

Defence Medical Services

Catterick Regional Rehabilitation Unit

Inspection Report

Catterick Leisure Centre,
Gough Road,
CATTERICK GARRISON,
DL9 3EL

Date of inspection visit 04 July 2018
Date of publication: 07 September 2018

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.

Ratings

Overall rating for this service	Good 
Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive to people's needs?	Good 
Are services well-led?	Requires improvement 

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

We carried out an announced comprehensive inspection at Catterick Regional Rehabilitation Unit (RRU) on 4 July 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. Overall, the RRU is rated as good. 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:

We found that this RRU 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.
- There was a system for reporting and recording significant events. However, we found an issue with a classification of a recent incident. We also identified examples where there was a lack of actions identified following an incident being reported.
- The RRU had clearly defined systems, processes and RRU's in place to minimise risks to patient safety. However not all staff always completed mandatory training in safety systems, processes and practices in a timely manner.
- There were procedures for assessing, monitoring and managing risks to patient and staff safety.
- The RRU had adequate arrangements to respond to emergencies and major incidents

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

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines and best practice guidelines for musculoskeletal conditions. However, the service did not always follow the defence medical services policy for access to the service.
- There was evidence of quality improvement including clinical audit however, the number of changes and vacancies in the staffing establishment, particularly affecting the leadership roles over the past few years. This had impacted on the team's ability to make sustainable progress with audit and quality reviews.
- Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the RRU's patient record system and their intranet system.
- Staff sought patients' consent to care and treatment in line with legislation and guidance.
- 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.

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

- Interactions we observed between staff and patients were friendly and caring. Staff were helpful and courteous and treated patients with respect.
- Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff 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 communicated with patients in a way that they would understand their care and treatment. Staff generally 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.

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

- The RRU uses information about the needs of the Population at Risk (PAR) within the Area of Responsibility (AOR) to inform how services are planned and delivered. We found they had a plan, which enabled them to meet the needs of the PAR, particularly those with complex needs, long-term or career-limiting conditions.
- The RRU provided assessment and treatment services between 9am and 5pm from Monday to Friday.
- The RRU had a system for handling concerns and complaints.
- There was a designated responsible person who handled all complaints in the RRU. The complaints policy and procedures were in line with recognised guidance and DMS processes.

We found that this RRU was not well-led in accordance with CQC's inspection framework.

- The service had a clear vision to deliver high quality care and promote good outcomes for patients. However, the service did not have a service strategy and we were not assured the service's mission statement was embedded.
- The service had an overarching governance framework, which supported the delivery of the strategy and good quality care. While there was a system and a process to identify risks associated with the RRU, we were not assured all potential risks had been identified or all staff were fully aware or involved in managing and mitigating the risks.
- 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.

- The service encouraged and valued feedback from patients and staff. It proactively sought feedback.
- There was a focus on continuous learning and improvement at all levels within the service.

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

- Despite the changes and vacancies in the staffing establishment particularly affecting the leadership roles, the team had worked hard to maintain an effective and efficient service for the patients.
- We saw some very positive examples of patients being involved in their care, particularly in the MIAC clinics. Staff took time to ensure patients had a good understanding of their condition using diagrams, MRI images and anatomical models.
- We received positive feedback from patients about their experience of the MIAC clinics and RRU courses.

Recommendations for improvement

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

- Ensure all staff are aware of a classification of incidents and actions identified following an incident being reported are shared and actioned.
- Audit and quality reviews should be embedded to ensure that the best outcomes possible are achieved for patients.
- Ensure all risk assessments are completed.
- Ensure there are processes in place to ensure all consumable items are checked and in date.
- Ensure a review is carried out of the risks associated with free/unsupervised access to one of the swimming pools, and mitigating actions are put in place.

Professor Ted Baker
Chief Inspector of Hospitals

Regional Rehabilitation Unit - Catterick

Detailed findings

Why we carried out this inspection

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

Background to the service

Regional Rehabilitation Unit (RRU) Catterick 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 Catterick Garrison, North Yorkshire and provides clinical management of moderate musculoskeletal conditions to the military population within a defined geographical area. There are 15 RRUs across the United Kingdom. RRU Catterick serves a population at risk (PAR) of approximately 20,000 personnel between the ages of 17 to 55 (or older if on extended contract) and also accepts out of area placements. The PAR is reported to be expected to increase over the next 10 years. The RRU reports its current stakeholders as follows:

- Patients
- All medical facilities (MF)s within the region
- All primary care rehabilitation facilities (PCRF)s within the region
- Other RRUs
- Eligible FR2020 reservists
- Spire and South Tees Hospital NHS Foundation Trust
- Catterick Leisure Centre – Nuffield Health
- Overseas – British Army Training Unit Kenya (BATUK) and British Army Training Unit Suffield (BATUS)
- Service personnel MEDEVAC'd from operational tours whose parent unit or home location is within catchment area. (MEDEVAC'd or Medical evacuation is the timely and efficient movement and enroute care provided by medical personnel to wounded being evacuated from a battlefield, to injured patients being evacuated from the scene of an accident to receiving medical facilities.)

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

The RRU provides co-ordinated clinical management to a tri-service population (Population of The Royal Air Force, The Army and The Royal Navy) within the defined geographical region. The clinical services include:

Multi-disciplinary Injury Assessment Clinic (MIAC)

Clinical assessment at the RRU is delivered through the MIAC. This is a combined clinical assessment by a specialist GP trained in Sports and Exercise Medicine (SEM) to diploma level, a physiotherapist (clinical specialist) and an exercise rehabilitation instructor (ERI). The GP should ideally be an experienced military officer. The MIAC is a critical element of clinical assessment and planning in the defence medical rehabilitation programme (DMRP). The MIAC will identify patient requirements and allocate appropriate early treatment based on clinical need, operational issues and individual circumstances. The role of the MIAC is to determine:

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

All patients being referred to the RRU for the first time should be seen in a MIAC. This is to ensure that there is an appropriate clinical plan for the patient and that the patient's case is being actively managed with interaction with relevant agencies.

Injury Assessment Clinic (IAC)

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

Onward Referral

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

- DMRC Headley Court
- Fast Track orthopaedic surgery
- Other secondary care and opinion such as orthopaedic opinion, pain management, etc.

Clinical Investigations

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

Residential Therapy

This is for patients whose condition necessitates a period of intensive daily rehabilitation (such as post orthopaedic surgery), whose condition may be exacerbated by travel or who cannot effectively perform their role or find protected time whilst in full time employment. Patients may be admitted for 3 weeks for rehabilitation of specific conditions (e.g. back pain) or into general groups with a range of differing injuries.

Regional Podiatry Service (RPS)

The aim of the RPS is to provide a clinical biomechanical podiatry service to all entitled service personnel within the RRU catchment area. Most of patients with biomechanical problems are managed effectively within Primary Healthcare (PHC) at the PCRFS. Where this management is unsuccessful or a Podiatrist/Biomechanical specialist opinion is required, the RPS will provide a highly skilled and specialist lower limb biomechanical assessment and treatment, together with the provision of both off-the-shelf and custom-made orthotics from an MOD approved supplier as

required. The RPS is commanded by and accommodated at the RRU. It consists of one full time Band 7 podiatrist (biomechanical) who will deliver clinics at the RRU.

The service was based in a privately managed leisure centre, facilities included a 25-metre swimming pool, a 16-metre swimming pool, a sports hall and a Cardiovascular (CV) / weights room.

The service lead (OC) and Regional Trade Specialist Advisor (RTSA) provide a regional SME and professional POC, conducting liaison visits with the satellite physio departments within region, providing support and guidance on HG or military processes, specific equipment care processes. The RTSA also provides ERI mentoring in the region to all civilian, military and locum ERIs. All new joiners in the region are invited to attend a day at RRU to meet personalities, be provided training on DMICP, shadow course and MIAC in order to ensure joined up care between PCRF and RRU.

Access to the service is through referral from other services in the DMRP and patients receive an initial joint assessment by a doctor (a specialist GP trained in sports and exercise medicine) and a clinical specialist physiotherapist, in the Multidisciplinary Injury Assessment Clinic (MIAC) located at the RRU. Patients can access one to one treatment and rehabilitation courses to treat their conditions. Courses 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, locum doctors, regional trade specialist advisor (RTSA)/lead exercise rehabilitation instructor, (ERI) ERIs, a podiatrist and administrators.

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

Our inspection team

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

How we carried out this inspection

Before visiting, we reviewed a range of information about the RRU. We carried out an announced inspection on 4 July 2018. During the inspection, we:

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

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

Reviewed patient notes, complaints and incident information.

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

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

- Is it well-led?

What people who use the RRU say

Patient survey results were collected and reviewed following each course. Results from February 2018 to April 2018 showed the RRU was performing in line with other RRUs. There were 84 respondents, but not every respondent provided a response to every question. 96% of patients said they would recommend this facility to family and friends.

- 95% of patients felt people listened to their comments, compliments and complaints.
- 88% of patients said they felt involved in decisions regarding their care.

As part of our inspection, we also spoke with 19 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.

