

Defence Medical Services

St Athan Regional Rehabilitation Unit

Inspection Report

Regional Rehabilitation Unit
St Athan,
Barry
CF62 4WA

Date of inspection visit 20 November 2018
Date of publication: 7 January 2019

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?	Outstanding 
Are services well-led?	Good 

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

We carried out an announced comprehensive inspection at St Athan Regional Rehabilitation Unit (RRU) on 20 November 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.

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

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

- There was an effective system available for staff to report significant events, incidents, near misses and concerns. Learning was shared both locally and regionally.
- Staff understood their responsibilities and adhered to safeguarding policies and procedures.
- The premises were appropriate for the services being provided and equipment was serviced and maintained to ensure the safety of patients.
- Hydrotherapy sessions had been stopped to ensure the safety of patients. The session would recommence when the pools safety policy met military standards.
- Standards of cleanliness and hygiene were maintained at the RRU and the majority of staff adhered to infection prevention and control policies and procedures.
- Patient records were organised, up to date and shared and stored appropriately however, patient goals were not always recorded. This finding aligned with a recent notes audit carried out by the RRU.
- Risks to patients who used services were assessed and their safety monitored and maintained. Comprehensive risk assessments were also completed for various aspects of service delivery.

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

- Patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Evidence-based, best practice guidance had been developed for defence rehabilitation services and was used to direct how care and treatment was delivered.

- A standardised outcome measure to review quality of life had recently been introduced at the RRU, however at the time of the inspection there were no plans to use this information to evaluate the service provided at the RRU.
- When benchmarked against other RRUs, data demonstrated patients' needs were being met and they were seeing benefits from care and treatment provided at the RRU.
- Staff had the skills, knowledge and experience to carry out their role. Staff were encouraged to develop their knowledge and skills and review each other's practice to ensure they delivered effective care and treatment.
- There was evidence of strong multidisciplinary working both internally in the RRU and externally with other providers.
- Consent to care and treatment was sought in line with national guidance and legislation.
- Patients were supported to manage their own health and wellbeing and to take responsibility for their rehabilitation and recovery.

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

- Patients were consistently positive about the care they received from the staff at the unit.
- We observed compassionate and supportive interactions between staff and patients.
- Patients felt included in decision making about their care and treatment, and felt listened to by the staff.
- Staff understood the impact patients' conditions and their care and treatment had on their wellbeing.
- Staff recognised when patients were not coping emotionally and worked hard to overcome this to ensure they benefitted fully from care and treatment.

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

- Patients individual needs were central to the planning and delivery of tailored services at RRU St Athan.
- Patients received a holistic and personalised approach to their rehabilitation through the innovative person-centred model of care utilised at the RRU.
- Staff at the RRU engaged in learning opportunities across the wider military DMS system and with local external services providers military personal could be referred to. This practice helped to optimise care and treatment for patients.
- The system wide approach taken at the RRU was integral to how services were planned and delivered, to enable joined up working, and to meet the needs of individual patients in a timely way.
- There were innovative approaches to the future planning and delivery of services to ensure they met the needs of the population at risk.
- Action had been taken to ensure equality and to overcome the challenges of accessing NHS treatment for military staff in Wales.
- The unit was exceeding set targets for their key performance indicators for patients accessing services provided by the RRU.
- Technology was used to ensure patients had timely access to ongoing treatment, support and care.

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

- There was a clear leadership structure and leaders had the knowledge and experience to carry out their roles effectively. Staff felt supported by management.
- Leadership and culture at the unit reflected the vision and values of the DMS and were driving a wider systems approach to improve the quality of care for patients in the area.
- The governance framework ensured quality, performance and risks were understood and managed. However, governance arrangements at the RRU needed to mature and become embedded to provide a good oversight of safety, quality and risk.
- There were systems and processes to identify, manage and mitigate risks and a proactive approach was taken towards risk management. However, some gaps existed in identifying risks and clearly documenting information.
- Staff needed to be further engaged to develop their knowledge and understanding with the governance of the unit, particularly around risk.
- Patient's views and experiences were gathered and acted on to shape and improve the services and culture.

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

- Care and treatment provided to patients was bespoke and personalised to meet their individual needs and requirements of their demanding military roles.
- The trickle feed model enabled patients to access care and treatment at the earliest opportunity to maximise potential for improvement.
- All staff at the unit had a wider situational awareness as to the need for patients to become operationally capable as soon as possible.
- The unit was focused on enhancing care and treatment for patients, not just at the RRU, but across the region. The model of care provided at RRU St Athan was evolving to support the local PCRFS. The unit was developing the knowledge, skills and expertise of staff across the region and to provide an individualised approach for each unit within the region. This meant patients' care and treatment was optimised at an early stage.
- There was a strong culture of multidisciplinary team working both internally at the RRU and externally. We saw evidence of how staff at the RRU worked together to optimise care and treatment for patients and of how the RRU was working with local PCRFS and external healthcare services to provide more effective and efficient care and treatment for patients.

Recommendations for improvement

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

- Ensure infection, prevention and control procedures are followed in the MIAC clinic. These included hand hygiene procedures and cleaning of equipment after use.
- Make sure patient goals are consistently recorded in patient records.
- Ensure appropriate application of Duty of Candour when required following an incident.
- Continue to work on embedding governance processes and developing their maturity.
- Continue to engage staff with the governance of the unit so they have a better understanding of aspects of quality and risk within the service.
- Make sure lighting is improved in the clinic room to enable procedures to be carried out whilst maintain the privacy and dignity of patients.

Professor Ted Baker
Chief Inspector of Hospitals

Regional Rehabilitation Unit – St Athan

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) St Athan is a facility provided by the Defence Primary Healthcare (DPHC) Unit delivering intermediate rehabilitation within the Defence Medical Rehabilitation Programme (DMRP). The regional rehabilitation unit (RRU) is located at St Athan in the Vale of Glamorgan in Wales and provides clinical management of moderate musculoskeletal conditions to the military population within a defined geographical area. There are 14 RRUs across the United Kingdom.

RRU St Athan's population at risk (PAR) is expected to increase over the next 10 years. RRU St Athan supports a population of 6500 where the majority of the population is specialist infantry, specialist signal regiments and marine expeditionary brigade personnel. This population provides significant challenges for rehabilitation due to the injuries sustained and the requirement to regain the required fitness levels to enable military personnel to carry out their physically demanding military roles.

Multi-disciplinary Injury Assessment Clinic (MIAC)

Clinical assessment at the RRU is delivered through the MIAC. This is a combined clinical assessment by a consultant trained in Sports and Exercise Medicine (SEM) to consultant level, a physiotherapist (clinical specialist) and an exercise rehabilitation instructor (ERI). The doctor 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
- Welsh Fast track – This pathway requires additional clearance to refer patients into secondary care.
- 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 into one of two pathways for their care and treatment. The first is a trickle feed model of staggered starts (4 per week) to give quicker access into the service for patients and the second model is whereas the second is the traditional course structure of all 15 patients starting on the first day.

Regional Podiatry Service (RPS)

The aim of the RPS is to provide a clinical biomechanical podiatry service to all entitled service personnel within the RRU catchment area. The majority of patients with biomechanical problems are managed effectively within Primary Healthcare (PHC) at the PCRFS. Where this management is unsuccessful or a Podiatrist/Biomechanical specialist opinion is required, the RPS will provide a highly skilled and specialist lower limb biomechanical assessment and treatment, together with the provision of both off-the-shelf and custom-made orthotics from an MOD approved supplier as required. The RPS is commanded by and accommodated at the RRU. It consists of one PT/FT Band 7 podiatrist/physiotherapist (biomech) who will deliver clinics at either the RRU or regionally through a peripatetic service.

The service lead (OC) and Regional Trade Specialist Advisor (RTSA) provide a regional subject matter expert and professional point of contact conducting liaison visits with the satellite physio departments within region, providing support and guidance on healthcare governance 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 PCRFS 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 consultant 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, MIAC doctor, regional trade specialist advisor (RTSA)/lead exercise rehabilitation instructors (ERIs), a podiatrist and administrators.

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

Our inspection team

Our inspection team was led by a CQC inspector. The team included three 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 unit. We carried out an announced inspection on 20 November 2018. During the inspection, we:

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

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

Reviewed patient notes, complaints and incident information.

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

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

What people who use the unit say

Patient survey results were collected and reviewed following each course. Results from April 2018 to June 2018 showed the unit was performing in line with other RRUs. The majority of respondents, 83% strongly agreed with the statement 'overall I was satisfied with my care,' with the remaining respondents agreeing with this statement. All 100% of patients said they would recommend the RRU to family and friends.

- 100% of patients said they felt involved in their care and treatment.
- Five out of six questions relating to communication between the patient and clinician, the large majority of responses were 100% positive. However, 13% of respondents felt they did not understand words used by the physiotherapist or ERI.

As part of our inspection, we also spoke with 17 patients. Patients were consistently positive about their experience at the RRU. This reflected the outcomes of the patient satisfaction questionnaires completed by patients of finishing their rehabilitation at the RRU. Patients told us they were able to access the service easily and had been included in the development of their goals and treatment plans. Patients told us instructors were very helpful. Patients said they did not feel isolated or unsupported at any point during their rehabilitation.

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. We found incidents were investigated. Themes were identified and appropriate action had been taken to minimise further occurrences

- There was an effective system available for staff to report significant events, incidents, near misses and concerns. Staff understood their responsibilities to raise concerns and record these. Incidents were reviewed, thoroughly investigated and closed by the service lead.
- A spreadsheet of all incidents was maintained. This incident log was held electronically and provided a brief overview of the incident, when the incident was submitted, and the outcome of the root cause analysis and actions taken as a result.
- There had been 11 incidents reported between since January 2018. Themes were identified and appropriate action had been taken to minimise further occurrences. These included six incidents involving infection, prevention and control issues, loss of IT systems and telephones for 72 hours, patient injury during treatment, failure of equipment whilst in use and the lack of lifeguard present during hydrotherapy sessions.
- We reviewed the incident of a patient sustaining a heat associated injury during treatment. The incident had been investigated thoroughly and learning and actions identified. Actions included signage in the treatment room advising staff and patients of best practice, further training which had been completed with staff and a full brief for any new staff starting at the unit when this occurred. Staff at the unit were able to tell us about the incident and the changes to practice which had been made to prevent reoccurrence in the future.
- Once incidents had been identified, lessons were learnt and action was taken to improve safety at the Regional Rehabilitation Units (RRU). Updates and learning from significant incidents which had occurred at other RRUs regionally was shared between the staff. Staff told us how an incident and outcome of an incident involving a piece of equipment breaking, was shared with other regional RRUs. Staff were also able to tell us about an incident which occurred involving a piece of equipment at another regional RRU, in which, learning from the incident was shared and implemented to ensure the safety of patients at RRU St Athan.
- Principles of Duty of Candour were not always followed. 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. There was no evidence, that for one incident which required the application of the duty of candour that this had been completed. Evidence demonstrated information had been given to the patient as to how the unit planned to prevent this incident occurring again in the future, however there was no evidence to state a formal apology had been provided to the patient.

