

Defence Medical Services

Aldershot Regional Rehabilitation Unit

Inspection Report

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

Ratings

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

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

We carried out an announced comprehensive inspection at Aldershot Regional Rehabilitation Unit (RRU) on 5 June 2019.

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 practice was safe in accordance with CQC's inspection framework

- There was a system for reporting and recording significant events. Incidents were investigated. Themes were identified and appropriate action had been taken to minimise further occurrences.
- Essential systems, processes and practices were available to ensure patient safety.
- Risks to patients who used services were assessed and their safety was monitored and maintained.
- The unit had adequate arrangements to respond to emergencies and major incidents.

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

- Patient's needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance.
- There were effective systems for the management, monitoring and improving outcomes for patients.
- 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.
- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the unit's patient record system and their intranet system.
- Staff sought patients' consent to care and treatment in line with legislation and guidance.
- The service identified patients who may be in need of extra support and signposted them to relevant services.

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

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

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

- The unit used information about the needs of the Population at Risk (PAR) within the Area of Responsibility (AOR) to inform how services were planned and delivered.
- Facilities were not always appropriate for the services that were planned and delivered. The numbers of patients being seen in the service had increased, often there would be three courses running concurrently.
- Patients did not always have timely access to initial assessment, diagnosis or treatment.
- The unit had a system for handling concerns and complaints.

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

- There was a clear vision and a mission statement set out for the service, with quality and safety as the top priority.
- The service had an overarching governance framework, which supported the delivery of the strategy and good quality care. This outlined the governance structures and procedures and ensured responsibilities were clear and that quality, performance and risks were understood and managed.
- The management in the service demonstrated they had the experience, capacity and capability to run the service and ensure high quality care.
- Feedback was collected and used to adapt and develop the way the courses ran.
- There was a focus on continuous learning and improvement at all levels within the service.

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

- Patients were consistently positive about the care they received from the staff at the unit.
- Patients felt included in decision making about their care and treatment and felt listened to by the staff.
- 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 unit had a quality improvement plan which aligned with the strategy. Staff were actively encouraged and empowered to lead and engage in quality improvement activities.
- Staff spoke highly of the leadership team and how they were supported and empowered to develop their knowledge and skills.

Recommendations for improvement

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

- The unit was not using the common assurance framework (e-CAF) assessment which had been deemed as essential and should have been used from March 2019, following a defense medical service (DMS) directive. However, we saw evidence there were mechanisms to support service improvements and the delivery of good quality care. It was

difficult to evidence how often and how robustly the eight domains including safety, clinical and cost effectiveness, governance, patient experience, accessible and responsive care, care environment and amenities, public health, and occupational health were being assessed and reviewed.

- Patients did not always have timely access to initial assessment at MIAC clinics. Between January 2019 and March 2019, 45% of patients had received an initial assessment at the MIAC clinic within 20 days. Which is below the DMS target of 85%. Managers were aware for the reasons. For example, lack of capacity of key staff, such as doctor and podiatrist. These capacity concerns had been escalated through the chain of command and noted on the risk register, whilst staff awaited the opportunity to agree a solution.
- Some documentation lacked detail for example, team meeting and governance meeting minutes, incidents form actions and complaint actions. Without detailed minutes, there was a risk, team members not present, may miss essential feedback information and we could not be assured meetings were reflective of the governance issues for the service. However, we did not see any evidence of any negative effects of this during inspection.

Professor Ted Baker
Chief Inspector of Hospitals

Regional Rehabilitation Unit – Aldershot

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, 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) Aldershot 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 Aldershot in Hampshire and provides clinical management of moderate musculoskeletal conditions to the military population within a defined geographical area. There are 15 RRUs across the United Kingdom.

RRU Aldershot supports two Regions, 13 PCRFS and 16 Medical Centres. RRU Aldershot's population at risk (PAR) is 25,000. The majority of the population is Army, some RAF and fewer Navy. 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 specialist GP trained in Sports and Exercise Medicine (SEM) to diploma level, a physiotherapist (clinical specialist) and an exercise rehabilitation instructor (ERI). The GP should ideally be an experienced military officer. The MIAC is a critical element of clinical assessment and planning in the defence medical rehabilitation programme (DMRP). The MIAC will identify patient requirements and allocate appropriate early treatment based on clinical need, operational issues and individual circumstances. The role of the MIAC is to determine:

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

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

Injury Assessment Clinic (IAC)

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

Onward Referral

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

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

Clinical Investigations

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

Residential Therapy

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

Regional Podiatry Service (RPS)

The aim of the RPS is to provide a clinical biomechanical podiatry service to all entitled service personnel within the RRU catchment area. 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 a MOD approved supplier as required. The RPS is commanded by and accommodated at the RRU. It consists of one full time Band 7 podiatrist (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 SME and professional POC, conducting liaison visits with the satellite physio departments within region, providing support and guidance on HG or military processes, specific equipment care processes. The RTSA also provides ERI mentoring in the region to all civilian, military and locum ERIs. All new joiners in the region are invited to attend a day at RRU to meet personalities, be provided training on DMICP, shadow course and MIAC in order to ensure joined up care between 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 specialist GP trained in sports and exercise medicine) and a clinical specialist physiotherapist, in the Multidisciplinary Injury Assessment Clinic (MIAC) located at the RRU. Patients can access one to one treatment and rehabilitation courses to treat their conditions. Courses run for three weeks. Patients are expected to attend for the duration of the course and can live on site or off-site locally. During courses, patients can access one to one treatment at the same time.

The RRU is staffed by a service lead, a clinical specialist physiotherapy lead, physiotherapists, 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 Aldershot has not been inspected by CQC previously.

Our inspection team

Our inspection team was led by a CQC inspector. The team included two inspectors, a CQC internal observer and three 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 5 June 2019. During the inspection, we:

Spoke with eleven staff, including physiotherapists, exercise rehabilitation instructors (ERIs), business manager, 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 patients attending MIAC, IAC, Shockwave and Podiatry. Between 3 to 28 September 2018, 85 questionnaires were completed and returned.

All patients attending either a MIAC, IAC, Shockwave or Podiatry appointment in September 2018 were given a survey at reception and asked to fill it out after the appointment. Patients attending Rehabilitation Courses are given questionnaires as part of the end of course process. Of the 85 surveys completed, seven contained erroneous or incomplete data. The erroneous data were instances where patients answered that they strongly disagree with any question relating to delivery of care or administration but would then rate the overall quality of service as excellent and the overall experience as very good. All patients who answered 'Strongly Disagree' to all aspects of their service also would 'definitely recommend' this service to a friend or family member. This demonstrates that the patients who answered these surveys filled out one aspect of the survey incorrectly, but it is not possible to determine which aspect as none contained any supporting comments.

Results from 3 to 28 September 2018 showed that most patients are happy with the service provided at RRU Aldershot. The patients who indicated they were not happy did not leave any supporting comments. It cannot be determined whether the answers were in error or whether patients were in fact unhappy with their care. The patients who responded negatively, all answered positively when asked general questions about the service at the RRU. There were no complaints received during the period when patients were seen. The most likely indication for improvements is that the satisfaction surveys are too long, and do not effectively gain meaningful input from patients. Most surveys are rushed through just after an appointment. The next patient survey was to be shortened, with more emphasis on gaining meaningful feedback

From the administration analysis, we saw the responses were mostly positive. There were no supporting comments to any of the negative responses. The telephones in the administration office all had answerphones on which patients could use. Directional signage to the RRU was being improved, and the appointment letters had been reviewed since the survey was completed. There had been no complaints relating to how polite the administration staff were with patients.

