

Defence Medical Services

Portsmouth Regional Rehabilitation Unit

Inspection Report

HMS Nelson
Queen Street
Portsmouth
PO1 3HH

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

We carried out an announced comprehensive inspection of Portsmouth on 22 February 2018.

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:

Are services safe?	No action required	✓
Are services effective?	No action required	✓
Are services caring?	No action required	✓
Are services responsive?	No action required	✓
Are services well-led?	No action required	✓

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

We carried out an announced comprehensive inspection at Portsmouth Regional Rehabilitation Unit (RRU) on 22 February 2018.

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

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.
- Systems and processes to keep patients safe were embedded at the unit. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally.
- There was evidence of some quality improvement in the service provided. There was a quality improvement plan identified which was in line with the strategy. This included planned service improvements together with improvements, which had been suggested by staff and patients. However, due to increased turnover of staff this was not embedded. The team had recognised this as a focus for the coming months now they were established.
- Patients were positive about their interactions with staff and said they had been treated with compassion.
- Staff were aware of current evidence-based guidance.
- Staff had received the mandatory training required to provide them with the skills and knowledge to deliver safe care and treatment.
- The training compliance at the time of inspection was at 100%.
- Results from the patient feedback showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available.
- The unit was equipped to treat patients and meet their needs however, the facilities did impact on the service's abilities to provide confidential treatment sessions.
- There was a clear leadership structure and staff felt supported by management.

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

- There were effective systems for reporting and recording incidents. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally.
- There was a strong team approach to multidisciplinary working between the exercise rehabilitation instructor (ERI) and Physio team. This included the assessment and treatment of patients and reviewing each other's practice.
- Clear actions had been taken to improve access to podiatry, following delays due to a vacancy. The service had received approval to recruit a locum podiatrist during the recruitment process of the permanent podiatrist but this has not been filled because of a lack of applicants.
- Staff showed an encouraging, sensitive and supportive attitude to people who used services and understood and respected people's personal and social needs.
- 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.
- Management in the unit demonstrated they had the experience, capacity and capability to run the service and ensure high quality care.
- There was a clear leadership structure and staff felt supported by management.

Recommendations for improvement

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

- Staff seeing patients in the Multidisciplinary Injury Assessment Clinic (MIAC) did not always undertake the five moments of hand hygiene. All staff should follow hand hygiene guidance.
- Privacy and confidentiality for patients could be improved. We observed treatment, progress and end of course discussions being held in the gym area, which was being used by other patients, other MoD staff attending the PT gym and contract staff carrying out roofing repairs. We are aware staff always checked patients were happy to commence treatment and conversations in the gym area however, we would suggest a review of the situation, as it is not best practice.
- A rolling programme of clinical improvement work should be embedded to ensure that the best outcomes possible are achieved for patients.
- Staff should be aware of the standard operating procedure to formalise the process for when there was a problem with the pool and it was out of use.

Professor Ted Baker

Chief Inspector of Hospitals

Regional Rehabilitation Unit - Portsmouth

Detailed findings

Why we carried out this inspection

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

Background to the service

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

RRU Portsmouth serves a population at risk (PAR) of 15,280 personnel broken down as follows:

- HMS Nelson – 6,000 personnel
- HMS Excellent – 1,300 personnel
- Thorney Island – 1,200 personnel
- HMS Collingwood – 2,000 personnel
- HMS Sultan – 2,000 personnel
- Southwick Park – 1,000 personnel
- Marchwood – 580 personnel
- RM Poole – 1,200 personnel

Additionally, care is provided to patients on home sick leave and reservists that reside in the region.

Access to the service is through referral from other services in the DMRP and patients receive an initial joint assessment by a doctor (a specialist GP trained in sports and exercise medicine) and a clinical specialist physiotherapist, in the Multidisciplinary Injury Assessment Clinic (MIAC) located at the RRU. Patients can access one to one treatment and rehabilitation courses to treat their conditions. Courses generally run for three weeks and are condition specific. (On occasions, course content could be compressed to two weeks to accommodate RRU staff leave.) 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 specialist physiotherapy lead, physiotherapists, a doctor, lead exercise rehabilitation instructor (ERI), ERIs and administrators. At the time of inspection, the service had a vacancy for a full time band 7 podiatrist and a part time (16 hours) MIAC doctor.

Facilities include four treatment rooms, two gym areas, one containing fitness and strength equipment and one large shared gym area, a classroom/group treatment room and access to the swimming pool on site. The large gym area was shared with the naval base physical training department.

The Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject of regulatory inspection by CQC and CQC has no powers of enforcement. This inspection is one of a programme of inspections that CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

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

Our inspection team

Our inspection team was led by a CQC inspector. The team included a CQC Inspector and a CQC Inspection Manager. The team were joined by two Defence Medical Services (DMS) Specialist Advisor in Rehabilitation and a representative of the DMS.

How we carried out this inspection

Before visiting, we reviewed a range of information about the unit. We carried out an announced inspection on 22 February 2018. During the inspection, we:

- Spoke with a range of staff, including physiotherapists, exercise rehabilitation instructors (ERIs), administrators, service lead, and 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?