Overview of safety systems and processes

- Essential systems, processes and practices were available to ensure patient safety. Staff received mandatory training in safety systems, processes and practices. Training compliance was set at 100% for the RRUs. Out of the 28 training courses, staff were fully compliant for 12 out of the 28 courses. These courses included infection control, fire safety, basic life support and equality and diversity. Other modules such as manual handling, health and safety, unconscious bias and business continuity saw levels of compliance between 50% and 91%.
- There was 0% compliance with Caldicott level 2 training. We were told that there was currently no funding for staff to attend Caldicott level two training. However, we saw evidence of confirmation from senior management that the defence information management passport training, was considered sufficient to cover the information required by staff were required to be aware of regarding confidentiality. Staff were 100% compliant with this training.
- During a further discussion about mandatory training compliance, the service lead identified that the data available was not wholly accurate. The systems for storing and recording mandatory training compliance had recently changed. During the transition to the new database, staff, due to not having a copy of their certificate, were unable to provide evidence that they were compliant with specific mandatory training courses, despite verbally stating they had completed the courses. Due to the lack of evidence, the database showed that training had not been completed. The service lead had not made staff complete the course again as they trusted each member of staff and their honesty regarding their training. The service lead was concerned about the additional time and resource if staff were to repeat training they had already completed as it would deplete the service. Staff were due to become compliant in all with mandatory training during the next required cycle to refresh and update compliance with various courses.
- 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. Training was usually completed by staff in the allocated governance weeks written into the service delivery plan.
- Arrangements for safeguarding reflected relevant legislation and local requirements. Staff received safeguarding training to level two in line with national guidance. The guidance recommends staff should be trained to one of five levels of competency, depending upon role and interaction with adults and children. There was 100% compliance with this training.
- Staff could access advice, support and guidance about safeguarding concerns by a member of staff who had received level three safeguarding training based at the local medical facility on site at St Athan. The RRU were supported by the local medical facility on site at St Athan by a member of staff who had received level three safeguarding training. This set up was common across the RRUs.
- Staff understood their responsibilities and adhered to safeguarding policies and procedures. Staff knew the clinical lead was the first point of contact for any safeguarding

concerns they may have, and were aware of the additional support provided by the medical facility onsite. There had been no safeguarding issues raised by staff at St Athan in the last six months.

- Systems, processes and practices protected patients from avoidable harm. All staff were Disclosure and Barring Service (DBS) checked and their professional registration and expiry date was reviewed. This ensured all staff at the unit were safe and fit to practice at the unit. All staff had an up to date DBS check. This meant we were assured systems, processes and practices related to DBS checks protected patients from avoidable harm. Information was held electronically and a check of the professional register or equivalent had been completed for all staff.
- 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.
- The premises was appropriate for the services being provided and ensured the safety of patients. The service was delivered from a large refurbished aircraft hangar on the St Athan base. There were designated areas for cardiovascular work, weights machines, a balance and proprioception area and a large open space for other activities to take place in.
- Arrangements for the maintenance and use of equipment ensured patient safety. Equipment was used, maintained and serviced in line with manufacturers' instructions. An electronic inventory log was maintained and held information as to when maintenance had taken place for the equipment at the RRU. The log showed servicing was in date.
- Issues with equipment were reported verbally to the RTSA on site. This resulted in the equipment being put out of use and a request for a repair was booked. A response was provided within 24 hours to acknowledge the initial email of request for repair and equipment was fixed within seven days. Records were maintained on an electronic spreadsheet.
- Electrical testing of equipment at the RRU was maintained. Electrical equipment was tested to ensure it was safe for use. Stickers on electrical equipment identified these checks had taken place.
- Staff ensured patient safety when introducing patients to the equipment. All patients were provided with a demonstration of the equipment they needed to access to support their rehabilitation programme. Patients were advised to not use equipment if they had not received a demonstration and a supervised trial use of the equipment. Each piece of equipment also contained a sticker to ask patients not to use equipment they were unfamiliar with it, and to request the support of a member of staff.
- Resuscitation equipment was available in the gym area and was checked daily to ensure it was ready for use in an emergency. An automated external defibrillator was available in the main rehabilitation area. We reviewed the checks for this equipment which had taken place in September, October and November. These were all complete. Staff also had access to a first aid kit and eye wash kit. Additional information was also provided next to the resuscitation equipment to provide easily accessible information to staff in case an emergency situation arose. Information available included flowcharts to support staff with the use of the AED, for patients who may be choking or experiencing tachycardia or bradycardia.
- Pool based rehabilitation sessions carried out as part of the course had been put on hold to ensure the safety of patients attending the session. The session was usually run at a local leisure centre, however, their pool safety policy did not meet the same specification as the military standards. Therefore, use of the pool had been stopped. It was not mandatory at the RRUS for a pool based therapy session to be incorporated into the rehabilitation programme. At the time of our inspection, there were ongoing contract negotiations to manage this issue and get the sessions reinstated once pool safety

standards ensured the safety of the patients attending. Patients were attending yoga sessions as an alternative. There was no timeframe in which pool therapy sessions would recommence.

- Standards of cleanliness and hygiene were maintained at the RRU. The premises were clean and tidy. The environment was visibly clean and some equipment was safely stored off the floor and in designated areas to ensure safety of patients and staff in the pool area. Further racking had been ordered for the RRU to store the remaining equipment off the floor.
- There had been a trend of incidents reported and an associated risk on the risk register regarding the current cleaning contract for the RRU, however this risk was being managed to safely manage infection prevention and control issues at the RRU. We reviewed this risk in detail. There had been concerns with the cleaning contract which had resulted in a lack of cleaning schedule and frequency of cleaning at the RRU. This was acknowledged as an issue across all RRU services as the change in contract had been a national process. We viewed emails, documents and minutes of meetings associated with this risk. Staff involved with this issue told us there was a local agreement with RRU team and cleaning manager to try and improve service provided and their capacity to clean the unit more thoroughly. They were awaiting roll out of amendments to contract requirements (phase one had been completed, phase 2 was rolling out with this RRU being in phase two of the roll out). It was expected the amendments would help to clarify what was and was not required from the service and how this was going to be delivered. Once this roll out had taken place, the risk was to be reviewed again and possibly retired and re-written, or amended as appropriate.
- A physiotherapist at the RRU was the infection prevention and control (IPC) clinical lead for the unit. Staff could discuss any issues around infection prevention and control with them. Staff were aware of who held this role. The annual IPC audit had been completed the week prior to our inspection in November 2018 with the unit demonstrating 83.3% compliance. The audit identified actions which needed to be taken and issues which needed to be discussed with staff at the next governance meeting.
- Most staff we observed in clinic undertook the five moments of hand hygiene and were bare below the elbows. However, not all staff in the MIAC clinic did not always undertake the five moments of hand hygiene after treating a patient. Also, we did not see evidence that equipment used during the consultation was cleaned appropriately after use. There was no equipment to facilitate this task stored in the MIAC room. This meant the spread of infection was not always managed safely at the unit.
- The management of clinical waste ensured the safety of patients. Staff followed guidance for the storage and disposal of waste. A clinical waste bin was available for use. Sharps were disposed of in sharps box. The sharps box was held in the clinic room and brought into MIAC room when the doctor carried out injection therapy. Sharps boxes were appropriately labelled, dated and signed.
- There was access to fluid spill kits (a cleaning kit to clear up any bodily fluid spillages) to safely manage any bodily fluid spillage and the risk of cross infection. This was available in the MIAC clinic room. However, the spill kit was out of date and had an expiry date for 2015. This was raised with the lead clinician and the service lead during the inspection who took appropriate action to remove the spill kit and arrange a replacement.
- 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.
- A records audit for the inpatient course had been completed in August 2018. The notes audit reviewed 30 random patient records between May and June 2018. The audit had identified areas of variable compliance. For example, 100% of consultations were being completed within 24 hours of the patient appointment and 97% of the patient records

demonstrated consent had been sought from patients. However, areas of low compliance included only 21% of the patient records including perceptions of the patients' needs and only 24% identified a written list of the patient's problems. Only 27% of patients had their goals identified in their records. An analysis of the audit had been completed along with actions points being identified. However, it was unclear whether these actions had been completed or who was responsible for their completion. A further audit was due to be completed in six months to review compliance.

- A further records audit had been completed for the MIAC in June 2018. For this audit, 20 random sets of patient records between March and May 2018 had been reviewed. The audit showed for the majority of patient records, the MIAC team were compliant with completing the rehab menu template appropriately for recording patient assessment and treatment. However, a small number of minor issues were identified. These included areas of the subjective and objective assessment, including patient expectations and recording of medication. There was no identification from the audit how these issues had been shared and whether this had been completed. A re-audit was due to be completed in December 2018.
- We reviewed the notes audit carried out in August 2018 for the inpatient rehabilitation course. It reviewed 30 patient notes between May and July 2018. Mandatory compliance was measured for use of the rehab standard template (100%), completing mandated questions (67%), documenting consent (97%), and completing notes within 24 hours of appointment (100%). Review of the subjective assessment criteria on the audit demonstrated compliance of between 21% and 93%. On average compliance in this section for the nine items scored was 60%. Other aspects of the audit ranged in compliance between 24% and 100% with some items being deemed not appropriate. The audit identified overall themes, areas for improvements and cascade of information required through the healthcare governance meeting.
- The service used the defence medical information capability programme (DMICP) to store and access electronic patient records. This allowed staff to access patient records, in line with their role and the level of access they would require to view the information needed to treat the patient.
- Patient records were organised, up to date and shared and stored appropriately. We reviewed eight patient records for patients attending the multidisciplinary injury assessment clinic (MIAC) and rehabilitation courses. Records included referral information, patient assessments, consent and treatment plans which were all complete.
- No medicines were stored at the RRU. Medicines required for injection therapy and associated anaphylaxis were brought to the unit from the medicine centre on designated injection therapy days. Once at the RRU, medicines were stored in a locked draw in the MIAC clinic room. No fridge was required for the medicines used at the clinic. 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 and a standard operating procedure for medicines management at the RRU was also available. This was due for review in June 2020.

Monitoring risks to patients

- Risks to patients who used services were assessed and their safety monitored and maintained. Staffing levels, skill mix and caseloads were planned and reviewed to ensure people received safe care and treatment at all times in line with relevant tools and guidance. Actual staff met planned staffing levels. Between January 2018 and November 2018, RRU St Athan had a staffing fill rate of 100%. Staff employed at the unit included four physiotherapists, three band 6 and one band 7, one podiatrist, two exercise

rehabilitation instructors (ERI), MIAC doctor, two administrators, one military Major and one regional trade specialist advisor.

