educational sessions could be very technical for them to understand.

- Patients had their needs assessed, their care goals identified and their care planned and delivered in line with evidence-based, guidance, standards and best practice. This was monitored to ensure compliance. Patients were assessed at the start and during treatment using evidence based measures. For example, we were told about a patient with a knee condition who was assessed using a thomas test (a test to measure muscle length) and a single leg press test (a test to test individual muscle strength and control). These tests were specific to the patient’s presentation and used throughout the course to monitor progress.

- Validated patient reported outcome measures (PROMS) were used to assess the patient at the start and the end of their treatment. This meant that the patient’s response to treatment could be evidence the effectiveness of treatment. Outcome measures included the owesty disability index (ODP), disabilities of the arm, shoulder and hand (DASH), lower extremity functional scale (LEFS), patient health questionnaire (PHQ9), generalised anxiety disorder assessment (GAD7),
work and social adjustment scale (WASAS). Outcome measures were chosen to reflect the condition the patient had, for example a lower limb specific PROM would be chosen for a patient with a knee condition, or a spine specific PROM would be chosen for a patient with a back condition. All outcome measures were collated, reviewed, reported on and discussed to reflect on best practice and the outcomes for patients.

- Patients had clear and personalised outcome goals for their treatment. Patients who attended a rehabilitation course were issued with a red booklet, which defined their treatment plan and goals. This was used throughout the course to track progress and update plans and goals.

- We reviewed a sample of clinical outcomes including clinical outcomes for the spine course from a service evaluation completed in September 2017. This reviewed outcomes for 69 patients and presented them in relation to the types of intervention they had, Multidisciplinary Injury Assessment Clinic (MIAC) and course, and their ongoing pathway of care including discharge or onward referral. Overall results (MIAC and course pathway) showed that for the ODI 68% of patients improved (scores had reduced) and of these, 48% improved more than the minimal clinically important difference. The minimal clinically important difference is the smallest change in an outcome that a patient would identify as important. 21% of patients showed deterioration (scores had increased) in ODI scores, only 10% of these were greater than the MCID, and all these patients received ongoing treatment from their condition.

- Further review of clinical outcomes for ODI for 45 patients between June 2016 and May 2017 indicated that three patients (6.7%) ODI scores were unchanged. Three patients (6.7%) ODI worsened but not enough to be considered a minimal detectable change and no patients (0%) ODI scores worsened above a minimal detectable change. 17 patients (37.7%) ODI improved but not enough to be considered a minimal detectable change, and 22 patients (48.9%) ODI improved by more than the figure required to indicate a minimal detectable change.

- Clinical outcomes for upper limb patients were measured using the disabilities of the arm, shoulder and hand (DASH) score. Results showed most patients improved during the course however due to a small number of patients this could not be looked at in further detail.

- An audit of joint injections given to patients by one of the MIAC doctors in 2017 indicated that 17 out of 24 (71%) patients reported improvement in their condition at six weeks or more after injection.

- A project to review outcome measures and how the service was assessing and achieving improved outcomes for patients was being led by a member of the team. This was a national project that also had a local focus as staff had identified this as an important aspect of their service they wanted to improve. The aim of the project was to review the type of outcome measures being used to improve compliance, examine the results to evidence if patients were improving, and consider how further outcome data could be gathered to improve practice further. The project was having an effect on national defence medical services and the whole rehabilitation pathway for patients so they could receive the most effective care and outcomes.

- Pain levels were assessed and managed in relation to the individual. We observed staff responding to patients who reported pain in their class activities. A verbal assessment of the level of pain took place and patients were quickly offered advice on how to adapt the exercise to reduce their pain so they could continue. 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) when patients were assessed and in response to treatments so staff could monitor the effect on pain.

Management, monitoring and improving outcomes for people

There was evidence of quality improvement including clinical audit:
• 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 MOD.

• Registered professionals were up-to-date with their continuing professional development (CPD) and supported to meet the requirements of their professional registration. A register of staff professional registration was held and staff undertook a number of work based activities including training, journal club, higher education learning, and peer review to meet the requirements of their CPD.

• Staff were supported to deliver effective care through opportunities to undertake training, learning and development and through meaningful and timely supervision and appraisal. A number of staff told us about role specific educational training they were completing and the support they had from the service to do this. For example one member of staff was completing a degree in sport and exercise science, one a master of science (MSc) in physiotherapy, and another a MSc in physiotherapy plus specialist training in diagnostic ultrasound scanning. Some staff reported that funding for courses was offered by the service however, some staff reported that securing funding could be difficult. Exercise rehabilitation instructors (ERIs) undertook courses to develop knowledge and skills and then presented this training to other ERIs’ at regional training days so the learning could be cascaded.

• Regional in-service training and development days were organised for staff and included role specific training so individual learning needs could be met. Staff told us how these sessions were well-organised, often included expert speakers, and staff were given time to attend. The training lead had received feedback form staff that more combined training for staff would be beneficial and so these sessions were scheduled to take place in the coming year.

• A peer review took place between all staff including staff of different grades and discipline. This allowed staff to review their practice, learn from others, and embedded a culture of feedback and improvement. Staff told us this was very valuable and took place in both a formal way through planned peer review, and informally when they needed support with their practice.

• Temporary staff who worked in the service such as locum doctors and physiotherapists were included in learning and development opportunities available to permanent staff. The manager of the service told us it was important that all staff were seen as part of the team and given the same opportunities. New staff who started with the service shadowed other members of staff to allow them an introduction to the service and to make sure they were competent in working in that role.