What people who use the unit say

Patient survey results were reviewed for new patients attending three courses at the service from 4 December 2017 to 15 December 2017. The results showed the unit was performing in line with

other RRUs. All 32 survey forms distributed were returned. This represented 100% of the patients treated at the unit in the last course.

- 88% of patients said they would recommend this facility.
- 91% of patients felt people listened to their comments, compliments and complaints.
- 91% of patients said they felt involved in decisions regarding their care.

As part of our inspection, we also spoke with 10 patients. All were positive about the standard of care received and thought staff were approachable, committed and caring. Patients said they had been given the tools to manage their condition and their own rehabilitation. Staff were 'super helpful' they 'knew their stuff'. Staff ensured patients fully understood their own treatment programmes and took time to discuss any issues or concerns they had with completing their programmes.

Detailed findings

Are services safe?

Our findings

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

The shortcomings did not have a significant impact on the safety and quality of clinical care.

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. There was a system for reporting and recording significant events. Staff 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 February 2017 to January 2018, 17 incidents had been reported. Senior staff had reviewed all incidents, themes were identified and appropriate action had been taken to minimise further occurrences. We reviewed three incident files at the time of the inspection. These included an injury to a patient during recreational therapy, a delay in orthotic provision and an incomplete injection log. 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 treatments were delivered safely, while not limiting the opportunity for patients to progress.
- Patients involved in incidents were not always kept fully informed during the incident review process. There was not a formal process for feeding back to patients about any changes in practice following incident investigation once patients had been discharged.
- The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that registered providers of services must follow when things go wrong with care and treatment). This meant 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 was to blame. In incidents we reviewed, an apology had been given.
- Lessons were learned and shared, and action taken as a result of investigations. 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.

- Staff described 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.
- Updates and learning from significant incidents which had happened at other Regional Rehabilitation Units (RRU) was available to staff on the intranet update page and if appropriate, discussed at staff meetings. Staff told us about learning which had been shared from other units.

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

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare.
- All staff were trained to safeguarding level two, 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 interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training relevant to their role.
- At the time of inspection, the service did not have a lead member of staff for safeguarding. The trained staff member had left the service in December 2017. A staff member to take on the lead role had been identified however, due to a lack of local courses running; they had not been trained to the required level. This had been identified on the service's risk register and actions had been taken to mitigate the risk. Staff had access to an appropriately trained staff member in medical department in the adjacent building. This allowed staff direct access to an appropriate member of staff while patients were in the department being treated.
- Staff had a programme of mandatory training in safety systems, processes and practices. The compliance level for the service was set at 100%. Levels of compliance were recorded on an electronic system. We saw records, which showed all training had been carried out by all eligible staff. Mandatory training included healthcare governance awareness, office safety, unconscious bias, security general threat brief, and safeguarding children level two.
- Resuscitation equipment was available in the department and at the swimming pool. An automatic external defibrillator (AED) was available and easily accessible in the poolside office and in the gym. A resuscitation bag the necessary equipment to deliver basic life support, was located in the MIAC clinic area. It was located in the treatment room, which had a keypad lock on the door, this could delay access by a few seconds.
- Items such as pocket masks, first aid kits, eyewash bottles and emergency blankets were also available on both gym and pool sites. Checks carried out on the first aid kits and AED identified equipment was in date. Records confirmed checks on the equipment took place each day the clinic was open.
- A qualified lifeguard was on duty at the swimming pool when patients were receiving treatment to protect both patients and staff. The lifeguard on duty would support the staff in the event of an emergency. There was a clear accident and emergency procedure available for staff working in the pool area, located on the wall next to the emergency call bell and telephone by the pool. The bell alerted other staff to provide assistance and the telephone enabled the emergency to be reported to the naval base emergency services. There was access to buoy's (floating device) and throw bags at various points around the pool to help

anyone who may be in distress or required assistance. There was also access to evacuation boards to recover people from the pool who had a suspected spinal injury.