- 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. A physiotherapist and ERI to manage the generals course and a physiotherapist and ERI to manage the trickle feed patients.
- 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 had access to and automated external defibrillator at the unit and additional information and flow charts to advise them how to support a patient who was deteriorating from various conditions, including choking.
- Comprehensive risk assessments regarding service provision were carried out using a clear methodical approach and actions to mitigate any risks had been identified. Risks completed for the service included risk assessments for strength training and group therapy, specific individual programmes, theraband and lifting and carrying. These documents were held electronically and there was also a paper copy maintained at the unit. We reviewed several risk assessments. Each had a description of the identified risk, a risk rating, actions to mitigate the risk, timeframe and date in which the risk required a review.
- The unit had an up to date fire risk assessment and carried out regular fire drills. Weekly and monthly checks were carried out at the RRU and a weekly fire alarm check was also carried out. The most recent fire drill for staff at the unit occurred on 1 November 2018. The drill ensure staff understood their role, responsibilities and what they needed to do in the event of a fire at the unit. Fire training also featured as part of the induction for new members of staff starting at the unit.

Arrangements to deal with emergencies and major incidents

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

- Potential risks for the service were anticipated and planned for, in advance. The unit had a local business assurance and resilience plan. This document was in date and due for review on October 2020. The business continuity plan was specific to RRU St Athan and identified the main threats and risks and how a major incident would be managed both inside and outside of normal working hours. The document provided guidance on alternative locations and outlined how the service would continue to run. The document also provided details as to who needed to be notified of the incident and a list of contact telephone numbers.
- The RRU had suffered a critical failure of its IT and telephone systems for 72 hours in August 2018. The investigation identified that a more timely initiation of the business continuity plan was required if this event was to occur again in the future. The action taken from the investigation was that the RRU had set up a 'crash out' box containing all of the required equipment to enable continuity and deliver of the services in times of IT and telephony failure, to enable faster implementation of the business continuity plan.

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

Good



Our findings

Effective needs assessment

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

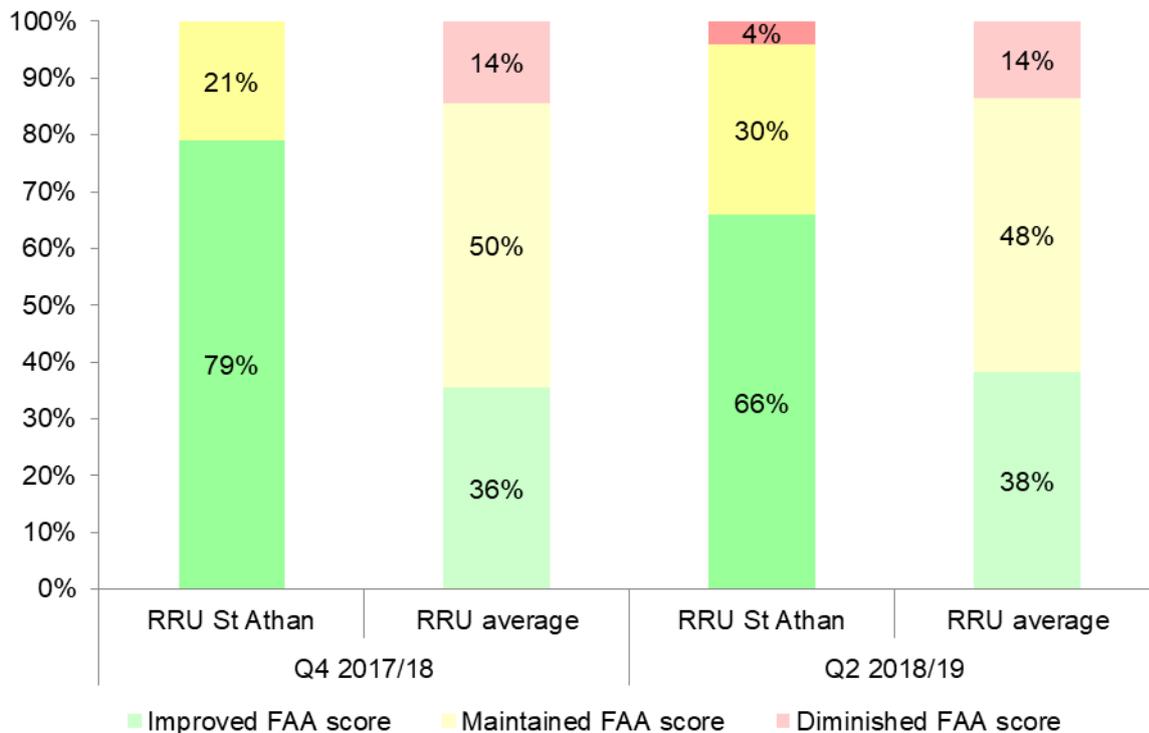
- Patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Relevant and current evidence-based guidance had been identified and developed for defence rehabilitation services and was used to direct how services, care and treatment were delivered. These guidelines determined the necessary assessments and treatments required for specific conditions.
- Rehabilitation was delivered in line with evidence based practice guidance on treating musculoskeletal conditions and provided a holistic approach to rehabilitation. Courses and the trickle feed provided bespoke, personalised treatment programmes for patients, which included attending condition specific exercise rehabilitation and education sessions. The education sessions for the course were based on best practice guidance and had been written centrally and had to cover a range of information to accommodate for different levels of baseline knowledge and understanding between the patients. These education sessions were due to be reviewed to ensure the content was pitched at an appropriate level for patients.
- Staff had access to best practice guidelines to inform the care and treatment they provided to patients. Specific guidelines had been produced to cover a range of conditions seen at the clinic, for example, the management of foot and ankle pain and the management of back pain. The 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. References to the guidelines and evidence which had been used to develop the documents was also identified within the document.
- Evidence based care and treatment was featured in discussions at the annual defence medical services (DMS) conference. Staff at the unit had recently attended this prior to our inspection. Staff told us, on returning to the unit, they would discuss the 'take home' messages regarding best practice care and treatment presented at the conference, and where required, incorporate this into clinical practice. This follow up discussion had not yet taken place at the unit due to the conference only taking place the week prior to our inspection.
- Pain was assessed and managed according to each individual patient. Pain was assessed using a visual analogue scale (a straight-line scale from one to ten which could be used to rate their level of pain) when patients were assessed and in response to

treatments so staff could monitor the effect of these on pain. We saw evidence in the notes we reviewed that pain was discussed and pain also featured in assessment clinics such as the podiatry and MIAC clinic we observed. Patients told us staff asked about their pain during sessions and altered exercise programmes accordingly. Patients felt their pain was managed well.

Management, monitoring and improving outcomes for people

- Validated patient reported outcome measures (PROM) were used for all patients attending the regional rehabilitation unit (RRU), however further direction was needed from DMS senior leaders as to how the RRU were to use information from PROMs to evaluate the service provided and identify areas for service improvement.
- There was a clear approach to monitoring and benchmarking the quality of the service and outcomes patients received following an episode of treatment. The evidence available demonstrated that patients' needs were being met. The RRU collected data from an outcome measure completed on initial contact and discharge from the RRU. The measure used was functional activity assessment (FAA) score. This included outcome scores for all discharges (care pathway complete and care pathway continuing). We received data for January and March 2018 and July and September 2018. We were unable to review data from quarter one (April – June 2018) due to the dashboard being reconfigured at that time. Data we reviewed demonstrated RRU St Athan had higher percentages of improved functional activity assessment scores than the overall RRU average. This meant patients were seeing benefits from the outcomes of care and treatment they were receiving at the unit.

The results for RRU St Athan and the RRU average are displayed in the chart below.



- Quality information was collected, but at the time of inspection was not being used to evaluate the service provided at the RRU. A standardised outcome measure was used

pre and post treatment at the RRU for patients, the MSK-HQ. The MSK-HQ is a short questionnaire which allows people with musculoskeletal conditions to report their symptoms and quality of life in a standardised way. The use of this measure had been introduced across the RRUs in the last three months. However, when asked how this information was going to be used to evaluate the service provided at the RRU, staff were unsure. At the time of our inspection, information as to the future plan for evaluation of the service using the measure had only been provided to the unit verbally. It was confirmed by a senior member of the DMS team that there was not a clear written policy in place at the time of the inspection. There was a planned review of the MSK-HQ data for service evaluation from data collected between September 2018 and February 2019.

- Objective measures were routinely used pre and post treatment to measure any improvements to the patient's condition following the course of treatment. These measures were patient specific to provide an objective measure associated with the patient's injury. Objective measures used included the single leg bridge, straight leg raise, single leg seated press, multi stage walking test, inverted row and the plank.
- Patients had their needs assessed, their care planned and delivered and their care goals identified when they started treatment at the RRU. Prior to starting the course, the patient would be assessed by the physio and ERI to identify their individual needs. During this session short medium and long-term goals would be set in conjunction with what the patient wanted to achieve. Goals set were specific, achievable, measurable and had a timeframe for completion. This enabled a treatment programme to be designed specifically to meet the individual needs of the patient. However, patient goals were not always documented in the patient's electronic record. In only four out of the eight sets of records reviewed reflected the goals set by patients aligned to their rehabilitation. This was in line with the findings of the records audits and low compliance with the documentation of goals.
- Staff ensured treatment was reviewed and optimised for patients. Patients' care and treatments were reviewed on a weekly basis at a multidisciplinary meeting. This provided the opportunity for treatment programmes to be reviewed, to progress patients further and add additional exercise to optimise treatment.
- Patients were attending alternative rehabilitation sessions in replacement of the pool therapy sessions which had been temporarily stopped. Patients were attending other sessions including yoga at the RRU to continue with their rehabilitation to optimise their potential to improve their condition.

Effective staffing

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and on a continual basis. A policy was in place for the statutory professional registration of healthcare professionals in the defence medical services (JSP 950 leaflet 5-1-5). This covered the requirement for professional registration, confirmation of registration on and during appointment, and a list of registered healthcare professionals who could be employed by the Ministry of Defence.
- Registered professionals were supported to meet the requirements of their professional registration. A register of staff professional registrations 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.
- The learning needs of staff were identified and regional in-service training was held at the RRU. Topics for in-service training were decided between the clinical lead physiotherapist and the staff. Staff from the RRU attended the training along with staff from the wider military system including the PCRf and external services including consultants and

radiologists from the local hospital used by the RRU to further intervention for patients if required. This multidisciplinary in-service training enabled greater discussion about treatment of various conditions to optimise care and treatment for patients.

