Defence Medical Services

Colchester Regional Rehabilitation Unit

Inspection Report

Colchester Regional Rehabilitation Unit
Building E04,
Merville Barracks,
Colchester,
Essex,
CO2 7UT

Date of inspection visit 15 November and 4 December 2019
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This report describes our judgement of the quality of care at this service. It is based on a combination of

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 Colchester Regional Rehabilitation Unit (RRU) on 15 November and 2 December 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. We do not have a legal duty to rate but we have highlighted good practice and made recommendations on issues which the service could improve.

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 an effective system available for staff to report significant events, incidents, near misses and concerns. Staff understand their responsibilities to raise concerns and record these. Incidents were reviewed, thoroughly investigated and closed by the service lead.
- Essential systems, processes and practices ensured patient safety.
- Risks to patients who used services were assessed and their safety monitored and maintained. Staffing levels, skill mix and caseloads were planned and reviewed to ensure people received safe care and treatment at all times, in line with relevant tools and guidance.
- The unit had adequate arrangements to respond to emergencies and major incidents.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Although the service had a child protection procedure, dated August 2019, there was no safeguarding vulnerable adults' procedure. None of the staff at the RRU had completed safeguarding vulnerable adults training.

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.

- 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. There were helplines and welfare phone numbers on display for patients in the waiting area. Staff talked to patients during appointments about other services they could access, to help them manage their condition and improve the outcome of rehabilitation.

- Although validated patient reported outcome measures (PROM) were used for all patients attending the RRU, the service did not use these to benchmark their service or identify areas for improvement.

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

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

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

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

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

- The unit provided assessment and treatment services between 8am and 5pm from Monday to Thursday and from 8am to 1:30pm on Friday

- 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

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 the top priority.

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

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

- Staff actively sought feedback from patients and made changes to the service as a result of feedback.

- There was a focus on continuous learning and improvement within the service.

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

- We saw some very positive examples of patients being involved in their care. Staff took time to ensure patients had a good understanding of their condition using diagrams, diagnostic images and anatomical models. They had a holistic view of patients and assessed the full impact of an injury on a patient.

- We received positive feedback from patients about their experience of the MIAC clinics and courses at the RRU.

- The RRU team was coherent and had a shared vision of the service they wanted to provide for patients.

- RRU Colchester attended a multidisciplinary meeting once a month at the PCRF, with the local hospitals staff and GPs to make clinical decisions

Recommendations for improvement

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

- The service should consider using patient outcome measures to drive improvements within the service and benchmark their service's outcomes against others.

- The service should consider carrying out regular hand hygiene audits.

- The service should develop a safeguarding vulnerable adults' policy and ensure all staff receive safeguarding vulnerable adults training.

- The service should consider the use of numbers tags on their emergency trolley to ensure there is an audit trail of it being checked and include a more comprehensive checking tool.

Professor Ted Baker
Chief Inspector of Hospitals

Regional Rehabilitation Unit – Colchester

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) Colchester 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 Colchester in Essex 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 Colchester population at risk (PAR) supports a population of 9000 where the population consists of: 16 Air Assault Brigade (High Readiness), 3 x infantry (2 Para, 1 RGR), 7 Para RHA, 16 Med Regt, 216 Sig Sqn, 13 AA Regt (REME/RLC), Pathfinders, Colchester Garrison, Royal School of Military Engineering, Joint Helicopter Force – 3 & 4 Regt AAC (Apache), 3 REME Battalion and the Military Correction Training Centre (MCTC). They support seven PCRFs:

- Colchester (including MCTC)
- Wattisham
- Wimbish
- Woodbridge
- Chatham
- Maidstone
- Shorncliffe

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 three 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 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 SME and professional POC, conducting liaison visits with the satellite physio departments within region, providing support and guidance on HG or military processes, specific equipment care processes. The RTSA also provides ERI mentoring in the region to all civilian, military and locum ERIs. All new joiners in the region are invited to attend a day at RRU to meet personalities, be provided

training on DMICP, shadow course and MIAC in order to ensure joined up care between PCRF and RRU.

Access to the service is through referral from other services in the DMRP and patients receive an initial joint assessment by a doctor (a specialist GP trained in sports and exercise medicine) and a clinical specialist physiotherapist, in the Multidisciplinary Injury Assessment Clinic (MIAC) located at the RRU. Patients can access one to one treatment and rehabilitation courses to treat their conditions. Courses run for three weeks. Patients are expected to attend for the duration of the course and can live on site or off-site locally. During courses, patients can access one to one treatment at the same time.

