

Defence Medical Services Edinburgh Regional Rehabilitation Unit

Inspection Report

Redford Barracks
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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 Edinburgh on 3 May 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 Edinburgh Regional Rehabilitation Unit (RRU) on 3 May 2018.

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

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

- There was an effective system available for staff to report significant events, incidents, near misses and concerns, however staff did not always raise ongoing recurrent issues. This impacted on the team's ability to provide consistent, high quality care for patients.
- Compliance with the majority of mandatory training was 100%.
- Staff understood their responsibilities and adhered to safeguarding policies and procedures.
- The maintenance and use of equipment did not always ensure patient safety.
- Not all staff were aware of the correct systems and processes for the management of medicines held at the unit. For example, the process for issuing and collection of medicines.
- Patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Relevant and current evidence-based, best practice guidance had been identified and developed for defence rehabilitation services and this was used to direct how services, care and treatment was delivered.
- The patient specific functional scale outcome measure had recently been introduced. All patients attending the RRU for the April/May course had an outcome measure completed. However, it was not possible to see evidence for an overall course evaluation following a review of the outcome measure at the time of inspection due to the recent introduction and the data not having been collected and reviewed. Objective measures were used pre and post treatment to identify improvements which had been made to the individual patient's condition following treatment.
- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis. Staff were encouraged to develop and to drive improvements in their areas of interest within the RRU.
- There was a strong team approach to multidisciplinary working within the RRU.
- There were challenges with communication and team working between the RRU and primary care rehabilitation facilities (PCRF). Arrangements for sharing information with other professionals outside of the RRU did not always ensure consistent and quality of care for the

patient. Steps had been taken to improve relationships however further work was required.

- Patients spoke positively about the care they received from the staff at the unit. We observed compassionate and supportive interactions and patients told us they felt included in decision making about their care and treatment, and listened to by the staff.
- Service delivery was planned to ensure it was responsive to patients within the area of responsibility. Staff were mindful of the large geographical patch the RRU served and where possible tried to accommodate the needs of the patients when arranging appointments. Additional peripatetic clinics were also held in different parts of the region.
- The unit was exceeding set targets for their key performance indicators. The RRU performed better than other RRUs for waiting times for courses, appointments and short notice cancellations.
- The infrastructure of the RRU was not purpose built to deliver the services provided which posed challenges to service delivery. Staff were aware of this and worked hard to overcome these challenges. This issue had been escalated to the risk register,
- There was a clear leadership structure and staff felt supported by management. Leaders were visible, encouraging and empowered 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.

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

- There was a strong team approach to multidisciplinary working within the RRU. All staff spoke highly about the team and how supportive everyone was.
- There was an open, honest and transparent culture at the RRU. Staff spoke candidly about the challenges they faced and identified how proactive they had been to manage these issues.
- Patients were positive about their interactions with staff and said they had been treated with compassion and dignity. All the staff demonstrated how passionate they were about providing high quality patient care. Staff were focused on doing their best by the patients. We observed kind and compassionate interactions between all staff and patients and saw how staff supported patients emotionally to cope with their condition.
- Service delivery was planned to ensure it was responsive to patients in their area of responsibility. Staff were mindful of the large geographical patch the RRU served and where possible tried to accommodate the needs of the patients when they arranged appointments for patients. The service also offered additional peripatetic clinics in different parts of the region.

Recommendations for improvement

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

- Functional emergency equipment should be available at the pool to ensure patient safety. The automatic external defibrillator (AED) at the pool was out of date for servicing and not working at the time of the inspection. RRU staff were aware of the issue and this had been escalated, however, staff were not able to identify when it would be repaired. Although this is not the RRU's piece of equipment, it was an asset belonging to the garrison; it was the only defibrillator available at the pool. If an event occurred where a patient required this piece of equipment, it would not be available. This posed a risk to patient safety.
- Staff should be aware of the correct procedures for managing medicines. Not all staff were aware of the correct system and process for the management of medicines held at the unit.

This was around issuing and the collection of medicines.

- All issues affecting patient care and service delivery should be reported as incidents to enable thorough investigations to occur and solutions to be found for ongoing problems. Staff did not always raise ongoing recurrent issues which impacted on providing high quality care for patients. We identified a challenging issue faced by the podiatry department to access specialist boots for patients and an issue regarding poor access to the electronic records system. Neither of these issues had been incident reported. This raised a question as to whether staff faced other similar recurrent challenges which had not reported as incidents, to enable suitable solutions to be found.
- Further work was required to overcome the challenges staff faced regarding communication and team working with local PCRFS to effectively manage patients. At times, there was a lack of clinical accountability from staff at the unit regarding ongoing patient care, when patients returned to the primary care rehabilitation facility (PCRFS). We identified incidents where patient's treatment may have been unnecessarily prolonged due to ineffective communication and team working.

Professor Ted Baker

Chief Inspector of Hospitals

Regional Rehabilitation Unit - Edinburgh

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 the 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) Edinburgh 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 Redford Barracks in Edinburgh 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 and Germany. RRU Edinburgh serves a population at risk (PAR) of 11,350 personnel broken down as follows:

- HMS Neptune and Kentigern House (4000)
- Edinburgh and HMS Caledonia (2500)
- Leuchars (800)
- RM Condor (750)
- Lossiemouth (2000)
- Kinloss (700)
- Fort George (600)

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 run for three weeks. 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.

We carried out a comprehensive announced inspection of this service. RRU Edinburgh has not

been inspected by CQC previously.

Our inspection team

Our inspection team was led by a CQC inspector. The team included two CQC Inspectors, joined by two Defence Medical Services (DMS) Specialist Advisors 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 3 May 2018. During the inspection, we:

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

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

Reviewed patient notes, complaints and incident information.

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

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

What people who use the unit say

Patient survey results were collected and reviewed following each course. Results from March 2018 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.

- 96% of patients said they would recommend this facility to family and friends.
- 100% of patients felt people listened to their comments, compliments and complaints.
- 100% of patients said they felt involved in decisions regarding their care.

As part of our inspection, we also spoke with 15 patients. All patients spoke positively of their experience of having treatment at the RRU. Patients said they were able to access the service easily and had accessed appointment times of their choice. They told us they were provided with useful information prior to attending the course and had been included in developing their goals and treatment plans. Any issues they had raised had been dealt with quickly and efficiently.

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.

- There was an effective system available for staff to report significant events, incidents, near misses and concerns. Staff were familiar with the electronic incident reporting system and knew how to access it. Locum staff accessed the system via permanent members of staff at the unit. All incidents were reviewed, investigated and closed by the service lead. The service lead would also escalate incidents if this was required.
- Staff did not always understand their responsibilities to raise concerns and record these. Staff told us about a recurrent challenge they faced which was around accessing specialist footwear for patients. Although this issue had occurred several times, it had not been incident reported. There was a missed opportunity for this issue to be escalated to find a solution to a problem for a recurrent issue challenging patient care and treatment to enable improvements to be made to the quality of care provided to patients. There was also an issue of poor access to the electronic records system following the systems moving to an updated version. This had resulted in case notes being written retrospectively several days following treatment. This issue had not been reported, which meant it could not be investigated and escalated as appropriate. We also saw examples where there had been an unnecessary delay, and patient's treatment had been prolonged due to communication issues with the PCRFs. These had not been reported as incidents. This questioned whether staff faced other issues which they were not incident reporting.
- A spreadsheet of all incidents was maintained. This incident log was held electronically and provided a brief overview of the incident, who was responsible for overseeing the actions, a required date for these to be completed and when they had been completed. Themes were identified and appropriate action had been taken to minimise further occurrences.
- There had been six incidents reported between March 2017 and March 2018. These included incidents such as incomplete post-operative case notes and injury to a patient following the use of a heat pack. We reviewed three incidents which had been reviewed and investigated. All issues had been thoroughly investigated and we saw evidence of

additional emails and correspondence identifying how issues beyond the control of the RRU had been escalated to find a resolution for the situation. Appropriate actions had been taken to manage all of the incidents.