- Staff were supported to deliver effective care and treatment through opportunities to undertake training, learning and development. Staff were supported and encouraged to attend additional military and external training to enhance their knowledge and skills. For example, one member of the team had recently attended additional training in mental health to be able to better support patients attending the RRU. When attending additional training staff then shared this learning during sessions with other staff at the unit to develop knowledge and skills of all of the staff at the unit. This meant all staff at the unit benefitted from the shared learning.
- Locum staff working at the unit were included in all learning and development opportunities available to permanent staff including in-service training and peer review.
- Rehabilitation was delivered by two staff using a combination of ERIs and physiotherapists. Different components of the course or trickle feed patients were delivered by either the ERI or physiotherapist individually, or as a pair when required. Approach to treatment was based on the skills of staff and this also allowed time for staff to treat patients on a one to one basis when required.
- A peer review took place between exercise rehabilitation instructors (ERI) and physiotherapy staff including staff of different grades and discipline. This provided an opportunity for staff to have their practice critically appraised to identify any areas which the needed to develop to ensure high quality care and treatment was provided for patients.
- The learning needs of staff were identified through an appraisal system. At the time of the inspection, 100% staff had completed either their mid-way review or appraisal within their stage of the reporting year. Staff were responsible to arrange their appraisal. This was due to the different requirements for military and civilian staff regarding specific times of the year when these needed to be completed.
- Newly appointed staff were part of a mandatory induction programme. The induction was overseen by the RTSA and ensured staff were familiar with the environment and their role and responsibilities on starting work at the unit.

Coordinating patient care and information sharing

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

- All staff at the RRU, were involved in assessing, planning and delivering patients care and treatment. Joint assessments allowed care and treatment to be optimised for patients due to the provision of a more co-ordinated approach to management of the patient's condition. For example, physiotherapists and ERIs jointly carried out initial patient assessments developing treatment plans for patients attending the course, and the doctor and clinical lead physiotherapist held a joint MIAC clinic. There was also a joint clinic with the physiotherapist, doctor and podiatrist held at the unit.
- Staff had the information they needed to deliver effective care and treatment to patients. Each member of staff had access to the electronic records system which held a contemporaneous, multidisciplinary records of the care and treatment of individual patients at the unit.
- Information needed to deliver effective care and treatment was available and accessible to staff in a timely way. The clinical lead physio told us that there were good relationships with local PCRFs which referred patients to the RRU. The clinical lead would always call

the referrer if a discussion was required about a patient with a complex presentation and additional information was required.

- Internally at the RRU, staff worked closely to plan ongoing care and treatment for patients. A multidisciplinary meeting was held at the RRU on a weekly basis between the clinical lead physiotherapist, physiotherapists and ERIs to discuss all of the patients on the general's course and part of the trickle feed group currently undergoing rehabilitation at the RRU. This meeting enabled the lead clinician to have full oversight of all of the patients at the unit. A review of their care and treatment ensured it was effectively meeting the individual needs of the patients to ensure positive treatment outcomes.
- Arrangements for discussing and sharing information with other professionals outside of the RRU ensured the quality of care for the patient. The unit held a weekly meeting where the local PCRf staff, along with RRU staff were able to bring along complex patient cases to discuss. This session was run by the clinical lead physio and ideas would be shared to support the clinicians in the provision of alternative treatment for patients to ensure the treatment provided was effective to treat their injury. This session enabled staff to pool knowledge and ideas to optimise care and treatment for patients and to also support the development of knowledge and skills of staff to support the development of the local PCRf.
- Staff understood the importance to have the whole multidisciplinary team available to be able to optimise care and treatment for patients. The day of the review meeting for patients attending the unit was changed to accommodate the podiatrist being able to attend the meeting on a weekly basis in alignment with their working hours.
- Arrangements for developing the knowledge and skills with external services, part of the wider system managing military patients enhanced the likelihood of patients experiencing better outcomes from their treatment. The RRU had close links with civilian consultants from the local hospital in Wales who patients from the RRU were referred to for medical intervention outside of the military. Staff from the hospital attended in-service training sessions with RRU and PCRf staff to discuss care pathways and care and treatment needs for specific conditions. These discussions were aligned to the demanding operational needs of the military personnel which for the hospital staff was essential to understand the demands of individual roles and the impact their interventions had on patients. The hospital also provided the opportunity for RRU and PCRf staff to attend the hospital to observe treatment consultations and surgery to develop knowledge and skills.
- Staff completed a handover following the course to transfer patients care back to the PCRf. This handover was completed electronically using the electronic records system. This included a summary of the patient's condition, how they had progressed throughout the course and any long term outstanding goals.
- Patients received clear information prior the course to fully inform them about the treatment they would receive and what was expected. Patients told us this information had been useful and informative.

Consent to care and treatment

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

- Staff understood relevant consent requirements and sought patients' consent to care and treatment in line with legislation and guidance.
- The consent policy was displayed on the wall in the RRU. The policy included the consenting process and staff responsibilities regarding consent processes. The policy also displayed the rights of the patient in the consent process.

- Verbal consent was sought from patients at the start of treatment. We observed individual patient treatment sessions when patients provided verbal consent to their assessment and treatment. Of the eight sets of patients records we reviewed, all of the patients had consented to their care and treatment.
- Patients were supported to make decisions about consenting to care and treatment. 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, risks and contraindications of treatment. All consent forms were signed and dated by the individual receiving the treatment and then scanned onto the electronic record system.

Supporting patients towards optimal function

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

- Patients were encouraged from the start to take ownership of their rehabilitation and promoted self-management from an early stage in the course. The course was designed to directly involve patients in setting short and long-term goals. Patients were supported to take responsibility for their rehabilitation with the view to ongoing self-management on completion of their course at the RRU in order to achieve their longer-term goal.
- Rehabilitation courses included education and information sessions to support patients in developing skills to help manage their own condition. For example, education about pain and pacing activities was delivered so patients could use these principles for their ongoing rehabilitation once they had left the course. Patients on the trickle feed course also received an educational element as part of their rehabilitation, however this was bespoke to the patients individual needs and also aligned to their operational requirements.
- Patient goals were specific so they could achieve what was required from their treatment. Goals were often focused on work-based activities to make sure patients were physically fit to return to the high demands of their operational duties following their rehabilitation.
- Information was available to support patients to manage their own health and wellbeing. In the waiting room there was information leaflets to provide advice and signpost patients to other mechanisms of support with issues such as drinking, mental health problems and stress control management.

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 adapted individual treatments in response to patient feedback. Staff were supportive in their approach to patients. Staff motivated and empowered patients to fully participate in activities to their own ability and drive their own rehabilitation.
- Patient's personal, cultural, social and religious needs were understood and respected. Individual needs of patients and the occupational needs of their employment were fundamental when devising treatment plans
- Results from a patient questionnaire, complete by patients who had participated in the RRU regional course between April 2017 and June 2018 showed largely positive results. The large majority of patients (83%) were strongly in agreement with the statement their physio and or ERI was courteous and considerate towards their needs and 100% of patients said they would recommend the RRU to friends and family members.
- Patients felt they were treated with dignity and respect. The patient satisfaction questionnaire demonstrated 100% of patients felt their dignity and respect was maintained, with 96% of patients feeling they were given all the privacy they required. The other 4% of patients either didn't know or this question was not applicable to them. However, we observed during a treatment session in the MIAC clinic privacy was not always maintained. During the session the door of the clinic room was opened to provide alternative lighting into the area so the ultrasound could be seen clearly. Patients in the gym area could clearly see into the treatment room. At the time, the overhead light in the room was not switched on. Additional lighting in the room would have helped to maintain the privacy of the patient undergoing treatment in the MIAC clinic room. Following the inspection, the unit provided us with evidence that the lighting issue in the MIAC room had been escalated to identify a resolution to the problem.
- All interactions between staff and patients were appropriate and respectful. Staff built up a rapport with patients quickly and we observed friendly communication, with them engaging in day to day conversation.
- Patients described staff as 'supportive' and 'encouraging.' Patients who had attended other RRUs in the past spoke favourably of St Athan in terms of the support that they had been given. One patient told us the felt there was a 'professional approach' from staff.
- Staff demonstrated a helpful supportive attitude towards patients. We observed staff interacting with patients and providing encouragement and praise during the sessions.

- Staff were passionate and motivated to see their patients benefit from their rehabilitation. It was evident from all interactions between patients and staff, and the way staff spoke about the patients, that provision of high quality care was the main focus.

Care planning and involvement in decisions about care and treatment

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

- Staff were able to form close professional relationships with the patients due to the nature of their work. Over the course duration of three weeks, they were able to spend time talking to patients about their care, treatments goals and progress. Staff showed an encouraging, and supportive attitude towards patients.
- The large majority of patients (70%) strongly agreed with the statement 'I was involved in making decisions about their treatment plan,' whilst 25% of patients agreed with this statement.
- Patients were encouraged to be active partners in their care. Results from the patient satisfaction questionnaire showed 100% of patients felt that their care and treatment was explained to them and staff kept them informed. All of the patients felt they were provided with clear instruction and felt they understood the risks and benefits of specific treatment methods. However, although a large majority of patients (83%) felt staff used words and phrases which they understood, however, 13% of patients disagreed and felt this was not the case.
- Staff communicated with patients to make sure they understood why they were doing specific exercises. We observed staff clearly demonstrate exercises to patients and take the time to explain the relevance of the exercise and how this would benefit the patient. Staff took the time to correct the technique used by patients to ensure they were the exercises would have optimum impact on the patient.
- There were opportunities for patients to ask questions and be involved in their care and treatment. Due to the nature of the model at the RRU, there were opportunities for staff to work 1-1 with patients. This provided a safe environment for patients to ask questions about their treatment. This in turn helped facilitate patients to take control to manage their rehabilitation independently with guidance from the staff.

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.

- It was evident staff clearly understood the impact which patients care, treatment or condition had on their wellbeing. Staff spoke clearly about the needed to make sure patients were receiving care and treatment at the right time to optimise their chance for recovery. Staff had recognised with the patient group coming through the unit, mental health issue could pose a challenge to engagement with rehabilitation and the patients future. To be able to support patients emotionally, a member of staff had attended

additional training in mental health issues and the unit had good links with the mental health team onsite.

- Staff supported patients to manage their emotional needs and understood how working in a high-pressured environment could affect engagement with rehabilitation and jeopardise their ability to make a full recovery from injury. For example, ERI's worked to support a patient who was finding compliance with rehabilitation a challenge due to other work commitments. The ERI's worked to provide coping strategies for this patient and restructured the rehabilitation programme to promote improved engagement and self-management of the situation.
- Patients were encouraged to link with other course participants while they were completing their rehabilitation. Patients had the opportunity to stay in RRU accommodation on site, which provided them with the opportunity to socialise together during the course, during meal times, and in the evening.
- Staff responded to patients who were experiencing pain quickly and effectively. Patients told us that staff always reviewed their pain and acted quickly to alter exercise programmes for patients to respond to their individual needs.