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

Our inspection team

Our inspection team was led by a CQC inspection manager. The team included another inspector 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 15 November and 2 December 2019. During the inspection, we:

Spoke with 10 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 days 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

The RRU collected feedback following course completion. Feedback was gathered on the organisation, the presentations and lessons of the course. Following the RRU course, 100% of patients stated they would recommend the facility for treatment.

As part of our inspection, we also spoke with 11 patients. 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 they felt supported to continue with their rehabilitation after course had been completed.

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.

- 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 were closed by the service lead. The RRU had a significant event reporting policy dated August 2019. All staff had signed to indicate they had read it.
- 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.
- From January to November 2019, RRU Colchester had ten reported incidents reported within their significant incident log. The most common type of incident related to medication, which equated to two incidents. Based on the impact and probability, all 14 incidents were risk graded as a near miss, no harm or minor.
- 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. For example, staff gave an example of where a patient had sustained an injury from sitting on an equipment cage. This had resulted in signage being placed around the cage and staff advising patients not to sit there.
- 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. There were no incidents reported which would have required the application of duty of candour to have been completed. Staff we spoke with had a good understanding of the duty of candour, and we saw posters displaying duty of candour and an explanation of what it was around the RRU.

Overview of safety systems and processes

Essential systems, processes and practices were available to ensure patient safety. However, staff did not received training in safeguarding vulnerable adults

- Staff received mandatory training in safety systems, processes and practices. Training compliance was set at 100% for the RRUs. Out of the 27 training courses, staff achieved 100% compliance with training. Mandatory training course included, but were not limited to, basic life support, manual handling, fire safety awareness, healthcare governance and the management of information and defence information management systems.
- 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, which was written into the service delivery plan.
- Arrangements for safeguarding reflected relevant legislation and local requirements. Staff within the service received safeguarding children level one or two dependent on their interaction with children in line with the requirements of the intercollegiate guidance, Safeguarding children and young people - roles and competences for healthcare staff (2014). Compliance with safeguarding training for children level one and two was 100%.
- The service had a child protection procedure, dated August 2019, but no safeguarding vulnerable adults' procedure. None of the staff at the RRU had completed safeguarding vulnerable adults training.
- 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 had. Staff gave us examples of what they would raise as a safeguarding concern.
- The RRU were supported by the local medical facility on site at Colchester by a member of staff who had received level three safeguarding training. This set up was common across the RRUs. There had been no safeguarding issues raised by staff at Colchester. We saw contact details for safeguarding leads clearly displayed on staff noticeboards.
- 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. This meant we were assured systems, processes and practices related to DBS checks kept patients safe. 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 service had suitable premises and equipment and looked after them well to ensure the safety of staff and patients. There was a wide range of equipment to aid patient's recovery and rehabilitation.
- The main entrance to the RRU had an area for visitors to sign in, but no reception area. The administration team was in an office a small distance from the main entrance, so could not see who was entering and exiting the building. The team at the RRU had submitted a business case to have a window put in the wall by the main entrance, so the administrative team would be able to greet visitors to the unit.
- The RRU was on the ground floor and accessible. There was a gym for cardiovascular work, which contained a variety of equipment, free weights, weights machines, balance and proprioceptive equipment. The unit had a treatment room with cubicles in, a classroom area for presentations, a separate MIAC clinic area for assessment and

treatment in separate clinic rooms. There was also changing facilities and accessible toilets.