Good



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. However, we found an issue with a classification of a recent incident. We also identified examples where there was a lack of actions identified following an incident being reported

- Systems were 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. All incidents were reviewed, investigated and closed by the service lead. They would also escalate incidents if this was required.
- The service lead (OC) had access to and maintained a spreadsheet of incidents that had been reviewed and managed by them. 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. The current OC did not have ready access to RRU incident log prior to their time managing the service. As the incident log shown was linked to the individual rather than the service we were not assured themes for the RRU as a whole, would have been identified. Without this information, it would be difficult to ensure oversight of all historic incidents and that appropriate action had been taken to minimise further occurrences.
- We saw there were systems in place for incident reporting. However, we were not assured all incidents were always correctly categorised. We also identified examples where there was a lack of actions identified following an incident being reported. Five incidents had been reported by staff between June 2017 and May 2018. We looked all five incidents, all had been reviewed and investigated. All were graded as 'no harm' with three of the five closed, as of June 2018. Three of the five incidents identified problems with referral process. One incident highlighted the excessive temperatures due to the broken air conditioning RRU. The final incident we reviewed, was the reporting of an acupuncture needle being missed and as a result, left in situ post treatment. The patient complained of "uncomfortable pain" and was taken out of their next treatment session. Once the needle was removed, they returned to complete the session. This incident had been classified as 'no harm'. It had been identified via the investigation that a needle had been missed in the counting in and out process. There were no actions recorded on the ASER system however we were informed, as a result of the incident, the clinician had provided a learning exercise to other senior members of the RRU team, raising awareness of methods to minimise the risk of missing a needle. In addition,

they had planned to undertake an in-service training session at the next regional meeting. We did not see any formal documented guidance to reflect the changes to practice. We did not see a review of the counting in, counting out process. Without this, there was a risk of a future potentially harmful occurrence.

- 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 the incident we reviewed where this needed to be applied, it was not clear if the principles of duty of candour had been followed.

Overview of safety systems and processes

The RRU had clearly defined systems, processes and RRUs in place to minimise risks to patient safety. However not all staff always completed mandatory training in safety systems, processes and practices in a timely manner.

- Essential systems, processes and practices were available to ensure patient safety. However, not all staff completed mandatory training in safety systems, processes and practices in a timely manner.
- Training compliance was set at 100% for the RRUs. Training included infection control, equality and diversity and healthcare governance awareness. Information about training compliance provided by the service in February 2018 showed seven of the 29 courses had been carried out by all eligible staff. Training compliance for all staff at the RRU was 100% in the topics:
 - Safeguarding Children & Young People Level 1
 - Safeguarding Children & Young People Level 2
 - Caldicott Level 1
 - IPC Passport Parts 1&2
 - Healthcare Governance Awareness
 - Military appraisal writing for civilian reporting officers
 - Unconscious bias

Four modules had a completion rate of less than 50%, these were:

- Fire safety awareness,
- Security general threat brief,
- Health and safety awareness for line managers,
- Managing civilian staff.

Compliance with other mandatory subjects was reported as:

- Equality & Diversity 92%
- Basic Life Support 92%
- DII User Stage 1- Basics 92%
- DII User Stage 2 - Moss Team Site User 92%
- Well-Being, Resilience & Stress 92%
- Defence Information Passport 92%
- DSE 92%
- Manual Handling 92%
- Health & Safety Awareness (All Non-Managers) 89%
- AED 83%
- Anaphylaxis 83%
- Business Continuity 83%
- Office Safety 83%
- Caldicott Level 2 78%

- Work Place Induction (WIP)75%
- Data Protection Overview 75%
- Environmental Awareness75%
- DMICP 67%
- Training compliance had improved at the time of inspection. The majority of staff had completed their necessary training. Staff who had training outstanding had a plan in place to achieve compliance.
- 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 week-long administration 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. Eligible staff completed safeguarding children level 1 and 2. There was 100% compliance with this training.
- The safeguarding lead role for the RRU was aligned with the OC position. The OC had completed safeguarding level 3
- Staff demonstrated they understood their responsibilities and adhered to safeguarding policies and procedures. However, there had been no safeguarding incident recently reported at the RRU.
- All staff should have had Disclosure and Barring Service (DBS) checked and their professional registration and expiry date reviewed. This was to ensure all staff at the RRU were safe and fit to practice at the RRU. Information provided prior to the inspection showed, one of the twelve eligible staff has no data relating to DBS clearance. However, during inspection we were shown evidence this issue had been addressed. This risk had been recorded on the risk register and mitigation actions had taken place until the DBS had been received. This meant we were assured systems, processes and practices related to DBS checks kept patients safe.
- Prior to the inspection we were provided with information that eight of the twelve eligible staff had no data relating to security vetting clearance. While on inspection we were shown evidence, this issue had been addressed. However, this issue had not been placed on the risk register, therefore no mitigating actions had been identified or documented.
- 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.
- Staff were clear on the frequency in which equipment needed to be reviewed and serviced. A policy was available providing information about equipment care and staff knew where to find this. 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. This ensured all appropriate checks had been carried out.
- An equipment inventory log was maintained by RRU staff. 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 also readily available. Records confirmed checks on the equipment took place each day the clinic was open.
- A resuscitation equipment was available in the swimming pool. It was located within the sports complex, in a central point to all three swimming pools. It was the responsibility of the lifeguards to get that in the case of an emergency. During pool sessions, staff ensured the AED was available and easily accessible if required at the poolside.
- Staffing levels and competency were appropriate at the swimming pool during treatment sessions to protect both patients and staff. There were two qualified lifeguards on duty at the swimming pool when treatment sessions were carried out. The lifeguards on duty would manage emergency incidents, supported by the RRU staff. Lifeguards were managed by the company that managed the leisure centre and not the RRU or MOD.
- 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 by leisure centre staff, four times a day to maintain the correct chlorine levels and pH balance. This ensured the pool was safe for use. The swimming pool was managed by the company managing the leisure centre not 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 duty manager would make RRU staff aware in advance of any sessions being carried out.
- We were told regular informal meeting were held between the leisure centre staff and RRU staff to ensure good communication. However, as these meetings were not minuted we were unable to evaluate their effectiveness.
- 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.
- During the inspection, we raised a health and safety issue with the OC and the leisure centre duty manager. We identified a door that led to poolside was not secured. Therefore, when the pool was not in use, no one was in attendance poolside. There were family changing rooms in that area, and we had also observed primary school classes in that corridor. There was a risk an unsupervised child could gain access to the pool area, with potential for very serious consequence. While a private facilities management company managed the centre, the premises was owned by MOD, and was in our view, a health and safety risk. Following inspection this issue was raised with the focal POC within the DMS. Since inspection, we have been provided with evidence demonstrating how the private provider had taken action to reduce the chances of this re-occurring.
- 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 safely and appropriately when not in use.
- We reviewed consumable items held in the clinic rooms. These included disposable cleaning cloths, syringes, dressings, saline and bandages. Most of the consumable items checked were all in date. However, we found two items out of date, one pack of acupuncture needles and a bottle of liquid plaster remover. These were brought to the attention of staff at the time of inspection and removed.
- The RRU maintained a record as to when items had been opened. This meant they were generally 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 RRU 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 daily Monday to Friday.
- There was a local lead and deputy for infection prevention and control. This role was held by the physiotherapist at the RRU 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 RRU 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 clinical location to access records and view the information required to treat the patient.
- Patient records were organised, up to date and shared and stored appropriately. We reviewed 13 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 PCRF and addressed.
- We did not see evidence of the patients' perspective or expectations in the notes we reviewed. However, we did see evidence that a clear diagnosis and impression of condition had been explained to all patients in all sets of notes we reviewed.
- A records audit had been completed on the patient records for MIAC new patient consultations between October 2018 and December 2017. The audit had looked at 46 sets of records with compliance being measured against six areas. These included mandatory compliance, subjective assessment, objective examination, analysis, treatment planning and documentation. The RRU achieved 93% compliance across the six areas against a target of 100%. The audit had shown an overall improvement in MIAC recording. Results identified areas for improvement, these included master template not being used, mandated FAA not being used, consent, past medical history, allergies, employment, evidence of shared decision making and patients beliefs and expectation being recorded. The results were collated and disseminated to all staff including individualised results. In the event of results demonstrating less than 85% compliance a further audit in three months after training/mentoring. An action plan was devised following the audit this was shared with all staff at the staff meeting and at the MIAC reflective practice meeting.

- We did not see any evidence of audits of the records for the patients attending the courses. This meant the quality of the record keeping for any staff who did not write in the patient records for MIAC new patient consultations were not audited.
- Arrangements for recording and storing medicines minimised risks to patient safety. Only a small amount of medicine was held at the RRU. Staff we spoke with 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 June 2017 and May 2018 there had been no medicines incidents reported.
- 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 on the days the service was open. It had been noted the room temperature exceeded 25 degrees in June. The lead physiotherapist had contacted the regional pharmacist who had assured the medicines would not be compromised if kept below 30 degrees but would have a shorter shelf life. The medicine would then be disposed of by the pharmacy team in September to ensure patient safety.
- There was a system to enable to ensure medicines used on patients could be tracked to ensure patient safety. The RRU maintained an audit log of medicines, linking these to patients which they had been used to treat. Information about medicines used on patients was also recorded in the patient's notes. The pharmacy also maintained records of medicines ordered for patients.

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 did not meet planned staffing levels. At the time of inspection, Catterick had the following vacancies:
 - MIAC doctor – post filled by 3 locum staff
 - 2IC – gapped on last postings board (post not currently covered, next board July 2018)
 Staff employed at the RRU included:
 - three physiotherapists, one of whom was a locum,
 - one podiatrist, three exercise rehabilitation instructors (ERI),
 - three locum MIAC doctors,
 - four administrators, two were contractors, employed by a facilities management company and two were civil service employees,
 - one military major also a physiotherapist,
 - one regional trade specialist advisor (RTSA), who had had started at the service on the week of the inspection.
- The major, a physiotherapist, and RTSA, an exercise rehabilitation instructor (ERI), both worked clinically and would cover staff absences in the department by carrying out assessments and running groups. All staff told us all staff would step in to support sessions in times of staff shortage.