• Work experience staff undertook placements in the service to learn about how the service ran and provide development opportunities for their practice. At the time of inspection, a physiotherapist was placed in the service to gain this experience.

• A member of staff led a journal club, which selected a recent publication to review and discuss. This allowed staff to consider changes to practice and the evidence behind them so improvements could be made. This contributed to the CPD requirements of the clinical staff in the service.

• Arrangements were in place for professional revalidation of medical staff. A policy was in place for the revalidation of doctors in the defence medical service and MOD (JSP 950 leaflet 10-2-2). This covered the requirement for appraisal based revalidation, the frequency of revalidation, and possible outcomes. A member of the medical staff we spoke with told us they received an
annual appraisal and that their revalidation was completed, their next review date was 2020. We reviewed a document, which confirmed this.

**Effective staffing**

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- Staff, teams and services worked together to deliver effective care and treatment. All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people’s care and treatment. Patients were assessed during their initial appointment in the MIAC by a doctor and a physiotherapist together. The joint assessment allowed a coordinated treatment to be planned and resulted in the patient only needing one assessment. In addition at any point during a patient’s treatment joint assessments or treatment could take place to meet the needs of the patient and the occupational needs of their employment, for example a podiatry and physiotherapy assessment, or a physiotherapy and exercise rehabilitation assessment.

- Staff delivered treatment that was appropriate for their roles and met the needs of the patients. For example, the doctor in the MIAC would delivery image guided steroid injections, a physiotherapist would deliver manual therapy and acupuncture, and an ERI would deliver exercise therapy and fitness training. Staff told us they all worked within their scope of practice and that the best combination of clinical skills would be brought together for the patient.

- Courses were delivered by staff in pairs using a combination of ERIs and physiotherapists. Working in this way allowed different components of the course to be delivered by either the ERI or physiotherapist individually, or as a pair when required. This resulted in a specific approach to treatment based on the skills of staff and increased the available time for staff to treat patients on a one to one basis.

- Care was delivered in a coordinated way when different teams or services were involved. Staff could refer to other services within defence such as the medical centre or mental health services. A referral was completed, attached to the electronic patient record, and sent to the appropriate service. In addition, referrals could be made to services outside of defence such as the local GP out of hours service if required.

**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.

- Staff had all the information they need to deliver effective care and treatment to people who used services. An integrated health record (IHR) was in place for all patients that included the patient’s full medical record. This allowed comprehensive information to be available to appropriate clinicians when they were treating the patient. The IHR could be accessed from any defence medical computer terminal through secure log in and included an automatic update of the patients’ demographic information so records were correct at the time of viewing.

- The service used the defence medical information capability programme (DMICP) to store and access electronic patient records. The system allowed access to records across the United Kingdom, overseas, and on the battlefield. This allowed staff in any location to access records and view the information required to treat the patient wherever they were.

- A crib sheet for each patient was used to handover their care to other members of staff within
the service. This included a summary of the patient’s condition, their progression with treatment, and risks associated with the patients and how these were being managed, and their specific goals for treatment. Time was set aside for handover to take place so that all staff were fully up to date with the patients and their treatment plans.

- Patients told us they received clear information prior the course to fully inform them about the treatment they would receive and what was expected.

**Consent to care and treatment**

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

- Staff understood the relevant consent and decision making requirements of legislation and guidance and people were supported to make decisions. Consent to treatment guidance was available to staff and included an update in 2015 in response to changes in legislation, however the document was due for revision in January 2017 and this had not taken place. The guidance stated the different types of consent and the procedure to gain valid consent from a patient.

- Verbal consent was obtained from patients at the start and during their ongoing treatment. We observed patient assessments where verbal consent was gained from the patient before continuing with the assessment or treatment. Patients were given appropriate information to understand risks and benefits and allowed time to consider their treatment options and consent.

- Written consent was obtained for treatments that involved a higher level of risk to the patient such as shockwave therapy and joint injections. Shockwave therapy is an electrotherapy treatment for soft tissue and bone conditions. We reviewed the consent file, which included best practice guidelines for each treatment, patient information, written consent forms, aftercare advice, and outcome measurements.

**Supporting patients towards optimal function**

The unit identified patients who may be in need of extra support and signposted them to relevant services. For example:

- People were supported to attend and complete rehabilitation and manage their own condition. An overview of the courses run was available in the patient waiting area. This allowed patients to see what was on offer and when the courses were running.

- Signposting of additional support services took place and information for patients on these services was available. In the waiting room, there were helpline and welfare phone numbers on display for patients. During patient appointments we observed staff talking to patients about other services, they could access to help them manage their condition and improve the outcome of rehabilitation.

- Education and information was included in the rehabilitation courses and patients’ skills were developed to help manage their condition. For example, education on pain flair ups and pacing activities was delivered so patients could use these principles for their ongoing rehabilitation once they had left the course.

- All patient goals were specific to the individual patient so they could achieve what was required from their treatment. Goals were often focused on work-based activities to make sure patients could return to their normal work and life after their rehabilitation.
Are services caring?

Our findings

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

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- We observed caring, friendly and professional staff interactions with patients. We saw patients were treated with kindness and understanding. Staff demonstrated a non-judgemental and supportive approach to patients while motivating them to fully participate. We observed compassionate care provided to patients during consultation and while participating in course activities. We saw staff during the hydrotherapy session engaging with patients individually, motivating, encouraging and providing a fun and challenging environment for rehabilitation. Patients were fully engaged with the session and we observed them discussing their treatment with staff who were attentive and quickly adapted treatment in response to patient feedback.