From the MIAC analysis, the answers showed that clinical delivery, overall experience and cleanliness were all rated highly. All patients who answered the question, would recommend the RRU to friends and relatives. The few negative responses are in relation to people being able to overhear, however, of the 51 MIAC responses, one patient was concerned and unhappy that other people could hear what was discussed. There were no supporting comments on this patient's survey, and the patient scored all other responses highly. There was a television in the waiting area which was switched on daily, and the MIAC consultation was conducted in a single patient treatment room. There were no complaints raised at the time relating to patients being able to overhear.

From the podiatry analysis, all patients who answered 'Strongly Disagree' or 'Disagree' on both general points and delivery of care in the podiatry clinic answered the survey inconsistently. The patients who strongly disagreed on questions relating to confidentiality or the ability of others to overhear all answered positively to the remainder of the questions in the survey, indicating the service was either excellent or good, and that they would recommend the service to others. The podiatry treatment was conducted in a multi-patient treatment room, where it was possible that other people could be present.

From the shockwave (ESWT) analysis, one patient who received treatment during September 2018 completed a satisfaction survey. The patient strongly agreed with all the questions in relation to delivery of care, rated as highly as possible in the general RRU questions, and standard of cleanliness. When asked about whether the patient would recommend this facility to a friend or family member and whether they felt they could be overheard, the replies were both negative. The patient offered no comments. Since all other responses were as positive as possible, these answers are likely to be erroneous.

As part of our inspection, we also spoke with patients. All patients were consistently positive about their experience at the RRU which 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 and 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. Incidents were investigated. Themes were identified and appropriate action had been taken to minimise further occurrences.

- There was a 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, investigated and closed by the service lead. However, we did note some documentation lacked detail. For example, actions taken following an incident. There was a risk, team members not directly involved in the incident reporting process may miss essential feedback information.
- A spreadsheet of all incidents was maintained. This incident log, a service wide record, 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.
- We saw RRU Aldershot had recorded 14 incidents in the significant event log from October 2017 to April 2019. Four incidents were risk rated as medium. Two related to patient accidents, one regarding staff accidents and one regarding documentation. The remaining ten incidents were either risk rated as low or did not have a risk rating assigned.
- We reviewed the incident log and found some of the actions completed lacked detail. Without detail, there was a risk, team members not present, may miss essential feedback information.
- Staff were able to describe a recent incident and the outcome of the incident involving a patient slipping using a piece of equipment. However, we were not assured this incident had been shared across other regional RRUs. Staff were able to tell us about incidents which occurred at another regional RRU in which learning from the incident was shared and implemented to ensure the safety of patients at RRU Aldershot.
- The duty of candour relates to openness and transparency. It requires staff to be open, transparent and candid with patients when things go wrong and offer an apology to the

patient as soon as the incident had been identified, irrespective of who was to blame. We did not see evidence of any incidents that had occurred that required the application of duty of candour so we were unable to assess this for this location.

Overview of safety systems and processes

Essential systems, processes and practices were available to ensure patient safety.

- Most staff received mandatory training in safety systems, processes and practices. Training compliance was set at 100% for the RRUs.
 - Clinical staff were fully compliant for 21 out of their mandatory 28 courses (96.4%).
 - Admin staff were fully compliant in 20 of 22 of their mandatory courses (98.5%).
 - Management staff were fully compliant in 25 of 26 of their mandatory courses (99%).
 - Locum staff were compliant with eight out of their mandatory 15 courses (74.2%).
- 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. The RRU had a safeguarding lead who was trained to level three. If the safeguarding lead was not present for example, due to leave or training, staff were supported by the local medical facility on site 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 MIAC doctor was the safeguarding lead was the first point of contact for any safeguarding concerns they may have. There had been no safeguarding issues raised by staff at RRU Aldershot.
- Systems, processes and practices kept patients safe. All staff were Disclosure and Barring Service (DBS) checked and their professional registration and expiry date was reviewed. This ensured all staff at the unit were safe and fit to practice at the unit. 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.
- Arrangements for the maintenance and use of equipment ensured patient safety. Fitness and strength equipment such as weights and treadmills were cleaned before and after patient use. Equipment was used, maintained and calibrated in line with manufacturers' instructions.
- The gym premises were appropriate for the services provided. Gym equipment was in good working order and equipment was stored away on suitable shelving and racks in labelled boxes. Larger cardiovascular equipment was well maintained in the gym area which was arranged neatly.
- A policy was available providing information about equipment care which was available for staff. There was a system to check equipment on a regular basis using a 373 form. We reviewed files containing 373 forms which demonstrated appropriate checks had been completed of equipment. This ensured all appropriate checks had been carried out and any faults were then escalated as required.

- The RRU maintained an equipment inventory log. Records showed equipment maintenance and safety checks had been carried out and equipment was safe for use.
- 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.
- All staff were competent to use the equipment available at the RRU to ensure patient safety. Records were maintained for each staff member to demonstrate their competence to use equipment which was signed and dated by the assessor.
- There was a procedure for staff to follow when reporting faulty equipment. There was an equipment information board available for staff in the staff room. The board contained information and flow charts for staff to support them with the process of reporting faulty equipment and how to accurately fill out the associated paperwork. Staff could also seek support from the equipment lead at the unit. Equipment faults were dealt with in a timely way and work was carried out within seven days.
- Resuscitation equipment was available in the gym area and clinic area was checked daily to ensure it was ready for use in an emergency. An automated external defibrillator was available in the main waiting area.
- 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 10 patient records for patients attending the multidisciplinary injury assessment clinic (MIAC) and rehabilitation courses. All of the 10 records we reviewed included referral information, patient assessments, consent, treatment plans, goals, which were all complete. Of the 10 records we reviewed, only two did not contain the patient's individual goals.
- A records audit had been completed in January 2019 for the RRU course which included the admission and discharge notes. Notes were randomly chosen from each of the three courses. The unit had scored 100% in a number of areas including completion in 24 hours, documented consent, information about presenting condition, full objective assessment and past medical history information. Other aspects also scored highly at 92% for including information about current medication and the individuals job role and requirements, and treatment goals. However, the audit identified that only 52% of patient's expectations/perceptions of their needs were recorded. Also, only 42% of patients had documentation which included changes to treatment plans and 42% were seen on a 1-1 basis where specific advice and information given was recorded. Recommendations were then developed from the outcome of the audit and feedback to staff to enable improvements to be made with record keeping.
- A DMICP records audit was completed for 20 patients who were seen at both RRU Aldershot and the London MIAC across a two month period between May and June 2018. Both clinics achieved 100% in the majority of areas. However, at RRU Aldershot, only 30% of records reviewed contained the expectations of the patients or the perception of their needs within the record. The London MIAC also scored 40% for this. Also, only 30% of the London MIAC records contained information about contraindications/precautions or allergies and only 30% of records contained information of relevant medical investigations. Findings of the records audit were feedback to staff to enable improvements to be made.
- 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.
- 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 on the spines and lower limb course and two staff for 12 patients on the upper quadrant course. 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 provide 1-1 support for patients if required.
- 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 an automated external defibrillator at the unit. Information on poster on the wall identified where the defibrillator and emergency crash bag could be located if required. Additional information was also available in the gym for staff to refer to. This included flow charts to advise them how to support a patient who was deteriorating including basic life support. Staff also had access to a first aid kit which had been checked in March 2019 and a fluid spill kit if required.
- Comprehensive risk assessments regarding service provision were carried out and actions to mitigate any risks had been identified. Risks completed for the service included risk assessments for the gymnasium and fixed resistance training, the staff rest room, recreational therapy and indoor fitness training. These documents were held electronically. We reviewed four 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.
- Staff at the service said the lack of administration staff at the London MIAC posed a risk. This had been identified as a risk on the RRUs risk register of breaching Caldicott principle four and data protection legislation. Principle four is Access to personally identifiable information should be on a strict need to know basis. Only those individuals who need access to personally identifiable information should have access to it. The staffing establishment for administration staff was four staff, working at different grades (three E1 and 1 E2 staff). Recruitment challenges had meant that the E2 post had been vacant since November 2018. Also, at the time of the inspection, a locum member of staff was due to leave the RRU three days following our inspection. This left the RRU with a vacancy for one administration staff. At the time of the inspection, controls were in place to mitigate the risks posed and staff at the RRU were supporting the administration team by helping out wherever possible. The plan was to upgrade the E2 post to create an E1 position for an administrative member of staff to be based at the London MIAC to mitigate the risks.