- 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.
- Locum staffing had been identified as a risk on the risk register. As two 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 RRU could provide cover for the physiotherapy staff but not the MIAC doctor role. If the physiotherapy role post or any of the MIAC doctors' posts were left vacant for longer than two or three weeks this would impact on service delivery at the RRU. Action had been taken to mitigate risks which were ongoing. For example, there was ongoing work to review the staff eligible to fill this post. Through the MIAC working group.
- 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 informed us the evacuation process for the pool was led and managed by the lifeguards on duty if this event was to occur. RRU staff would provide support to the lifeguard staff.
- Fire drills were carried out at the RRU. The regional trade specialist advisor (RTSA) was responsible for arranging annual fire drills 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 was responsible for carrying out a weekly fire checks at the RRU.

Arrangements to deal with emergencies and major incidents

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

- Potential risks for the service were anticipated and planned for, in advance. The RRU had a business continuity 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 leisure centre provider also had an emergency action plan. This was to ensure emergency situations were dealt with in a manner which minimised the risk to customers and staff. It identified action in the event of various emergency situations. These documents were included and discussed as part of the induction process for new members of staff.
- Staff received annual basic life support training and there were emergency medicines available in the RRU. Emergency medicines were easily accessible to staff in a secure area of the RRU and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The RRU had a defibrillator available on the premises and oxygen with adult masks. A first aid kit and accident book were also available. Checks carried out on the first aid kits and AED identified equipment was in date.
- There was access to buoy's (floating device) and throw bags at various points around the pool to help anyone who may be in distress or require assistance. There was also access to evacuation boards to recover people from the pool who had a suspected spinal injury.

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

Good



Our findings

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

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines and best practice guidelines for musculoskeletal conditions. However, the service did not always follow the defence medical services policy for access to the service.

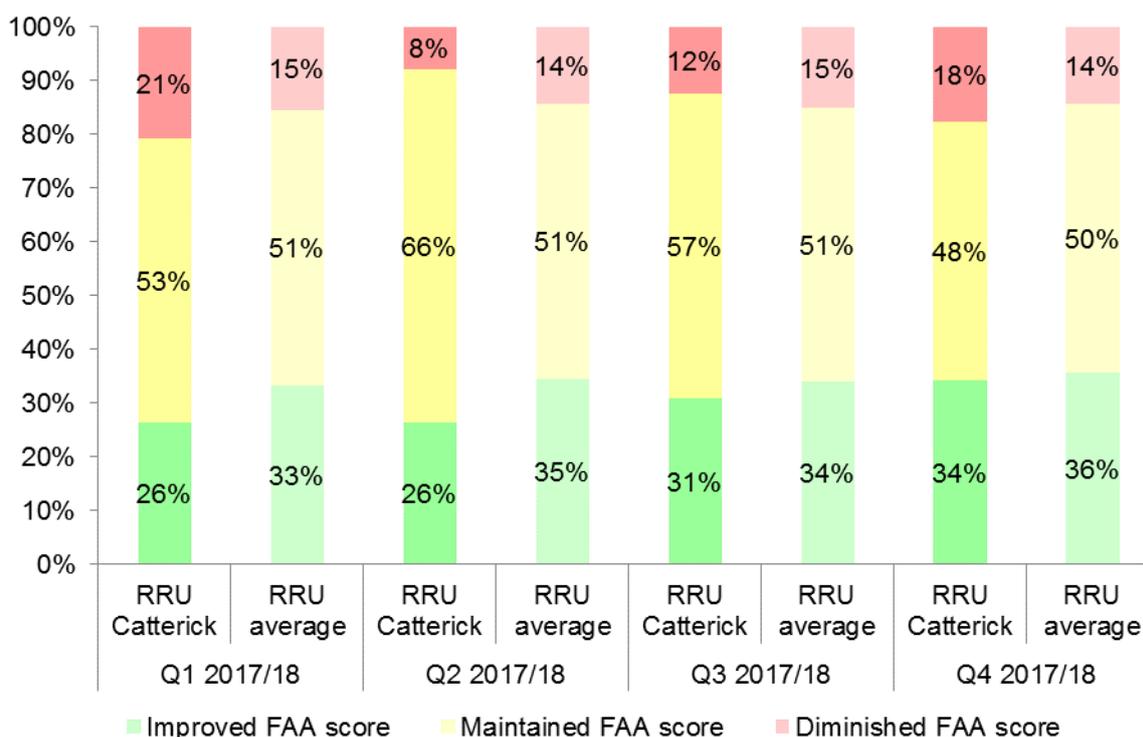
- Patient's needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance.
- We were told, not all patients received a multi-disciplinary injury assessment clinic (MIAC) before being allocated a course. The defence medical services policy stated, *all patients being referred to the RRU for the first time should be seen in a MIAC*. Without this, there was risk the patient would not receive *an appropriate clinical plan and that the patient's case was not being actively managed with interaction with relevant agencies*. Spine and hip and groin patients were always seen in MIAC. Most of the lower limb referrals were referred on to a course without a MIAC. We were told this was because lower limb patients were generally straight forward, the referrals from the PCRFS were clear of any ambiguity and identified the patients' needs for example they had been unable to regularly attend the PCRFS due to work or personal reasons and they required a consistent approach. The OC triaged from the electronic referral and a review of the DMICP record before completing a paper triage form that was handed to the RRU administration team. Patients were offered a place on the course they were not specifically told that they were bypassing a part of the process. The patient was given a full assessment with an ERI and physio as part of the course process, any issues picked up at this assessment would result in a referral to a MIAC. The team at the RRU were aware that this was not following policy, but due to the numbers of referrals received, without making this change the waiting times would be impacted for patients. There would be an increase in waiting times as there were not sufficient clinic appointments to meet the current need. The service did not collect information on the numbers of patients who attended a course without attending a MIAC first. However, we did not see any evidence of any negative effects of this process during inspection.
- 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, management of:
 - lower limb tendinopathy,
 - exertional lower limb,
 - foot and ankle pain,
 - shockwave therapy,
 - Guidance for post-operative surgery at South Tees hospitals, produced by South Tees Hospital.

The documents 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. All documents reviewed, were in date, with evidence they were frequently reviewed and contained references to the guidelines and evidence which had been used to develop the documents.

- Rehabilitation courses were delivered in line with evidence based practice guidance on treating musculoskeletal conditions and provided a holistic approach to rehabilitation. The included exercise rehabilitation, education sessions, psychological wellbeing sessions such as relaxation, and individual treatment sessions.
- The individual education sessions were based on courses that had been written centrally, they covered a range of information to accommodate for different levels of baseline knowledge and understanding between the patients. Education sessions were reviewed frequently, using patient feedback, to ensure the content was user friendly and pitched at an appropriate level for the variety of patients that attended.
- Patients' needs were assessed. Their care goals were identified and their care was planned and delivered in line with evidence-based guidance, standards and best practice. This was monitored to ensure compliance. Patients were assessed at the start, during treatment and at the end of treatment using evidence based measures. Validated patient reported outcome measures (PROMS) were used to assess the patient at the start and the end of their treatment. This meant the patient's response to treatment and it's the effectiveness could be evidenced.

Changes in functional activity assessment (FAA) score between initial contact and discharge contact were collected from DMICP. This included outcome scores for all discharges (care pathway complete and care pathway continuing). Over the four quarters of 2017/18 RRU Catterick had increased it's percentage of improved FAA score from 26% in quarter 1 to 34% in quarter 4 although this has consistently been lower than the RRU average. The annual score for diminished FAA score was the same as the RRU average with the RRU having a higher percentage of patients with maintained FAA scores.



- Outcome measures included for patients attending for treatment of:
 - lower limbs: functional activity assessment (FAA), Tampa-Scale of Kinesiophobia (TSK), quadruple Visual Analogue Scale (VAS), Lower Extremity Functional Scale (LEFS), Patient-Specific Functional Scale (PSFS), % change Patient global impression of change (PGIC)
 - spines: % change PGIC, FAA, TSK, Quadruple VAS, Oswestry Disability Index (ODI), Start Back (for subgrouping for targeted treatment systems for low back pain patients), PSFS
 - upper limb: FAA, The Disabilities of the Arm, Shoulder and Hand (DASH) questionnaire, Oxford Shoulder Instability Score (OSIS), Neck Disability Index (NDI), TSK, % change PGIC, VAS
 - hip and Groin: FAA, NAHS Non-arthritis Hip Score (NAHS), The Copenhagen hip and groin outcome scores (HAGOS), % change PGIC, VAS Extracorporeal Shockwave Therapy treatment (ESWT): VISA A, (to evaluate the clinical severity for patients with chronic Achilles tendinopathy) VISA P, (Responsiveness of the VISA-P scale for patellar tendinopathy in athletes) Foot Function Index (FFI), Oxford shoulder, Oxford Elbow, NAHS, VAS
 - The MIAC clinic used: VISA A, VISA P, Oxford Shoulder, Oxford Elbow, NAHS, HAGOS, FFI, VAS, Quick DASH, TSK, Kujala, (Anterior Knee Pain Scale) KOOS (Knee Injury and Osteoarthritis Outcome Score), UK musculoskeletal health questionnaire – (MSK) MSK –UK(military), Exercise-induced leg pain (EILP) Questionnaire
- 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.