- The swimming pool was checked four times daily to maintain the correct chlorine levels and pH balance, ensuring the pool was safe for use. Staff from the RRU were not responsible for these checks, and did not have access to the test register to ensure regular testing had been carried out. If there was a problem with the pool and it was out of use, staff told us someone from the swimming pool would make RRU staff aware in advance of any sessions being carried out. Staff were unaware of any standard operating procedure document held by the RRU to formalise this procedure. The pool had not been out of use during the reporting period.
- There was access to fluid spill kits (a cleaning kit to clear up any bodily fluid spillages) to safely manage any bodily fluid spillage and the risk of cross infection. Staff had access to kits for blood spillages, urine and vomit in the event of a situation occurring. Each of the kits had been checked and were in date.
- A comprehensive risk assessment had been completed for risks concerning the swimming pool, with identified risks being managed positively. Five risks had been identified. These included medical problems associated with exercise, drowning, exacerbation of symptoms, slips, trips and falls and infection. Each risk identified the control measures, a risk rating and a named person with oversight of the risk. The risk assessment had been completed in September 2017 and was due for a review in September 2018.
- Individual care records were written and managed in a way, which kept people safe. Patient records were electronic and could be accessed on computers around the department. All electronic patient records were password protected and access was limited to staff with authorisation to view them. The system provided an audit trail of every member of staff who had accessed or amended patient records.
- A policy was available for staff identifying the Caldicott principals and how they should be applied. Caldicott principals are the seven confidentiality principals, which outline how personal confidential data should be stored. The service lead overseeing the RRU was the Caldicott lead for the unit. Information about the Caldicott principals was available to staff around the department identifying the principals and their responsibilities. There had been no audits carried out at the RRU to identify compliance with the principals.
- Patient records were organised, up to date and shared and stored appropriately. We reviewed a combination of 10 patient records from the multidisciplinary injury assessment clinic (MIAC) and rehabilitation courses. Records included referral information, patient assessments, consent, treatment plans, goals, outcome measures pre and post treatment and were all complete. We were told emotional and psychological screening was not routinely carried out unless a concern was picked up by a member of the team at the MIAC clinic. Issues of this nature would usually be identified at the patient's primary care rehabilitation unit and addressed.
- Notes audits were completed annually and included five sets of records comprised the initial assessment and a follow up for each clinical area of the Regional Rehabilitation Unit (RRU). Clinical areas included MIAC, lower limb, spines, hip and groin courses and podiatry. Compliance was measured against eight areas. These included mandatory compliance, subjective assessment, objective examination, analysis, treatment planning, treatment implementation, transfer of care and documentation. The target for compliance was 75%. A records audit had been completed in April 2017; however, actions arising from the audit had not been implemented into practice. All but one area of the RRU was compliant with the 75% target. The MIAC and spines course achieved 77%, the lower limb course achieved 79%, the hip and groin course achieved 81% whilst the podiatry clinic demonstrated 65% compliance. One consistent omission from patient records across all areas on the RRU was the lack of evidence about the patient's perception of their needs. There were five recommendations following the audit. These included one for the MIAC team, one for the

course team, two for podiatry and one to debrief all staff regarding the audit findings. We were told due to the challenges the RRU had faced with regards to staffing, the recommendations from this audit had not been implemented into practice and staff had not been de-briefed regarding the outcome of the audit. A re-audit was due to be completed in April 2018. Now the staffing situation had improved and a request had been made to employ a podiatrist we were told recommendations following the next audit would be actioned and assurance gained to ensure new recommendations were embedded into practice.

- Chaperones were available if required. Notices advising on availability and how to access chaperones were on display in the waiting areas and in treatment areas throughout the service. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.
- The unit maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. Standards of cleanliness and hygiene were maintained at the pool and the environment was free from clutter. The environment was visibly clean and all equipment was safely stored off the floor and in designated areas to ensure safety of patients and staff in the pool area.
- The unit flight lieutenant was the infection prevention and control (IPC) clinical lead who was based in the department full time. Staff could approach them to discuss any issues around infection prevention and control. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- Most staff we observed in clinic undertook the five moments of hand hygiene and were bare below the elbows. However, we did observe staff seeing patients in the MIAC clinic did not always undertake the five moments of hand hygiene. Staff uniforms appeared clean and tidy.
- Equipment was cleaned before and after patient use. Equipment covers and chairs in the department were covered in wipe-able fabric to allow them to be cleaned between patient uses. All chairs and equipment were in good condition.
- The maintenance and use of equipment kept 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 which 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 generally checks had been completed on all equipment. Staff were aware when forms had not been completed as per policy and followed these up so they could be assured checks had taken place for all equipment.
- Issues with equipment were reported verbally to the appropriate person on site. This resulted in the equipment being labelled and being put out of use and a service or repair was booked. Staff felt equipment was repaired and made fit for use quickly. This process was documented on the appropriate spreadsheet.
- Most 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. Equipment that did not have completed stickers on was however, recorded as checked on the equipment service log. Therefore, we were assured the equipment had been serviced.
- 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.
- The arrangements for managing medicines, including emergency medicines in the unit, minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal). There was a medicines management policy available and

staff participating in the obtaining, storing, handling, prescribing, supplying and disposing of medicines were suitably trained and their competency assessed. In the reporting period, February 2017 to January 2018 there had been no medicines incidents reported by staff.

- Appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through DBS

Monitoring risks to patients

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

- There was a health and safety policy available to all staff on the intranet.
- The unit had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the unit. There was a fire evacuation plan, which identified how staff could support patients with mobility problems to vacate the premises.
- There were systems in place for testing and maintenance of medical equipment. All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. There were effective systems in place regarding the storage of clinical items. All items in the clinic room checked, such as disposable cleaning cloths, syringes, dressings, saline and bandage were in date. There was a record kept when items had been opened.
- Risks to people who used services were assessed and their safety monitored and maintained. Staffing levels, skill mix and caseloads were planned and reviewed to ensure people received safe care and treatment at all times, in line with relevant tools and guidance. Actual staffing levels did not meet the planned staffing levels for the service. Staffing levels for the service were set at twelve whole time equivalent (WTE) staff to include four clinical civilian staff (two physiotherapists, a podiatrist, and a doctor), two administrators, one flight lieutenant, one leading hand, one petty officer, one chief petty officer physical training (CPOPT) and one military major (Maj) who was the service lead and a physiotherapist. In the reporting period February 2017 and January 2018, the actual staffing level for the service was at 90.5%. The service had one vacancy for a podiatrist (24 hours per week) since April 2017 and a vacancy for a MIAC doctor (17.5 hours per week) since January 2018. RRU Portsmouth had received approval to recruit a locum podiatrist during the recruitment process of the permanent podiatrist but this has not been filled because of a lack of applicants. The Major, a physiotherapist and CPOPT, an exercise rehabilitation instructor (ERI), both worked clinically and would cover staff absences in the department by carrying out assessments and running groups. All staff told us they would step in to support sessions in times of staff shortage.