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 which had been updated in June 2018.

The purpose of the Business Continuity Plan (BCP) was to provide a means of ensuring the continuation of the RRU functions in the event of a peacetime disaster affecting the RRU building and/or its personnel. Examples of a disaster could be a fire, flood, total computer failure or terrorist attack. The BCP provided a guide for management on the day of crisis, identified vital actions to be taken on days 1-28. Within 28 days of the crisis, it was hoped that staff should be able to work normally, whilst making a controlled transition to a long-term operating posture. The BCP listed the temporary facilities that were required by the RRU at alternative locations.

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

Patient's needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance.

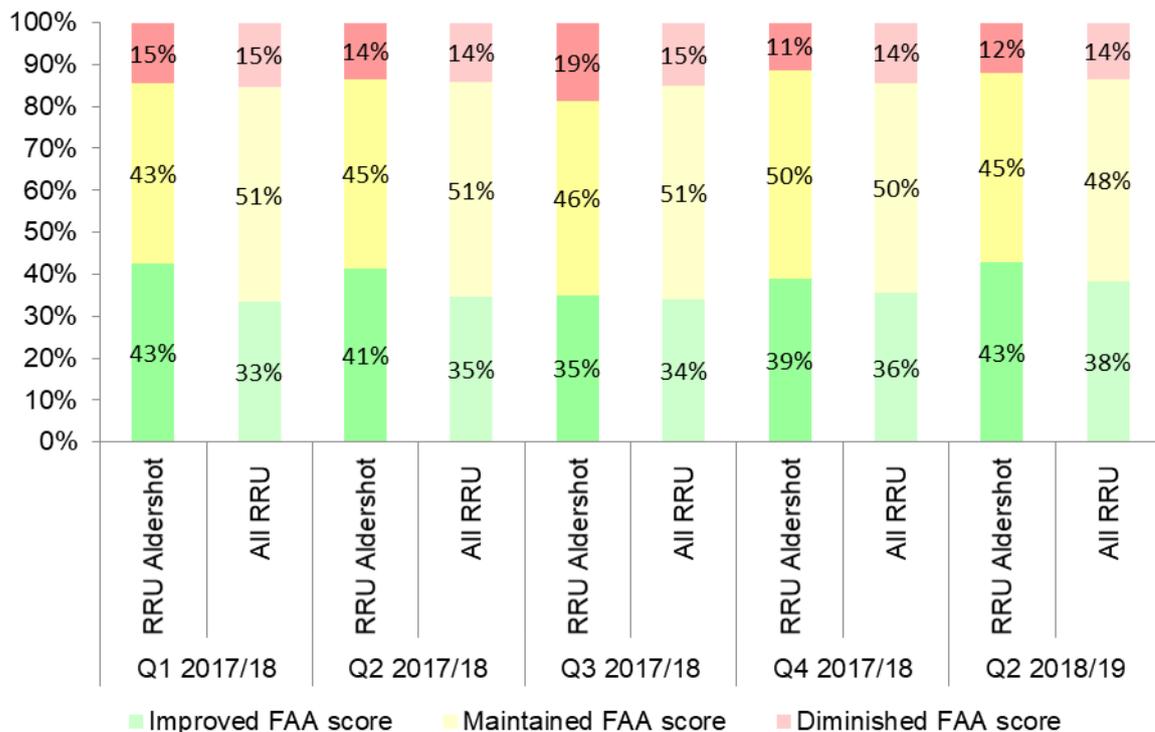
- Relevant and current evidence-based guidance had been identified and developed for defence rehabilitation services and was used to direct how services, care and treatment were delivered. These guidelines determined the necessary assessments and treatments required for specific conditions.
- Rehabilitation was delivered in line with evidence based practice guidance on treating musculoskeletal conditions and provided a holistic approach to rehabilitation. 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.
- Staff had access to best practice guidelines to inform the care and treatment they provided to patients. Specific guidelines had been produced to cover a range of conditions seen at the clinic, for example, the management of foot and ankle pain and the management of back pain. The document contained flow charts identifying specific care pathways. Each document identified specific clinical features which may be found for different presenting conditions and identified the approach to management of the condition which needed to be taken by the RRU. The document also identified red flag (serious pathology) which would need immediate attention and escalation if identified. References to the guidelines and evidence which had been used to develop the documents was also identified within the document.
- Pain was assessed and managed according to each individual patient and patients felt their pain was managed well. 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 of discussions around pain in the patient records we reviewed.

Management, monitoring and improving outcomes for people

There were effective systems for the management, monitoring and improving outcomes for people

- Validated patient reported outcome measures (PROM) were used for all patients attending the RRU. The RRU had recently introduced the MSK-HQ outcome measure which was completed by all patients. The aim of completing this measure was to provide better oversight of the improvements patients made during their rehabilitation journey. The measure was to be completed at the PCRf, the RRU and again by the PCRf and was validated to detect changes when completed at 6 week intervals. Data from January to April 2019 had been reviewed. The data showed 72% of patients had seen improvements in their condition from attending the lower limb course, 81% had seen improvements from attending the upper quadrant course and 78% had seen improvements from attending the spines course. However, on further review, of the 151 patients, only 26 (17%) had an MSK-HQ completed between four weeks and four months post rehabilitation course. Work was required to improve the uptake and compliance with this measure within PCRfs. However, of the of those that had the MSK-HQ reviewed at these times frames, 80% demonstrated a sustained improvement in their condition.
- There was a clear approach to monitoring and benchmarking the quality of the service and outcomes patients received following an episode of treatment. Changes in functional activity assessment (FAA) score between initial contact and discharge contact are collected from DMICP. This includes outcome scores for all discharges (care pathway complete and care pathway continuing). The results for RRU Aldershot and the RRU average are displayed in the chart below:



- Objective measures were routinely used pre and post treatment to identify improvements which had been made to the individual patient's condition following the course of treatment. These measures were patient specific to provide an objective measure associated with the patient's injury. Some measures were used across each of the three courses. These included the multistage locomotive test. Objective measures used for the lower limb course included the leg press, knee to wall and figure of eight. The spines course used the modified press up and modified sit up test, whilst the upper quadrant course used included the modified press up test. Where appropriate, other outcome measures were used with patients such as the PHQ-9 and the GAD-7. These measures looked at anxiety and depression which could have a profound impact on the patient engaging and progressing with their rehabilitation.
- 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 patients would identify a goal they wished to achieve. Patients were then encouraged to identify three further short term goals following an education session they received as part of the course. Goals set were specific, achievable, measurable and had at timeframe for completion. This ensure the treatment programme specifically met the individual needs of the patient.