- Once incidents had been identified, lessons were learnt and action was taken to improve safety at the Regional Rehabilitation Units (RRU). Incidents were discussed at the monthly practice development meeting. Staff were all aware of clinical incidents which had occurred in the service, were able to discuss them and tell us about service improvements made in response to them.
- Updates and learning from significant incidents which had happened at other RRUs was available to staff on the intranet update page and if appropriate, discussed at staff meetings. During a discussion with the staff, they were able to tell us about learning and outcomes following incidents which had been shared across other RRU's.
- There was no formal process to keep patients informed of the outcome of incidents in which they had been involved. Patients would be informed of any actions following the incident whilst they continued their treatment at the RRU, however, there was no system or requirement to provide ongoing feedback once they had left the RRU.
- The duty of candour relates to openness and transparency. It requires staff to be open, transparent and candid with patients when things go wrong and offer an apology to the patient as soon as the incident had been identified, irrespective of who was to blame. In one incident we reviewed where this needed to be applied, this had occurred appropriately an apology had been given to the patient involved.

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

- Essential systems, processes and practices were available to ensure patient safety. Staff received mandatory training in safety systems, processes and practices. Training compliance was set at 100% for the RRUs. Training included infection control, equality and diversity and healthcare governance awareness. Training compliance for all staff at the unit was 100% in the majority of topics. However, there were four courses where compliance was 89%. These courses were healthcare governance awareness, office safety, unconscious bias and security general threat brief. Staff were due to complete these course at the first available opportunity. Although compliance was 89%, this only equated to one member of staff not having completed the training.
- An overview of mandatory training compliance was stored electronically. A lead member of staff had a designated role to monitor mandatory training compliance at the RRU. Staff also received an email prompt when their mandatory training required updating. Training was usually completed by staff in the break between courses.
- Arrangements for safeguarding reflected relevant legislation and local requirements. Staff received safeguarding training to level two in line with national guidance which recommends staff should be trained to one of five levels of competency, depending upon role and interaction with adults and children. There was 100% compliance with this training. Staff also completed safeguarding children level 2. There was 89% compliance with this training, however due to the small number of staff working at the clinic this on equated to one member of staff who had not completed the training.
- The safeguarding lead role for the RRU was aligned with the MIAC doctor position. At the time of our inspection, a locum doctor was working part time hours at the unit. The doctor had completed safeguarding training level three however, there were certain days when the doctor was not available at the RRU. This issue had been identified on the risk register. Actions had been taken to mitigate the risk and there was a local agreement with the Edinburgh Medical Facility on site for any safeguarding concerns to be reported to their

safeguarding lead. Staff were aware of this procedure.

- Staff understood their responsibilities and adhered to safeguarding policies and procedures. There had been one safeguarding incident recently reported at the unit. The concern was raised by the ERI who reported this to the service lead. The patient was then referred to the supporting Edinburgh Medical Facility for a review.
- Systems, processes and practices kept patients safe. All staff were Disclosure and Barring Service (DBS) checked and their professional registration and expiry date was reviewed. This ensured all staff at the unit were safe and fit to practice at the unit.
- Chaperone posters were displayed around the RRU. We saw posters on notice boards in the gym and in the clinic room highlighting the opportunity for patients to have a chaperone present for any appointments they attended.
- Arrangements for the maintenance and use of equipment ensured patient safety. Fitness and strength equipment such as weights and treadmills were cleaned before and after patient use. Equipment was used, maintained and calibrated in line with manufacturers' instructions.
- The gym premises, while small and in need of refurbishment, was appropriate for the services provided. Gym equipment was in good working order and equipment was stored away and off the floor on suitable shelving and racks. However, there was no separate waiting area for patients attending the RRU. Staff had made a small waiting area in the gym which included a small seating area and some reading material for patients.
- A policy was available providing information about equipment care and staff knew where to find this. Staff were clear on the frequency in which equipment needed to be reviewed and serviced. There was a system to check equipment using a 373 form. We reviewed the file containing 373 forms which demonstrated appropriate checks had been completed on all of the equipment. Staff were aware when forms had not been completed according to the policy and followed these up. This ensured all appropriate checks had been carried out. The RRU also maintained an equipment inventory log. This identified the item of equipment, its unique identifier status and maintenance history. Records showed equipment safety checks had been carried out and equipment was safe for use.
- Resuscitation equipment was available in the gym area. An automatic external defibrillator (AED) was available and easily accessible. Additional equipment to deliver basic life support such as face masks were located in the MIAC clinic area. Additional equipment was stored in the treatment room which had a lock on the door which could delay access by a few seconds. Records confirmed checks on the equipment took place each day the clinic was open.
- Functioning resuscitation equipment was not available at the swimming pool. An automatic external defibrillator (AED) was available and easily accessible at the poolside however, at the time of inspection, the battery was showing as needing replacement and the electrode pads were out of date and at risk of deterioration. Staff were aware of the issue and this had been escalated, however, it had not been followed up to gain assurance it had been fixed. Although this was not the RRU's piece of equipment, it was an asset of the garrison that managed the pool, this was the only defibrillator available at the pool. If an event occurred where the health of patient under the care of the RRU deteriorated and this piece of equipment was required, it would not be available. Survival from cardiac arrest depends on the reliable operation of AEDs. This posed a risk to patient safety.
- Staffing levels and competency were appropriate at the swimming pool during treatment sessions to protect both patients and staff. There were two qualified lifeguards and a pool manager on duty at the swimming pool when treatment sessions were carried out. The lifeguards on duty would support the staff in the event of an emergency. These members of staff were managed by the garrison and not the RRU.
- There was a clear accident and emergency procedure available for staff working in the pool area. There was access to buoy's (a 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 patients from the pool who had a suspected spinal injury.