Arrangements to deal with emergencies and major incidents

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

- All staff received annual basic life support training and there were emergency medicines available in the unit. Emergency medicines were easily accessible to staff in a secure area of the unit and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The unit had a defibrillator available on the premises and oxygen with adult masks. A first aid kit and accident book were available. Resuscitation equipment was available at the swimming pool. An automatic external defibrillator (AED), pocket masks, first aid kits, eyewash bottles and emergency blankets were available and easily located in the poolside

office. Checks carried out on the first aid kits and AED identified equipment was in date. There was access to buoy's (floating device) and throw bags at various points around the pool to help anyone who may be in distress or require assistance. There was also access to evacuation boards to recover people from the pool who had a suspected spinal injury.

- The unit had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

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. For example, the National Institute for Health and Care Excellence (NICE) guideline NG59 Low back pain and sciatica in over 16s: assessment and management was used to guide treatment for low back pain. The service also 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 rationale for treatment based on the clinician's assessment and the needs of the patient.
- The unit had systems to keep all clinical staff up to date. Staff had access to best practice guidelines, including those from NICE via the intranet and staff meetings. They used this information to deliver care and treatment that met patients' needs. Staff were confident in 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 were in line with evidence based practice guidance on treating musculoskeletal conditions and provided a holistic approach to rehabilitation. Courses provided individual treatment programmes, which included attending condition specific exercise rehabilitation, education sessions, psychological wellbeing sessions such as relaxation. Patients were complimentary about this approach and felt it was beneficial in giving them the tools to manage their condition. Patients had clear and personalised outcome goals for their treatment. Patients who attended a rehabilitation course were issued with an individual programme, which defined their treatment plan and goals. This was used throughout the course to track progress and update plans and goals.
- 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, during treatment and at the end of treatment using evidence based measures. Validated patient reported outcome measures (PROMS) were used to assess the patient at the start and the end of their treatment. This meant the patient's response to treatment and it's effectiveness could

be evidenced. Outcome measures included the standardised modified walking locomotive test, STarT back and patient health questionnaire (PHQ9). The Tampa Scale for Kinesiophobia had been used with patients where there were concerns with fear avoidance in terms of pain and exercise. 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. These tests were specific to the patient's presentation and used throughout the course to monitor progress. All outcome measures were collated and reviewed. However, at the time of inspection, we did not see evidence of course evaluation following a review of the outcome measures. The audit log at the RRU had a service evaluation for changes of outcomes measures on course planned for April 2018.

- The service was part of a national project to review outcome measures and how the service was assessing and achieving improved outcomes for patients. This was being led by another RRU. 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. The project was still ongoing at the time of the inspection so we were not able to report on the results.
- 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. Staff were supported to attend role specific educational training. For example, one member of staff was completing a Bachelor of Science (BSc) in sports and exercise therapy. Staff reported that funding for courses was offered by the service. There was an expectation that staff who undertook courses to develop knowledge and skills presented this training to other staff 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 these sessions

were well-organised, often included expert speakers, and staff were given time to attend. The training lead had received feedback from 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 exercise rehabilitation instructor (ERI) and Physiotherapy 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.
- There was a quality improvement plan identified which was in line with the strategy. This included planned service improvements together with improvements, which had been suggested by staff and patients. However, due to increased turnover of staff was not embedded. The team had been recognised as a focus for the coming months now the team was established.

Effective staffing

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

- Between January and December 2017, Regional Rehabilitation Unit (RRU) Portsmouth had a staffing fill rate of 90.5%.
- RRU Portsmouth had an ongoing vacancy for a podiatrist (24 hours per week) since April 2017 and a MIAC doctor (17.5 hours per week) since January 2018. RRU Portsmouth had approval to recruit a locum podiatrist during the recruitment process of the permanent podiatrist but this had not been filled because of a lack of applicants. All staff told us they would step in to support session in times of staff shortage. The Maj and CPOPT both worked clinically and would cover staff absences in the department by running carrying assessments and running groups.
- There had been high turnover within the RRU over the past year. A new Leading Physical Trainer (LPT) ERI started in post in January 2017, a new Flight Lieutenant (Flt Lt) physiotherapist, Second-in-Command (2IC) started in March 2017, a Band 7 podiatrist position had been unfilled since April 2017. A new band 6 physiotherapist started in July 2017 and a new Officer Commanding (OC), also a physiotherapist had started in post in August 2017.
- The unit had a mandatory induction programme for all newly appointed staff. This covered topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of unit development needs. At the time of the inspection, four of the seven staff (57%) at RRU Portsmouth had completed appraisals in the 2017/18 reporting year. All other members of staff were in date within their stage of the reporting year. The MIAC doctor was not included in the appraisal information submitted by the RRU and two members of staff had not been in post long enough for an appraisal to be required.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating professionals.
- Staff delivered treatment, which 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 shockwave therapy, and an

ERI would deliver exercise therapy and fitness training. Staff told us they all worked within their scope of practice and the best combination of clinical skills would be brought together for the patient.