- A swimming pool was available for RRU staff to provide hydrotherapy sessions to patients, which was located near to the RRU. A separate team maintained the pool and provided lifeguarding support.
- Equipment was stored tidily with some on designated racks and off the floor to assist adequate cleaning of the facilities.
- Arrangements for the maintenance and use of equipment ensured patient safety. Equipment was used, maintained and serviced in line with manufacturers' instructions. A comprehensive equipment database 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. We looked at a variety of equipment and saw servicing stickers, which indicated equipment had been serviced in the last 12 months in line with manufacturer's guidelines and the servicing log.
- Issues with equipment were reported to the team leaders on site. This resulted in the equipment being put out of use out of use and a request for a repair was booked. Records on issues logged were maintained on the equipment database, which showed the problem recorded, the date it was logged, the action which had been taken and the date the issue was resolved.
- Issues with equipment were reported verbally to the RTSA on site. This resulted in the equipment being put out of use out 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 an electronic spreadsheet.
- Electrical testing of equipment at the RRU was maintained to make sure 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 individual pieces of 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 trial use of the equipment.
- An automatic external defibrillator (AED) was available and easily accessible in the entrance corridor of the RRU and was checked daily to ensure it was ready for use in an emergency. We reviewed the checklists and saw that all checks had been completed.
- Additional information was also provided next to the resuscitation equipment to provide easily accessible information to staff in case and emergency arose. Information available included flowcharts to support staff with the use of the AED. We checked the AED which was charged and ready for use.
- In addition to the AED, we saw emergency drugs were available and kept in a trolley secured with tags. We reviewed the contents and saw all drugs were in date. We saw a list of all the contents of the emergency trolley, but there was no checklist to indicate each item on the list had been checked regularly. As the tags were not numbered, there was no audit trail of how often the tags had been removed and the trolley checked.
- Standards of cleanliness and hygiene were maintained at the RRU. All areas we visited were visibly clean and tidy.
- There was a cleaning schedule to indicate which areas needed to be cleaned each day. Cleaning was carried out by an external contractor.
- Staff and patients cleaned equipment in between each patient use.
- The unit had an infection control and prevention policy which was dated June 2019 and was in line with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and the National Institute of Health and Care Excellence guidelines. All staff had signed to indicate they had read the policy.

- A member of staff at the RRU was the infection prevention and control (IPC) clinical lead for the unit. Staff could approach them to discuss any issues around infection prevention and control and staff were aware of who held this role. The most recent IPC audit had been completed in June 2019 and looked at the environment. We saw the unit had scored 97% and that it had been recognised that all actions had been completed from the last inspection.
- There were handwashing sinks and alcohol-based hand sanitising gel within all areas we visited, and we saw there was soap and paper hand towels available next to the sinks.
- During our inspection, we saw most staff either washing their hands or using the hand sanitising gel correctly, in line with the 'five moments of hand hygiene' and National Institute for Health and Social Care Excellent (NICE) quality standard (QS) 61, statement three. However, not all staff washed their hands in between patient contacts. The unit did not conduct hand hygiene audits.
- Sharps were disposed of in sharps boxes. The sharps boxes were held in the clinic rooms and treatment areas. Sharps boxes were appropriately labelled, dated and signed.
- 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 information needed to treat patients.
- Patient records were organised, up to date and shared and stored appropriately. We reviewed five 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. Outcome measures were completed at the initial assessment and goal setting was clearly in line with treatment aims.
- Record audits were carried out at the RRU and included notes of all staff groups. The most recent audit was in June 2019 and recommendations to address areas where compliance was not 100% had been identified. These included feedback to staff and a re-audit in six months. This was in line with Health and Care Professions Council's Standards of performance, conduct and ethics, Department of Health (2003), the Data Protection Act (1998), the human rights act (1998) and the public records act (1958).
- Medicines required for injection therapy were kept locked in a fridge in the MIAC clinic area and a store area. Only staff who were authorised to access medicines could do so. Staff monitored the temperature of the fridge and the store cupboard. This ensured that even when staff weren't present to check the temperature, they were assured the fridge and storage cupboard had not become too hot or too cold. There was a process to contact the pharmacy technician for advice, if the temperature rose above 25 or below 8 degrees centigrade.

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.

As at November 2019, there was an establishment of 11 WTE staff at RRU Colchester. A breakdown by team and role can be found below:

Team	Role	WTE staff
MIAC	Physiotherapists (band 7)	2
	Doctors	0
Rehab course	Physiotherapists (band 6)	1
	Exercise Rehabilitation Instructors (ERIs)	2
Podiatry	Podiatrists	1
Administration	Administration	2
Management	Management	3
Total		**11**

(Source: DMS provider information return – P7 Planned vs. actual)

From December 2018 to November 2019, there was a vacancy rate of 4.9% for staff working at RRU Colchester. A breakdown by team and role can be found below:

Team	Role	Vacancy rate
MIAC	Physiotherapists	4.5%
	Doctors	N/a
Course	Physiotherapists	0.0%
	ERIs	0.0%
Podiatry	Podiatrists/Biomech	0.0%
Administration	Administration	33.3%
Management	Management	20.0%
Total		**4.9%**

It should be noted that two doctor posts in the MIAC service were staffed with locums for the whole period, but the RRU identified no substantive posts for these roles.