- The swimming pool was checked three times a day to maintain the correct chlorine levels and pH balance, ensuring the pool was safe for use. The swimming pool was an asset belonging to the garrison and not managed by the RRU. Therefore, the RRU was not responsible for these checks. Despite this, we saw evidence regular testing was carried out. If there was a problem with the pool and it was out of use, one of the qualified lifeguards or the pool manager would make RRU staff aware in advance of any sessions being carried out.
- A risk assessment had been completed concerning risks associated with the swimming pool. Each patient who attended sessions at the swimming pool had an up to date risk assessment completed. This included a check of contraindications, precautions and clinical pathways.
- Standards of cleanliness and hygiene were maintained. The environment at the RRU was visibly clean and tidy. Equipment in the clinic rooms and in the gym was stored appropriately when not in use. We reviewed consumable items held in the clinic rooms. These included disposable cleaning cloths, syringes, dressings, saline and bandages which were all in date. The unit also maintained a record as to when items had been opened. This meant they were aware when the item needed to be disposed of to ensure patient safety.
- The management of clinical waste ensured the safety of patients. Staff followed guidance for the storage and disposal of waste. There were colour coded clinical waste bins in the clinic rooms. Sharps were disposed of in sharps boxes which were in use at the time of inspection. These were appropriately labelled, dated and signed.
- The unit had reliable systems which protected patients from healthcare associated infections. We observed staff running clinics undertaking the five moments of hand hygiene and were bare below the elbows. Alcohol gel dispensers were available for use around the gym and in clinic rooms. Equipment and chairs were wiped down following patient use. A cleaning company cleaned the RRU in the evening and at lunchtime Monday to Friday.
- There was a local lead and deputy for infection prevention and control. This role was held by the physiotherapist at the unit who held a full time role. This member of staff was responsible for infection control matters and for the annual infection control audit. Staff could access extra support and advice regarding infection control issues from the lead.
- An infection prevention and control audit was carried out annually at the RRU. The most recent audit was completed in April 2018 where the unit was 91% compliant, against a target of 85%. An action plan had been identified to rectify the nine areas which did not meet the required standards. These included policies procedures and guidelines, and infection control procedures for the consulting rooms and patient equipment. Actions had been prioritised and an owner assigned to each action. The results of the audit were discussed with all staff at the monthly meeting and actions were reviewed on a monthly basis. At the time of our inspection, two actions had been closed with the rest ongoing.
- There was a policy available to ensure safe management of individual patient records JSP 950 leaflet 1-2-11. The policy outlined the management of records from their creation to destruction.
- The service used the defence medical information capability programme (DMICP) to store and access electronic patient records. This allowed staff in any location to access records and view the information required to treat the patient. However, a recent upgrade of the system had resulted in poor access to patient records. Staff told us and we saw evidence that a recent migration of notes had resulted in staff not being able to access notes on the day of treatment. For example, staff had written notes retrospectively on the 23 April 2018 following treatment on 17 April. Despite this causing disruption at the unit, although senior staff were aware, the issue had not been incident reported. At the time of the inspection,

this issue had been resolved and all notes were up to date.

- Patient records were organised, up to date and shared and stored appropriately. We reviewed 10 patient records for patients attending the multidisciplinary injury assessment clinic (MIAC) and rehabilitation courses. Records included referral information, patient assessments, consent, treatment plans, goals, which were all complete. 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. We did not see evidence of the patients' perspective or expectations in all of the notes we reviewed. Of the ten sets reviewed, only four had documented evidence of the patient's perspective or expectations.
- A records audit had been completed in April 2018. The audit had looked at four sets of records with compliance being measured against eight areas. These included mandatory compliance, subjective assessment, objective examination, analysis, treatment planning, treatment implementation, transfer of care and documentation. The RRU achieved 86% compliance across the eight areas against a target of 75%. Results identified areas for improvement. These included documentation of contraindications, admission outcome measures, goals, treatment plans and the patient's perception of their needs and expectations. The action plan identified the results would be feedback and discussed during the practice development meeting with all staff. We were unable to review if this occurred as this meeting had not been held for May 2018 at the time of our inspection. Further recommendations had been made to support staff and encourage compliance and standardisation with the required notes format.
- Arrangements for recording and storing medicines minimised risks to patient safety, however, not all the relevant staff were aware of the management of medicines processes available at the RRU. There was a medicines management policy JSP 950 9-2-1 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 March 2017 to March 2018 there had been no medicines incidents reported. There was a lack of clarity about the process for managing medicines available at the unit. Only a small amount of medicine was held at the RRU. There was confusion about the process for obtaining medicines and assigning these in a way in which they could be traced and for auditing purposes. However, on the day of the inspection, the MIAC doctor was not available as it was his non-working day. It was the doctor who would have overall responsibility for ordering and management of the medicines available at the unit.
- Risks to the storage of medicines which had temperature restrictions were mitigated and managed. Medicines stored at the RRU had a temperature limitation which stated they should not exceed 25 degrees. There was no refrigerator on site; however the room temperature where they were stored was monitored daily. If the room temperature exceeded 25 degrees the medicines would then be disposed of by the pharmacy team to ensure patient safety. The introduction of room temperature monitoring had been introduced in May 2017 following a recommendation from the unit's external review process in October 2016. There had been no record of any temperature breaches since this process had been introduced.
- There was a system to enable to ensure medicines used on patients could be tracked to ensure patient safety. The RRU did not maintain an audit log of medicines, linking these to patients which they had been used to treat, however the pharmacy maintained records of medicines ordered for patients. If required, the pharmacy could retrieve this information. This system was recommended and implemented following the units external review process in October 2016. Information about medicines used on patients was also recorded in the patient's notes.

Monitoring risks to patients

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

- Risks to patients who used services were assessed and their safety monitored and maintained. Staffing levels, skill mix and caseloads were planned and reviewed to ensure people received safe care and treatment at all times in line with relevant tools and guidance. Actual staff met planned staffing levels. Between April 2017 and March 2018, RRU Edinburgh has a staffing fill rate of 100% for its 10.2 whole time equivalent (WTE) staff. Staff employed at the unit included physiotherapists, one podiatrist, exercise rehabilitation instructors (ERI), MIAC doctor, two administrators, one military Major, one regional trade specialist advisor. There were ongoing vacancies for a band 6 physiotherapist who would take the role of second in command of the unit, an ERI, and a MIAC doctor. At the time of the inspection these roles were being covered by locum staff. There had been delays recruiting staff due to decisions needing to be made by more senior management.
- Locum staffing had been identified as a risk on the risk register. As three roles at the RRU were covered by locums, there was a risk of these staff leaving at short notice. If this occurred, for a short period of time the remaining staff at the unit could provide cover. If the post was left vacant for longer than two or three weeks this could have an impact on service delivery at the RRU. Action had been taken to mitigate risks which were ongoing. For example, there was ongoing work to ensure funding was available to cover any vacancies which may arise. The service lead was also looking at arranging renewal of locum contracts.
- Turnover rates for the RRU had been high with five new members of staff joining the RRU between January and August 2017. Since August 2017 no staff had left the RRU. However, in the months following our inspection, further staff changes were due to take place with four staff members leaving the unit. Sickness rates were low with 17 days being lost to sickness over the previous year.
- Comprehensive risk assessments regarding service provision were carried out and actions to mitigate any risks had been identified. Risks completed for the service included risk assessments for the clinical area and MIAC room, the individual specifics and aqua therapy. These documents were held electronically. We reviewed three risk assessments. Each had a description of the identified risk, a risk rating, actions to mitigate the risk, timeframe and date in which the risk required a review.
- The staff to patient ratio on the courses was determined to ensure the safety of patients. The ratio of staff to patients was two staff for 15 patients. Different components of the course were delivered by either the ERI or physiotherapist individually, or as a pair when required. Approach to treatment was based on the skills of staff and this also allowed time for staff to treat patients on a one to one basis when necessary.
- Staff could identify and respond appropriately to patients whose health was at risk of deteriorating and managed changing risks to patients who used services. Staff were aware of the procedure they would follow if a patient's health deteriorated whilst under their care. There was a flow chart displayed in the gym to remind staff of the procedure to follow. Staff leading aqua therapy sessions were aware of the evacuation process for the pool and the support they would receive from the lifeguard on duty if this event was to occur.

- Fire drills were carried out at the unit. The regional trade specialist advisor (RTSA) arranged an annual fire drill to ensure staff would know what to do in the event a fire breaking out at the RRU. The RTSA was also the lead for fire safety and also carried out a weekly fire checks at the RRU.