- Staff took time to interact with people who use services in a respectful and considerate manner. We saw reception staff were polite, friendly and helpful both on the telephone and when patients arrived at the clinic or used the waiting areas. Reception staff were visible from the waiting area and we observed staff leaving their reception desk and interacting with patients when they arrived to welcome them and answer any questions they had.

- Staff showed an encouraging, sensitive and supportive attitude to people who used the services and understood and respected people’s personal and social needs. Interactions between staff and patients in clinics were calm, non-judgemental and allowed the patient time to speak about their personal and social needs as well as their condition. In cases where a person’s social needs were having an impact on them, they were given the time to talk about this and staff signposted appropriate services, which may help them. Staff acknowledged and showed empathy towards the impact that a patient’s condition was having on their ability to return to their normal duties and encouraged patients to set appropriate and realistic goals to work towards achieving a return to work.

- People’s privacy and dignity was respected. Single sex changing facilities were available for patients in the RRU and at the swimming pool. Assessment and treatments for patients that may be sensitive or require them to undress were carried out in individual clinic rooms. Exercise rehabilitation and educational sessions took place as a group in the gym and this was separate from the other areas of the clinic including the waiting area and reception.

- When people experienced pain, discomfort or emotional distress staff responded in a compassionate, timely and appropriate way. We observed staff during the gym based classed and the hydrotherapy session responding to patients quickly and confidently when they had pain or discomfort. Patients were not limited in their session when this occurred but encouraged and supported and motivated to complete an alternative exercise that was more appropriate.
Care planning and involvement in decisions about care and treatment

- Staff communicated with people so that they understood their care, treatment and condition. We observed patient assessments were through explanations were given by staff to patients about their condition, prognosis, and their symptoms. During the courses, educational sessions were included to provide theory and physiology behind a patient's condition and pain. The explanation of pain was supported by the use of diagrams, video clips, and discussion of examples to illustrate the theory. Staff linked the theory to patient experiences of those on the course to help patients identify directly with what was discussed.

- Staff provided advice and signposting to further information and patients were encouraged to ask questions about their care and treatment. Throughout the educational sessions and assessments that we observed patients were asked on multiple occasions if they had any questions or if they needed any clarification on what was being discussed. For example, we saw staff checked patients understanding by pausing through the education sessions, checking understanding and encouraging patients to ask questions if they had them. During a clinical assessment, we observed one patient asking questions about their ongoing clinical care, their condition, and the availability of some equipment they needed to manage their condition. The member of staff allowed time for the patient to ask the questions, provided clear answers and checked throughout that the patient understood what would happen next and if they had any further questions. By allowing for this time to ask and answer questions the patient then did not need to return for additional sessions as they had the answers they needed.

- People who used services were routinely involved in planning and making decisions about their care and treatment. Patients were encouraged at every opportunity to take ownership of their recovery and plan to continue their rehabilitation once they had finished treatment. During the spine course in both the education and exercise, sessions staff offered advice and ideas on how patients could achieve this. Patients were given choices on the type of care and treatment. We observed staff discussing with patients the options available to them, the benefits and any drawbacks of these options, and then asked the patient what their thoughts and decisions were about their care and treatment. When patients were not ready to make decisions they were encouraged to ask further questions and take additional time to make this decision.

Patient and family support to cope emotionally with care and treatment

- People who used services receive the support they need to cope emotionally with their care and treatment. Staff understood the impact of that a person’s care, treatment or condition will have on their wellbeing. Staff told us about the impact on patients of their condition and how this could result in them having to significantly change their job role or in the longer term be discharged from the military. We observed staff discussing with patients the emotional effects of their condition and rehabilitation and offering support and empathy regarding these issues. Staff talked to patients about additional support that was available to them to address their emotional needs and encouraged them if this was required.

- Additional emotional support was available to patients if required and the doctor who worked in the service would review patients if there were concerns over their wellbeing. The doctor and senior clinical staff could undertake a review and offer additional support or refer onto other services including mental health services and support from their military unit. Patients were encouraged to use their own emotional support systems including friends and family and also worked based support such as staff in their own unit who could provide this support.
• People were encouraged to link with other course participants while they were completing their rehabilitation. At the time of the inspection, about half the patients were staying on site in the RRU accommodation. Patients had the opportunity to socialise together during the course and also during meal times and in the evening. Patients told us this was very beneficial as they could support and encourage each other.
Our findings

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

Responding to and meeting patients' needs

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.

- Services provided reflected the needs of the military population and occupational needs of their employment within the geographical area of responsibility. The geographical area of responsibility was the region that the RRU covers and the military population within that region. Patients could contribute to a weekly course summary so concerns could be reviewed and addressed before the course continued during the next week. Patients were encouraged to put comments up on a white board so the group could review them together and action appropriate solutions in a timely way.

- A comments book was placed at reception and available to patients to use at any time. We reviewed the book and saw there were comments written about treatment and courses patients had attended. Staff told us this was valuable to review as it added to feedback on the service however, the book was not formally checked and themes or trends were not reported on.

- The service had a visiting trauma and orthopaedic consultant who provided appointments for patients at the RRU. This enabled patients to receive specialist assessments locally, without having to visit another hospital location. It also allowed staff to work together with the specialist to provide continuity of care for patients with more complex needs.