From December 2018 to November 2019, the RRU reported one WTE leaver across the service. This equated to a turnover rate of 0.8% across all staff roles and teams.

(Source: DMS provider information return – P10 Turnover)

From December 2018 to November 2019, the RRU reported two sick days for MIAC staff and eight sick days for administrative staff. This equated to a sickness rate of 0.5% for MIAC staff and 1.6% for administrative staff.

(Source: DMS provider information return – P9 Sickness)

- Comprehensive risk assessments regarding service provision were carried out using a clear methodical approach and actions to mitigate any risks had been identified. 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.
- Control of Substances Hazardous to Health (COSHH) regulations, requires employers to control substances that are hazardous to health. These can take many forms and include chemicals, mists, vapours, fumes, gases and asphyxiating gases and germs that cause diseases. We saw that COSHH substances were stored in a locked cupboard and had up to date risk assessments completed. In addition, pool water was checked three times a

day by the pool maintenance teams. If the pool water was found to contain levels of chemicals higher than was required or bacteria, the pool would be shut whilst staff rectified the problem. The RRU team told us they would hold alternative treatment sessions in the gym.

- Pool sessions were run with one member of staff to a maximum of 15 patients, this was in line with the defence medical rehabilitation ratio. In addition, the service had restructured some course elements to allow one ERI to be lifeguarding while the other was teaching. We saw the risk assessment for the pool, which included all elements of risks to patients and staff and each risk had a risk rating. This was in line with, Health and safety in swimming pools (HSG 179), 2018, which states a risk assessment must be undertaken to determine the level of supervision required.
- Staff practised pool evacuation every six weeks to ensure they were able to respond to an emergency in a timely way.
- 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. All staff bar one had complete basic life support, anaphylaxis and AED training.
- 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.

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 RRU had a local business continuity plan dated June 2019. The business continuity plan was specific to RRU Colchester 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 in an emergency situation.
- The unit had its most recent fire risk assessment completed in September 2019. Weekly and monthly checks were carried out at the RRU by the building custodians. We saw fire doors were closed around the unit and intumescent strips were intact on the door surrounds we checked. All fire extinguishers we saw had been checked within the last six months. One hundred percent of staff had completed fire safety training.

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.

Management, monitoring and improving outcomes for people

- Validated patient reported outcome measures (PROM) were used for all patients attending the RRU. However, the RRU did not provide any information on their use of Patient Reported Outcome Measures (PROMs) for the courses and clinics that they ran. They told us the information was collected centrally, but they did not use the measures to identify areas for improvement in their own service or benchmark against other units.
- 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. 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 at timeframe for completion. This enabled a treatment programme to be designed specifically to meet the individual needs of the patient.
- Staff ensured treatment was reviewed and optimised for patients, by reviewing goals and objective measures at each treatment session.

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 supported to meet the requirements of their professional registration. A register of staff professional registration was held and staff undertook a number of work-based activities including training and peer review. This ensured they met the requirements of their continuing professional development.
- The learning needs of staff were identified and regional in-service training (RIST) 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.
- The RIST program was made up of four training days throughout each year, which were open to ERI's, Physiotherapists and Doctors within the regional PCRFs, as well as all clinicians at RRU Colchester. We saw a sample of a RIST and included regional updates and forums for ERIs and physiotherapists. This multidisciplinary in-service training enabled greater discussion about treatment of various conditions to optimise care and treatment for patients.
- Clinicians carried out peer to peer review. 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 an appraisal, which was in line with their target. 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 ensured staff were familiar with the environment and their role and responsibilities on starting work at the unit. We spoke with staff who told their induction had helped them become familiar with the environment and become part of the team quickly

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, including those from different services 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.
- 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.
- 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 which patients from the RRU were referred to for medical intervention outside of the military. 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.
- RRU Colchester attended a multidisciplinary meeting once a month at the PCRF, with the local hospitals staff and GPs to make clinical decisions.
- 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.
- The unit had a fast track agreement with an independent hospital. So, if a patient needed to be referred onto another service quickly, for example for a scan or surgery, this could be done.