Arrangements to deal with emergencies and major incidents

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

- Potential risks for the service were anticipated and planned for, in advance. The unit had a local business assurance and resilience plan. The document provided details as to the actions which needed to be taken in the event of loss of any of the critical day to day functions of the RRU. These included loss of the MIAC, the course, weather contingency, loss of pool facilities, loss of staff and loss of IT at the RRU. The resilience plan had been followed by the service lead over the winter months due to the severe weather conditions affecting the safety of some of the staff to get into work safely. The document was included and discussed as part of the induction process for new members of 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.

- Patient's needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Relevant and current evidence-based best practice guidance had been identified and developed for defence rehabilitation services and was used to direct how services, care and treatment were delivered. These guidelines determined the necessary assessments and treatments required for specific conditions.
- Staff had access to best practice guidelines, to inform the care and treatment they provided to patients. Specific guidelines had been produced to cover a range of conditions seen at the clinic, for example, the management of foot and ankle pain and the management of back pain. The document contained flow charts identifying specific care pathways. Each document identified specific clinical features which may be found for different presenting

conditions and identified the approach to management of the condition which needed to be taken by the RRU. The document also identified red flag (serious pathology) which would need immediate attention and escalation if identified. References to the guidelines and evidence which had been used to develop the documents was also identified within the document.

- Rehabilitation courses were delivered 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 and education sessions. However, at the course debrief, some patients fed back that the educational sessions could be very detailed which was not always necessary and could be difficult to understand. The individual education sessions had been written centrally and had to cover a range of information to accommodate for different levels of baseline knowledge and understanding between the patients. These education sessions were due to be reviewed to ensure the content was user friendly and pitched at an appropriate level for patients.
- Pain was assessed and managed according to the individual patients. 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) during assessments and in response to treatments. This meant staff could monitor the effect of pain. We observed staff responding to patients who reported pain in their class activities. An assessment of the patient's level of pain occurred and patients were quickly offered advice on how to adapt the exercise to reduce their pain so they could continue. All patients said their pain and symptoms had been taken into account and managed well. One person provided an example of where their treatment plan had been modified to account for their level of pain.

Management, monitoring and improving outcomes for people

There was evidence of quality improvement including clinical audit

- Validated patient reported outcome measures (PROM) had recently been implemented for used with all patients attending the RRU for the April/May course. Until recently, outcome measures had not always been routinely used to assess patients at the start and the end of treatment, to review their response to treatment. Outcome measures were only continued and used at the RRU if they had been initially implemented by the referring PCRF. If this had not occurred, the RRU would not implement an outcome measure. As the RRU is only part of the rehab pathway for the patient it would be useful to also use outcome measure that had already been completed by the PCRF in order to see progression over a longer period.
- Since April 2018, staff at the RRU had implemented the patient specific functional scale outcome measure for all patients attending the RRU. This measure looked at individual activity limitation and functional ability, measuring functional outcomes for patients. However due to this measure having only been recently introduced, it was not possible at the time of inspection, to see evidence of course evaluation following a review of the outcome measure. Despite outcome measures not being routinely used, staff had experience of using measures such as the standardised modified walking locomotive test and patient health questionnaire (PHQ9).
- Objective measures were routinely used pre and post treatment to identify improvements which had been made to the individual patient's condition following the course of treatment. These measures were chosen specifically to provide an objective measure associated with the patient's injury. The included the single leg press, step down test and muscle strength testing.
- The service was part of a national project being carried out to look at the best practice

guidelines available for anterior cruciate ligament injuries (a ligament found in the knee). This project was being led by physios and ERI's located at RRU's nationally. This group aimed to identify where best practice guidance needed to be updated to ensure patients were receiving the most effective treatment and outcomes for this condition. The aim of the project was to review the most current evidence based guidelines and research available to make improvements to the whole rehabilitation pathway for patients and to the best practice guidance documents within DMS. At the time of the inspection this project was ongoing.

- Patients had their needs assessed, their care planned and delivered and their care goals identified when they started treatment at the RRU. Prior to starting the course, the patient would be assessed by the physio and ERI to identify their individual needs. This enabled a treatment programme to be designed specifically to meet the individual needs of the patient.
- Short and long term goals were also identified in conjunction with the patient. The patient was then reviewed midway through the course and at the end ensuring they had achieved their goals and their longer term goals were still realistic and achievable.
- Staff ensured treatment was reviewed and optimised for patients. Patients were reviewed midway through the course by the course staff and the clinical lead. This provided the opportunity for treatment programmes to be reviewed, to progress patients further and add additional exercise to optimise treatment.

Effective staffing

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

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis. A policy was in place for the statutory professional registration of healthcare professionals in the defence medical services (JSP 950 leaflet 5-1-5). This covered the requirement for professional registration, confirmation of registration on and during appointment, and a list of registered healthcare professionals who could be employed by the Ministry of Defence.
- Registered professionals were supported to meet the requirements of their professional registration. A register of staff professional registration was held and staff undertook a number of work based activities including training, and peer review. This ensured they met the requirements of their continuing professional development.
- Local in-service training was also held at the RRU on a monthly basis. Topics covered included plyometrics, neuromuscular training outcomes and clinical governance. Staff told us there had been positive changes to the content of the course and individual patient assessments as a result of in-service training sessions. Regional in-service training and development days were held quarterly. These were organised for staff and included role specific training to ensure individual learning needs could be met. Training included topics such as chronic pain.
- A peer review took place between exercise rehabilitation instructors (ERI) and physiotherapy staff including staff of different grades and discipline. This provided an opportunity for staff to have their practice critically appraised to identify any areas which the needed to develop to ensure high quality care and treatment was provided for patients.
- Staff were supported to deliver effective care and treatment through opportunities to undertake training, learning and development. Permanent staff had access to nationally run courses across the MOD. They told us the service lead encouraged and supported them to

engage with these. Staff were also encouraged to create their own learning and development opportunities in areas they were interested in. One band six physiotherapist planned to set up a pain working group to look at the management of pain across the RRUs and how this could be improved.

- Locum staff working at the unit were included in all learning and development opportunities available to permanent staff. Staff told us they were involved with local and regional in service training and would also take their turn to lead training sessions following attendance at any courses. This meant all staff at the unit benefitted from the shared learning. Although locum staff did not have access to MOD courses, they told us the service lead would support any requests for external training they felt would benefit from attending and which would benefit patients attending the unit.
- Staff were focused on identifying areas of practice which required improvement. The clinical lead had identified an area of practice which was being omitted in patient assessments and treatment plans. To improve this, the clinical lead held local in service training sessions for staff and carried out joint reviews with the other physiotherapists and ERI's. Staff felt this training had been invaluable to develop their practice to enable them to provide better care and treatment for patients. A joint review of each patient attending the course was also carried out at the midway point between a member of staff taking the course, the clinical lead and the patient. This ensured treatment was optimised for the patient.
- The learning needs of staff were identified through an appraisal system. At the time of the inspection, all staff had completed either their mid-way review or appraisal within their stage of the reporting year. Staff were responsible to arrange their appraisal. This was due to the different requirements for military and civilian staff regarding specific times of the year when these needed to be completed.
- Newly appointed staff were part of a mandatory induction programme. This was carried out by the regional trade specialist officer. The induction orientated staff to the unit and also covered topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We saw evidence of completed induction form staff members working at the unit.