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.

- There was a policy 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 up-to-date with their continuing professional development (CPD) and 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. These included training, peer review and research journal reviews.
- Staff were supported to attend role specific educational training. For example, a Master of Science (MSc) in sports and exercise therapy. Staff reported that funding for courses was offered by the service. There was an expectation that staff who undertook courses to develop knowledge and skills presented this training to other staff at regional training days so the learning could be cascaded.
- MIAC GP completed the medical appraisal and revalidation process in line with General Medical Council (GMC) 2012 scrutiny of medical professionalism guidance.
- Peer reviews between exercise rehabilitation instructors (ERI) and physiotherapy staff including staff of different grades and disciplines took place. This provided an opportunity for all 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. The RRU reported that as of May 2019, all required staff had a completed appraisal. This was in line with the RRU appraisal rate target of 100%. 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.
- Regional in-service training and development days were organised for staff and included role specific training so individual learning needs could be met. Staff told us these

sessions were well-organised, often included expert speakers, and staff were given time to attend.

- 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.
- 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. Patients were supported to make decisions about consenting to care and treatment. We saw clear evidence of this documented in all 10 records we reviewed.
- 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. We reviewed two records for patients who had received injection therapy and one who had received shockwave therapy. 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 their rehabilitation.
- Patients were encouraged from the start of treatment, 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 goals. This included an education session on goal setting. There was also an expectation that patients were to develop a programme for their continued rehabilitation once they had left the RRU. This was reviewed by the course instructors who supported patients to develop their programmes. 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 were also provided with a booklet which included information on cardiovascular training and other information to support their ongoing self-directed rehabilitation once they had left the unit.
- Information was available to support patients to manage their own health and wellbeing. In the waiting room and education room there was information providing advice and signpost patients to other mechanisms of support with issues such as drinking, smoking and diet and nutrition.

Good



Are services caring?

Our findings

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

Kindness, dignity, respect and compassion

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

- Patients were treated with compassion. Staff discussed treatments with patients and were able to adapt individual treatments in response to patient feedback. Staff were supportive in their approach to patients and motivated and empowered them to fully participate in activities to their own ability, and to drive their own rehabilitation.
- Staff took time to interact with people who used services in a respectful and considerate manner. We saw reception staff were polite, friendly and helpful both on the telephone and when patients arrived at the RRU.

- Staff were passionate and motivated to see patients benefit from their rehabilitation. It was clear during the group activity we observed that staff were committed to supporting patients to progress, and that provision of high-quality care was the main focus.
- 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.
- Staff demonstrated a helpful supportive attitude towards patients. We observed staff interacting with patients and providing encouragement and praise during treatment sessions

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.

- Patients told us they felt listened to and supported by staff. They felt they had sufficient time during their initial assessment and ongoing consultations to make an informed decision about the choice of treatment available to them. Care plans were personalised and tailored to individual patient needs.
- Staff formed close professional relationships with 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.
- Patients were encouraged to be active partners in their care. Treatment plans were designed in conjunction with patients and they were supported by the staff at the at the RRU to take ownership of their ongoing long-term rehabilitation.
- Staff communicated with patients to make sure they understood the anatomy of the human body which provided the basis for the rehabilitation programme. We observed staff clearly explaining the foot and ankles and shoulder to groups of patients in a clear way. This supported patients to understand and engage fully with the rehabilitation process.
- There were opportunities for patients to ask questions and be involved in their care and treatment. This turn would help to 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 recognised when patients needed additional support to help them understand and be involved in their care and treatment. We saw staff talking to patients about their care and made time to ensure they understood what they were saying.
- Staff understood the impact which patients care, treatment or condition had on their wellbeing.
- 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.
- Staff responded to patients who were experiencing pain quickly and effectively.
- Patients were encouraged to connect with other course participants while they were completing their rehabilitation. There were opportunities for patients to socialise together

during the course, during break and meal times and in the evening if staying onsite. Patients had the opportunity to stay in RRU accommodation on site if they lived too far away to commute daily.

Are services responsive to people's needs?

Good



Our findings

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

Responding to and meeting patients' needs

The unit used information about the needs of the Population at Risk (PAR) within the Area of Responsibility (AOR) to inform how services were planned and delivered. However, facilities were not always appropriate for the services that were planned and delivered. The numbers of patients being seen in the service had increased, often there would be three courses running concurrently.

- The unit had a plan, which enabled them to meet the needs of the PAR, particularly those with complex needs, long-term or career-limiting conditions.
- Services provided reflected the needs of the military population and occupational needs of their employment within the geographical area of responsibility. The RRU treated patients from all three military services.
- The service provided a number of services:
 - Multi injury assessment clinics (MIAC) which offered:
 - Sport and exercise medicine (SEM) specialist assessment and diagnosis,
 - access to fast track imaging and surgery, at a local independent hospital.
 - diagnostic ultrasound
 - injection therapy
 - Injury assessment clinics (IAC) were run by either the GP and band 7 (specialist) physio therapist which offered:
 - sport and exercise medicine (SEM) specialist assessment and diagnosis,
 - access to fast track imaging and surgery, at a local independent hospital.
 - diagnostic ultrasound
 - injection therapy
 - Regional podiatry service, which provided service to:
 - prevent, diagnose, treat and rehabilitate abnormal conditions of the feet and lower limbs.
 - prevent and correct deformity, keeping people mobile and active,
 - relieve pain.