- Patients were able to access further courses and treatment at the RRU or other services offered by defence medical if they required additional treatment. This was often the case for patients who had complex conditions and required a longer or more intense period of rehabilitation. We observed a patient in the Multidisciplinary Injury Assessment Clinic (MIAC) who required a second course of treatment at the RRU, this was discussed with the patient and facilitated quickly at a suitable time.

- Where people’s needs were not being met, this was identified and used to inform how services are planned and developed. Feedback from patients resulted in changes to how the service was planned, developed and delivered. Staff and patients told us about examples of when feedback had resulted in changes to the content of courses so their needs could be met. These changes were made on a course by course basis so specific needs could addressed, for example yoga and mindfulness sessions had been added to courses in response to patient feedback. Staff told us how a detailed review took place every six months to ensure people’s needs were met and best practice guidelines were followed.

- New patient appointments and follow up appointments in MIAC had recently been increased from 40 to 60 minutes for a new appointment, and 20 to 30 minutes for a follow up. This had been as a result of patients’ needs not being met in the shorter appointment time. This change in service was audited and demonstrate that although there was a loss of 20 minutes of patient
contact time per day, staff felt this would give a better experience to patients. Ongoing audit was planned to review this again in the future.

- Facilities and premises were appropriate for the services that were planned and delivered. A wide range of fitness and strength equipment was available for patients so they could complete the required rehabilitation. A full inventory of all equipment was held electronically which provided information on what the equipment was, its cost, and where it was purchased or hired from. Staff told us the equipment was well utilised with most equipment being used by patients on a daily basis. If an item of equipment was not being used often, the team would review this to see if it could be integrated into the course, or if an alternative piece of equipment would be more appropriate.

- The main gym area was spacious with additional areas for cardiovascular machines and some of the specialist equipment. Courses were held in the gym and the number of people in the course was set at a level appropriate to the space available. Some patients and staff commented that more room would be an added benefit, but this was not possible due to the design of the premises.

- A 30 metre swimming pool was available for rehabilitation in water. This was not used as a hydrotherapy pool but was an appropriate facility to use for exercises and fitness training. A hydrotherapy pool is a treatment pool with warm water used to undertake specific rehabilitation exercises. The pool was spacious and a wide variety of equipment was available for patients to use during their exercise. The environment allowed staff to supervise and guide patients from the side of the pool so they were fully engaged with the session.

- Patients told us the accommodation they stayed in to attend the course was organised, clean and tidy and ready on arrival. The accommodation was on the same military site as the RRU so they were close the RRU and could easily attend for the duration of their treatment or course. There was an option for patients to live off site for the duration of the course as long as they were within reasonable travelling distance to attend daily.

- Meals were provided in on site and was sufficient to meet the needs of the patients. Some patients commented that there was a long walk to the building where meals were provided and sometimes this could be an issue especially for those who found walking difficult.

- Services were planned to take account of the needs of different people. A verified equality and diversity policy was in place for the service, 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. The policy was in date and had a review date of May 2018. All staff completed Equality and Diversity training every three years. In addition Line managers undertook further training called ‘Equality and Diversity Training for Line Managers’.

- Chaplaincy services were available to patients with a number to call in the waiting area. No other information was visible on any other religious support services available.

**Access to the service**

- People did not always have timely access to initial assessment, diagnosis or urgent treatment. The MIAC service received 564 referrals between October 2016 and September 2017. The target for undertaking new patient assessments was set at 80% of initial assessments to be completed within 20 working days of referral. During one quarter (April 2017 to July 2017), this target was met, however overall the service did not achieve this with 65% of initial assessments being completed within 20 days between October 2016 and September 2017. Between the
reporting period October 2016 and September 2017 a total of 141 patients (25%) waited between 21 and 30 days for an initial assessment. For the same period 55 patients (10%) waiting over 30 working days. Staff told us the reason for the delay in accessing MIAC was due to a reduced number of doctors available to run the clinic. Options to increase the number of clinics and see more patients without a doctor had been considered, but was not implemented as this would have reduced the quality of the service for the patients.

- The RRU received 292 referrals between October 2016 and September 2017 for its rehabilitation courses. The target for patients to be offered a course starting within 40 days after their initial appointment was 90%. The service did not achieve this in any quarter or overall with only 74% of patients being offered a course within 40 days of initial assessment. This was 16% below the required level and in each quarter, there were some patients who waited over 60 working days for a course start date. Between the reporting period October 2016 and September 2017 a total of 60 patients (20%) waited between 41 and 60 days for an initial assessment. For the same period 15 patients (5%) waiting over 60 working days.

- Action was taken to minimise the time people have to wait for treatment or care. Referral numbers into the service had stayed consistent over the year however, the service had seen an increase in the number of booked appointments. Between October and November 2016 there were 207 booked appointments, between January to March 2017 254 booked appointments, April to June 2017 280 booked appointments, and July and September 2017 298 booked appointments. This consistent increase had resulted in an improvement in access so that more patients could assess appointments within the target time frames.

- At the time of the inspection, patients were being booked into appointments up to the 22 January 2018. This was to proactively book patients and to reduce the number of patients waiting without knowing when their treatment would be. Staff told us the waiting list was higher than they would have liked.

- The Podiatry service received 287 referrals between October 2016 and September 2017. The target for to be offered a podiatrist appointment was set at 85% of patients to be offered an appointment within 20 working days of referral. Between October 2016 and March 2017 this target was not met, however there had been an improvement in accessing this service between April 2017 and September 2017 when the target had been met with 85% or more patients accessing the service within 20 working days. They had achieved this improvement by increasing the number of hours the podiatrist was available to treat patients.