Coordinating patient care and information sharing

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

- Staff within the RRU worked together to deliver effective care and treatment. All necessary staff were involved in assessing, planning and delivering patient care. Staff carried out joint assessments to optimise care and treatment for patients by providing a more co-ordinated approach to management of the patient's condition. For example, physiotherapists and ERIs jointly carried out initial patient assessments developing treatment plans for patients attending the course, and the doctor and clinical lead physiotherapist held a joint MIAC clinic.
- Arrangements for sharing information with other professionals outside of the RRU did not always ensure quality of care for the patient. There were challenges with communication and team working between the RRU and primary care rehabilitation facilities (PCRF). Staff reported that relationships with the local PCRF's were variable within their area of responsibility.
- The RRU relied mostly on an electronic tasking system through DMICP electronic record to communicate with local PCRF's. Staff told us if they received a referral which was not appropriate or unsuitable for the RRU, this would be rejected and a message would be sent via the electronic tasking system.

- Staff told us they frequently tasked staff at the PCRf via the electronic records system regarding communication about patients they had referred to the RRU. Although the challenges of communicating verbally more often were recognised, for example constraints and clashes with working schedules and lack of time, staff did not often communicate verbally with the PCRf's to manage care and treatment for patients with complex needs. We identified two patients during the inspection where treatment had been prolonged due to the lack of communication and team working between the RRU and PCRf. Best practice would be to communicate verbally for patients with complex needs to ensure more effective and co-ordinated management of these patients. This questioned the accountability of staff at the RRU with regards to shared care of a complex patient. We were told once the patient had returned to the PCRf the patient was no longer the responsibility of the RRUs
- To improve relationships between the RRU and PCRf, the service lead had set up quarterly Scottish Rehab Forum meetings and regional in-service training. This was to provide a platform to improve relationships, share ideas to improve the quality of care provided to patients, discussion of specific patient pathways and better communication of changes and improvements to systems and processes. This was an issue which had been raised had been the communication between the RRU and PCRf. An action from this was to encourage better communication between course clinicians and PCRfs both pre and post admission. This included staff all discharge summaries and plans are available on the electronic records system within two days following patient discharge. This would ensure information was passed back to the referring clinician in a timely manner. During discussions with staff, it was clear there was more work to do to improve communication and team working between the PCRf and RRUs.
- Not all staff had the information they needed to deliver effective care and treatment to patients. Each member of staff had access to the electronic records system. Each patient had an individual integrated health record which included the patient's full medical records. Staff had different levels of access to patient's medical records according to their need. For example, ERI's only had access to the rehabilitation notes, physiotherapists had access to the MIAC clinic notes, whilst the doctor had full access to patient's medical records. However, the podiatrist had raised three incident reports about lack of access to an electronic system to be able to see scans prior. This interfered with the ability to base treatment plans on information provided the result of the scan. The podiatrist had to wait until the doctor was available to share this information. We saw evidence the service lead had escalated this issue to provide the podiatrist with access, however this was still ongoing at the time of our inspection.
- Staff completed a handover following the course to transfer patients care back to the PCRf. This handover was completed electronically using the electronic records system. This included a summary of the patient's condition, how they had progressed throughout the course and any long term outstanding goals.
- Patients received clear information prior the course to fully inform them about the treatment they would receive and what was expected. Patients told us this information had been useful and informative.

Consent to care and treatment

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

- Staff sought patients' consent to care and treatment in line with legislation and guidance. Verbal consent was obtained from patients at the start and during their ongoing treatment. We observed where verbal consent was gained from the patients 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. Patients told

us they were asked for their consent at the beginning of their treatment and on an ongoing basis for each treatment.

- All patients signed a consent form at their initial assessment at the MIAC. The paper record was then scanned into the electronic system and stored with the patient's record.
- Written consent was obtained for treatments which involved a high level of risk. Patient records for patients which had undergone either shockwave therapy (electrotherapy treatment for soft tissue and bone conditions) or injection therapy contained a consent form identifying benefits and contraindications of treatment. All consent forms were 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 this entailed.

Supporting patients towards optimal function

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

- Patients were encouraged from the start to take ownership of their rehabilitation. Staff promoted self-management from an early stage in the course. Patients were supported to take responsibility for their rehabilitation and ongoing management of their condition on completion of their course at the RRU. This included booking a review appointment with their PCRF and continuing their rehabilitation to achieve their long term goals.
- Rehabilitation courses included education and information sessions to support patients in developing skills to help manage their own condition. For example, education about pain and pacing activities was delivered so patients could use these principles for their ongoing rehabilitation once they had left the course.
- Goals were specific to each individual patient so they could achieve what was required from their treatment. Patients set short and long term goals at the start of the treatment at the RRU. These were reviewed midway and at the end of the course. 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

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

and respect.

- Results from the RRU patient survey showed patients felt they were treated with compassion, dignity and respect. Between January and March 2018, 84 patients attended a course at RRU Edinburgh. Patients were provided with a feedback questionnaire post course, of which 80 were returned. Results were positive with patients stating they would recommend the unit. Results also demonstrated how patients felt included in decision making about their care and treatment and listened to by the staff.
- Staff understood and respected patient'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. Therapy staff adapted treatment sessions to suit individual needs, for example, to account for an individual level of stamina or pain.
- Staff took the time to interact with patients who used services and those close to them in a respectful and considerate manner across the clinics, the course and at the swimming pool. Staff also interacted with patients attending the unit in a caring and supportive manner. Administration staff had a friendly and caring approach to patients. On their arrival they made patients feel at ease, guided patients through various procedures and interacted in a friendly and supportive way. The administration team spoke about how they treated patients as family.
- All staff patient interactions were appropriate and respectful. Staff built up a rapport with patients quickly and we observed friendly communication with them engaging in day to day conversation. We also observed staff injected a level of humour which was well received by patients on the course.
- Interactions between staff and patients were friendly, compassionate and professional. Staff taking the individual specifics session went around the room and addressed each patient throughout the session. Staff made sure patients were managing with their rehabilitation programme and we observed staff providing advice to patients to adapt or modify their techniques where appropriate. This ensured treatment was optimised to achieve the best outcomes for the individual patient.
- Staff were passionate and motivated to see their patients benefit from their rehabilitation. Staff explained how they experienced job satisfaction from seeing patients improve. It was evident from all interactions between patients and staff that provision of high quality care was the main focus.
- Patient's privacy and dignity was respected. An individual clinic room was available for patients for MIAC or podiatry appointments. There was also a further clinic room which had two treatment spaces separated by curtains. This meant if two patients being treated at the same time conversations could be overheard. However, there were signs visible around the gym and patients were asked prior to being treated as to whether they were happy for treatment to go ahead and given the option of receiving their treatment in private. Gym sessions were provided in a group setting and individual treatments were available if a patient had a concern or wanted their injury reviewed. We saw the physio take a patient to the clinic room for further assessment during a group session.
- Single sex changing facilities were available at the RRU and at the swimming pool.

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 and staff provided detailed explanations about their condition, prognosis, and their symptoms. Patients felt listened to, supported by staff, and told us they had been included in forming their own treatment plans and goals.
- Treatment sessions carried out at the pool were explained in detail to the patients. Patients said they were listened to and there were plenty of opportunities for them to ask questions about their individual treatment programmes.
- Staff communicated with patients to ensure they understood their care and treatment. Rehabilitation activities or tasks were clearly explained at the beginning of each session. Staff provided patients with the opportunity to ask questions and clarify information and gave sufficient time for this.