- Residential rehabilitation courses for a three-week block. Patients would attend for an injury specific course for example, a course that provided rehabilitation for a range of injuries for lower limbs, spines and upper limbs.
- The service was based in purpose built centre sports centre, facilities such as the reception, pool and gym were shared with other military personnel, for example, the army boxing association. RRU specific rehabilitation sessions in the pool and gym were only attended by RRU patients.
- Sharing the facilities with other military personnel presented other challenges for the staff in providing rehabilitation services. The gym area was divided into two with a partition between the two areas. The other half of the gym was used by the army boxing association for training sessions and boxing matches. Staff commented, that on occasions, training sessions on the other half of the gym could be quite loud and it was, at times very difficult to hear course instructions. However, the staff from both services had a good professional relationship and would work together to ensure sessions for both services would not be impacted.
- There had been some recent change to the delivery of the courses. Within the area of responsibility, the population at risk did not generate the need for the number of spinal courses planned. A review of the requirements for the population at risk between January and March 2019 identified that there was a greater need for additional lower limb courses rather than spinal courses. Due to the findings, some spinal classes were replaced for lower limb classes to meet the demand for the lower limb course.
- The space available in the main gym was not always adequate to accommodate the three group sessions running concurrently. The main gym area provided space for group sessions and also an additional area for cardiovascular machines and some of the specialist gym equipment. Staff were aware of the challenges posed by the limited space available. They were creative when using the limited space available to them and looked where possible to have the three courses undertaking different activities in different places to maximise the space available in the gym.
- The RRU was working with the PCRf to provide better continuity for patients with regard to their exercise programmes. The RRU and PCRf had started to use an electronic system, where the patients exercise programme could be shared between the services. This meant there was an increased responsibility from each of the services to provide a seamless, joined up service for patients, where all parties knew what was happening for the patient. This helped to optimise the patient's potential to progress with their rehabilitation.
- The RRU was part of a pilot programme to incorporate further aspects of wellbeing into the group courses to support patients. The programme consisted of additional information regarding mental wellbeing, health and lifestyle which began in Summer 2018. Since the pilot began, the staff at the RRU, in conjunction with feedback from patients had worked hard to develop the programme to flow with the current structure of the courses, rather than the programme be another standalone element to the course. This ensured patients engaged with the content to optimise their potential to recover.
- A military orthopaedic consultant held regular clinics at the RRU, this had improved liaison with local NHS providers and decreased reliance on external surgical opinion. The RRU aimed to offer these clinics monthly, but this was dependant on the consultant's military commitments.
- If the RRU was unable to meet the needs of the patients though the clinics and courses, patients were referred on to ensure they received appropriate treatment. For example, patients could be referred onto specialist services within the military such as the DMRC, or NHS if this was in the best interests of the patient.
- A wide range of fitness and strength equipment was available for patients, so they could complete the required rehabilitation. A full inventory of all equipment was held

electronically which provided information on what the equipment was, its cost, and where it was purchased or hired from. Staff told us the equipment was well used with most equipment being used by patients on a daily basis.

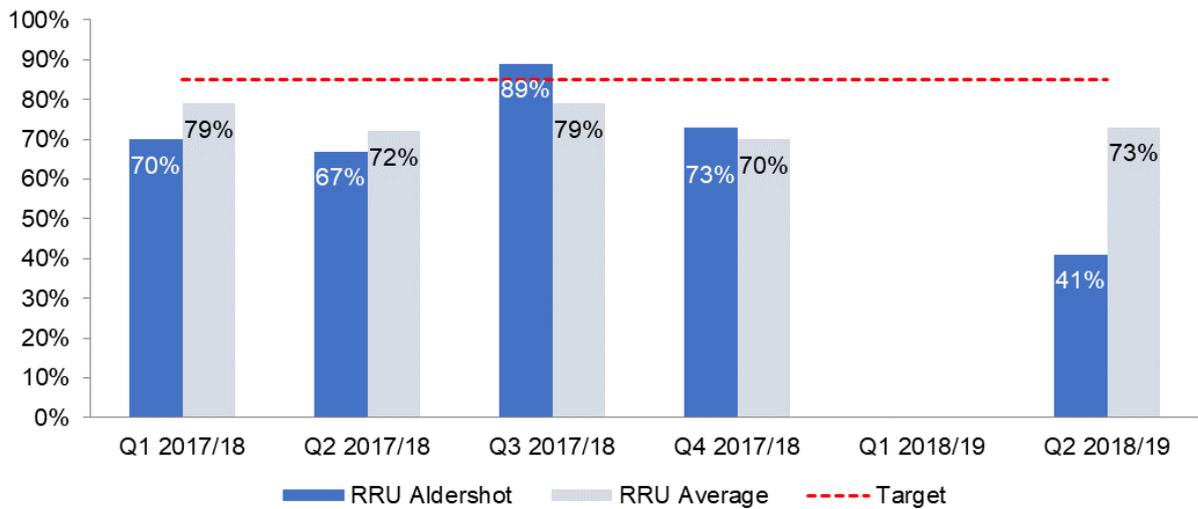
- There were limited security measures. The main door was accessed using a key pad where the key code was changed regularly. Reception staff monitored people accessing the RRU. All leisure centre members had to present or swipe a membership card to access the facilities. The garrison managed security and this was subject to regular risk assessment. RRU staff were kept informed of any issues and or concerns.
- Following feedback, patients has requested additional sessions, in certain areas such as relaxation, pilates cardiac training. The team offered 'sign up' sessions for the last 30 minutes of each day. Patients could choose to sign up to attend an additional session of their choice which added to their treatment programme.
- Patients were offered to take advantage of a meditation/mindfulness application on their mobile telephones to support their rehabilitation. The application provided sessions of guided meditation to its registered users with the goal of mindfulness. Staff reported this had been positively received by patients.
- Staff were very aware of the risks of treating patients in a shared area, they always checked patients were happy to commence treatment and have conversations in the gym area. Staff could access the treatment rooms to ensure privacy for difficult/confidential conversations when necessary.

Access to the service

Patients did not always have timely access to initial assessment, diagnosis or treatment in a way which suited them. Capacity concerns had been escalated through the chain of command and noted on the risk register, whilst staff awaited the opportunity to agree a solution.

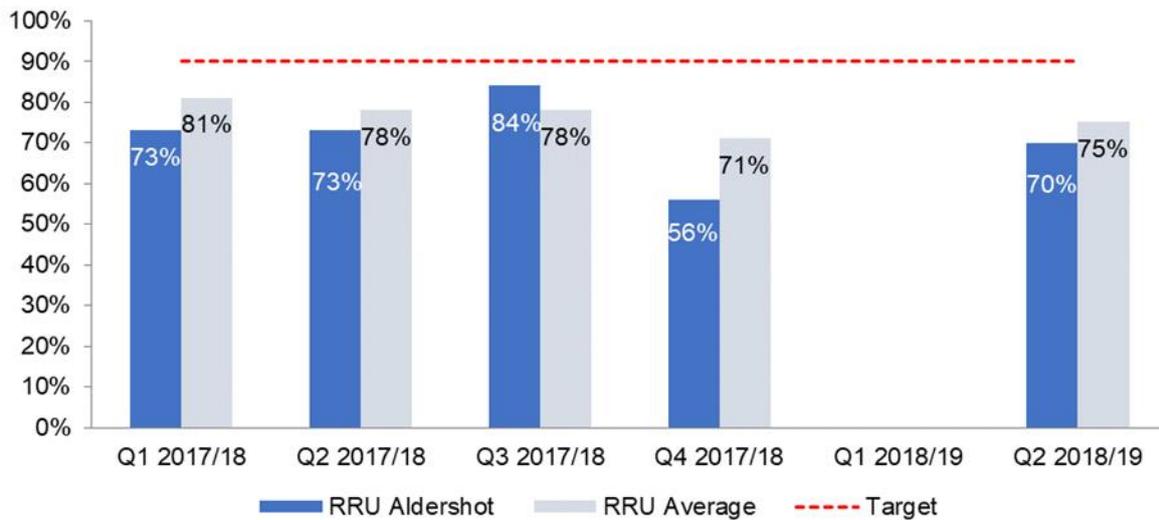
- The target for undertaking new patient assessments in a MIAC was set at 85% for initial assessments to be offered within 20 working days of referral. The unit provided their own performance date for that showed between January 2019 and March 2019 45% of patients had received an initial assessment at the MIAC clinic within 20 days. This was below the DMS target of 85%. We were not provided with RRU average data for this time period, so we were unable to comment whether RRU Aldershot had performed either better or worse when compared to other RRU's in this time period. RRU Aldershot has met the target once since quarter one 2017/18 (in quarter three 2017/18 and this was one of two quarters in which the RRU performed better than the RRU average.