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.
- 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 five sets of patients records we reviewed, all of the patients had consented to their care and treatment at each treatment session. The service used to gain written consent from patients prior to the administration of injections but had stopped doing this. We saw they documented verbal consent and gave patients post injection advice leaflets.
- Patients were supported to make decisions about consenting to care and treatment. They received written information for treatments which involved a high level of risk. We

reviewed the information given, which was clear and comprehensive. Risks to patients were also explained and documented their treatment record, which we saw.

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.
- 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 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 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 considered when devising treatment plans.
- 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 the sessions.
- We saw staff taking the time to listen to patients' concerns and dealing with them in a sensitive manner.

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.
- Patients were encouraged to be active partners in their care.
- 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. Patients told us staff at the RRU gave clear explanations to them about their injuries and how they would benefit from specific exercises.

- 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.
- Each patient was assigned a physiotherapist and ERI for the duration of courses. Patients told us they appreciated this individual attention as they built a good rapport with staff and staff new their issues well. This enabled them to tailor care and treatment to their specific needs.

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 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.
- 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.

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 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.

- RRU Colchester provided services to meet the needs of the military population and occupational needs of their employment within the geographical area of responsibility. The RRU provided a service to seven Primary Care Rehabilitation Facilities (PCRFs) within the region.
- The RRU treated patients from all three military services, however the majority of patients were predominately army. The RRU ran two courses concurrently. The generals course ran for three weeks, whilst the specialist hip and groin course ran for two weeks. If the RRU was unable to meet the needs of the patients through the 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, an alternative RRU or NHS if this was in the best interests of the patient.
- If problem was a more general musculoskeletal issue, patients would be seen in a Multidisciplinary Injuries Assessment Clinic (MIAC)

  The MIAC was run by a doctor and a physiotherapist and offered one or more of:

  1) Management advice to PCRF
  2) Referral on for further investigations.
  3) Ultrasound guided injection.
  4) Referral on for intensive rehabilitation at the RRU.
  5) Referral on for secondary care opinion.

- If the problem related to specific biomechanical issues of the foot, ankle or lower limb they would be reviewed by a band 7 podiatrist who provided a management plan which may involve on or more of:
  1) Advice to the PCRF on patient management.
  2) Orthotics or biomechanical intervention.
  3) Referral onto Intensive Rehabilitation Course.
  4) Referral into MIAC if needed.