Patient and family support to cope emotionally with care and treatment

Staff communicated with patients in a way that they would understand their care and treatment. Staff recognised when patients 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 understood the impact a patient's care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially. One member of staff told us about a patient who was not progressing due to the impact of their condition on them emotionally. Staff told us how they managed this patient and following further intervention they had made good progress throughout the rest of the course.
- Staff responded to patients who were experiencing pain quickly and effectively. We saw evidence of this during the activity we observed. The patient was provided with support and the task was adapted to respond their individual need.
- Patients were encouraged to link with other course participants while they were completing their rehabilitation. Patients had the opportunity to stay in RRU accommodation on site, which provided patients with the opportunity to socialise together during the course, during meal times, and in the evening.
- Patients were supported to manage their own health, care and wellbeing and to maximise their independence. Patients 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 short and long term treatment goals. These were reviewed midway and at the end of treatment at the RRU. Patients told us they understood their injury and how to manage this better following the educational elements of course.
- Patients received copies of their treatment plans. These consisted of printed pictures and a written description of the exercises and the repetitions required. This ensured patients had a comprehensive plan to follow and that the information was not overwhelming for them. Staff taking the group therapy and individual specific training reviewed each patient during the sessions. They asked patients how they were and whether they needed any support. If they noticed someone with a poor technique staff supported patients to improve this.

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.

- Services provided reflected the needs of the military population and occupational needs of their employment within the geographical area of responsibility. The RRU treated patients from all three military services. A generals course (a course that provided general rehabilitation for a range of injuries) was held at the RRU. The generals course was held and patients with a range of injuries including upper limb, lower limb and back injuries attended for a period of three weeks for rehabilitation. Within the area of responsibility, the population at risk did not generate the need for specific courses. If the RRU was unable to meet the needs of the patients through the generals course, patients were referred on to ensure they received appropriate treatment. For example, patients could be referred onto specialist services within the military such as the DMRC, an alternative RRU or NHS if this was in the best interests of the patient.
- 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.
- The unit took account of the needs of patients when planning individual treatment and the local service. The RRU covered a large geographical patch. A DMRC consultant visited the RRU every eight weeks to meet the needs of patients receiving treatment at the RRU. This enabled patients to receive a DMRC opinion locally, without having to travel further afield for this appointment. It also allowed staff to work together with the specialist to provide continuity of care for patients with more complex needs. A military trauma and orthopaedic consultant also visited the RRU to hold orthopaedic clinics every two to three months. Patients had access to a specialist orthopaedic opinion with specific military insight. This enabled a more timely approach to occupational medicine decision making regarding the future employability of patients.
- Service delivery took into account the needs of patients living in the north of the area of responsibility. Patients living in the north would need to travel four hours to attend a clinic appointment at the RRU. To reduce travel time for these patients, peripatetic MIAC and podiatry clinics were run in the north of the region, for example in Lossiemouth and Condor every six or eight weeks. During peripatetic visits, the podiatrist took the time to provide

training for staff at the PCRFs to develop their knowledge and skills treating patients with foot problems. These clinics made more effective use of resources such as cost and time. However, these additional clinics were popular and staff told us they became fully booked up quickly. Therefore, patients could not always get an appointment more locally.

- The facilities and premises were not owned by the RRU and therefore not purpose built to deliver the services provided. This posed challenges to delivering services. The building was tired and ageing. Staff told us any problems which arose or minor work requests were raised as early as possible to ensure they were managed in a timely way. The RRU had also put in a case to have a sink unit plumbed into the MIAC clinic room rather than having a standalone sink with bottles of clean and dirty water attached which had to be disposed of. This had been declined the first time, however a further case had been put forward by the service lead who was confident this may be passed this time. There was one gym area where equipment was stored around the outside of the area. This left little space for other activities. Staff told us when delivering certain elements of the course, such as group therapy, they had to split the class into two groups to ensure there was enough space to carry out activities. Staff were well aware of the challenges they faced with regards to the infrastructure of the building. 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. This risk had been highlighted on the risk register and steps had been taken to mitigate risks to the service. The unit had been marked for closure in 2022. There was an element of uncertainty at the unit, which was recognised by senior staff about the future of staff jobs when the unit closed. Senior staff told us they frequently attending meetings held about the barracks and their future, and kept staff informed.
- The pool facilities and premises were appropriate for the aqua therapy sessions delivered as part of the course. There was also an alternative for patients who were not suitable for this session due to their condition or due to fear of water. A member of staff would provide a session back at the gym for these patients. The session could also be adapted for non-swimmers. A staff member would get into the pool and conduct a one to one session in the shallow end of the pool.
- Where patient'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. We saw examples displayed on the wall of 'you said, we did,' identifying feedback from patients and how the RRU had acted to improve the delivery of the service. Patients who had returned for a second course said they had seen changes in the course content. This demonstrated staff had acted on feedback to improve the service provided.

Access to the service

The unit provided assessment and treatment services between 9am and 5pm from Monday to Friday

- Patients had 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 offered within 20 working days of referral. The service met and exceeded this target throughout 2017. Between 88% and 97% of patients had received an initial assessment at the MIAC clinic within 20 days. Data demonstrated RRU Edinburgh had performed better when compared to other RRU's 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. The RRU had met this target throughout 2017. Data demonstrated between 92% and 97% of patients were offered a course starting within 40 days of their MIAC appointment. The RRU had performed better than other RRU's with this performance indicator throughout 2017.
- Offering patient's access to a podiatrist within 20 working days of a referral was another performance target set by the DMS. The target for this was 85%. The RRU had met this target between April and June 2017 where 99% of patients saw a podiatrist within an allocated time period. This target was also met between October and December 2017 where 98% of patients were offered an appointment and saw a podiatrist within 20 working days of a referral. Data for July to September demonstrated the RRU was very slightly under the expected target with 83% of patients seeing the podiatrist within the target timeframe. We were unable to see any data for January to March 2017 due to this information being held on a file which was corrupt at the time of our inspection.
- MIAC services, RRU courses and podiatry appointments at RRU Edinburgh all performed better at the end of 2017 than the RRU target of 5% for short-notice cancellation rates (cancellations with notice of less than one working day). Performance improved throughout the year. The MIAC short notice cancellation rate at the RRU ranged between 2% and 6%, and remained at 4% between July and December 2017. This was consistently better than the RRU average which ranged between 7% and 13%.
- The RRU course short notice cancellation rate at RRU Edinburgh was an average of 4% between January and March 2017. From March 2017, short notice cancellation for the RRU course had remained at 0%. Data demonstrates performance at RRU Edinburgh was consistently better than the RRU average which ranged between 2% and 11%.
- The podiatry appointment short notice cancellation rate at RRU Edinburgh had greatly improved from 18% at the start of 2017 to 4% by the end of 2017. Data for the RRU average was not available for January to March 2017. However, data available demonstrated the RRU had performed better than the RRU average between March to December 2017. The RRU average ranges between 9% and 13% between March and December 2017.
- Clinics and courses were rarely cancelled due to them being planned in advance. This meant considerations as to holding the course and numbers attending needed to be carefully planned in likely periods of high staff absence and patient preference, for example during school holidays. If this was to occur, the numbers allocated to the course would be reduced from 30 to 15. Cancelling clinics and courses only occurred for MIAC clinics in the event of illness of the doctor. Staff looked internally for cover to be found for example, for physiotherapists carrying out MIAC clinics. Cover for any absent physiotherapist and ERI staff running courses course was also found within the team.
- 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 the service or clinical lead.