- Staff told us that patients sometimes waited longer than they should for treatment and acknowledged that shorter waiting times would be better. The demand for the services could not always be met within the agreed targets due there not being enough courses run. In addition on some occasions there was a delay in referrals coming into the service from other health services in defence and this could also mean patients waited longer than they should. Patients we spoke to told us that they felt access to courses was timely and any delays experienced were often due to delays experienced at their station rather than at the RRU. Staff told us that while patients were waiting they were often receiving ongoing treatment for their condition and so were not left completely without treatment.

- People accessed care and treatment at a time to suit them. The service was open between normal working hours Monday to Friday. Patients who attended for an initial appointment were given a choice of appointment times within normal working hours. For patients attending courses, there were set start dates for the courses and then a commitment to attend for three consecutive weeks to complete the course. For the duration of the course patients would be released from their normal working duties and attendance at the course would be classed as their work for that time. If courses were fully booked or started on a date, which was not suitable then other RRU’s would be contacted to offer the patient an alternative option. We observed
one consultation where a patient was booked onto a course at a time that corresponded with a natural pause in their other work duties so to reduce the impact on them and their unit.

- A process was in place to contact patients to book them into appointments or classes. The service would make three attempts to contact patients with the first contact always being by telephone. If after three attempts the patient was not contactable or did not contact the service, they would be referred back to their medical centre.

- The service prioritised care and treatment for people with the most urgent needs. Clinics were set up to include both urgent and routine patient appointments. Staff told us that this would be reviewed and changed if the number of patients with urgent needs increased. For example, during times of war, the service had an increase in the number of urgent patients to see and so appointment types would be changed to reflect this. At the time of the inspection, the service had one urgent initial assessment appointment per week and this was meeting the needs of urgent patients.

- Physiotherapists reviewed all referrals coming into the service so patients could be triaged and prioritised. Staff told us they often spoke with the referrer and the patient if it was not clear how urgent the referral was so they could offer the patient access to treatment in an appropriate timeframe.

- There was an appointments system, which was easy to use and supported people to access appointments. Patients were able to book follow up appointments or book onto courses while in the department so they were clear when they were next attending. We observed appointments in the MIAC and the podiatry clinic and both patients were able to leave their appointment and immediately confirm and book onto their next appointment with the reception team.

- A patient tracking alert on the appointment system identified when patients had not attended a follow up appointment. This allowed staff to contact them quickly and either arrange another appointment or discharge them as appropriate.

- There was a board on the wall next to the administrators that visually represented how many patients were in each class. This allowed staff to easily identify classes, which were full or those, which had spaces to book into without the need to review each class on the electronic diaries.

- Care and treatment was only cancelled or delayed when absolutely necessary. Attendance rates for all three services were MIAC 80%, RRU course 82%, and podiatry 79%. Following poorer performance between October and December 2016 all services had showed an improvement in attendance rates between January and September 2017. Almost all cancellations were due to patients cancelling their appointment.

- Short-notice cancellations by patients for example cancellations made with less than one working days’ notice, had improved for all services. For MIAC the short term cancellation rate had reduced from 16.4% between October and November 2016 down to 1.4% between April and June 2017. For RRU courses the short term cancellation rate had reduced from 27.6% between October and November 2017 to its lowest rate of 1.4% between April and June 17; this had risen slightly to 2.3% between July and September 2017. For Podiatry appointments, the short term cancellation rate had reduced from 34.3% between October and November 2017 to its lowest rates of 6.4% between July and September 2017.

Listening and learning from concerns and complaints

The unit had a system for handling concerns and complaints.

- People’s concerns and complaints were listened and responded to, and used to improve the
quality of care. People who used the service knew how to make a complaint or raise concerns. They were encouraged to do so, and were confident to speak up. Patients we spoke with understood how they could complain or raise a concern. There were multiple ways to comment or complain and these included a comment book, by email, by telephone, in person, or using a confidential feedback form.

• A policy was in place for complaints about healthcare services provided by defence (JSP 950 leaflet 1-2-10). This covered how complaints could be made, how the complaint would be dealt with including stages of communication and investigation, and how significant events should be raised if they are identified within the complaint. The policy stated that informal verbal complaints could be dealt with locally by the end of the next working day. If complaints were formal then further steps to managing the complaint would take place including: obtaining consent, acknowledging complaint, local investigation, further meeting with the complainant, decision letter, and information on appeal.

• For the reporting period January to October 2017, the service had received three complaints. Two were associated with administrative processes and booking appointments, and one regarding communication. Complaints were dated as complete an average of three days after being logged, with the longest time being six days and the shortest time being the same day. We reviewed three complaints, two were concerning appointment information and received by email and one was about communication and received verbally. In all cases, the complainant was communicated with to tell them the complaint had been received and what would happen next, an appropriate investigation was carried out, staff were open and honest in acknowledging errors, action was taken and lessons were learnt. Lessons learnt and changes to practice were communicated in team meetings, this was clearly evidenced in one complaint however in the other two we could not identify this discussion in team meeting minutes.

• Staff told us how they were empowered to resolve concerns with patients as soon as they arose and that they encouraged patients to raise concerns at any point. Patients told us they were clear how they could raise concerns and complaints. Staff confirmed they would always escalate concerns or complaints to the service lead so this process could be managed in line with the policy and learning could be shared.
Are services well-led?