- Courses were always delivered by two staff, using a combination of ERIs and physiotherapists. Different components of the course were delivered by either the ERI or physiotherapist individually, or as a pair when required. Approach to treatment was based on the skills of staff and this also allowed time for staff to treat patients on a one to one basis when required.
- When different teams or services were involved in a patient's care, care was delivered in a coordinated way. Recommendations for referrals to other services such as the medical centre or mental health services were discussed with the patients' medical officer.

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 the information they needed to deliver effective care and treatment to people who used services. An integrated health record (IHR) was in place for all patients, which included the patient's full medical record. This allowed comprehensive information to be available to appropriate clinicians when they were treating the patient. There were various levels of authorisation for different members of staff across the RRU for accessing patient's personal information and records. For example, Physiotherapists and exercise rehabilitation instructors were able to review RRU therapy information and primary care information about the patient. They would not have access to other information if the patient was also under another service, such as the mental health service.
- 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.
- Staff worked together and with other health and social care professionals to meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged. Information was shared between services, with patients' consent, using a shared care record
- From the sample of 10 records we reviewed, we found that the unit shared relevant information with other services in a timely way, for example when referring patients to other services.
- Handover of patients care to other members of staff within the service were structured and informative. They 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 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 (including the Mental Capacity Act 2005). The process for seeking consent was monitored through patient records audits.
- All patients signed a consent to treatment form at their initial assessment at the MIAC. The paper record was scanned into the electronic system and stored with the patient's record.
- 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 gained for treatments, which involved a high level of risk. We observed two patient records that had undergone either shockwave therapy (electrotherapy treatment for soft tissue and bone conditions) or injection therapy. Both records contained a consent form identifying benefits and contraindications of treatment, which had been signed and dated by the individual receiving the treatment. Records also demonstrated patients were provided with further information regarding the treatment to ensure their understanding of what the treatment entailed. 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 service identified patients who may be in need of extra support and signposted them to relevant services. There were helpline and welfare phone numbers on display for patients in the waiting room. Staff talked to patients during appointments about other services, they could access to help them manage their condition and improve the outcome of rehabilitation.

- Patients were supported to attend complete courses, take responsibility for their rehabilitation and ongoing management of their condition on completion of their course at the RRU. 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.
- Rehabilitation courses included education and information session to support patients' in developing skills to help manage their own 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.
- Patient goals were specific to each 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.
- Staff encouraged patients early on during the course to carry out self-directed warm ups and exercise sessions. Staff were always available to provide support and advice as required, however the patient was encouraged to take the responsibility to drive their own rehabilitation. At the end of the course, each patient was allocated an individual session with the course instructors. During the session, advice and guidance was provided and patients were encouraged to continue to manage their rehabilitation back at their local unit. Patients were encouraged to book a review appoint with their unit two weeks following discharge from the course to ensure they remained on track with their rehabilitation and recovery.

Are services caring?

Our findings

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

Kindness, dignity, respect and compassion

Members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Interactions between staff and patients were caring and friendly. Staff were courteous, helpful and treated patients with respect.
- Compassionate care was provided to patients participating in course activities. Staff demonstrated a supportive approach to patients while motivating them to fully participate in activities to their own ability.
- When staff discussed treatment with patients, they were attentive and able to adapt individual treatments in response to patient feedback. Patients were fully engaged with all sessions observed.
- Consultation and treatment room doors were closed during consultations, conversations taking place in these rooms could not be overheard.
- Staff knew if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.
- Patients were satisfied with the care provided by the unit and said their dignity and privacy was respected. Comments highlighted staff responded compassionately when they needed help and provided support when required.
- Results from the RRU patient survey showed patients felt they were treated with compassion, dignity and respect. The RRU collected course feedback for the 22 courses from January 2017 to January 2018. All feedback was positive with the courses frequently described as excellent. Staff were described as approachable, friendly, supportive and knowledgeable. There were comments on the course being flexibly adapted to patients' needs and patients gaining greater confidence by the end of the course.
- Staff understood and respected people's personal, cultural, social and religious needs. The individual needs of patients and the occupational needs of their employment were considered when devising treatment plans.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during initial assessment and ongoing consultations to make an informed decision about the choice of treatment available to them. We also saw that care plans were personalised.

- Staff were able to form close professional relationships with the patients due to the nature

of their work. This meant they were able to spend time talking to patients about their care, treatments goals and progress. Staff showed an encouraging, sensitive and supportive attitude to patients

- Patients felt involved in decision making about the care and treatment they received. Patient assessments were thorough; staff gave explanations to patients about their condition, prognosis, and their symptoms. Patients felt listened to, supported by staff, and had sufficient time during initial assessment and ongoing consultations to make an informed decision about the choice of treatment available to them. Individual care plans were person centred.