- 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 within five working days whilst routine referrals were seen within 20 days. Referrals were allocated according to clinical and/or military needs. Referrals would be classed as urgent 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.
- Administration staff were very aware of the large geographical patch covered by the RRU and where possible, tried to accommodate patient appointments around travel time. Staff worked hard to align appointments for patients. Administration staff told us if patients were attending more than one appointment at the RRU, they would try to ensure these appointments were booked for the same time. Staff told us they tried where possible to ensure patients travelling long distances travelled with someone else so they were not alone during the journey.
- There was a clear process for patients who did not attend appointments. For patients who did not attend, the appropriate professionals were informed at the RRU and the referring PCRf and this was recorded in the patient's records. A further appointment would then be made with the patient. If they did not attend this appointment, they would then be discharged from the RRU and referred back to the referring clinician at the PCRf. Administration staff told there was usually a very valid explanation from patients as to why they did not attend their appointment as attending rehabilitation was a mandatory requirement of their role.
- Patients had access to fast track diagnostic imaging for identifying and monitoring diseases or injuries, if required, at a local private hospital. However, access to appointments within the mainstream healthcare system in Scotland was more challenging. If patients required this they would be referred by the medical officer of the referring unit. This would often be accompanied with long waits for appointments and treatment. Therefore, patients would not be fully fit and able for duty for extended periods. The DMS did have a backup service which patients could attend where they were likely to be seen in a more timely way. This issue was on the risk register for the RRU with actions ongoing at the time of our inspection.
- Services were planned to take account of the needs of different patients. All reasonable efforts and adjustments were made to enable patients to receive their care or treatment. The unit was fully accessible for all patients. 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. All staff at the RRU had completed equality and diversity training.

Listening and learning from concerns and complaints

The unit had a system for handling concerns and complaints.

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

- Concerns and complaints were listened and responded to and used to improve the quality of care. There was a policy available to provide guidance for staff about complaints made about healthcare services provided by the defence (JSP 950 leaflet 1-2-10). This covered how the complaint was to be dealt with, including the stage of communication and investigation. The policy stated informal verbal complaint would be dealt with locally by the end of the next working day.
- Between March 2017 and March 2018, the service had received three complaints. However, these were not complaints about the RRU. Two of these were requests about how to make a complaint about another facility the patient had been referred to by the RRU and the other involved a member of staff supporting a patient to make a complaint to a secondary rehabilitation facility. Appropriate advice was provided in a timely way to support this request. The third was a verbal complaint about the lack of food available for a patient with specific dietary requirements. This was raised immediately with the catering department and resolved. As these issues were not complaints directly associated with care or treatment provided by the RRU, we were unable to monitor the service's response to managing complaints.
- Patients were clear how they could raise concerns and complaints. Patients were able to describe how they would provide feedback or make a complaint. None of the patients we spoke with said they had needed to raise any concerns.

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 clear vision and a mission statement set out for the service, with quality and safety the top priority. The mission statement for the RRU was 'to sustain and improve the training and operational effectiveness of injured service personnel by provision of high

quality targeted rehabilitation, accelerating their return to optimal physical capability, whilst influencing their psychological and social health.’ The vision and team ethos identified ‘a combined approach from the whole RRU team, supporting positive attitude, and striving always to improve quality with the consistent aim to progress service delivery for patients. Through fostering and valuing our team spirit, there will be trust in each other to deliver for the team and the patient. Respect for staff and patients, the maintenance of the highest professional standards and safe, caring delivery.’

- Staff understood the vision and understood the importance of continuously improving service quality and safety. It was clear from interaction we observed during the inspection and the nature of the working environments all staff were committed to working towards the vision. Staff gave us examples as to recent changes made to improve the quality of the service for the patients. Examples on how staff had acted on patient feedback was also on posters in the gym at the RRU.
- 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. The document provided a detailed account of how services ran, what services were included, care pathways, all treatment referral clinical guidelines and facilities.
- The strategy for all defence medical services detailed in the defence rehabilitation concept of operations document which had been developed centrally. Staff at the RRU told us how they had been engaged with developing the local service development plan in January 2018. This document identified how the local strategy and objectives for the RRU were to be delivered. This specific plan ensured the RRU was working in line with the central overarching DMS strategy. These objectives had been developed by the staff who had identified where improvements could be made with the service.
- Progress against delivering the strategy was monitored and reviewed by all staff at the RRU. There was a specific Service Development Plan for RRU Edinburgh which had been developed, and was reviewed by the whole RRU team at the monthly governance meetings. Areas for development included improving staff awareness of clinical governance and utilising the spectrum of training opportunities available. Each objective outlined specific tasks required to meet the objective, how this would be measured, included a named owner responsible for the objective and a timescale in which the objective and its tasks needed to be completed.

Governance arrangements

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

- There was an effective governance framework to ensure quality, performance and risk were understood and managed. There was an overarching ministry of defence (MOD) corporate governance policy (JSP 525). This covered the structure of MOD governance, governance principle, roles and responsibilities, governance control processes and risk management processes. The policy was not specific to the RRU but provided context and guidance about how MOD governance processes worked.
- There were clear governance arrangements providing good oversight of safety, quality and risk at the RRU. A practice development meeting was held monthly, which all staff at the RRU attended. This meeting had a rolling agenda. We saw meeting minutes from October

2017 to March 2018. Topics routinely discussed were safety, including infection, prevention and control and the risk register, clinical effectiveness, governance, patient focus and feedback from the overarching RRU governance meeting. Documentation of the meeting was comprehensive and included embedded links to further documentation to support conversations. 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

- Staff at the unit had a good understanding of performance, quality and safety. Real time data around performance, quality and safety were discussed monthly at the governance meeting. For example, actions from the service development plan were reviewed to identify areas where further work was required. Patient feedback information was also discussed to identify areas of good practice and areas which required improvement. From this, actions were developed and assigned to the most appropriate member of staff to implement. Staff reported they had good oversight of patient feedback, safety, quality, and activity at the RRU.
- A common assurance framework (e-CAF) assessment was a live document used to support the delivery of good quality care. The document was also reviewed as part of the rolling agenda for the monthly practice development meeting. An electronic version of the document had been introduced at the unit two months prior to our inspection. The framework was based on eight domains. These included safety, clinical and cost effectiveness, governance, patient experience, accessible and responsive care, care environment and amenities, public health, and occupational health. The last review using the CAF took place on 16 April 2018. The unit was compliant in six out of the eight domains and partially compliant for safety and care environment and amenities. The serials under the domains which required action to be taken had an associated action plan and a designated person overseeing implementation of the action. The e-CAF did not have the facility to apply a timeframe to the action to ensure they were completed in a timely manner. We saw evidence of an email written by the service lead where this had been fed back and escalated, along with other issues to identify areas for improvement to make the document more user friendly.
- There was an external review process looking at quality safety and performance carried out between the RRU's. This was a peer review process where service leads from other RRU's would review the e-CAF document and provide a rating for the service. From this an action plan was developed to enable the RRU to make improvements where required. The last assessment of this nature which occurred at the RRU was in October 2016. Of the eight domains, three were fully complaint and five were partially complaint. Recommendations were made and an action plan was developed to make improvements. All actions following this assessment had been completed. At the time of the inspection, there was no planned date for the RRU's next assessment, however, these were usually carried out every two years.
- The service was provided with a quarterly dashboard, which detailed performance information on a number of key performance indicators. This included referral numbers, time taken to offer an appointment, numbers of patients who failed to attend or cancelled appointments, waiting times, and clinical outcomes. Each indicator was shown next to the average performance across the other RRU's. This meant an overall comparison could be made to benchmark how well the unit was performing, however this was not a requirement. We reviewed dashboard data for four quarters, which gave comprehensive data for the service. Data demonstrated in a number of areas the RRU was performing better than other RRU's such as their waiting times for courses and appointments and for short notice cancellations.
- There was alignment between what staff raised as ongoing concerns and recorded risks. Staff identified the infrastructure of the unit was not the most appropriate for the service

being delivered. This risk was on the risk register and action had been taken to mitigate risks.