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



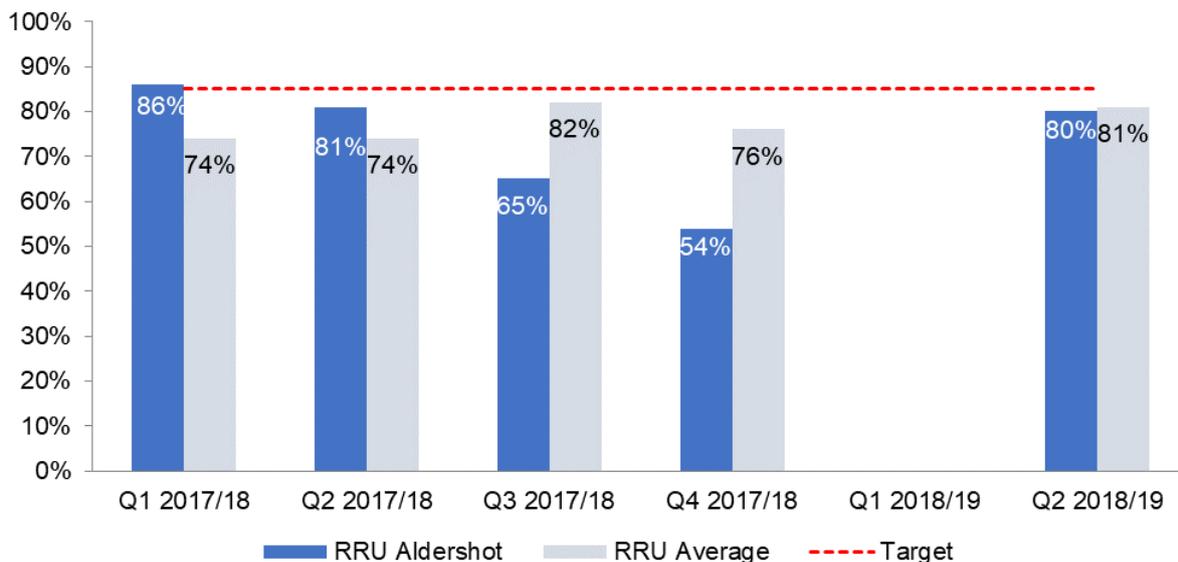
- RRU Aldershot received a mean average of 58 new accepted referrals from quarter one 2017/18 to quarter two 2018/19 (excluding quarter one 2018/19). There was no data available for any of the RRUs in quarter one of 2018/19 as the dashboard was being reconfigured.
- Lack of doctor availability was the main factor which had contributed to the unit not meeting the target for access to MIAC and IAC clinics. The OC told us although the unit had an establishment for doctors of 1.5WTE, the requirement to meet the demand of the population at risk required a higher capacity for doctor cover. However, the OC was clear that if the capacity of the MIAC was increased, this would create a challenge to follow up patients which would have a significant impact across the system. The unit was using the local specialist in exercise medicine (SEM) military doctor to prevent the backlog of patients when the locum doctor was unable to cover a MIAC session. These capacity concerns had been escalated through the chain of command and noted on the risk register, whilst staff awaited the opportunity to agree a solution.
- The target for accessing an RRU course was for 90% of patients to be offered a course starting within 40 working days of the MIAC appointment. RRU Aldershot provided information on their own performance for The RRU had met this target. Data demonstrated between January 2019 to March 2019, 91% of patients were offered a course starting within 40 days of their MIAC appointment. No RRU average was provided for the most recent period of performance.
- RRU Aldershot did not meet the 90% target between quarter one 2017/18 and quarter two 2018/19. The RRU performed worse than the RRU average in all but one quarter of the period.

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



- The RRU had performed worse than other RRU's with this performance indicator within this time period.
- Offering patient's access to a podiatrist within 20 working days of a referral was another performance target set by the DMS. The RRU provided information on their own performance January 2019 to April 2019, the RRU did not meet the target with 79% of patients accessing a podiatrist appointment within the target timeframe. No RRU average was provided for the most recent period of performance. The OC told us that podiatrist availability was a factor in the unit not meeting this KPI. Also, due to the PAR being stood down in August, referrals received for the service and uptake of appointments were limited during this time. This meant the unit received a higher than usual number of referrals in September and October which led to reduced availability, capacity and KPI performance.

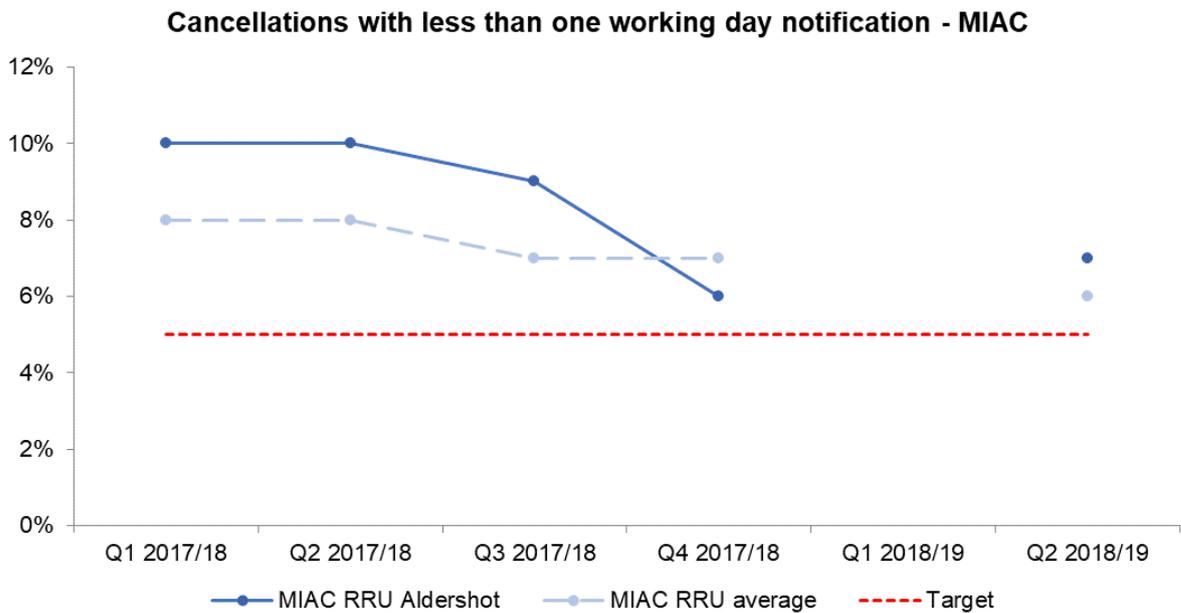
Access to podiatrist for first appt within 20 working days