Patient and family support to cope emotionally with care and treatment

Staff communicated with people in a way that they would understand their care and treatment. Staff recognised when patients and relatives needed additional support to help them understand and be involved in their care and treatment. We saw staff talking to patients about their care and made time to ensure they understood what they were saying.

- Staff responded in a compassionate, timely and appropriate way when patients experienced physical pain, discomfort or emotional distress.
- Staff understood the impact a patient's care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially. Patients we spoke with said they felt staff acknowledged their emotional needs. Additional emotional support was available to patients if required. 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 from their military unit. Patients were encouraged to use their own emotional support systems including friends and family and also work based support such as staff in their own unit who could provide this support. Recommendations for referrals to other services such as mental health services were discussed with the patients' medical officer.
- People were encouraged to link with other course participants while they were completing their rehabilitation. Patients had the opportunity to stay in RRU accommodation on site, which enabled patients the opportunity to socialise together during the course and also during meal times, and in the evening. However, at the time of the inspection, none of the patients were staying on site. Patients told us they did find opportunities to provide support and encourage each other during the course day.
- Patient information leaflets and notices were available through the unit, which told patients how to access a number of support groups and organisations.
- Patients were supported to manage their own health, care and wellbeing and to maximise their independence. Patients and, where appropriate, relatives were routinely involved in planning and making decisions about their care and treatment by the staff. As part of the initial assessment process, patients identified their own treatment goals and these were reviewed periodically throughout their treatment working with the staff. Patients received copies of their treatment plans.
- Staff referred patients on to services, which provided counselling, advice and support to assist them in coming to terms with their condition and circumstances, when necessary.

Are services responsive to people's needs?

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

- The unit took account of the needs and preferences of patients when planning individual treatment and the local service.
- The facilities and premises were not purpose built, they were aging and were shared with the naval base physical training department. As a result, there were challenges for the staff to provide services, which were planned however, staff were aware of the issues and did work to mitigate the risk. The issues included:
 - At the time of the inspection, we observed treatments and progress discussions being held in the gym area, which was being used by other patients, other MoD staff attending the PT gym and contract staff carrying out roofing repairs to the leaking roof using a cherry picker. The gym was in a grade 2-listed building where the roof was leaking. There was a risk of extreme temperatures in both the summer and winter. There was a loss of workspace and excessive noise in all treatment areas when the physical training department was using the shared gym area for example for boxing matches or football tournaments. Staff always checked patients were happy to commence treatment and have conversations in the gym area. However, there were so many distractions, privacy and confidentiality for patients could be compromised.
 - In the waiting area, there were inadequate toilet facilities; patients were required on occasions to access toilet facilities in other areas on site.
 - Access to the podiatry treatment room and classroom/group treatment room was via an external staircase, which was slippery during wet weather and not accessible for patients with poor mobility. Staff would find alternative treatment areas to treat patient who were unable to use the stairs.
 - There were episodes of excessive noise in all treatment areas when the royal marine band activities took place in the outside areas beside the department.
- Staff would adapt the timetable to accommodate events where possible. The chief petty officer had developed a good working relationship with the physical training team and facilities team on site and worked to ensure events affecting service provision were planned for and alternative arrangements were put in place to limit the impact to patients. On occasions, the service would relocate to other areas of the site.
- The staff mitigated the risks by following relevant standards of practice to ensure safe

running of the department and undertaking dynamic risk assessments prior to all activities. For example, room temperatures were being monitored and actions would be put in place to respond to high or low temperatures, which would impact on patient safety. For example, adapting or ceasing the exercise programme or relocating to an outside area.

- The facilities and premises issues had been raised appropriately via the management structure and other sites were being investigated. However, at the time of inspection there were no firm plans in place.

Access to the service

The unit provided assessment and treatment services between 8:15am and 5pm Mon to Thursday and 8:15am and 2pm on Fridays.

- Patients had access to care and treatment at a time to suit them. The Regional Rehabilitation Unit (RRU) operated between normal working hours Monday to Friday. The administration team oversaw the appointment system. Patients were allocated an initial appointment and information would be sent to the referring unit. If this was not convenient, the appointment could be altered to suit the needs of the patient. Patients were given a choice of dates and time in line with availability to access the courses or follow up appointments. Patients were able to book follow up appointments or book onto courses following their initial appointment so they were clear when they were next attending. This also ensured there was no delay between the initial appointment and patients starting on a course or attending a follow up appointment.
- Patients did not always have timely access to initial assessment, diagnosis or urgent treatment. The target for undertaking new patient assessments was set at 85% for initial assessments to be completed within 20 working days of referral. The service met this target from:
 - July 2017 to September 2017 where 91% of people received an initial assessment within 20 working days of referral.
 - October 2017 to December 2017 where 87% of people received initial assessments within 20 working days of referral.
- However the assessment target was not met from:
 - January 2017 to March 2017 as only 72%, patients received an initial assessment within 20 working days of referral.
 - April 2017 to June 2017 as only 81%, patients received an initial assessment within 20 working days of referral.

Where the assessment target was not met there was no information about how much longer patients had to wait following referral.