Are services responsive to people's needs?

Outstanding



Our findings

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

Responding to and meeting patients' needs

The unit uses information about the needs of the Population at Risk (PAR) within the Area of Responsibility (AOR) to inform how services are planned and delivered. We found they had a plan, which enabled them to meet the needs of the PAR, particularly those with complex needs, long-term or career-limiting conditions.

- Patients individual needs were central to the planning and delivery of tailored services at RRU St Athan. The model of care, provided by the unit reflected the individual and holistic needs of the military population and met the occupational based requirements of patient's employment within the geographical area of responsibility. The RRU treated patients from all three military services.
- The RRU provided two models of care. The trickle feed model was a specifically adapted rehabilitation course which catered to the increased demand for availability of military staff and the need to reduce waiting times. This model enabled individuals to be ready for active duty within defined timeframes of their operational commitments. The trickle-feed service provided services to the specialist infantry population at risk or high-performance individuals (e.g. those awaiting promotion courses or about to deploy in a front-line role). The nature of the rehabilitation was bespoke to meet the needs of the individual's role. The model enabled flexible delivery of the service where rehabilitation could be tailored specifically for patients which were unable to spend a full three weeks away from work or conversely, patients which needed longer away from their role due to their injury.
- The unit also provided a general's course (a course that provided general rehabilitation for a range of injuries) which was held at the RRU. The generals course was held and patients with a range of injuries including upper limb, lower limb and back injuries attended for a period of three weeks for rehabilitation. Within the area of responsibility, the population at risk did not generate the need for specific courses.
- If the RRU was unable to meet the needs of the patients though the trickle feed and generals course, patients could be 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 other healthcare services if this was in the best interests of the patient.
- The trickle feed model provided continuity of care, flexibility and choice for patients ensuring their full engagement in rehabilitation to optimise their ability to make a full recovery. On starting the trickle feed course, patients were assessed and a personalised rehabilitation programme was set up in conjunction with the patient. Instructors worked 1-

1 with patients for periods of time during their session and tailored their exercise programme accordingly for the session, in conjunction with information provided by the patient at the start of the session. Additional exercises could be added or exercises simplified depending on how the patient had responded to their previous session. Rehabilitation was also progressed accordingly, in line with operational requirements.

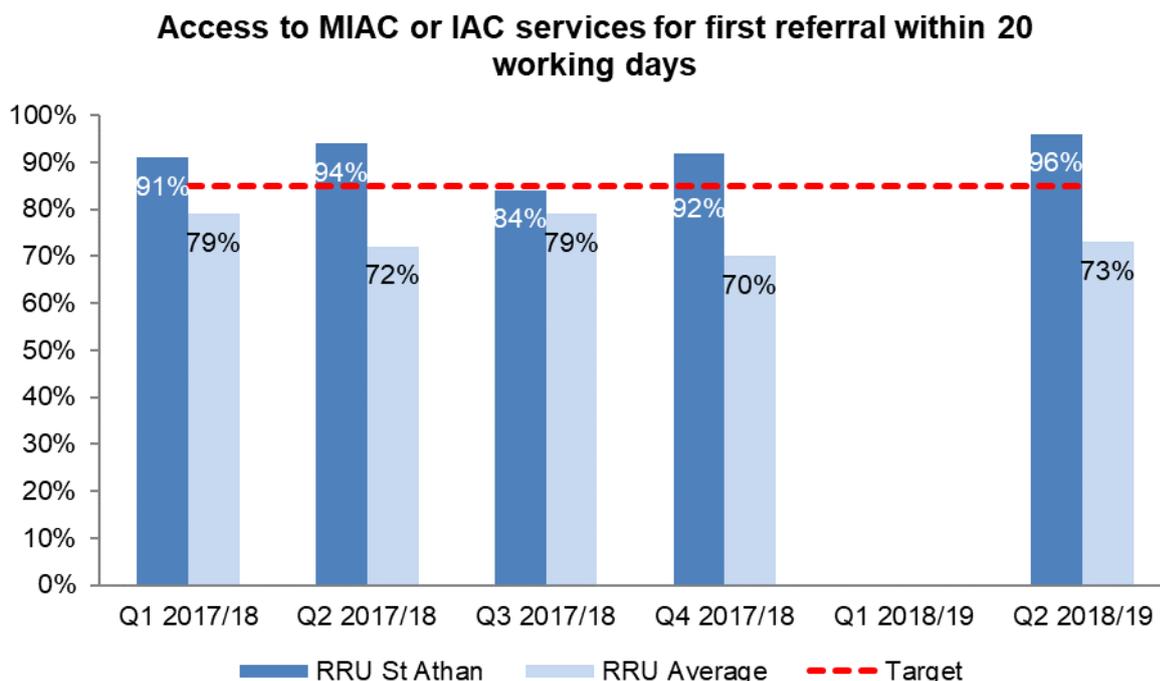
- Services were planned to take into account the holistic needs of different people including those in vulnerable circumstances. The RRU had close connections with local mental health teams and occupational health nurses. This was a requirement due to the large number of complex patients requiring specialist input, suffering from anxiety and depression. This enabled the RRU to have a holistic understanding as to whether the patient was ready to return to work. This enabled the RRU team to work closely with the chain of command involved with the individual to establish an appropriate strategy to return the patient to active duty when appropriate to do so.
- A shared drive to meet individual patients needs and optimise their chance of recovery had created opportunities for learning between the RRU, the wider military DMS system it supported and the local hospital. It was the role of the band 7 clinician at the unit to provide clinical support to the PCRFs across the region. In order to provide additional support, the clinician had facilitated opportunities for learning. These included staff at the local hospital attending in-service training provided by the RRU and local PCRFs. In turn, staff from the RRU and PCRf had the opportunity to observe treatment and surgery at the local hospital. This shared learning provided a better understanding as to the challenges they faced to meet individual patient needs and patient and military expectations.
- The adoption of a system wide approach and involvement of local PCRFs was integral to how services were planned and delivered. This enabled joined up working to meet the needs of individual patients in a timely way. A system had been developed to enable the local PCRf to liaise with the band 7 clinician at the RRU via telephone to arrange scans for patients. This would enable patients with high operational needs, needing to return to active duty within a shorter timeframe access the right care and treatment in a timelier way, without having to attend an appointment at the RRU MIAC clinic, but with all the benefits of discussing their condition with the MIAC clinician. This also enabled care and treatment to be optimised for the patient to support return to active duty.
- There were proactive approaches to providing integrated person-centred pathways of care involving other services particularly for people with high operational needs. The RRU worked with a local infantry unit battle school as part of the wider military system. The RRU were able to support the unit to arrange a fast track MRI scans for injured military personnel. There was a 48-hour timeframe in which a decision needed to be made as to whether it was appropriate for the person to remain in the course with the injury they had sustained.
- There were innovative approaches to the future planning and delivery of services for patients with high operational needs. It was evident the need to optimise patient access and care and treatment for patients was a key priority for staff at the unit. A recent review had been carried out on the trickle feed model and the service as a whole at RRU St Athan. Performance data had been reviewed along with patient feedback and a decision had been taken to carry out a six-month pilot of a dual trickle feed model of care. This model would continue with the current trickle feed system, however the generals course would also be run on a rolling trickle feed system. This was due to be piloted from April 2019 for a period of six months and if successful would continue. Staff were aware of the challenges that the new model may present, for example increased demand on staff to provide continuous access to services, but were keen but to implement the developed model to benefit the population at risk.

- The RRU had been a driving force ensuring equality and overcoming the challenges to accessing NHS treatment for military staff in Wales. Escalation of concerns and identification of the challenges to accessing NHS care for military patients in Wales had led to a Welsh accelerated MOD contract and pathway for patients into the system. Referrals were at the discretion of the clinical lead physio at the RRU and sent to a fortnightly panel for funding to be agreed.
- Facilities and premises were flexible to meet the needs of a range of people who used the service. The RRU had a wide range of fitness, strength and conditioning equipment to meet the specific rehabilitation needs of the PAR. Additional funding had been secured to ensure additional equipment required was available. Bespoke rehabilitation environments were available including a large gravel pit to rehabilitate walking, running and landing on unstable surfaces, a balance and proprioception area and access to a large variety of cardiovascular equipment, weights machines and free weights.

Access to the service

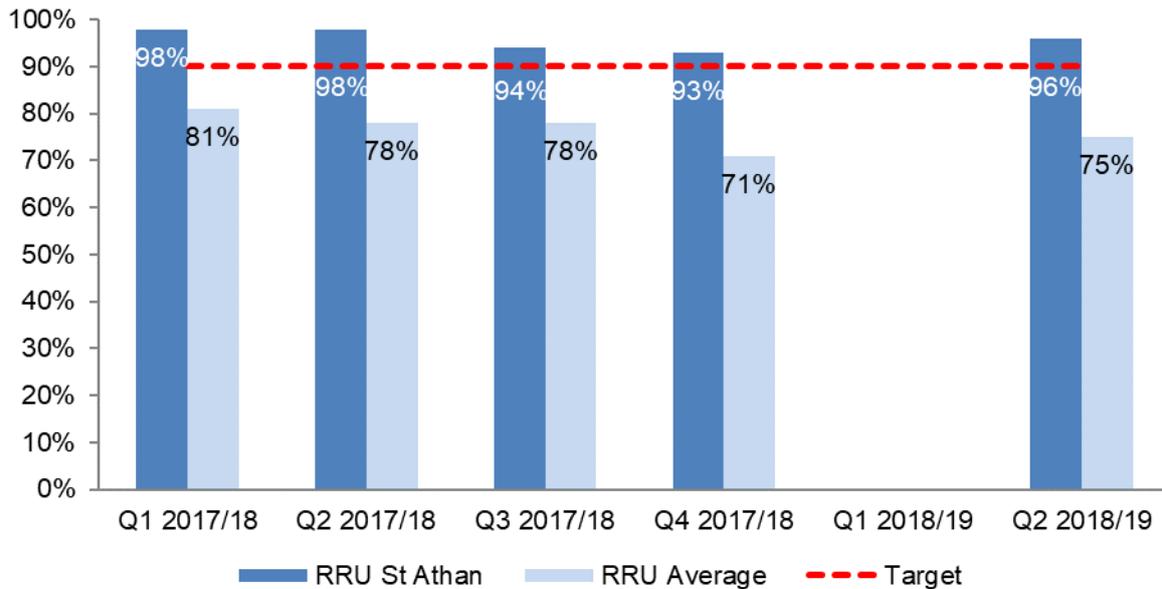
The unit provided assessment and treatment services between 9am and 5pm from Monday to Friday

- Patients had timely access to initial assessment, diagnosis or urgent treatment in a way which suited them and the unit way exceeding DMS targets for access to services.
- The target for undertaking new patient assessments was set at 85% for initial assessments to be offered within 20 working days of referral. The service and both met and exceeded this target between April 2017 and September 2018. Between this time period, the RRU received an average of 72 referrals for the MIAC clinic per quarter. Between 84% and 96% of patients had received an initial assessment at the MIAC clinic within 20 days. Data demonstrated RRU St Athan had performed better when compared to other RRUs in this time period. Data was unavailable for quarter one of 2018/2019 due to the dashboard being reconfigured.