Management, monitoring and improving outcomes for people

There was evidence of quality improvement including clinical audit, however, the number of changes and vacancies in the staffing establishment, particularly affecting the

leadership roles over the past few years. This had impacted on the team's ability to make sustainable progress with audit and quality reviews.

- Validated patient reported outcome measures (PROM) were being used with all patients attending courses. Outcome measures were used to assess patients at the start and the end of treatment, to review their response to treatment. Outcome measures implemented by the referring PCRf were continued at the RRU. Use of outcome measure implemented by the PCRf meant it would be possible to identify progression over the whole rehabilitation process.
- Staff worked with patients to identify short and long-term treatment goals. The patient and staff reviewed their goals midway through the course and at the end ensuring they had achieved their goals and their longer-term goals were still realistic and achievable. This provided the opportunity for treatment programmes to be reviewed, to progress patients further and add additional exercise to optimise treatment.
- There was a programme of clinical and internal audit, which was when completed would be used to monitor quality and systems to identify where action should be taken. Audits included both clinical and operational audits. Each audit had a named member of staff to lead, a defined objective, and information on how often it should be repeated. Audits completed on an ongoing basis were:
 - MIAC Satisfaction Questionnaires
 - medicines management stock audit
 - Course patient satisfaction Questionnaires.

Other audits were timetabled to be completed throughout the year at various time scales.

These included:

- DMICP MIAC Notes Audit
 - Plantar fasciitis pathway mx/outcomes
 - IAC MRI request/results SE
 - IPC Unit Evaluation - Annual audit
 - DPHC Medicines Management Risk Audit
 - Waste Pre-acceptance Audit
 - DPHC IPC Audit Tool 6.1: Waste Management
 - Podiatry - evaluation of patient questionnaires
 - IPC DPHC quarterly
 - IPC DPHC Hand hygiene audit/kitchen audit
 - DMICP injection therapy notes entry audit
 - Audit DASH outcomes: UL course, evaluation of usefulness as questionnaire
 - MIAC Viscosupplementation Injection review
 - Audit: Y balance as a useful outcome measure in rehab courses
 - Audit: Does a 3/52 rehab course change Start Back scores: use as a relevant PROM
 - Audit: Continuation of rehab input after referral to RRU course
 - SE: % podiatry input for LL problems vs foot pathologies
 - Audit: Podiatry PSQ
- For 2018, 77 audits had been timetabled, 29 audits had been completed. A high number of changes and vacancies in the staffing establishment, particularly affecting the leadership roles over the past few years had impacted on the team's ability to make sustainable progress with audit and quality reviews.

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 use of yoga techniques in rehabilitation, standardising PROMs across PCRFS and RRU. 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 particularly from the learning from the yoga course. 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 they needed to develop to ensure high quality care and treatment was provided for patients. Staff spoke positively about the learning gained from the peer review process.
- Staff were supported to deliver effective care and treatment through opportunities to undertake training, learning and development. One Band seven physio therapist was involved with national clinical specialty planning (Hip and Groin Working Group) and course 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 physiotherapist had funded and attended an external course 'my athletic shoulder'. Learning from this had benefitted the clinician professionally and the patients attending the service.
- 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.
- Locum staff were included in all learning and development opportunities available to permanent staff. They were involved with local and regional in-service training and had the opportunity to take their turn to lead training sessions following attendance at any courses. This meant all staff at the RRU benefitted from the shared learning. Although locum staff did not have access to MOD courses, the service lead supported any requests for external training, for example courses provided via their agency, if they felt would benefit patients attending the RRU.
- 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 RRU 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 RRU.

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 RRU's patient record system and their intranet system.

- RRU staff worked together to deliver effective care and treatment. All clinical 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 ensured quality of care for the patient. Staff had worked hard to overcome any 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 very positive. A number of the RRU staff had worked at the local PCRFs within their area of responsibility this meant they had good working relationships and effective lines of communication.
- 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. Staff would follow up these electronic handovers with a phone call if the patient had complex needs or required specific treatment management.
- Staff had all 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 had access to the rehabilitation notes, physiotherapists had access to rehabilitation notes and MIAC clinic notes. The doctor had full access to patient's medical records.
- 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 staff gaining verbal consent from the patients before commencing assessments or treatments. 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 to take ownership of their rehabilitation from the start. Staff promoted self-management from an early stage in the course and throughout. 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.
- Patient goals were specific to each individual 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 generally focused on work-based activities to make sure patients could return to their normal work and life after their rehabilitation.

Good



Are services caring?

Our findings

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

Kindness, dignity, respect and compassion

Interactions we observed between staff and patients were friendly and caring. Staff were helpful and courteous and treated patients with respect.

- Patients were treated with compassion, staff discussed treatments with patients and were able to adapt individual treatments in response to patient feedback. Staff were supportive in their approach to patients, they motivated patients to fully participate in activities to their own ability.
- Patient's personal, cultural, social and religious needs were understood and respected. Individual needs of patients and the occupational needs of their employment were considered when devising treatment plans.
- MIAC and podiatry clinics were carried out in a consultation rooms, conversations taking place in these rooms could not be overheard. However, other treatments such as individual physiotherapy were carried out in curtained cubical spaces or in the shared gym area. Staff were aware of the privacy and confidentiality for patients could be compromised when they were treated in these areas. Staff always checked with patients if they were happy to commence treatment and conversations in these areas. Treatment could be scheduled to enable access to areas that were more private if necessary.
- A defence medical services patient questionnaire was used to anonymously gather views and experiences from patients following their treatment and gather patient feedback after completion of the RRU courses. Respondents were also asked whether they were concerned that other people could overhear the discussion during their pre-admission assessment to which 47% responded 'yes, but I don't mind', 11% responded 'I don't know' and 42% responded 'no, other people can't overhear'. Patients we spoke with did not have any concerns about their privacy or confidentiality.
- Results from the RRU patient survey showed patients felt they were treated with compassion, dignity and respect. Between February 2018 to April 2018, 84 patients who attended a course at RRU Catterick responded to a feedback questionnaire post course. Results were positive with 98% patients stating they would describe their experience of their visit as 'good' or 'very good'. Results also demonstrated how patients felt included in decision making (88%) about their care and treatment and listened to by the staff. All responders said they had received a good quality of service of clinical care.
- We spoke with 19 patients during our visit. They told us they were satisfied with the care provided by the RRU so far and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided

support when required. Patients said the session attended provided was a good education session with a practical element.

- The service had received nine written compliments between August 2017 and 27 June 2018.

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.

- We saw very positive examples of patients being involved in their care, particularly in the MIAC clinics. Staff took time to ensure patients had a good understanding of their condition using diagrams, MRI images and anatomical models.
- Patients told us, they had received very useful information, a clear diagnosis and an appropriate treatment plan during the MIAC clinics.
- Patients were involved in decision making about the care and treatment they received. Care plans were personalised. Patients were listened to and supported by staff. Staff and patients had sufficient time during initial assessment and during ongoing consultations to make an informed decision about the choice of treatment available to them.
- Patients were provided with advice and signposting to further information and were encouraged to ask questions about their care and treatment throughout their time in the service.
- Patients described staff at the RRU as being “really thorough” and “very professional” Patients said they liked the way the courses were run.

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 generally 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.

- We observed staff responding when patients experienced physical pain, discomfort or emotional distress in a compassionate, timely and appropriate way.
- 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 were supported to identify their own treatment goals and these were reviewed periodically throughout their treatment working with the staff. Patients received copies of their treatment plans.
- Patients we spoke with said they felt staff acknowledged their emotional needs. Staff understood the impact a patient’s care, treatment or condition had on their wellbeing and on their relatives, both emotionally and socially.
- Staff could refer patients on to services, which provided counselling, advice and support to assist them in coming to terms with their condition and circumstances, if necessary. However, patients were encouraged to use their own emotional support systems

including friends and family and also work based support such as staff in their own RRU who could provide this support.

- People were encouraged to link with other course participants while they were completing their rehabilitation. Patients had the opportunity to stay in RRU accommodation within the garrison, which enabled patients the opportunity to socialise together during the course and also during meal times, and in the evening. However, most course participants lived locally and travelled to the course on a daily basis from home. Patients told us they were given plenty of opportunities and encouraged to support each other during the course day.
- Patient information leaflets and notices were available through the RRU, which signposted patients to access a number of support groups and organisations.

Are services responsive to people's needs?

Good



Our findings

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

Responding to and meeting patients' needs

The RRU 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. The service provided a number of services:
Multi injury assessment clinics (MIAC) which offered:
 - Sport and exercise medicine (SEM) specialist assessment and diagnosis,
 - access to fast track imaging and surgery, at a local independent hospital.
 - diagnostic ultrasound
 - injection therapyInjury assessment clinics (IAC) were run by the OC and band 7 (specialist) physio therapist. This clinic offered:
 - access to fast track magnetic resonance imaging (MRI) and ultrasound scanning.
 - extracorporeal shockwave therapy (ESWT)A regional podiatry service, which provided service to:
 - prevent, diagnose, treat and rehabilitate abnormal conditions of the feet and lower limbs.
 - prevent and correct deformity, keeping people mobile and active,
 - relieve pain.
- Residential rehabilitation courses for a three-week block. Patients would attend for an area of injury specific course for example a course that provided rehabilitation for a range of injuries for lower limbs, spines and upper limbs. The service also provided a ten-day hip and groin course and an advanced rehabilitation course.
- A military orthopaedic consultant held regular clinics at the RRU, this had improved liaison with local NHS providers and decreased reliance on external surgical opinion. It aimed that these clinics would be offered monthly, but this was dependant on the consultant's military commitments.
- If the RRU was unable to meet the needs of the patients though the clinics and courses, 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, or NHS if this was in the best interests of the patient.