Our findings

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

Vision and strategy

The unit had a clear vision to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and a set of values for the service, with quality and safety the top priority. The service had a mission statement, “to enable improvement of operational effectiveness of armed forces personnel, through education, empowerment and exercises based rehabilitation; accelerating their return to duty”. The mission was due for review in November 2017 and it was clearly displayed in the waiting area of the service.

- Staff told us they were clear on the vision for the service and during all conversations with staff, they told us that delivering excellent rehabilitation and education while empowering patients was their main aim. Quality and safety were seen as a priority with staff giving us examples of how the quality of the service was improved and how they felt safe during the work day.

- There was a robust, realistic strategy for achieving the priorities and delivering good quality care. A five year strategy detailed how the service would achieve its objectives in delivering good quality care. The defence rehabilitation concept of operations document was written by a central ministry of defence team and provided strategy and direction for all defence medical services. The service lead understood the document and how it linked to the service. It contained information on current provision of medical rehabilitation, the principles of delivery, how the service should operate, identified risks to the provision, and future plans.

- There was a specific strategy and operational guidance for the defence medical rehabilitation programme, which contained detail on how the local services fitted into the overall strategy and operational framework. This provided a detailed account of how services ran, what services were included, care pathways, all treatment referral clinical guidelines, facilities, and standard operating guidance for specific clinical services such as rheumatology.

- The vision, values and strategy for all defence medical services detailed in the defence rehabilitation concept of operations document had been developed by a central team and staff told us they were not engaged in this process. At a local level, staff told us they felt engaged and consulted when deciding how the strategy and objectives for the RRU were agreed and delivered.

- The specific strategy for the service was written by a central team however, staff gave multiple examples of how they had decided on what objectives to focus on. For example a working group had been formed to look at clinical outcome measures so the effectiveness of the services could be evidenced in the future, staff were working on adapting their classes to reflect the specific needs of the patients so the service could be more responsive, and podiatry services had adapted to increase appointment times and better meet the needs of the patients and staff.
Progress against delivering the strategy was monitored and reviewed by the central team, the service lead and the clinical lead. Staff had a good understanding of what they had achieved, the difference this had made to patients and what further objectives for the service were to be achieved in line with the strategy. There was a quality improvement plan in place that was in line with the strategy and this included planned service improvements together with improvements, which had been suggested by staff and patients.

**Governance arrangements**

- The governance framework ensured that responsibilities are clear and that quality, performance and risks are understood and managed. There was an effective governance framework to support the delivery of the strategy and good quality care. An overarching ministry of defence (MOD) corporate governance policy (JSP 525) was in place, which 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 on how MOD governance processes worked and the checks and balances in place to manage any MOD service.

- A common assurance framework (CAF) assessment was used to support the delivery of good quality care. The framework was based on eight domains: safety, clinical and cost effectiveness, governance, patient experience, accessible and responsive care, care environment and amenities, public health, and occupational health. The last review using the CAF took place in September 2016. Key areas of good practice were identified as medicines management, safety, fire safety and security assurance, and central governance spreadsheet. Key areas for development were identified as utilisation of all staff within AOR, retention of pervious evidence when updating policies and terms of reference, and staff training database. All domains had been completed with 85 objectives being reviewed, overall four out of eight (50%) of domains were coded overall as green (fully compliant) with the other four domains (50%) coded as yellow (partially complaint).

- Weekly governance meetings were held for the service. We reviewed the governance meeting minutes for 16 October 2017, which included discussions around minutes of the last meeting, CQC update, staff planner, and any other business. Out of a total of 13 invitees, only two attended the meeting and the documentation of the discussions were limited. Minutes for the meeting on 19 October 2017 were more comprehensive and eight out of the 13 invitees attended. The meeting covered the following topics: safety health and environmental protection (SHEP) / Fire safety / security, infection prevention and control, risk, business continuity plan, equipment consumable and infrastructure, quality assurance and improvement, significant event management, MODnet, occupational health, drugs and medical equipment, staff training, working group and regional update, area updates, complements and complaints, diary check and course planner, newsletter, and any other business.

- There was a holistic understanding of performance, which integrated the views of people with safety, quality, activity and financial information. Real time data was reviewed and discussed during the governance meeting to provide oversight and evaluation of service performance. For example, in the staff training section of the meeting, the staff training spreadsheet was reviewed and commented on to identify areas of positive performance and areas to improve on. Actions were then discussed and assigned to a member of the team to address and shortfalls.

- The service was provided with a quarterly dashboard, which detailed performance information on a number of key performance indicators. Included were 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 other RRUs so an overall
comparison could be made and the service lead could benchmark how well they were performing. We reviewed dashboard data for four quarters, which gave comprehensive data on the service.

- Staff were clear about their roles and understood what they were accountable for. Each member of staff we spoke with had a clear understanding of their clinical and operational roles and any additional projects or responsibilities they had. Staff could tell us which other staff were responsible for which aspects of the service, for example they could identify the infection prevention and control link member of staff and the individual responsible for safeguarding concerns.

- There were clear working arrangements with partners and third party providers. Service level agreements were up to date with third party providers with a clear review date set. For example, the cleaning agreement detailed what cleaning should take place and when, so this could be monitored. Partner working also took place with the Royal Air Force (RAF) estates team and swimming pool manager as the service used the pool for some class sessions. Staff and the pool manager worked closely together to provide a good experience for patients and staff told us the pool manager was always available and responsive to their requests. There was a clear service level agreement and standard operating procedure for using the pool that included who had responsibility for the environment, patients, and safety equipment.