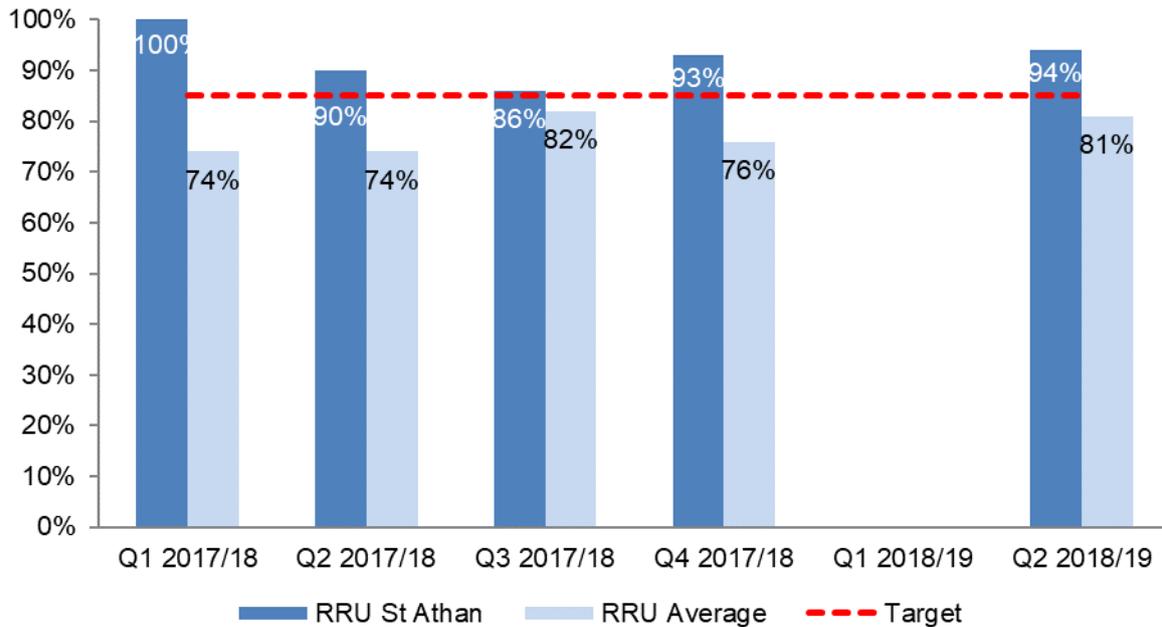
- There was a target for accessing an RRU course. This was for 90% of patients, to be offered a course starting within 40 working days of the MIAC appointment. The RRU had met this target and exceeded the RRU average performance. Between April 2017 and September 2018, between 93% and 98% of patients were offered a course starting within 40 days of their MIAC appointment. The RRU had performed better than other RRUs within this time period. Data was unavailable for quarter one of 2018/2019 due to the dashboard being reconfigured.

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



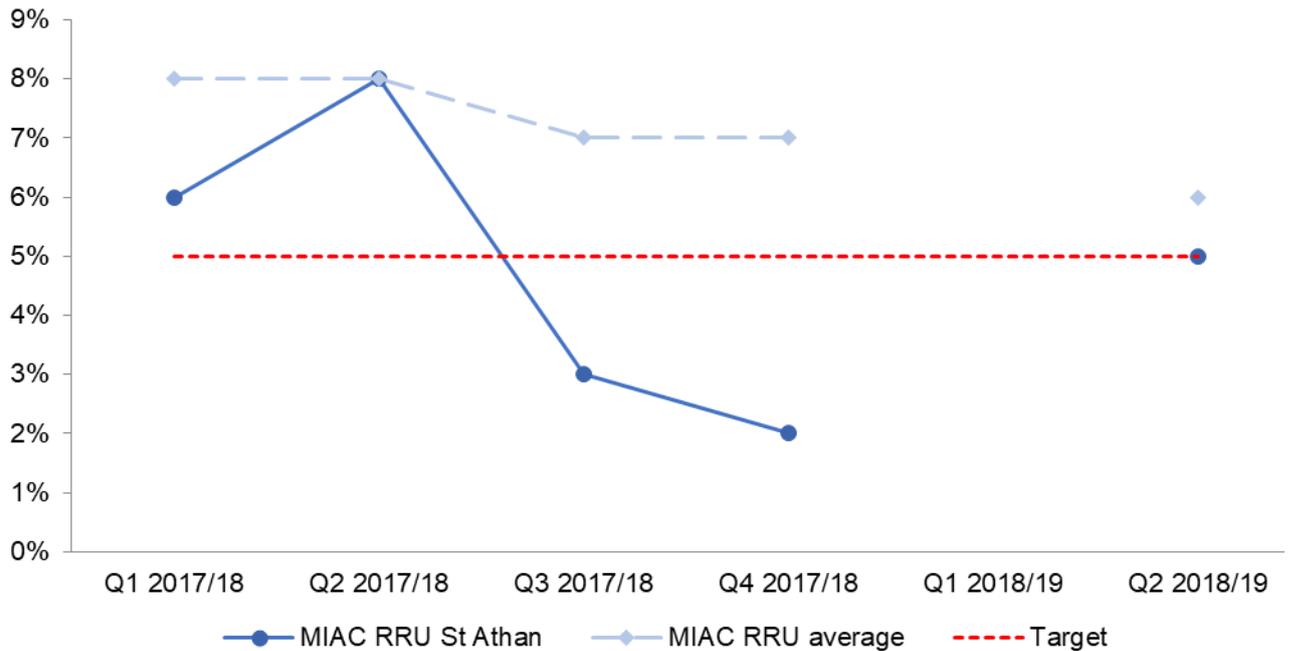
- Offering patients access to a podiatrist within 20 working days of a referral was another performance target set by the DMS. The target for this was 85%. The RRU had met this target between April 2017 and September 2018 where between 86% and 100% of patients saw a podiatrist within an allocated time period. The RRU had performed better than other RRUs within this time period. Data was unavailable for quarter one of 2018/2019 due to the dashboard being reconfigured.

Access to podiatrist for first appt within 20 working days



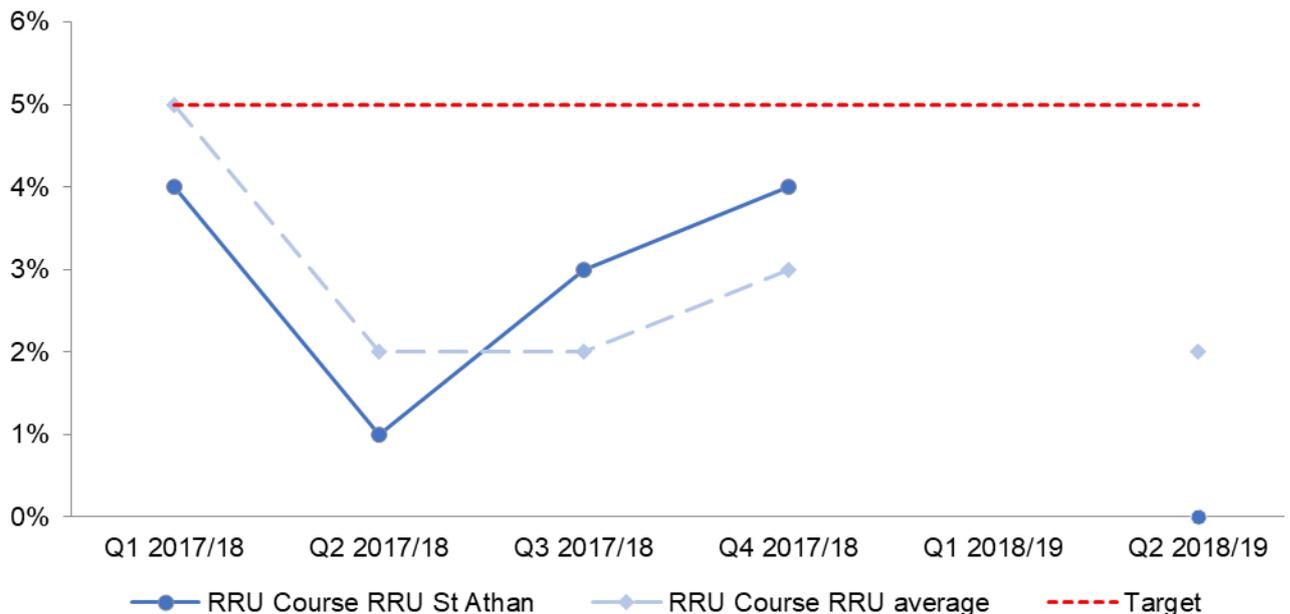
- Due to the nature of the population served and the need for individuals to return to operational duty at short notice, there was a high chance of patients having to cancel appointments at short notice. Despite some cancellation rates being higher than the RRU target, for the MIAC clinic and podiatry, the rate was still better than the overall RRU average.
- MIAC services short notice cancellation rate (less than one working day) at RRU St Athan ranged between 2% and 8% between April 2017 to September 2018. Between April and June 2017 and July and September 2017 short notice cancellations exceeded (were worse than) the RRU target of 5%, at 6% and 8%. However, despite exceeding the RRU target, data demonstrated performance was better than the RRU average between April and June 2017 and on par with the RRU average for July to September 2018. Overall data was showing an improving trend. Data was unavailable for quarter one of 2018/2019 due to the dashboard being reconfigured.