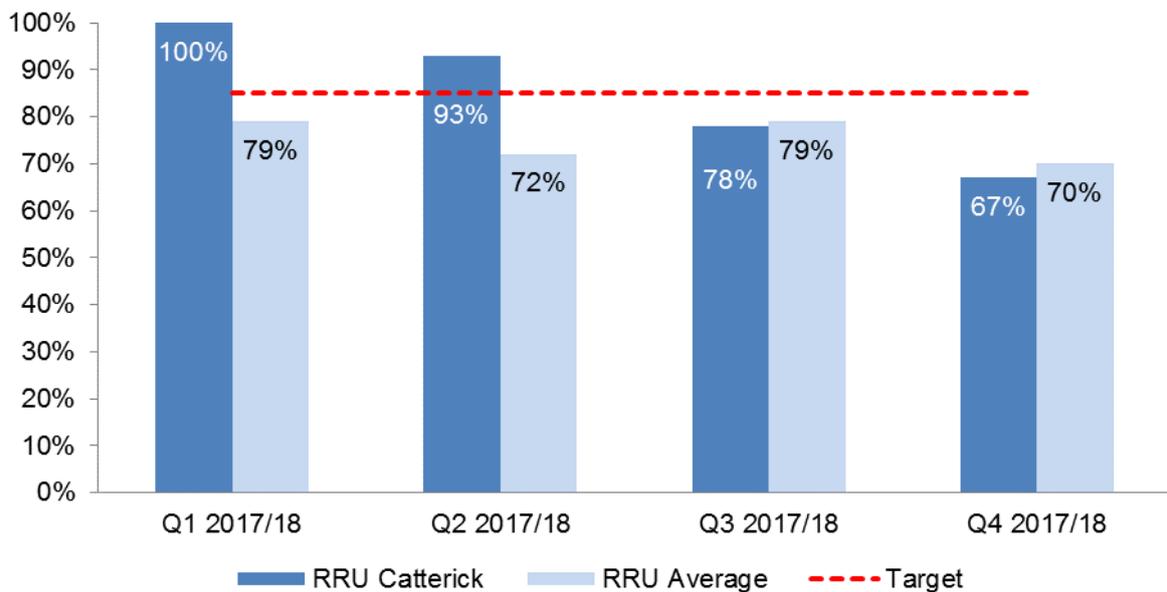
- The service was in the early stages of negotiating access to independent health/ NHS orthopaedic clinic to be held in RRU.
- Facilities were not always appropriate for the services that were planned and delivered. The numbers of patients being seen in the service had increased, the service had initially scoped for 30 patients on courses, however often there would be 45 patients in attendance. This had impacted on the way the facilities were utilised. Staff worked hard to plan for the course's use of facilities to reduce the impact of these increased numbers.
- A wide range of fitness and strength equipment was available for patients so they could complete the required rehabilitation. A full inventory of all equipment was held electronically which provided information on what the equipment was, its cost, and where it was purchased or hired from. Staff told us the equipment was well used with most equipment being used by patients on a daily basis.
- The service was based in a privately managed leisure centre, facilities such as the pool and gym were shared with the general public, though specific rehabilitation sessions in the pools were only attended by military personnel. There were limited security measures in place. Reception staff monitored people accessing the leisure centre, all leisure centre members had to present or swipe a membership card to access the facilities. Non-members were required to show their ministry of defence identity card to be allowed access. The garrison managed the security of the leisure centre and this was subject to regular risk assessment. RRU staff were kept informed of any issues and or concerns. Sharing the facilities with the general public presented other challenges for the staff in providing rehabilitation services. The gym area, was divided into two with a curtain between the two areas. Often half of the gym was used by a general public attending sports session such as five a side football and badminton. During our inspection, we observed new patient assessments and group sessions being held in the gym next to a toddler's gym session. It was very loud and it was, at times very difficult to hear course instructions.
- Staff were very aware of the risks of treating patients in a shared area, they always checked patients were happy to commence treatment and have conversations in the gym area. However, we were concerned patients' privacy and confidentiality for patients could be compromised. Respondents to the defence medical services patient questionnaire following treatment were also asked whether they were concerned that other people could overhear the discussion during their pre-admission assessment to which 47% responded 'yes, but I don't mind', 11% responded 'I don't know' and 42% responded 'no, other people can't overhear'. Patients we spoke with did not have any concerns about their privacy or confidentiality.
- At the time of inspection, the air conditioning system in the building had broken and the patients and staff had been experiencing extreme temperatures. Staff demonstrated awareness of the impact of the excessive heat could have on the course attendees, additional fans had been sourced and the staff had adapted the sessions to reduced activity levels as required. The situation had been escalated appropriately, however at the time of the inspection no date had been identified for repair. Staff also reported in the winter the gym facilities could be excessively cold. Again, staff were aware of the impact of working/exercising in the cold and adapted the course programme as appropriate.
- There were limited waiting and rest facilities, for patients attending the courses. Patients could use the small clinic waiting room and also the leisure centre seating area. However, this overlooked the children's swimming pool, which staff commented they did not feel was always appropriate.
- Staff had developed a good working relationship with the onsite leisure centre management team and worked to ensure events affecting service provision were planned for to limit the impact patients.

Access to the service

The RRU provided assessment and treatment services between 8am and 5pm from Monday to Thursday and between 8am and 1pm on a Friday.

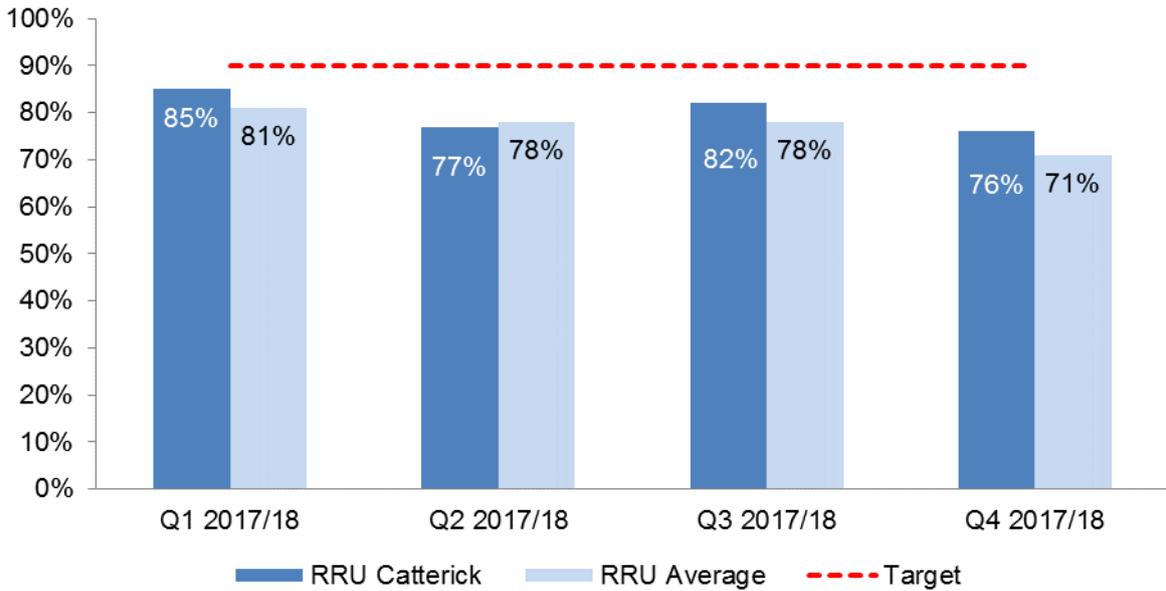
- Patients had timely access to initial assessment, diagnosis or urgent treatment. The target for undertaking new patient assessments was set at 85% for initial assessments to be completed within 20 working days of referral. RRU Catterick met the target and was above the RRU average in the first two quarters of 2017/18 but performance had deteriorated over the year. The RRU performed worse than the RRU average and target for the latest two quarters. Between October 2017 and December 2017 78% patients had received an initial assessment at the MIAC clinic within 20 days. This was just below the RRU average of 79% Between January 2018 and March 2018 67% patients had received an initial assessment at the MIAC clinic within 20 days, which was the RRU average of 70%.