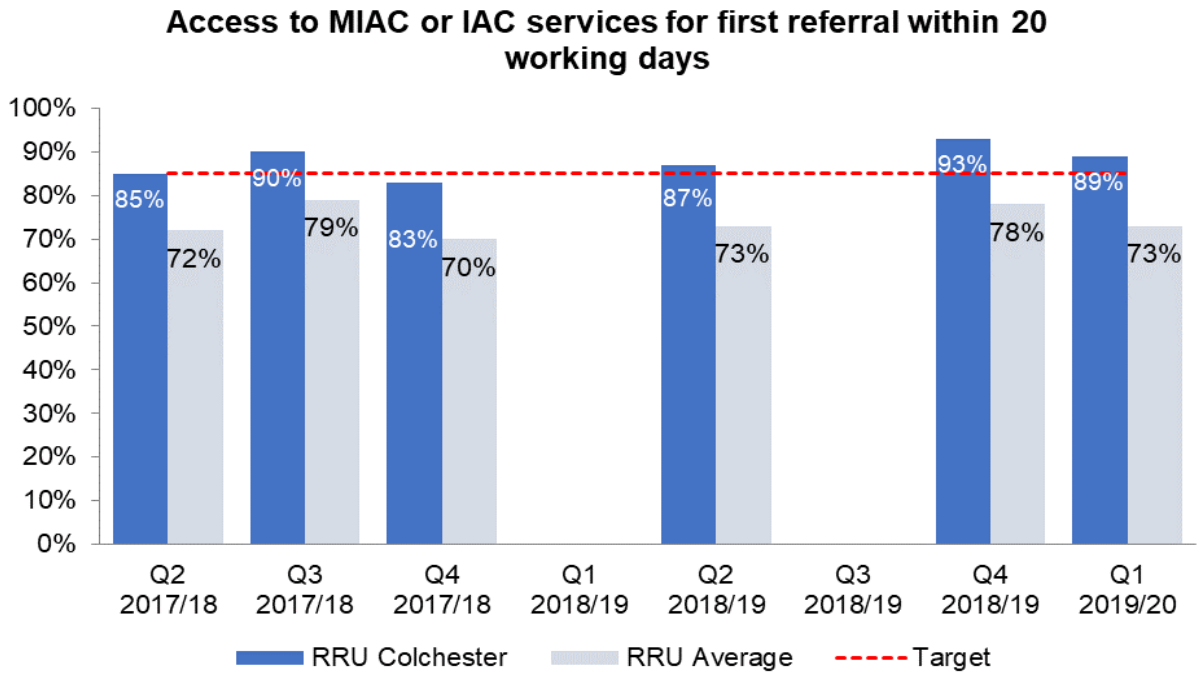
- Following the MIAC assessment, if more intensive rehabilitation was required, a referral would be made onto one of the three-week intensive rehabilitation courses. RRU Colchester ran two rehabilitation courses concurrently, followed by a one-week administration period, during which administration from the concluding course is completed, and preparations for the upcoming course were made. The RRU provided a lower limbs and generals course, due to the population served. If patient required an upper limbs course, they would be referred to another RRU.
- If the RRU was unable to meet the needs of the patients though the clinics and courses, patients were referred on to ensure they received appropriate treatment. For example, patients could be referred onto specialist services within the military such as the DMRC, or NHS if this was in the best interests of the patient.
- The service could also refer patients to a local independent hospital for surgical investigations or diagnostic imaging.
- The courses included protected MIAC appointments and a drop-in podiatry service during week two and three of the course.
- 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.
- The MIAC ran for 32 hours over four days every week and there was a monthly peripatetic clinic in Kent.
- The podiatry service ran for 21 hours a week over two and half days and there was a monthly peripatetic clinic in Kent.
- The RRU was working with the PCRF to provide better continuity for patients with regard to their exercise programmes. The RRU and PCRF used an electronic system (Rehab Guru), 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. The system also provided better governance, clinical and cost effectiveness, standardisation and patient satisfaction. It also helped to optimise the patient's potential to progress with their rehabilitation.
- Patients were provided with a course booklet, once they had booked onto a course. The information included what clothing was required, information about the pre and post course processes and a location map. Other useful information was also available about the accommodation, meals and what to do if the patient was no longer able to attend the course. It contained information about anatomy, injury healing time and descriptions of the exercises. There was dietary information, advice about footwear and sleep.
- 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 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.
- Facilities and premises were suitable to meet the needs of a range of people who use the service. The RRU had a wide range of fitness, strength and conditioning equipment to meet the specific rehabilitation needs of the PAR.

- There were a variety of information boards around the RRU, which contained a variety of information, for staff and patients and in response to patient feedback. We saw information on how to make a complaint, mental health and well-being, which included details of a number of ways to contact other agencies. Staff also displayed audit results, information about equality and inclusivity and patient feedback results.
- Where patient's needs were not being met, this was identified and used to inform how services are planned and developed. Feedback from patients resulted in changes to how the service was planned, developed and delivered. For example, patients had fed back, they felt the waiting area was too small for all course attendees, so the RRU had utilised the classroom area for patients to wait instead.