- The RRU average for assessment was lower than RRU Portsmouth for all quarters in 2017.
- The target for accessing an RRU course was for 90% of patients to be offered a course starting within 40 working days of the MIAC appointment. RRU Portsmouth and the RRU average failed to meet this target in all four quarters in 2017. At RRU Portsmouth the average ranged from 67% (April to June 2017) to 78% (October to December 2017) while the RRU average ranged from 77% (January to March 2017) to 81% (April to June 2017).
- In 2017, both MIAC and RRU courses saw an improvement in their short-notice cancellation rates (cancellations with notice of less than one working day) at RRU Portsmouth. The RRU course short notice cancellation at RRU Portsmouth improved across 2017 decreasing from 12% at the start of the year to 0% in the latest quarter. The MIAC short notice cancellation at RRU Portsmouth was similar to the RRU average, which had not met the target during 2017.

- Portsmouth had not had a podiatrist in post since April 2017. The service had been utilising other RRUs to provide a podiatry service specifically Aldershot. The service told us from April 2017 to January 2018 they had referred 106 patients to other RRUs. Of these 106 patients, 100 had been referred to RRU Aldershot, five to RRU Tidworth and one to RRU Plymouth.
- Referrals to alternative RRUs were stopped in January 2018 due to the impact this was having on the other services. At the time of our inspection, only urgent referrals were sent to other services.
- At the time of inspection, there were 17 non-urgent patient referrals on the podiatry waiting list.
- All reasonable efforts and adjustments were made to enable patients to receive their care or treatment. The unit was mostly fully accessible for all patients. Access to the podiatry treatment room and classroom/group treatment room was via an external staircase, which was slippery during wet weather and not accessible for patients with poor mobility. However, staff would find alternative treatment areas to treat patient who were unable to use the stairs.
- Patients reported they had received information about the service in a manner which they could understand.
- Referrals were received electronically using the specified pathway initiated by the primary care unit. Electronic referrals were monitored throughout the day by the administration team and were triaged on the same day by physiotherapists. If referral information was unclear, the referring unit would be contacted for further information in order to make an appropriate decision regarding appointment allocation. We were told, at times referrals were received which were inappropriate. If this was the case, these would be discussed with the referring unit and suggestions made as to further treatment options prior to the patient attending the RRU. If this treatment was unsuccessful then a new referral could be made to the RRU.
- The service prioritised care and treatment for patients with the most urgent need. Referrals were classed as urgent and routine. Urgent referrals could be seen at the first available clinic whilst routine referrals were seen within 20 working days. Referrals were allocated according to clinical and/or military needs and would be classed as urgent if the information identified red flags (symptoms indicating a more serious pathology) or if the patient was due to be deployed.
- Patients had access to care and treatment at a time to suit them. The RRU operated between normal working hours Monday to Friday. The administration team oversaw the appointment system. Patients were allocated an initial appointment and information would be sent to the referring unit. If this was not convenient, the appointment could be altered to suit the needs of the patient. Patients were given a choice of dates and time in line with availability to access the courses or follow up appointments. Patients were able to book follow up appointments or book onto courses following their initial appointment so they were clear when they were next attending. This also ensured there was no delay between the initial appointment and patients starting on a course or attending a follow up appointment.
- There was a clear process for patients who did not attend clinic appointments or RRU courses. For patients who did not attend a clinic appointment, the appropriate people were informed and this was recorded in the patient's records. An alert was set up on the system to identify a six week deadline for the patient to contact the RRU to re-book an appointment. If this did not occur, the patient would be discharged from the RRU. Non-attendance at one of the RRU courses meant it was at the clinician's discretion as to whether the patient was suitable to continue on the course or whether they were discharged from the RRU and referred back to the referring clinician.
- Patients had access to fast track diagnostic imaging for identifying and monitoring diseases or injuries, if required, at a local private hospital via a service level agreement.

Listening and learning from concerns and complaints

The unit had a system for handling concerns and complaints. There was a designated responsible person who handled all complaints in the unit. The complaints policy and procedures were in line with recognised guidance and DMS processes.

- Patient'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.
- For the reporting period February 2017 to January 2018, the service had received no complaints. However, staff told us if they did receive a complaint they would ensure lessons learnt and changes to practice were communicated in team meetings. We saw there was an agenda item in team meeting minutes. Without complaints to review, we were unable to monitor the service's response to managing complaints.
- Staff were supported to resolve concerns with patients as soon as they arose and they encouraged patients to discuss any concerns at any point. 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.
- Patients were clear how they could raise concerns and complaints. There were leaflets and notices available through the unit for example on notice boards in treatment rooms and patient waiting areas, which told patients how to raise concerns or make a complaint.

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

- 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. Staff at a local level felt engaged and consulted when deciding how the strategy and objectives for the Regional Rehabilitation Unit (RRU) were agreed and delivered.
- The unit had a mission statement , 'to sustain and improve the training and operational effectiveness of injured service personnel by provision of high quality targeted rehabilitation, accelerating their return to optimal physical capability, whilst influencing their psychological and social health'. It had been devised by the management team through a process of engagement with staff, in August 2017; it did not have date for review. There were clear links between the vision, strategy and the overall organisation strategy. The mission statement was displayed in the waiting areas. Staff knew and understood their role in achieving the values.
- 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, which 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 service had an overarching governance framework, which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured responsibilities were clear and that quality, performance and risks were understood and managed.