Access to MIAC or IAC services for first referral within 20 working days



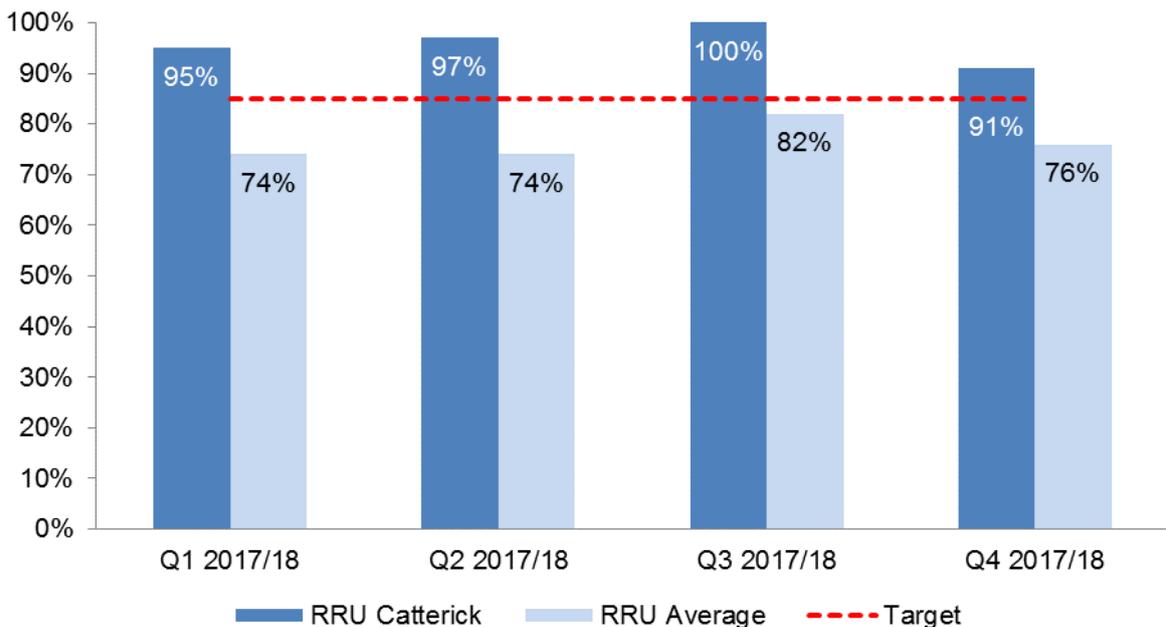
- The target for accessing an RRU course was for 90% of patients to be offered a course starting within 40 working days of the MIAC appointment. RRU Catterick received 174 referrals into this service between April 2017 and March 2018. RRU Catterick performed similar to or slightly better than the RRU average in 2017/18 but didn't meet the 90% target in any of the four quarters. Between October 2017 and December 2017 82% patients had received an initial assessment at the MIAC clinic within 20 days. This was just above the RRU average of 78% Between January 2018 and March 2018 67% patients had received an initial assessment at the MIAC clinic within 20 days, which was the RRU average of 71%.

All patients offered an RRU course starting within 40 working days of MIAC appt



- 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%. RRU Catterick had 295 referrals for a podiatrist appointment between April 2017 and March 2018. The RRU had consistently met this target for all four quarter. Between April and June 2017 95 % of patients saw a podiatrist within an allocated time period, the RRU average was 74%. between July and September 2017 97% of patients saw a podiatrist within an allocated time period. The RRU average was 74%. 100% of patients referred between October and December 2017 saw a podiatrist within an allocated time period. Th RRU average at this time was 82%. 91% of patients referred between January to March 2017 saw a podiatrist within an allocated time period, which was above the RRU average of 76%.

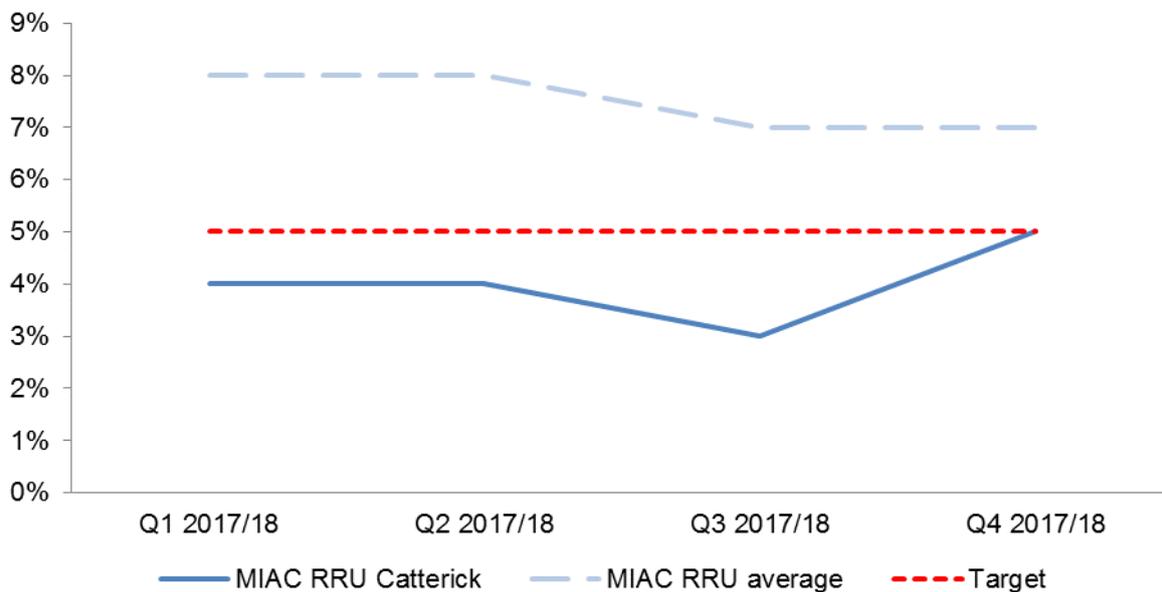
Access to podiatrist for first appt within 20 working days



- The target for short-notice cancellation rates (cancellations with notice of less than one working day) is 5% or less.

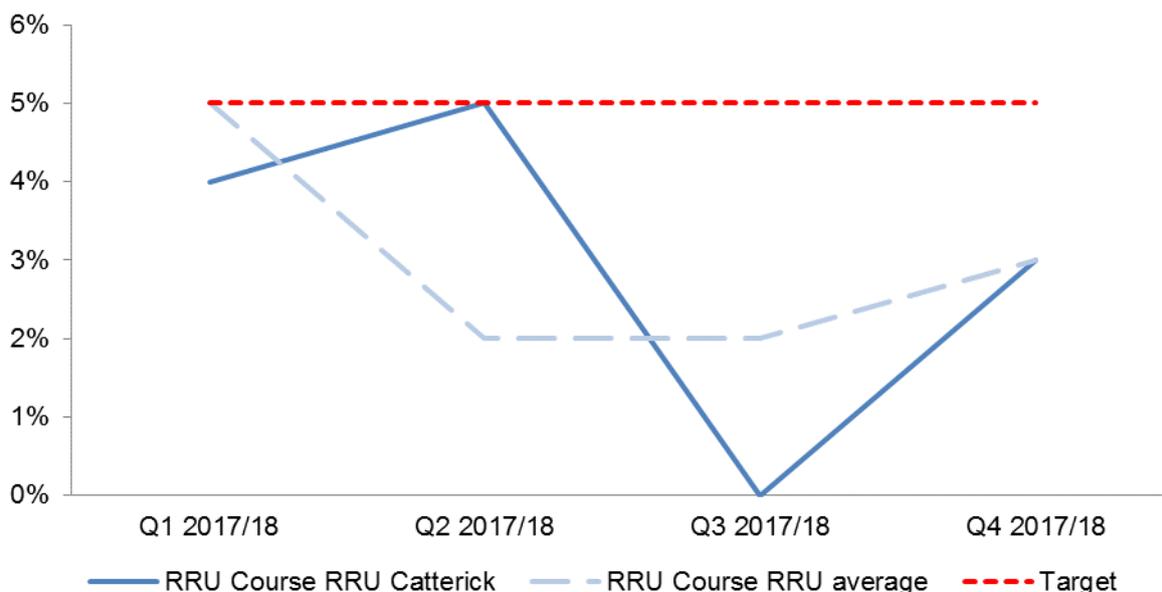
- The MIAC short notice cancellation rate at RRU Catterick ranges between 3% and 5% over 2017/18. This was consistently better than the RRU average and met the target in all quarters.

Cancellations with less than one working day notification - MIAC



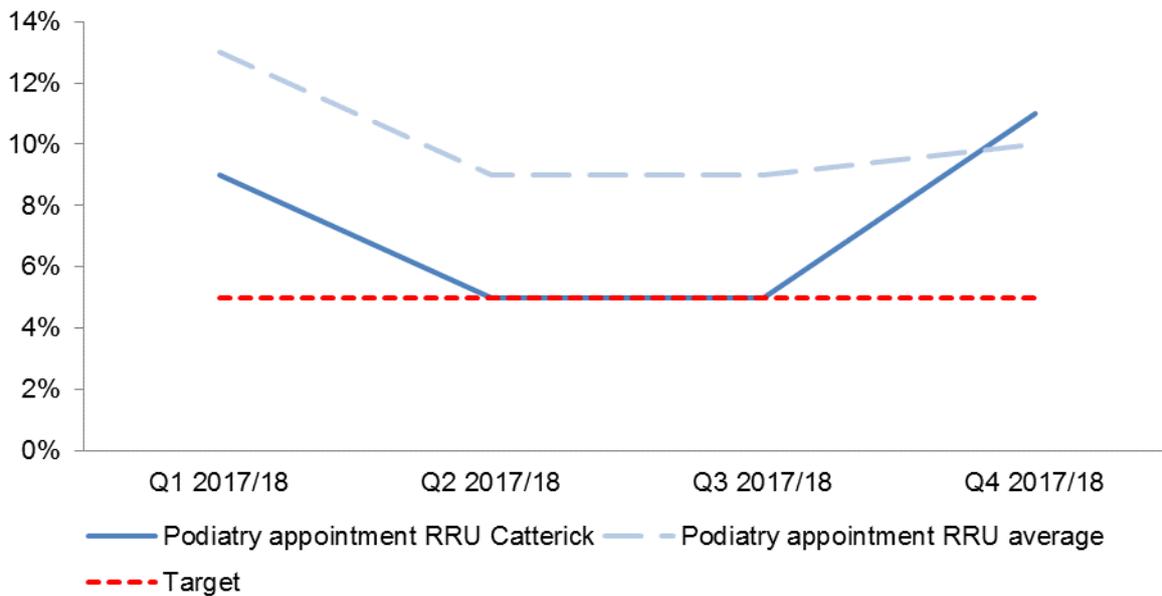
- The RRU course short notice cancellation rate at RRU Catterick varied over 2017/18 but had been below the target rate.