Access to the service

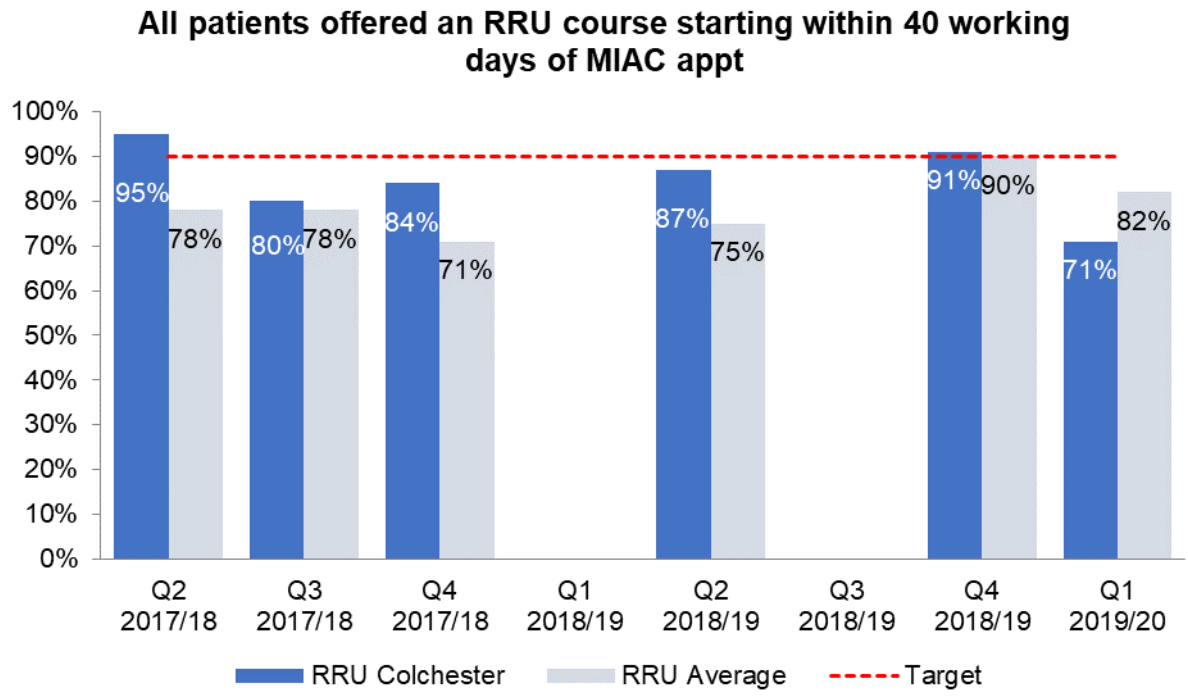
The unit provided assessment and treatment services between 9am and 5pm from Monday to Friday

- Patients had timely access to initial assessment, diagnosis or urgent treatment in a way which suited them.
- From quarter two 2017/18 to quarter one 2019/20, RRU Colchester received an average of 93 new referrals for MIAC services per quarter. The target for accessing MIAC services within 20 working days of referral is 85%. RRU Colchester met or exceeded the target in five of the six quarters where data was available. In the quarter where the target was not met, performance remained above the average performance for all RRUs. In the most recent quarter (quarter 1 2019/20), 89% of patients who were referred to RRU Colchester were offered a MIAC/IAC appointment within 20 working days.
- There was no data available for any of the RRUs in quarters one and three of 2018/19 as the dashboards were being reconfigured. Data for quarter 2 2019/20 was not available at the time of inspection.



- From quarter two 2017/18 to quarter one 2019/20, RRU Colchester received an average of 15 new referrals for its RRU course per quarter.

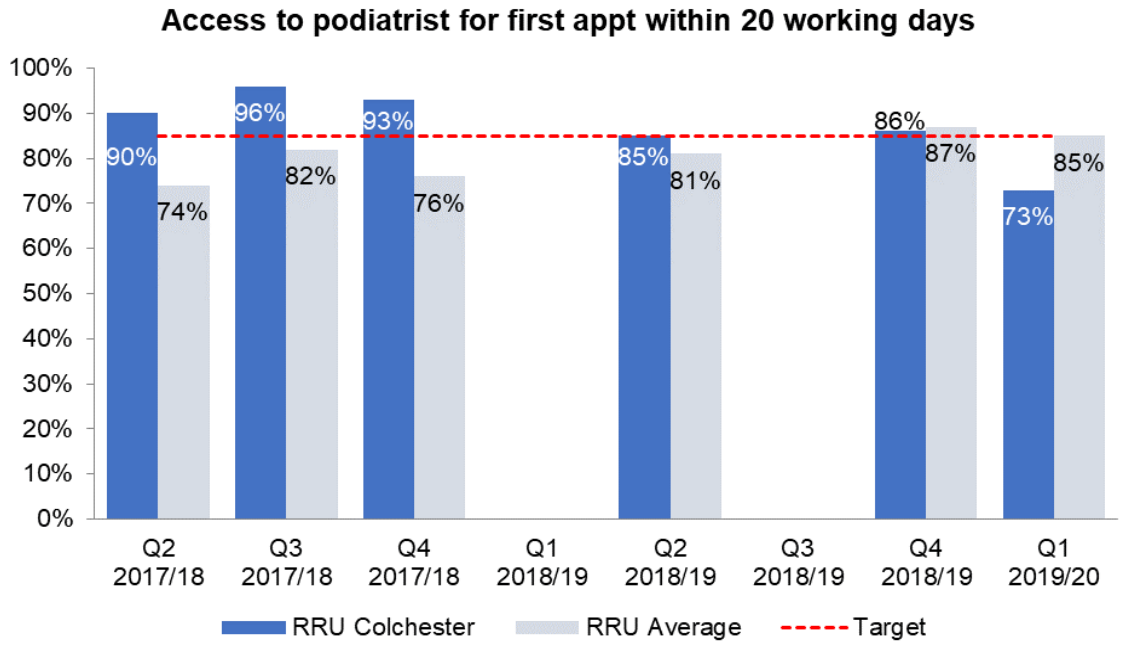
- The target for accessing an RRU course was for 90% of patients to be offered a course starting within 40 working days of the MIAC appointment. RRU Colchester did not meet the target in four of the six reported quarters but generally performed better than the RRU average. However, in the most recent quarter (quarter 1 2019/20), 71% of patients at RRU Colchester were offered an RRU course within 40 working days of MIAC appointment and the RRU performed worse than the RRU average. Data for quarter 2 2019/20 was not available at the time of inspection