Cancellations with less than one working day notification - MIAC



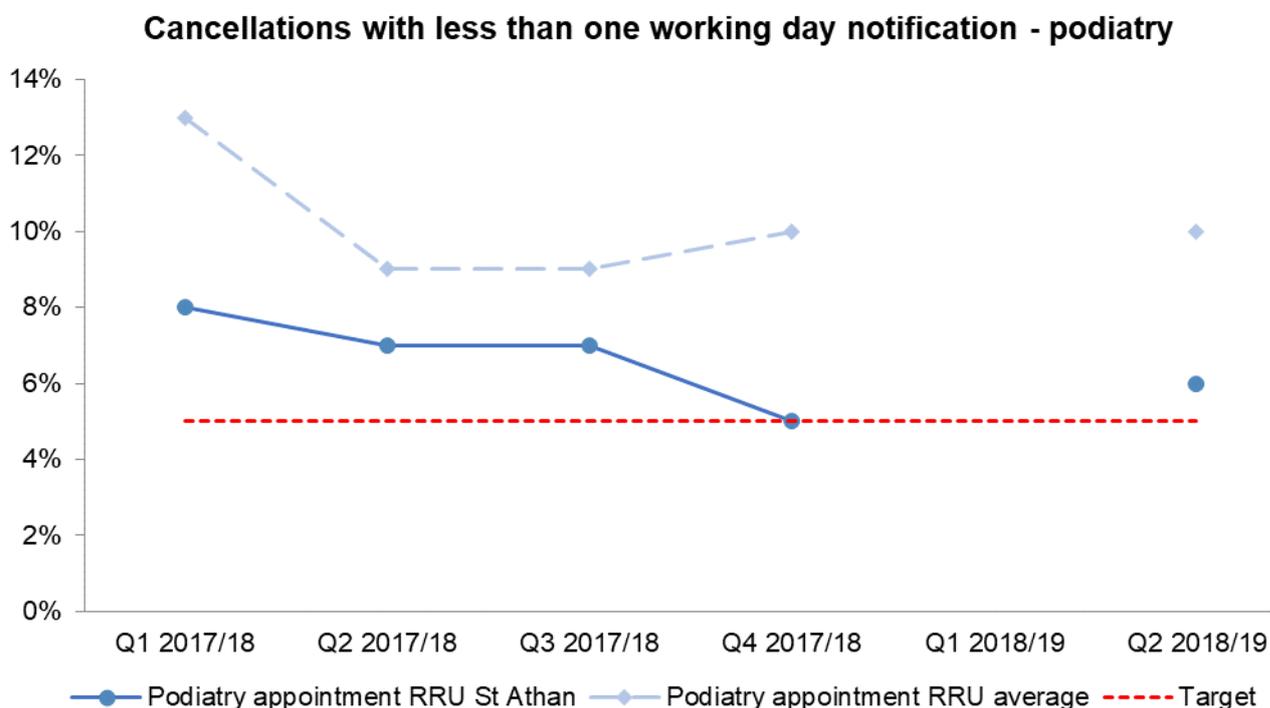
- RRU course short notice cancellation rate (less than one working day) at RRU St Athan ranged between 1% and 5% between April 2017 to September 2018. Between April and June 2017 and July and September 2017 short notice cancellations were below (were better than) the RRU target of 5% and similar to the RRU average. Data was unavailable for quarter one of 2018/2019 due to the dashboard being reconfigured.

Cancellations with less than one working day notification - RRU course



- Podiatry service short notice cancellation rate (less than one working day) at RRU St Athan ranged between 5% and 8% between April 2017 to September 2018. Between this time period short notice cancellations were worse than the RRU target of 5% between July 2017 and December 2017 but the same as the RRU target between January and

March 2018. Data was unavailable for quarter one of 2018/2019 due to the dashboard being reconfigured.



- Referrals were received electronically using the specified pathway initiated by the primary care unit. Electronic referrals were monitored throughout the day by the administration team and were triaged on the same day by the service or clinical lead.
- The service prioritised care and treatment for patients with the most urgent need. Referrals were classed as urgent and routine, and triaged by the clinical lead physiotherapist. Urgent referrals could be seen at the first available clinic within five working days whilst routine referrals were seen within 20 days. Referrals were allocated according to clinical and/or military needs. Referrals would be classified as urgent if the information identified red flags (symptoms indicating a more serious pathology) or if the patient was due to be deployed. The lead clinician would let the referrer know the outcome of the decision and would telephone a referrer when the referrals was inappropriate or there was an unusual clinical presentation.
- 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 patient and referring unit. If this was not convenient, the appointment could be altered to suit the needs of the patient. Patients were given a choice of dates and time in line with availability to access the courses or follow up appointments. Patients were able to book follow up appointments or book onto courses following their initial appointment so they were clear when they were next attending. This also ensured there was no delay between the initial appointment and patients starting on a course or attending a follow up appointment.
- Administration staff were very aware of the large geographical patch covered by the RRU and where possible, tried to accommodate patient appointments and also offered patients travelling a long way overnight accommodation.
- The trickle feed model provided a continuous route into the RRU for patients over a seven-week cycle. This meant patients did not need to wait to access the care and

treatment they required to overcome their injuries and were able to return to active duty in a more timely way.

- 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.
- Patients had access to fast track diagnostic imaging for identifying and monitoring diseases or injuries, if required, at a local private hospital.
- Technology was used innovatively to ensure patients had timely access to ongoing treatment, support and care. Alternative arrangements were made for patients within the population served by the RRU to accommodate for individual patient and operational needs. Telephone consultations were provided by the MIAC clinician where appropriate to update on test results, review rehabilitation programmes, and discuss further treatment. This prevented patients traveling long distances due to the large geographical area covered by the RRU and supported military operational commitments.
- Services were planned to take account of the needs of different patients. All reasonable efforts and adjustments were made to enable patients to receive their care or treatment. The unit was fully accessible for all patients. A verified equality and diversity policy was in place for the service, which outlined the requirements to treat all job applicants, staff, patients, or any other person fairly. The policy covered the requirements based on protected characteristics (race, age, sex, sexual orientation, marital status, disability) and any other characteristic defined. All staff at the RRU had completed equality and diversity training.

Listening and learning from concerns and complaints

The unit had a system for handling concerns and complaints.

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

- Concerns and complaints were listened and responded to and used to improve the quality of care. There was a policy available to provide guidance for staff about complaints made about healthcare services provided by the defence (JSP 950 leaflet 1-2-10). This covered how the complaint was to be dealt with, including the stage of communication and investigation. The policy stated informal verbal complaint would be dealt with locally by the end of the next working day.
- In November 2018, the service had received six compliments and one written complaint. The one written complaint was not directly linked to the RRU or the services provided and was out of the control of the RRU. The complaint was associated with the quality of the food on the camp. Despite being out of the RRUs control, we saw evidence that this issue had been escalated to the appropriate person to take the complaint forwards. The other six comments were positive and acknowledged the positive experience patients had on the course. We were unable to see any log of complaints received from January 2018. No log of complaints was maintained until the new service lead started in post in prior to our inspection.

- Patients were clear how they could raise concerns and complaints. Patients were able to describe how they would provide feedback or make a complaint. Information was also provided as to how to make a complaint in the patient's information pack.

Are services well-led?

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

Good



Our findings

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

Vision and strategy

- There was a clear vision and a mission statement set out for the service, with quality and safety the top priority. The mission statement for the RRU was 'to sustain and improve the training and operational effectiveness of injured service personnel by provision of high quality targeted rehabilitation, accelerating their return to optimal physical capability, whilst influencing their psychological and social health.' The vision and team ethos identified 'a combined approach from the whole RRU team, supporting positive attitude, and striving always to improve quality with the consistent aim to progress service delivery for patients. Through fostering and valuing our team spirit, there will be trust in each other to deliver for the team and the patient. Respect for staff and patients, the maintenance of the highest professional standards and safe, caring delivery.'
- Staff understood the vision and mission set out for the service. It was clear from speaking to staff and their interaction with patients, staff had a clear understanding of the importance of providing high quality, personalised rehabilitation to patients. Staff had an awareness of the wider situation and spoke clearly about the need for patients to be able to access care and treatment at the right time, to optimise their chances of returning to full operational capability in a timely way.
- There was a specific strategy and operational guidance for the defence medical rehabilitation programme, which contained detail on how the local services fitted into the overall strategy and operational framework. The document provided a detailed account of how services ran, what services were included, care pathways, all treatment referral clinical guidelines and facilities.
- The strategy for all defence medical services detailed in the defence rehabilitation concept of operations document had been developed centrally. The unit had also a quality improvement plan which aligned with the strategy. The quality improvement plan set out specific areas of planned service improvements, for example, around training. RRU infrastructure and clinical governance. The plan also included a record of activities carried out by staff, which were deemed to have an indirect effect on improving overall clinical delivery to patients. This was a result of experiences gained by staff when taking on additional roles and activities.

Governance arrangements

The service had an overarching governance framework, which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured responsibilities were clear and that quality, performance and risks were understood and managed. While there was a system and a process to identify risks associated with the unit, 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.
- Governance arrangements at RRU St Athan needed to mature and become embedded into the service to provide a good oversight of safety, quality and risk at the RRU. Some gaps existed in identifying and documenting risks and further staff engagement was required to ensure staff had a good understanding of quality, safety and risk at the unit.
- Governance meetings were held approximately every eight weeks. The topics covered included safe clinical governance including finance, patient focus, accessible responsible care, care environment and amenities, public health, and occupational health. We reviewed two sets of minutes from meetings which took place in August and October 2018. Minutes were complete and included items discussed and an actions log.
- There was a focus on issues relating to a forward view of the service and actions which needed to be taken in a proactive way. For example, in the October 2018 there had been a discussion on forward planning for return to clinics after the Christmas break and making sure adequate numbers of staff were on duty.
- In addition, staff meetings were held every two weeks which were documented. On the weeks between these meetings a diary check was completed which was an informal meeting that was not documented. This provided staff with the opportunity to talk through their diary plans and capacity and resolve any issues which may occur.
- A common assurance framework (e-CAF) assessment was a live document used to support the delivery of good quality care. An electronic version of the document had been introduced at the unit two months prior to our inspection. The self-assessment e-CAF framework was based on eight domains. These included safety, clinical and cost effectiveness, governance, patient experience, accessible and responsive care, care environment and amenities, public health, and occupational health. The unit was fully compliant in five out of eight domains and substantially compliant in three domains. These included clinical and cost effectiveness, governance and patient focus. Although three areas demonstrated substantial assurance of compliance with the domains, there were no associated actions to ensure the unit could improve to provide full assurance of compliance with the domains. Also, when reviewing the document, not all of the information was available on the e-CAF. Also, some of the sections were incomplete, however the required information was available to review on the document which was used prior to the e-CAF. This questioned how regularly this live document was being used to support service improvements and the delivery of good quality care.
- There were systems and processes to identify, manage and mitigate risks associated with the unit. The unit maintained a risk register which identified 14 risks. Risks were rated and management plans and mitigating actions had been identified to manage the risk. A responsible person had also been designated to oversee and manage the risk.
- Top risks included information confidentiality in line with Caldicott guidelines, due to the open plan space which was not conducive of maintaining confidential information. The service identified in August 2017 that the office set up resulted inpatients coming into the

office and potentially viewing other patient information. One incident report had been documented by the administrative staff in September 2018 who continued to be concerned by this. No incidents occurred which involved confidential information being shared inappropriately. Mitigations had been put in place to reduce this risk however it still remained on the risk register as a red risk with a score of 20. It was unclear whether the risk has been re-scored following the mitigation and whether 20 remained an appropriate risk rating despite mitigation.