Cancellations with less than one working day notification - RRU course



- The podiatry appointment short notice cancellation rate at RRU Catterick was better than the RRU average except for in the latest quarter. The short notice cancellation rate was the same as the target for two of the quarters and worse than the target in two of the quarters.

Cancellations with less than one working day notification - podiatry



- Clinics and courses were rarely cancelled. Courses were planned, staff who planned the courses took into consideration the numbers attending and the need to be carefully planned in likely periods of high staff absence and patient preference, for example during school holidays. Cancelling clinics and courses only occurred 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 RRU. 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 of 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 RRU. 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. We saw two incidents had been raised regarding the referral process in May 2018 which had caused a delay to patient accessing the service. Both incidents had been fully investigated and actions identified to prevent reoccurrence. Patients affected had received an apology and had attend the next available course.

- 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.
- 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. Attending rehabilitation was a mandatory requirement of their role, administration staff told us there was usually a very valid explanation from patients as to why they did not attend their appointment.
- Patients had access to fast track diagnostic imaging for identifying and monitoring diseases or injuries, if required, at a local private hospital. A military orthopaedic consultant held regular clinics at the RRU, this had improved liaison with local NHS providers and decreased reliance on external surgical opinion. However, at the time of the inspection this had been suspended until September while the consultant completed a deployment.
- 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 RRU 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 RRU had a system for handling concerns and complaints.

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

- The OC was the designated responsible person for dealing with complaints. Concerns and complaints were listened to 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. We saw patient advice leaflets called 'Making a complaint' available and accessible in the RRU. This stated formal written complaints would be acknowledged within two working days and a response would be received within ten working days.
- 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.
- Between March 2017 and March 2018, the service had received one formal complaint. The complaint had been responded to in line with guidance. The complainant was communicated with, to tell them the complaint had been received and what would happen next and an appropriate investigation had been carried out. We saw evidence the complaint had been appropriately shared with staff team, to ensure any identified learning was communicated.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Requires improvement



Our findings

We found that this practice was not 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. However, the service did not have a service strategy and we were not assured the service's mission statement was embedded.

- There was a mission statement set out for the service, with quality and safety the top priority. The mission statement for Catterick 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 capacity, whilst influencing their psychological and social health.' 'A posse ad esse' 'From possibility to actuality' However, we were not assured it was embedded, staff we spoke with were not aware of the mission statement.
- There was a strategy for all defence medical services detailed in the defence rehabilitation concept of operations document which had been developed centrally. Staff we spoke with were aware of this document.
- The service lead reported that at the time of inspection there was no strategy for RRU Catterick in place. However, staff were aware of the defence medical rehabilitation programme strategy. The service was planning to implement a service specific strategy based on the defence medical rehabilitation programme objectives and vision. However, at the time of inspection, there was no timescale for completion of this work.
- 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.

Governance arrangements

The service had an overarching governance framework, which supported the delivery of the strategy and good quality care. While there was a system and a process to identify risks associated with the RRU, we were not assured all potential risks had been identified or all staff were fully aware or involved in managing and mitigating the risks.

- There was an effective governance framework to ensure quality, performance and risk were understood and managed. There was an overarching ministry of defence (MOD) corporate governance policy (JSP 525). This covered the structure of MOD governance, governance principle, roles and responsibilities, governance control processes and risk management processes. The policy was not specific to the RRU but provided context and guidance about how MOD governance processes worked.
- A common assurance framework (e-CAF) assessment was a live 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 RRU 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, a RRU assessment, using the CAF took place on 26 April 2018. The overall assessment was partially compliant. The RRU was fully compliant in five out of the eight domains:
 - Domain 4 – Patient Experience
 - Domain 5 – Accessible and Responsive Care
 - Domain 6 – Care Environment and Amenities
 - Domain 7 – Public Health
 - Domain 8 – Occupational Health
 and partially compliant for:
 - Domain 1 – Safety
 - Domain 2 – Clinical and Cost Effectiveness
 - Domain 3 – Governance.

The serials under the domains which required action to be taken had an associated action plan, a designated person overseeing implementation of the action and a timeframe to the action to ensure they were completed in a timely manner.

- 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 November 2017. At the time of the inspection, there was no planned date for the RRU's next external 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 RRU 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:
 - Percentage all patients offered an RRU rehabilitation course starting within 40 working days of the MIAC appointment
 - Percentage of all cases referred to the Regional Podiatry Service who are offered an appointment with the Podiatrist within 20 working days
 - Percentage of patients failing to attend an appointment³ with less than 1 working days notification <5%: Rehabilitation Course

- There was a system and a process to identify risks associated with the RRU. However, we were not assured all potential risks had been identified or all staff were fully aware or involved in managing and mitigating the risks.
- The RRU maintained a risk register which identified seven risks:
 - E2 Admin position vacant risk entered on the register
 - Excessive temperature in CV suite, there were two entries for this risk one dated 16 October 2016 and one dated 14 May 2018
 - MIAC running with locum doctors - risk of loss of continuity of service
 - CP and F approver errors. There is a risk that items will be ordered and approved in error.
 - The new E1 employed at the RRU is taken on at risk, due to not having DBS clearance.
 - Clinical waste management. The contract was cancelled 6 years ago but service provider continued to collect till January 2018, now stopped.
- Prior to the inspection we had been informed eight of the twelve eligible staff had no data relating to security vetting clearance this risk was not recorded on the service risk register.
- We were not assured the service were always aware of risks affecting the leisure centre. During the inspection, we raised a health and safety issue with the OC and the leisure centre duty manager. A door that led to poolside was not secured. Therefore, when the pool was not in use and no one was in attendance poolside, there was a risk an unsupervised child could gain access to the pool area, with potential for very serious consequences. There were family changing rooms in that area, and we had also observed primary school classes in that corridor. While a private provider managed the centre, the premises is owned by MOD, and was in our view, a health and safety risk. Following inspection this issue was raised with the focal POC within the DMS. Since inspection, we have been provided with evidence demonstrating how the private provider had taken action to reduce the chances of this re-occurring.
- The risks identified 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. Most risks had been rated as 'tolerate' apart from a risk dated in January 2018 which had been transferred. This was regarding clinical waste management. The contract was cancelled 6 years ago but the provider continued to collect until January 2018 and now this was not being done. The consequence was clinicians were having to bag it up themselves. This had been passed to DPHC(SN) HQ to work with contracts to resolve.
- The risks identified by the OC during the inspection were:
 - infrastructure of the building, including being a lodger RRU within MOD / Civilian partnership, open access / safeguarding, flexibility of Use, heating / cooling and suitability for purpose as the service was initially scoped for 30 patients on courses
 - staffing, including dependency for MIAC Dr, gapping of 2IC role and staff turnover (OC's, Admin, QMSI),
 - Demand including, increased demand for LL courses requires maximum manning of 15 patients per course.

These were not effectively reflected on the most up to date risk register.

- While the risk register was a standing agenda for the healthcare governance meeting, we did not see any evidence of issues identified on the risk register being reviewed and discussed.
- We reviewed the minutes for the formal monthly healthcare governance meetings held 24 November 2017, 18 April 2018 and 29 May 2018 The meetings in November and April followed a standing agenda that covered areas such as risks, incidents, complaints and audits. actions were described. However, much of the content had been carried over from

one meeting to the next and the meeting held in May was describe as interactive and allowed the QMSI to brief all staff up on the following:

- CAF Document – Responsibilities and MAP
- SPoG – Responsibilities/Work strands
- DPHC Workbook – Responsibilities/Work strands
- Training Matrix – RV/Work strands
- CQC – Information about the pending CQC

Without detailed minutes, there was a risk, team members not present, may miss essential feedback information and we could not be assured meetings were reflective of the current healthcare governance issues for the service.

- The service did not always follow the defence medical services policy for access to the service. The policy stated, *all patients being referred to the RRU for the first time should be seen in a MIAC*. The majority of lower limb referrals were referred on to a course without a MIAC. Patients were not specifically told that they were bypassing a part of the process. The team at the RRU were aware that this was not following policy, but due to the numbers of referrals received, without this change, there would be an increase in waiting times as there were not sufficient clinic appointments to meet the current need. The service did not collect information on the numbers of patients who attended a course without attending a MIAC first. However, we did not see any evidence of any negative effects of this process during inspection.

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.