- From quarter one 2017/18 to quarter two 2018/19, RRU Aldershot received a mean average of 98 new accepted referrals for a podiatrist appointment per quarter. The target

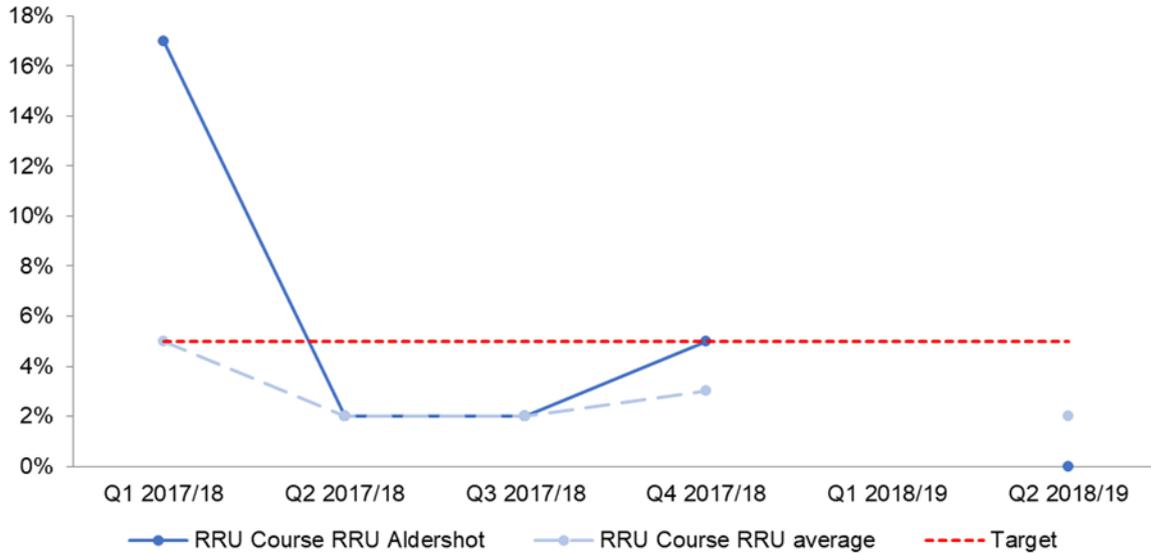
for this was 85%. Performance against the RRU average was variable with no identifiable trends.

- The target for MIAC short-notice cancellation rates (cancellations with notice of less than one working day) is 5% or less. The MIAC short notice cancellation rate at RRU Aldershot ranged between 10% and 6% over the period from quarter one 2017/18 to quarter two 2018/19. The cancellation rate at RRU Aldershot was greater than the RRU average in the majority of quarters of available data and worse than the target rate for all quarters. The RRU provided data for quarter four 2018/2019 which showed RRU Aldershot at 7% compared to an RRU average of 6%. Despite an improving picture, the cancellation rate at RRU Aldershot was greater than the RRU average in the majority of quarters of available data and the unit had not met the target rate for all quarters.



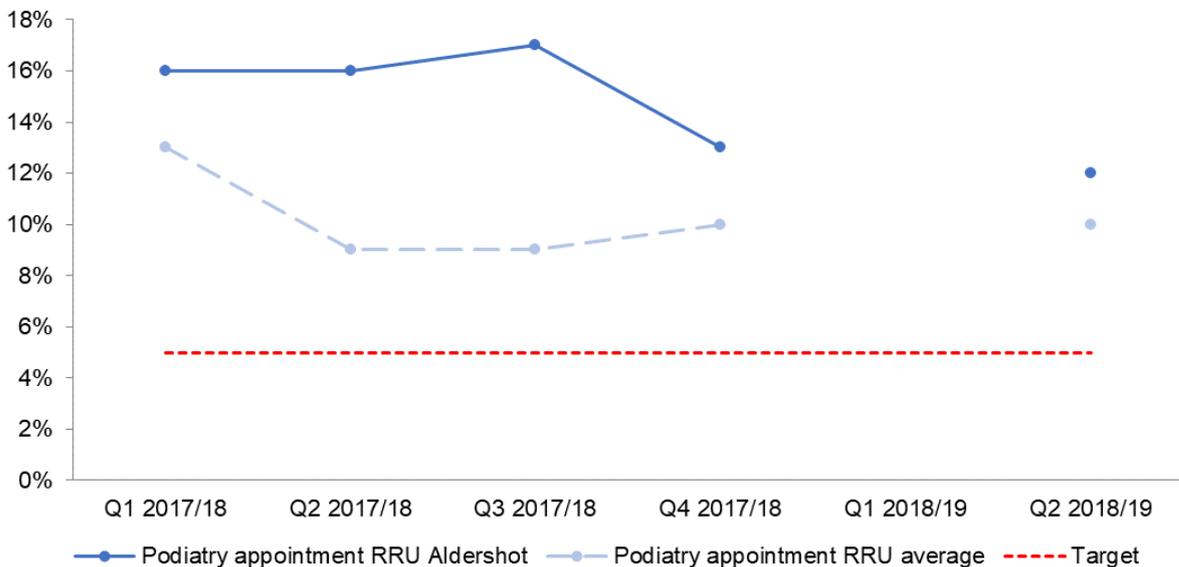
- There was no data available for any of the RRUs in quarter one of 2018/19 as the dashboard was being reconfigured.
- The RRU course short notice cancellation rate (less than one working day) at RRU Aldershot had improved considerably since the first quarter 2017/18 and was reported as 0% for the last quarter of available data (quarter two 2018/19). This was better than the RRU average.
- There was no data available for any of the RRUs in quarter one of 2018/19 as the dashboard was being reconfigured.

Cancellations with less than one working day notification - RRU course



- The podiatry appointment short notice cancellation rate (less than one working day) at RRU Aldershot has been worse than the RRU average in all five quarters of available data. The short notice cancellation rate has been higher than the 5% target in all five quarters.
- There was no data available for any of the RRUs in quarter one of 2018/19 as the dashboard was being reconfigured. (Source: Regional Rehabilitation Unit Dashboards Q1 2017/18 – Q2 2018/19)

Cancellations with less than one working day notification - podiatry



- Clinics and courses were rarely cancelled. Courses were planned, staff who planned the courses took into consideration the numbers attending and the need to be carefully planned in likely periods of high staff absence and patient preference, for example during school holidays. Cancelling clinics and courses only occurred in the event of illness of the doctor. Staff looked internally for cover to be found for example, for physiotherapists carrying out MIAC clinics. Cover for any absent physiotherapist and ERI staff running courses course was also found within the team.

- The RRU received referrals electronically and prioritised accordingly. The administration team received referrals for RRU Aldershot and London MIAC. Referrals were monitored throughout the day by the administration team and were triaged by the 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. 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 Thursday and between 9am and 1pm on Friday. The administration team oversaw the appointment system for RRU Aldershot and London MIAC. Patients were allocated an initial appointment at the most appropriate location 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 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.
- There was a clear policy and 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. Patients were discharged back to their medical officer at their referring unit if there were three repeated instances of failure to attend appointments.
- Patients had access to fast track diagnostic imaging for identifying and monitoring diseases or injuries, if required, at a local independent hospital.
- 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. There was a verified equality and diversity policy 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 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.