- There was an effective governance framework to 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.
- There were clear lines of accountability and clear responsibility for cascading information upwards to the senior management team and downwards to the clinicians and other staff on the front line.
- Clinical governance meetings took place monthly. We reviewed the minutes of the most recent clinical governance meetings. The agenda items included:
 - 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,
 - compliments and complaints,
 - diary check,
 - course planner, newsletter, and any other business.
- These meetings provided a robust arrangement for identifying, recording, and managing risks, issues and taking mitigating actions. The team, in addition carried out a weekly diary check to ensure all courses were covered by appropriate staff and to ensure any events affecting service provision were planned for and alternative arrangements were put in place to limit the impact on patients.
- 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.
- 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. Each of which had a number of serials. The last review using the CAF took place on 24 November 2017. While no key areas of good practice had been identified. All domains had been completed with five of the domains being coded overall as green (fully compliant) and three domains coded as yellow (partially compliant). All areas requiring action were recorded in the local service

management action plan and on the risk assessment where appropriate.

- The 37 fully compliant serials included risk management, safety notices, safeguarding, medicines management, clinical care is delivered in evidence based practice and resuscitation.
- The eight serials coded as partially compliant included safeguarding training, written policies and procedures, ensure safe sourcing, storage, handling and disposal of medicines and medical gases, dispensing – medicines are dispensed accurately and safely policy and promoting equality, privacy of patients.
- There was alignment between what people said was, 'on their worry list' and the recorded risks. Staff identified the impact the podiatry vacancy was having on patient care as on their worry list. This risk was on the risk register. Staff felt there was a risk of a delay in patients accessing the services they needed. This had been raised with senior staff actions had been taken.
- The issues associated with ageing facilities and shared premises with the naval base physical training department were also a concern to the staff, these issues were also on the risk register. These had been raised appropriately via the management structure and other sites were being investigated. However, at the time of inspection there were no firm plans in place.
- 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. We saw up-to-date copies of the local staff structure were available.
- 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.
- 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 Navy estates team and swimming pool manager as the service used the pool for some class sessions. The chief petty officer had developed a good working relationship with the physical training team and facilities team on site and worked to ensure events affecting service provision were planned for and alternative arrangements were put in place to limit the impact on patients
- 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.

Leadership and culture

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

- There was a clear leadership structure and staff felt supported by management. Staff told us managers were approachable and always took the time to listen to all members of staff.
- The unit was aware of, and had systems to ensure compliance with the requirements of the

duty of candour. (The duty of candour is a set of specific legal requirements that registered providers of services must follow when things go wrong with care and treatment.) This included support training for all staff on communicating with patients about notifiable safety incidents. Managers and staff encouraged a culture of openness and honesty. From incidents we reviewed, we found patients involved in incidents were not always kept fully informed during the incident review process. While patients were kept informed while they were being treated at the service, there was no formal process for feeding back to patients about any changes in practice following incident investigation once patients had been discharged. There was however, evidence an apology had been given at the time of the incident.

- Clear multidisciplinary team (MDT) working was evident throughout patient notes. Physiotherapist and ERIs contributed to and shared information on patient care. The unit held minuted multi-disciplinary meetings to support effective care planning and delivery. Staff confirmed the unit held regular meetings where patient's' treatment, progress and end of course discussions were discussed.
- There was an open culture within the unit and staff had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for unit staff to view.
- Staff felt respected, valued and supported and all staff were involved in discussions about how to run and develop the service. The administration staff felt well supported by their line manager. They felt the support structure worked well and felt appreciated and valued. They told us despite the staffing issues, they felt the team had communicated strongly and pulled together well, to manage and overcome the challenges they faced, they were proud to be part of the team. Staff were passionate about the care they delivered.

Seeking and acting on feedback from patients and staff

The service encouraged and valued feedback from patients and staff. It proactively sought feedback

- 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, completed anonymously, were used to 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 complaints were listened to, and monitored to check if their treatment was at a convenient time and location. The team culture was centred on the needs and experience of patients. Information received from patients was shared with staff and used to make changes within the service. Patients' post course feedback was used to review the quality of the information provided on each course. We saw feedback was shared with the whole team.
- For the reporting period February 2017 to January 2018, the service had received no complaints. The service had received four compliments from December 2017 and January 2018. One via email two via completed feedback surveys and one via verbal feedback. All complimented the staff on their friendly professional approach.
- Staff were encouraged to give feedback and discuss any concerns or issues with colleagues and management. Staff were confident to speak up, raise concerns, and be open. Staff told us they felt involved and engaged to improve how the unit and service was

run.

- 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.

Continuous improvement

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

- There was no control at a service level over the total number of staff available for the service, the 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 examples of how local changes had been made to the service to learn, improve and innovate.
 - Some staff were involved in regional projects such as the outcome measures project to improve and innovate. Staff continually reflected on further improvements that could be made.
 - A number of staff were undertaking educational courses. The content of these courses linked to their job roles. They were supported to complete this learning and staff brought their learning back and used it to educate other staff during training sessions.
-