- Staff were committed to providing a high standard of safe care, and spoke positively about the services that they provided. Despite the changes and vacancies in the staffing establishment particularly affecting the leadership roles, the team had worked hard to maintain an effective and efficient service for the patients.
- Staff did not express concerns about bullying or harassment. Senior staff complimented the attitude and dedication of all staff in the service.
- We were told the management style within the RRU was very much “Mission Command” whereby guidance / tasks were given to the appropriate individuals and they were responsible for establishing the best method to achieve the aim. Senior managers said this ensured staff felt empowered to work to their strengths to achieve the required output without micromanagement from above.
- RRU Catterick was fortunate to have a highly experienced clinical lead who had worked at the service for a number of years. They had provided stability to the team and had worked hard to provide support and consistency to the team and the service during the numerous staff and management changes.
- The clinical team had the skills and experience to operate effectively in the RRU.
- All staff were actively involved in staff, HCG and course debrief meetings, points made were discussed within the group for action or implementation. The OC and Band 7 had an “open door” policy and all members of staff said they felt able to speak about personal circumstances or in order to highlight areas of concern.
- The management team were involved in ensuring the standards of care was maintained and developed to ensure the service offered by the RRU continued to offer the best for the patient. The lead physiotherapist was involved with national clinical specialty planning (Hip and Groin Working Group) and course development, and the OC and QMSI involved

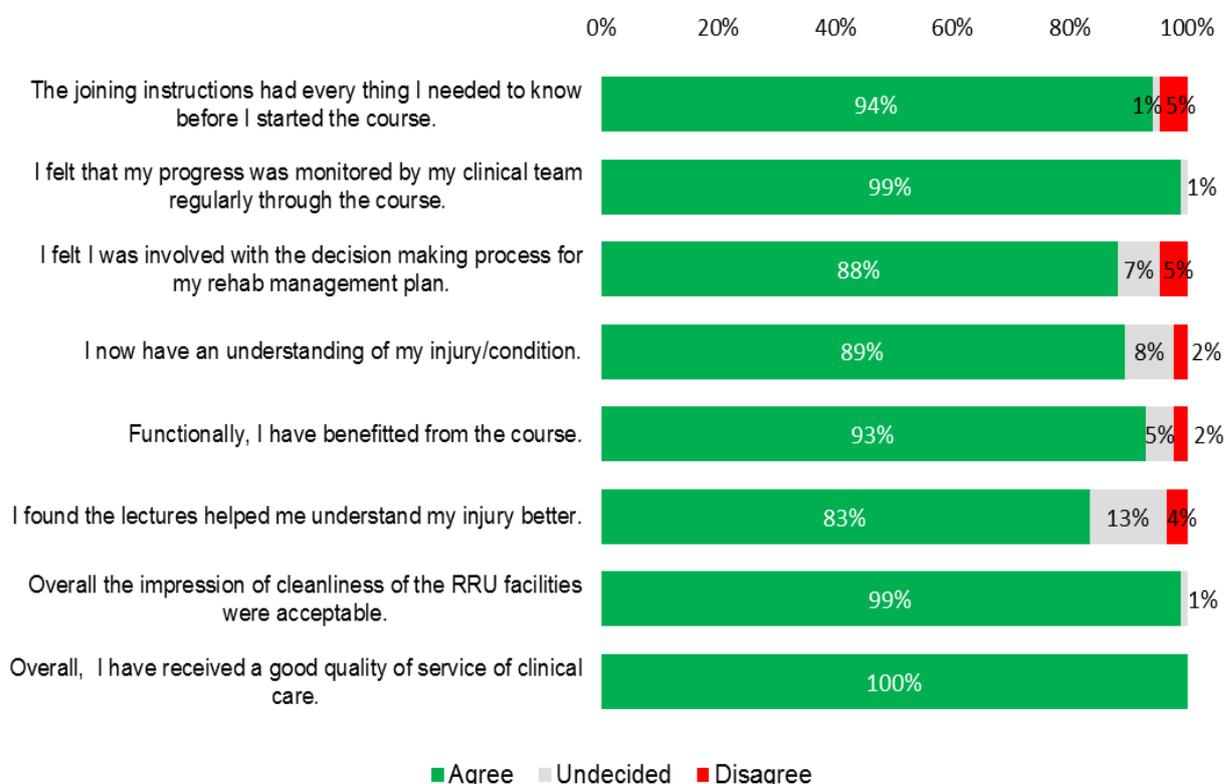
with developing the course content to reflect changes in medical employability standards and changing military PT emphasis.

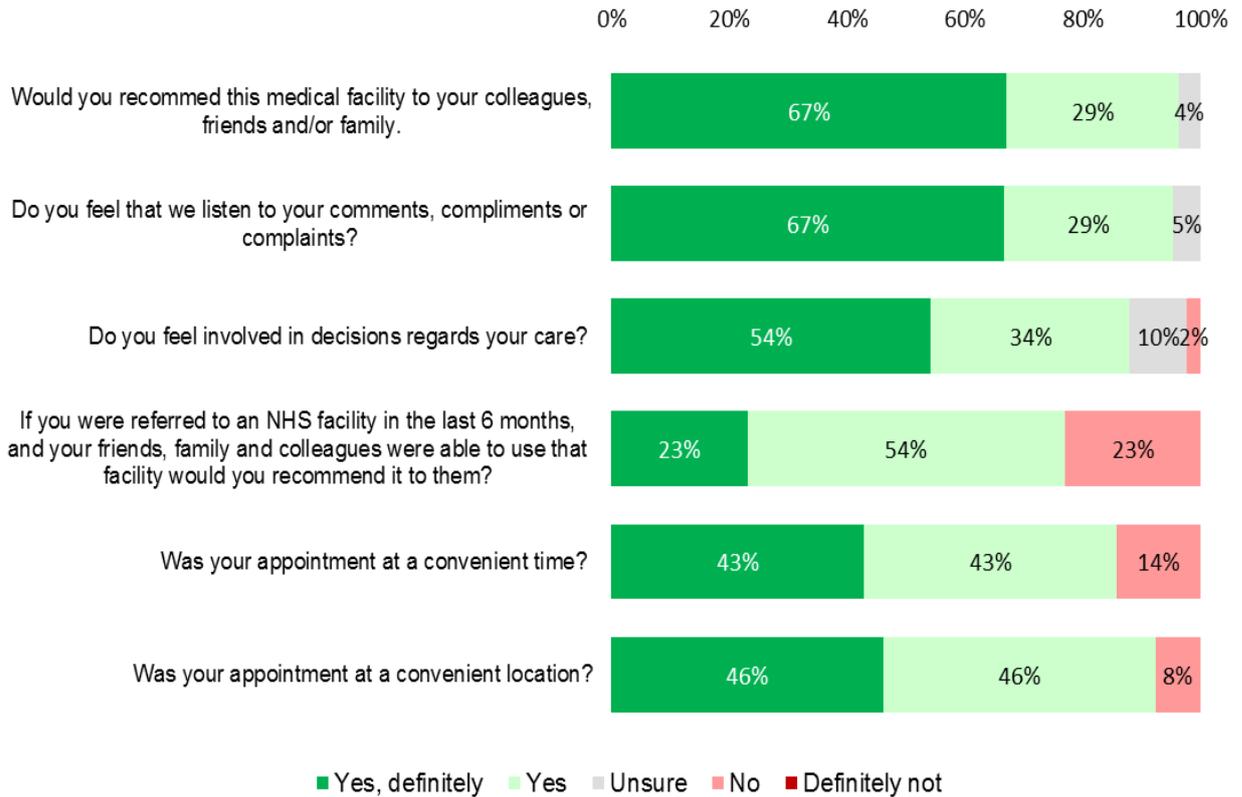
- Reports and appraisals were managed within the required timeframes and all MOD and military staff have annual objectives that are also reviewed midterm.

Seeking and acting on feedback from patients and staff

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

- The service collected and acted on patient's views and experience. They used the information to enable them to shape and improve the services and culture. A defence medical services patient questionnaire was used to gather views and experiences anonymously from patients following their treatment and gather patient feedback after completion of the RRU courses. Questions were focused on the clinical staff, administrative staff, cleanliness of the department, the quality of the service, and comments on patients' experience. Feedback sections included the administration of the course, course content, facilities, staff, and general feedback comments. Patients were also asked if they would recommend the facility to their friends, family and colleagues, if they felt their comments, compliments and complains were listened to, and if their treatment was at a convenient time and location.
- There were 84 respondents to the patient questionnaire from February to April 2018 but not every respondent provided a response to every question. Overall 98% of respondents would describe their experience of their visit as 'good' or 'very good'.





- The RRU also ran a MIAC patient satisfaction survey which had 71 respondents. Results for the third quarter of 2017 were positive with the RRU reporting that any negative comments were addressed at the time they were made.
- Feedback collected was used to adapt and change the way services were run. Patient feedback and comments were reviewed and discussed at team meetings. Any changes to practice and actions required were assigned to a member of staff to review.
- Patients and their military RRUs were actively involved in treatment decision making to ensure ongoing rehabilitation was planned and to allow patients the best opportunity to return to full duty. Staff would communicate with the patient's military base to update and discuss the progress of rehabilitation. We observed staff discussing the need for a patient to take a slower stream rehabilitation pathway with the patient and this was then discussed with their referring PCRf and their officer in command.

Continuous improvement

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

- The management team were actively involved with ensuring that the standard of care was maintained and developed such that the service offered by the RRU continues to offer the best for the patient. This includes the Band 7 being involved with national clinical specialty planning (Hip and Groin Working Group) and course development, and the OC and RTSA involved with developing the course content to reflect changes in medical employability standards and changing military PT emphasis.

- Staff shared learning to educate other members of staff at the RRU. Staff held 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.
 - The service held course development multidisciplinary meeting after each course to review the course, patient feedback and discuss developments or changes to make the course as effective as possible.
-