- The second highest risk was infection control issues including the lack of plumbing in clinical rooms. This also had associated mitigated actions which included using mobile water pumps suitable for hand washing. This risk was currently rated 16. Other risks included the infrastructure of the building and the future of St Athan RRU in its current location.
- A proactive approach was taken towards risk management and mitigation of identified risk however some gaps existed in identifying risks and clearly documenting information. The risk register included updates of current control measures and mitigation actions, and identification of outstanding issues which needed to be followed up. The risk register did not include information on the previous risk score so a comparison could not be made between the original risk and the new level of risk with the mitigations in place. This would have been beneficial to evaluate and plan for future mitigations.
- We reviewed one risk in detail. This was the retired risk on the register which related to health and safety issues at the swimming pool used to undertake hydrotherapy sessions for patients. This risk was retired as the service had stopped using the pool due to the risk. However, there had been no further identification as to ongoing issues which needed mitigation, for example, the impact of the lack of hydrotherapy sessions for patients access this service during their rehabilitation. This would have been beneficial to understand the impact of this action and the level of importance to resolve it in the future.
- There was evidence of actions to try and resolve this risk with regular meetings taking place with local provider and main base to discuss issues, work through military requirements for lifeguard cover and local provider provision in line with local authority. Options were being reviewed including increasing funding for extra lifeguard cover, changing the standard operating procedure and need for a lifeguard, changing the time of sessions to fit with when extra provision is available by provider, or searching for alternative provider. Escalation through head office was currently taking place for a decision to be made in the coming months.
- Staff at the unit had some understanding of risk at the unit however, their knowledge and understanding needed further development. For example, when talking about risks, staff did not talk about the impact the risk could have on service delivery and some key risks around the cleaning issues and the swimming pool were not identified as risks. Risks were mentioned through the minutes from the governance meetings, with an update given and actions specified. However, there was no reference to the risk register document and any evidence of in depth discussions of risks. Current provision of information did not provide staff with the level of detail and understanding needed to understand all of the risks associated with the unit. Further engagement of the staff with regards to governance issues at the unit was required.
- There was a systematic programme of clinical and internal audit used to monitor quality and identify areas for improvement. An audit log was maintained which identified which audits were to be completed, how often, when they needed to be reviewed and who was responsible for the audit. Audits had been completed for clinical records reviews, patient satisfaction of the courses and infection control. For 2018, eleven audits had been completed and a further two were due for completion between January and March 2019.
- We reviewed the audit procedure completed for confidentiality. There was one area identified that required action, which was not all staff wearing name badges. New name

badges had been ordered, however, the unit had been informed that there was no funding for name badges and staff would not receive new name badges. All other aspects were compliant for the general audit. The audit also included a staff specific section which reviewed individual knowledge and further actions identified to improve understanding of confidentiality.

- 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 RRUs. This meant an overall comparison could be made to benchmark how well the unit was performing. We reviewed the dashboard, which gave comprehensive information for the service. Data demonstrated, in a number of areas St Athan RRU was performing better than other RRUs such as their waiting times for courses and appointments and for short notice cancellations in all services but podiatry (6%). Despite this, the unit was still performing better than all of the RRUs combined, however, St Athan RRU was just falling short of the DMS target of less than 5%
- Staff were clear about their roles and understood what they were accountable for, including any additional roles and responsibilities they held. For example, all staff at the unit had secondary lead role in areas such as mandatory training and infection control, security and induction lead.

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.

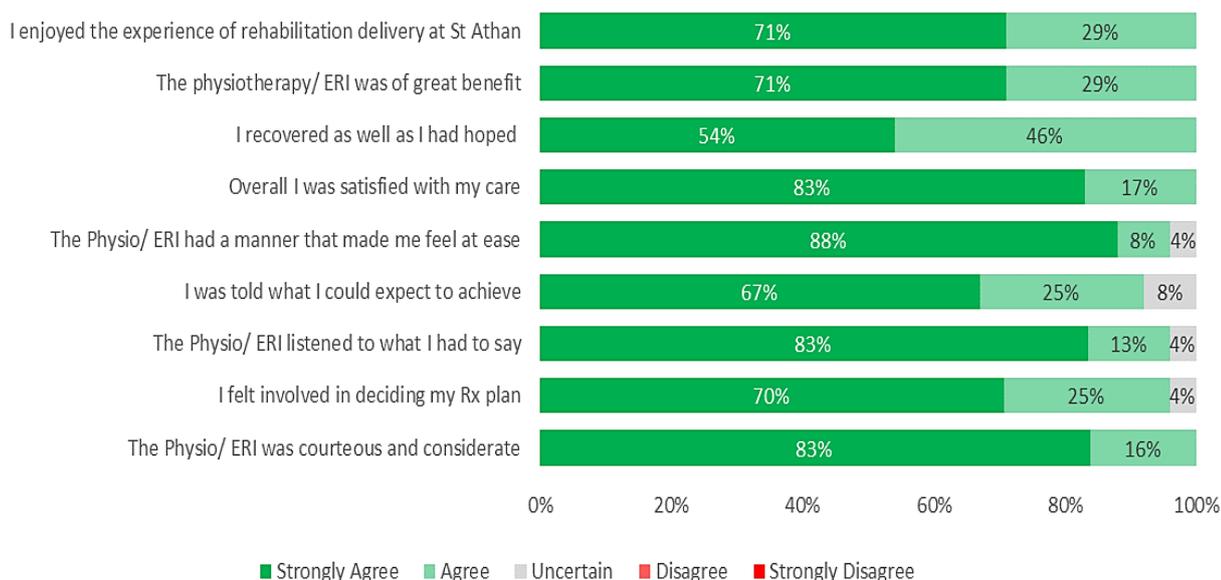
- Leaders had the skills, knowledge and experience to carry out their roles effectively. The service lead, despite being in post for only two months at the time of our inspection had skills knowledge and leadership skills from role held across their military career. The clinical lead had also held a longstanding role in the military and as a civilian. Staff spoke highly of the leadership from the service lead and clinical lead and how they were supported and empowered to develop their knowledge and skills. The service lead was very complimentary about the leadership and direction the clinical lead had provided during the six month gap the RRU had without OC cover and their commitment to the patients and the provision of a high quality service.
- Leadership and culture at the unit reflected the vision and values of the DMS, and were driving a wider systems approach to improve the quality of care for patients in the area. Leaders and staff demonstrated their commitment to improve quality of care for patients, by developing the knowledge and skills of the local PCRFS and supporting them to evolve. A weekly meeting was held once patients had completed their rehabilitation for the day for all staff at the RRU, which also included the staff from the local PCRFS. This meeting provided a platform for staff to bring complex cases to the group to be discussed. This enabled staff to get support from their peers and the clinical lead at the RRU with the aim of optimising care and treatment for patients. The service lead planned to further develop this meeting to include PCRFS staff from the region.
- There was a culture of strong team working both internally between RRU staff and externally with other organisations, to ensure the best care and treatment was provided for patients. Staff supported each other on a daily basis and worked together to provide high quality care for patients. Staff told us of the supportive relationships in the RRU and

of the opportunities they had as a team to review the care and treatment being provided to individual patients. Staff also worked closely with external providers of care for military staff, including consultants and radiologists from a local hospital. External staff regularly attended regional in-service training led by the RRU. This provided external staff with the opportunity to better understand the military requirements following the outcome of surgery and medical intervention to enable military personnel to get back to full operational activity. This enabled better team working due to all clinicians having a better understanding of the expectations of military requirements.

- Staff felt respected, valued and leaders encouraged supportive relationships between staff. Staff felt they could raise any worries or concerns and that these were always listened to and acted on. All staff at the unit, along with the service lead spoke of an open-door policy.
- Leaders were visible and approachable and staff were confident to speak up and raise concerns if required. The service had a military hierarchy of staff who delivered the services. Despite this, all staff felt confident and safe to speak openly about any concerns they had.
- Promoting the safety and wellbeing of staff was emphasised at the unit. Staff told us they looked after each other and set up healthy competition when they trained together at the unit. They also told us of the relaxed working environment and the supportive working relationships they had with each other.

Seeking and acting on feedback from patients and staff

- A defence medical services patient questionnaire was used to gather views and experiences from patients following their treatment. Questions were focused on the clinical staff, administrative staff, cleanliness of the department, the quality of the service, and comments on patients' experience.
- The analysis revealed that 83% of respondents strongly agreed with the statement 'Overall I was satisfied with my care', with the remaining respondents agreeing with the statement.



- Feedback was collected and used to adapt and develop the way the course ran. On completion of a course, all patients completed an end of course evaluation patient feedback questionnaire. Feedback was displayed in the RRU. Feedback identified that patients were satisfied with the care and treatment provided at the RRU. The only negative feedback provided by patients was about the food provided at their camp. This

issue did not relate to the RRU service provided and was largely out of the RRUs control. We did however see evidence this issue had been escalated to highlight repeated concerns raised by patients

- Staff were encouraged to give feedback and discuss any concerns or issues with colleagues and management. There was an open-door policy and staff felt comfortable to raise any issues or concerns with the service lead. They felt they were always listened to and well supported.
- Staff felt actively engaged with the planning and delivery of the service and shaping of the culture. The service lead echoed how the staff had been the driving force in developing the dual trickle feed approach which was due to be piloted at the unit in April 2019. The culture at the unit was developed around providing a personalised patient focussed service to meet the needs of each individual, in a timeframe which met their military operational requirements. Staff told us how they had been actively involved in developing the current model of care provided at the unit and how they had felt listened to and involved in looking to provide a higher quality service in the future for their population at risk within their area.

Continuous improvement

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

- The service had a quality improvement plan which covered specific areas of focus including rehabilitation courses, specialist clinics, clinical governance, RRU infrastructure /gym/equipment, training and miscellaneous. Examples of quality improvement programmes under rehabilitation included, a standard operating procedure for the trickle feed course, effectiveness of outcomes for courses, scoping trickle feed for both courses for patient group, improving joining instructions and course instructions. For specialist courses programmes included, improved access for routine secondary care, assess clinical effectiveness, reducing risk of MIAC capacity (Dr hours), satellite MIAC clinic at Hereford and best practice guidelines for MIAC clinic including timeframes pause points.
 - The quality improvement programme had clear objectives, a method of improvement, success criteria, who was responsibility, timescale, monitoring, key parts and outcomes. Workstreams clearly stated what was expected and a timeframe for completion.
-