- There were systems and processes to identify, manage and mitigate risks associated with the unit. The unit maintained a risk register which identified 17 risks. Risks were rated and management plans and mitigating actions had been identified to manage the risk. A responsible person had also been designated to oversee and manage the risk. Top risks included, the infrastructure of the building, the lack of level three safeguarding trained member of staff at certain points in the week, staffing, including the use of locum staff, and secondary care including the use of fast track surgery for patients. A proactive approach was taken towards risk management and mitigation of identified risks.
- There was a systematic programme of clinical and internal audit used to monitor quality and identify areas for improvement. An audit log was maintained which identified which audits were to be completed, how often, when they needed to be reviewed and who was responsible for the audit. Audits had been completed for clinical records, infection control and other audit of treatment outcomes for specific conditions. For 2018, eight audits had been completed and a further five were due for completion.
- Staff were clear about their roles and understood what they were accountable for, including any additional roles and responsibilities they held. For example, all staff at the unit had secondary lead role in areas such as mandatory training and infection control, security and induction lead. A deputy was also associated with these roles providing further support and could deputise for the lead in time of absence. Additional training was provided for these roles where appropriate.
- There was an openness and transparency between all of the staff with regards to ongoing issues and concerns regarding the unit. Issues were regularly discussed and there was a proactive approach taken towards management and mitigation of identified risks and concerns. Staff spoke open and candidly about these issues, how they impeded on their day to day tasks and how they worked to overcome these. However, at times, there was a lack of clinical accountability from staff at the unit regarding ongoing patient care, when patients returned to the primary care rehabilitation facility (PCRF). We heard of examples where a verbal handover did not always take place for patients with complex problems, where care needed to be shared to progress the patient. We were given examples where the PCRF had been tasked to work on specific exercises with a patient prior to a review in the MIAC clinic after six weeks. When the patient had returned to the clinic, they reported they had had limited contact with the physiotherapist at the PCRF for their ongoing rehabilitation. Staff at the RRU were clear once the patient was back at the PCRF it was the responsibility of the PCRF to manage the patient in accordance with the advice provided by the RRU. Staff were also clear the RRU did not own the patients and on leaving the RRU they were not responsible for the patient. Further work was needed to address the ongoing challenges of communication and team working between staff at the RRU and PCRF to optimise shared care and treatment for more complex patients.

Leadership and culture

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

- Leadership and culture reflected the vision, values, encouraged openness, transparency and promoted good quality care. Staff spoke about how supportive the service and clinical leads were. They also told us, as a team how they worked to support each other to ensure the quality and standard of the service remained high for patients. Administration staff

provided us with an example of how staff from the unit had supported them by agreeing to cover in their absence. Although this was a rare occurrence, the administration team provided some basic training to staff about the priority tasks which needed to be completed in their absence. This ensured systems and processes were not disrupted and the unit continued to run seamlessly.

- Leaders had the skills, knowledge and experience to carry out their roles effectively. The service lead had skills knowledge and leadership skills from role held across their military career. The clinical lead had held a longstanding role in the military as a civilian and had also held previous clinical roles in other healthcare environment, including private practice. Staff felt well supported by the service and clinical lead. Staff provided examples of how they had been supported by the leads. For example, staff valued the opportunity to jointly review patient's midway through the course. This provided valuable learning opportunities for staff and benefitted patients ensuring care and treatment was optimised.
- There was a culture of strong team working between staff in the RRU however, internally, staff worked closely to ensure the best care and treatment was provided for patients. Staff supported each other on a daily basis and worked together to provide high quality care for patients.
- Staff felt respected, valued and leaders encouraged supportive relationships between staff. Staff felt they could raise any worries or concerns and that these were always listened to and acted on. The service and clinical lead would work alongside staff on the course to provide cover for an absent member of staff. Staff appreciated this and felt it made for good supportive team working. All staff told us they would step in to support sessions in times of staff shortage.
- The culture encouraged candour, openness and honesty. During the inspection, staff spoke candidly about the challenges they faced and how they overcame them. For example, staff running the course told us how it was difficult to accommodate all 30 patients on the course to do the same thing during treatment sessions in the gym. This was due to the infrastructure of the building and the fact it was not purpose built for the RRU requirements. In this instance, staff told us they split the group into two teams and carried out different treatment ensuring patients experienced both treatment sessions.
- Leaders were visible and approachable and staff were confident to speak up and raise concerns if required. The service had a military hierarchy of staff who delivered the services. Despite this, all staff felt confident and safe to speak openly about any concerns they had.
- Promoting the safety and wellbeing of staff was emphasised at the unit. Staff provided us with examples where the service lead had emphasised staff safety was a priority during times of extreme weather conditions. Staff also told us as a team, they looked after their wellbeing by training together using the facilities available at the RRU.

Seeking and acting on feedback from patients and staff

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

- Patient's views and experiences were gathered and acted on to shape and improve the services and culture. On completion of a course, all patients completed an end of course evaluation and attended a course debrief run by the ERI. The course debrief allowed patients to raise concerns or issues about aspects of the course could be discussed to identify areas for improvement for future courses. The course debrief was held by a member of staff not involved with delivery of the course. This provided a neutral platform for

patients to speak freely and raise concerns and issues. Feedback was used to adapt and change services were run and was discussed with staff at the monthly practice and development meeting.

- Feedback was collected and used to adapt and develop the way the course ran. Information presented on the noticeboard demonstrated actions which taken in relation to feedback provided by the patients about the course. Patients had fed back that the pain lecture was too late in the day, the unit responded by moving this lecture to earlier in the day. Patients also raised the issue of the functional training sessions being cramped with all course members trying to use equipment at the same time. Following this feedback, the course programme was amended to ensure only one group attended the session at a time.
- Staff were encouraged to give feedback and discuss any concerns or issues with colleagues and management. There was an open door policy and staff felt comfortable to raise any issues or concerns with the service lead. They felt they were always listened to and well supported.

Continuous improvement

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

- Staff were focused on continually improving the quality to care within the unit. There was a quality improvement plan for the service. This identified quality improvements being led by staff at the unit. These were reviewed as part of the practice development meeting. A member of the admin team, at the time of the inspection, was attending quality improvement training course. This member of staff was using these newly developed skills to look at a quality improvement project around the process of contacting patients to book appointments.
 - Staff shared learning to educate other members of staff at the RRU. Staff attending training courses shared their knowledge and learning with all staff at the RRU. Staff were required to hold local training sessions for other staff at the RRU following any training courses they attended to support with their link roles or other development courses.
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