- Staff reported they were confident with the governance of the service and reported they had good oversight of patient feedback, safety, quality, and activity. Communication on these topics was regular and staff felt all information was shared appropriately.

- There was a comprehensive assurance system and service performance measures, which were reported and monitored, and is action was taken to improve performance. Assurance visits took place, which included an internal review of the service carried out by the inspector general assurance team using the CAF. The last visit to the service was February 2016. Results from the visit indicated the overall level of assurance was ‘substantial’. Areas which were coded as green which indicated the service had full assurance with systems of internal control established and demonstrating significant evidence of maximising patient safety and quality improvement included medicine management, health and safety, and fit for role which included supervision and clinical leadership. Areas identified that were coded as yellow indicated systems of internal control were established and demonstrating evidence of maximising patient safety and quality improvement, with some areas of minor weakness, included infection prevention control and waste management, accountabilities for example, who was responsible for additional tasks, and medical equipment. There were no areas coded amber, which indicated limited assurance or red, which indicated no assurance.

- A detailed action plan was formed in response to the assurance visit, which included all areas, which required attention. All actions stated what needed to be completed, if the action had been rejected, amended, or accepted, who was responsible for the action, and the date they were due for completion.

- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. A programme of audit was in place, which included both clinical and operational audits. Each audit had a named member of staff to lead, a defined objective, and information on how often it should be repeated. Audits completed on an ongoing basis were patient reported outcome measures (PROMS) and the anterior cruciate ligament audit. Notes audits were completed six monthly. Audits completed on a yearly basis were: injection, infection control hand washing, patient did not attend, and safety health and environmental protection. The audit programme was supplemented with a quarterly quality improvement and audit meeting where current results were discussed. For 2017, 11 audits had been completed and a further three were due for completion.
Physiotherapist clinical notes audits were undertaken annually for each member of staff with a compliance level set at 100%. We reviewed one clinical audit, which demonstrated 100% compliance against the audit. The audit was based on the chartered society of physiotherapy (CSP) quality assurance standards audit tool section eight, CSP code of members professional values and behaviour, health and care professions council (HCPC) standards of conduct, performance and ethics, ERI Standards of proficiency to practise, and defence medical information capability programme (DMICP). Notes were assessed against seven areas: mandatory compliance, subjective assessment, objective assessment, analysis, treatment planning, treatment implementation / intervention, and transfer of care / discharge.

Audits did not take place on the completion of 373 forms, which were used to document checks on equipment. Therefore, we were not assured these checks and forms were being completed correctly.

There were arrangements for identifying, recording and managing risks, issues and mitigating actions. There was a register for the service, which identified 12 current risks. The top scoring risks were associated with a lack of doctor cover for the service and levels of safeguarding training. All risks included an initial scoring, explanation, mitigating and control factors, a residual scoring, details of who owned the risk and when it was submitted and amended.

Risks were managed proactively. For example, the risk of a lack of substantive doctors working in the Multidisciplinary Injury Assessment Clinic (MIAC) had been managed and the effects on patients mitigated through the use of consistent locum doctors who had the skills needed to treat the patients. The service lead was currently identifying and contacting suitable doctors who could be considered for permanent roles to reduce this risk further.

There was alignment between the recorded risks and what people said is, ‘on their worry list’. Staff identified the impact that an external musculoskeletal therapy clinic was having on patient care as on their worry list. This risk was on the risk register. It was not clear to staff how the care pathway for these patients was organised and staff felt there was a risk of a delay in patients accessing the services they needed. This was raised with senior staff at the time of the inspection and was under review.

Other risks for the service were identified by staff as the lack of suitable doctors to work in the MIAC, and a lack of clarity on a senior physiotherapy role for the RRU’s in the region. Staff were aware of clear actions being taken to address these risks and they were represented on the risk register.

Leadership and culture

Leadership and culture reflected the vision and values, encouraged openness and transparency and promoted good quality care. Leaders had the skills, knowledge, experience and integrity that they needed and the capacity, capability, and experience to lead effectively. Each member of the team identified the service lead as the operational lead for the service. In addition, clinical staff told us they had an additional, identified clinical lead that provided them with support and guidance. Staff felt the distinction between the operational lead and their clinical lead was beneficial as their leaders had the right specific skills to lead effectively. The service lead spent 80% of their time managing and leading the department and 20% of their time working clinically. Staff reflected that both leaders would contribute to different aspects of the service if needed, for example, we heard about how the service lead would work on reception or cover a clinic if there was a staff shortage. This willingness to cover what was required and contribute to the team was considered a positive aspect of leadership.
• The service lead was a military member of staff and had skills, knowledge and experience of leadership from her military training and duties. The clinical lead was a civilian member of staff who had held senior clinical leadership roles in the NHS and the military. The service and clinical lead were both held in high regard by staff. There was respect for the leaders from staff and staff told us they felt comfortable and able to escalate issues or gain advice when needed. Leaders were experienced and skilled in their field and acknowledged areas of leadership they may need support with. Both the service lead and clinical lead worked together to provide the right support to staff.

• Staff at all levels reported they were encouraged to lead and told us about examples where they had done this. One member of staff told us that the service and clinical leads gave all staff autonomy to lead on certain aspects of their role and staff were supported to do this. This was reflected by the service and clinical leads who told us it was important for all staff to be seen as leaders and there was an expectation that these skills would be developed.