- Patients were clear how they could raise concerns and complaints. Patients were able to describe how they would provide feedback or make a complaint. None of the patients we spoke with said they had needed to raise any concerns.
- There was a designated person who handled all complaints in the unit. The complaints policy and procedures were in line with recognised guidance and DMS processes.
- The business manager was the designated responsible person for dealing with complaints. Concerns and complaints were listened and responded to and used to improve the quality of care. However, some documentation lacked detail, for example, actions taken from complaints raised. Without detailed actions, there was a risk, team members not involved in the complaint may miss essential information. However, we did not see any evidence of any negative effects of this during inspection.
- As of May 2019, there were three complaints recorded in the complaints register provided by the RRU, all of which had been investigated and closed. The older complaint, from June 2018, was the only formal complaint. The two most recent complaints were from March 2019. One was regarding an appointment not being cancelled after the patient had informed the RRU, and the other was regarding a short-notice booking onto a course which resulted in the patient having to pay for a hotel as accommodation was not available. Neither patient wished to make these a formal complaint. (Source: DMS provider information return - Complaints).

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 Defence Primary Healthcare (DPHC) was 'Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command'. The mission statement for Defence Rehabilitation was, 'deliver high quality rehabilitation to support planned and contingent operations in order to maximise the moral and physical components of fighting power'.

- RRU Aldershot's mission statement was "committed to providing professional and evidenced based clinical services in order to ENABLE personnel to achieve their recovery potential through the delivery of patient centred, multidisciplinary care, education and rehabilitation'. The whole team had been involved in the writing of the mission statement. This meant the staff understood the vision and mission set out for the service. The unit's culture reflected the mission statement, this was demonstrated in the way staff worked with and interacted with patients and each other. Staff had a clear understanding of the importance of providing high quality, personalised rehabilitation to patients. Staff spoke clearly about the need for patients to be able to access the right care 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, following discussion about the low response rate to patient satisfaction surveys, the patient satisfaction questionnaire had been developed to make it more accessible to patients, in order to gain more meaningful insight from patients.

Governance arrangements

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

- There was an established governance framework to ensure quality, performance and risk were understood and managed, elements required further development and maturity to establish a thorough and fully effective governance system. 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.
- An electronic common assurance framework (e-CAF) assessment was a live document used to support the delivery of good quality care. Despite a directive being issued on 1 March 2019 highlighting full operational capacity to advocate use of the e-CAF, the RRU was not utilising this document to its full capacity and advantage. 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. Of the eight domains, seven demonstrated full assurance whilst the care environment and amenities domain identified limited assurance. On reviewing the e-CAF at the RRU, we identified that the information identified on the document did not reflect the most current issues face by the RRU. There was only one action which had been added in June 2018. This action had been marked as urgent action being required, however, there was no scheduled completion date, or evidence to demonstrate action had been taken to manage the issue. Issues the RRU had previously or currently faced, such as the staffing challenges and

infection prevention and control issues had not been identified on the e-CAF, nor the action being taken to manage the issues. By not using the e-CAF as a live document, the RRU was not fully able to accurately appraise the current position of the unit. However, despite the unit not using the e-CAF, other mechanisms, such as the risk register were used to manage and monitor risk associated with the unit. We raised this with the OC at the time of inspection and we were shown evidence that the service had a plan to complete the e-CAF self-assessment in August 2019.

- There were systems and processes to identify, manage and mitigate risks associated with the unit. The unit maintained a risk register which identified 16 risks at the time of inspection. The top risks included security on entry to the building, frequent staff turnover and no appointed medicines management lead for London MIAC. Each risk was rated on impact and likelihood of it occurring. The risk was re-rated following the control which were put in place to manage the risk. Management plans and mitigating actions had been identified to manage the risk. A responsible person had been designated to oversee and manage the risks. The document also clearly identified when the risk register had last been reviewed and any further action which needed to be taken to continue to manage the risk. There were no risks scored above 15.
- There was an alignment with what staff raised as ongoing concerns and items which were held on the risk register. Staff at the unit had a good understanding of the risks associated with the RRU. They gave examples of risks on the register and how they were managed and told us that risk was a standard agenda item for discussion at their monthly clinical governance meetings. Risks were mentioned through the minutes from the governance meetings, with an update given and actions specified. However, as team meeting and governance meeting minutes lacked detail there was a risk, team members not present may miss essential feedback information.
- The service was provided with a quarterly dashboard, which detailed performance information on a number of key performance indicators. This included referral numbers, time taken to offer an appointment, numbers of patients who failed to attend or cancelled appointments, waiting times, and clinical outcomes. Each indicator was shown next to the average performance across the other RRU's. This meant an overall comparison could be made to benchmark how well the unit was performing.
- 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 safeguarding lead, equality and diversity lead and equipment lead. Additional training was provided for these roles where appropriate. Staff took on additional governance roles within their area of responsibility which helped to develop their knowledge and skills of the governance in that particular area.

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 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, staff did not feel like there was a hierarchy within the unit and described the environment as 'all inclusive.' Staff also described the RRU as a 'family' and spoke of the support they received from their peers and from all staff working in the RRU.

- Promoting the safety and wellbeing of staff was emphasised at the unit. Staff spoke of the supportive working relationships they had with each other and how they could recognise when colleagues were busy or needed help. Staff spoke of instances where they had covered for other staff members.
- There was a patient focused culture and staff were committed to supporting patient to progress with their rehabilitation to enable them to return to full active duty. We were given an example where a patient was concerned their chain of command would not provide them with the time they required to continue with their rehabilitation once they had left the RRU. The member of staff supported the patient by contacting the patient's chain of command to explain the importance of continued rehabilitation and the need for protected time for this to ensure their recovery.

Seeking and acting on feedback from patients and staff

Feedback was collected and used to adapt and develop the way the course ran.

- 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.
- As a result of patient's feedback regarding being able to take more ownership for their rehabilitation, the course had been developed to include three sessions which patients were able to choose which they would sign up for, which would best meet the needs of their rehabilitation to enable them to progress.
- Staff were empowered to drive change within the RRU. Staff were encouraged to continually look to improve service delivery at the RRU. For example, staff had identified a way to make better use of resources through altering the way the courses were delivered. Some generic education sessions such as the pain session which, at the time of the inspection, were delivered separately across all three courses was to be delivered in one session for all three of the courses from the next intake of the group course in July 2019. This would then be reviewed on the post course wash up meeting held by the staff following patient feedback and a discussion between the staff on the delivery of the course.

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 identify specific areas for improvement in the RRU. All staff at the RRU were responsible to taking part in quality improvement initiatives. For example, the patient satisfaction questionnaire had been developed to make it more accessible to patients, in order to gain more meaningful insight from patients. An electronic version had been developed along with a link to a mobile phone version of the questionnaire. Further quality improvement initiatives included movement to a wholly electronic referral and triage system. The quality improvement plan also included dates for review of the action which had been taken.
- Staff at the unit were in the process of developing specialist skills in women's health rehabilitation. The MIAC doctor was a member of the women's health rehabilitation working group and staff members had attended specific training such as post-natal pilates for women. It was anticipated, services would be provided for women prior to and returning from maternity leave.