• Consideration was given to succession planning and the leadership needs of the service. Military staff who worked in the service would spend a fixed period of time in their role before being transferred to other duties often at another location. To make sure staff who took over these roles had the knowledge, skills, and abilities to do them staff were encouraged to develop and lead so a clear succession plan was in place.

• Leaders understood the challenges to good quality care and could identify the actions needed to address them. There was a proactive approach to managing challenges to the service including the shortage of doctors to staff the clinic and the waiting lists for some of the services. At the time of the inspection, the service lead explained the actions taking place to try and reduce these challenges. There was an acknowledgement from more senior leaders that the challenges of the waiting lists could not always be directly changed at service level, as they did not have the ability to increase staff numbers or extend opening hours, and there was an acceptance that the waiting times were longer than the targets.

• Leaders were visible and approachable. Both the service lead and clinical lead were based in the department and easily available for staff to approach. We observed both leaders interacting with staff throughout the day in a professional, kind, and encouraging way. Staff we spoke with told us they could confidently approach any member of staff including the leaders of the service to ask questions and request support.

• Leaders encouraged appreciative, supportive relationships among staff and staff felt respected and valued. We observed all members of the team interacting with each other. Attendance at the weekly team meeting was a requirement for all staff if they were at work and provided an opportunity for staff to build relationships and work in a supportive way. We heard about examples of when staff were encouraged to achieve a good work life balance with the support from their leaders and colleagues. This included well planned and covered time off for paternity leave and staff being able to undertake adapted duties and remain at work when they had an injury.

• Action was taken to address behaviour and performance that was inconsistent with the vision and values, regardless of seniority. The culture encouraged candour, openness and honesty. A policy was in place for bullying and harassment complaints procedure (JSP 763). This covered both civilian and military personnel and outlined how staff could make a complaint and stages to resolve them. Staff told us they understood the expected levels of behaviour and performance and we heard from all staff how they felt confident to give both positive and improvement feedback to staff at all levels.

• Staff were confident to speak up, raise concerns, and be open. The service had a military hierarchy of staff who delivered the services and patients who attended the service were of mixed seniority. Despite this all people we spoke with reflected that they were confident and felt...
safe to speak up to an appropriate person when in the RRU.

- There was a strong emphasis on promoting the safety and wellbeing of staff. Staff told us there was an emphasis on promoting wellbeing. We were given examples and observed when staff were given flexibility to take part in well-being activities such as lunchtime physical training sessions. Staff also told us that their personal commitments such as childcare were taken into account and that they were supported to take time off if this was required.

### Seeking and acting on feedback from patients and staff

- People’s views and experiences were gathered and acted on to shape and improve the services and culture. A defence medical services patient questionnaire was used to gather views and experiences from patients following their treatment. Questions were focused on the clinical staff, administrative staff, cleanliness of the department, the quality of the service, and comments on patients’ experience. Patient feedback forms were used to anonymously gather patient feedback after completion of the RRU courses. Feedback sections included the administration of the course, course content, facilities, staff, and general feedback comments. In addition patients were asked if they would recommend the facility to their friends, family and colleagues, if they felt their comments, compliments and complains were listened to, and if their treatment was at a convenient time and location.

- A comments book was placed at reception and available to patients to use at any time. We reviewed the book and saw there were comments written about treatment and courses patients had attended. Staff told us this was valuable to review as it added to feedback on the service however, the book was not formally checked and themes or trends were not reported on.

- Feedback collected was used to adapt and change the way services were run. Patient feedback and comments were reviewed and discussed at the weekly team meeting. Any changes to practice and actions required were assigned to a member of staff to review.

- People who used services and their military units were actively engaged and involved in decision-making. We observed one consultation where the ongoing rehabilitation of the patient had been discussed with their military unit to allow further time for rehabilitation to take place. Staff told us this was normal practice to ensure ongoing rehabilitation was planned and to allow patients the best opportunity to return to full duty.

### Continuous improvement

- When considering developments to services or efficiency changes, the impact on quality and sustainability was assessed and monitored at a local level. We reviewed a number of service audits that had been used to review service developments and propose further changes. For example, changes to the appointment times in the MIAC had been reviewed prior to the change taking place to understand the effect this would have on quality and the number of patients that could be seen. Changes to the structure of the courses had also been evaluated to understand how this impacted on the patients to make sure the quality of care was not reduced. Staff told us they would feel confident that if changes were made and the result was a reduction in the quality of care then the service would be changed back.

- The service had the environment and equipment resources it needed to deliver sustainable care to patients. Staffing the service up to its set establishment was encouraged and when there were gaps in staffing the service lead was able to recruit locum staff to fill these gaps. At a service level there was no control over the total number of staff available for the service, this
staffing level was set by the central defence medical team. The current number of staff available for the service did not always result in patients being able to access the service within the waiting times set.

- Leaders and staff were focused on continuous learning, improvement and innovation. There were many examples of how local changes had been made to the service to learn, improve and innovate. A number of staff were involved in regional projects such as the outcome measures project to improve and innovate and staff continually reflected on further improvements that could be made. A number of staff were undertaking educational courses and the content of these courses linked to their job roles. They were supported to complete this learning and staff spoke passionately about how they could bring their learning back and use it to educate other staff during training sessions and consider how this could improve the service.

- Staff were focused on continually improving the quality of care. There was a quality improvement plan for the service, which included areas for development such as environment and amenities, patient care, health and safety, and staffing. All improvement had a designated lead and were updated with progress reports. This was a working document that could be added to as new improvements were suggested and completed and reflected feedback from patients and staff.