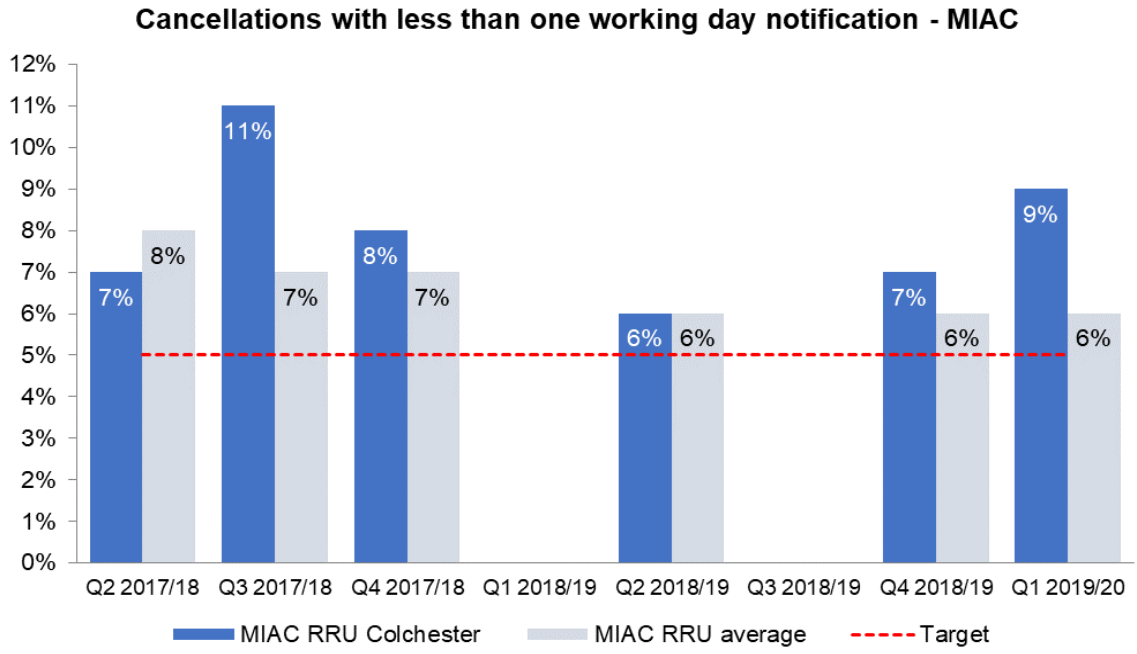
- From quarter 2 2017/18 to quarter 1 2019/20, RRU Colchester received an average of 76 accepted referrals for a podiatrist appointment per quarter.

- The target for accessing a podiatrist is for 85% of patients to be offered an appointment within 20 working days of a referral to the Regional Podiatry Service. RRU Colchester met the target and performed better than the RRU average in all quarters from quarter 2 2017/18 to quarter 4 2018/19. However, in the most recent quarter, RRU Colchester performed below the target and worse than the RRU average.

- There was no data available for any of the RRUs in quarters one and three of 2018/19 as the dashboards were being reconfigured. Data for quarter 2 2019/20 was not available at the time of inspection.

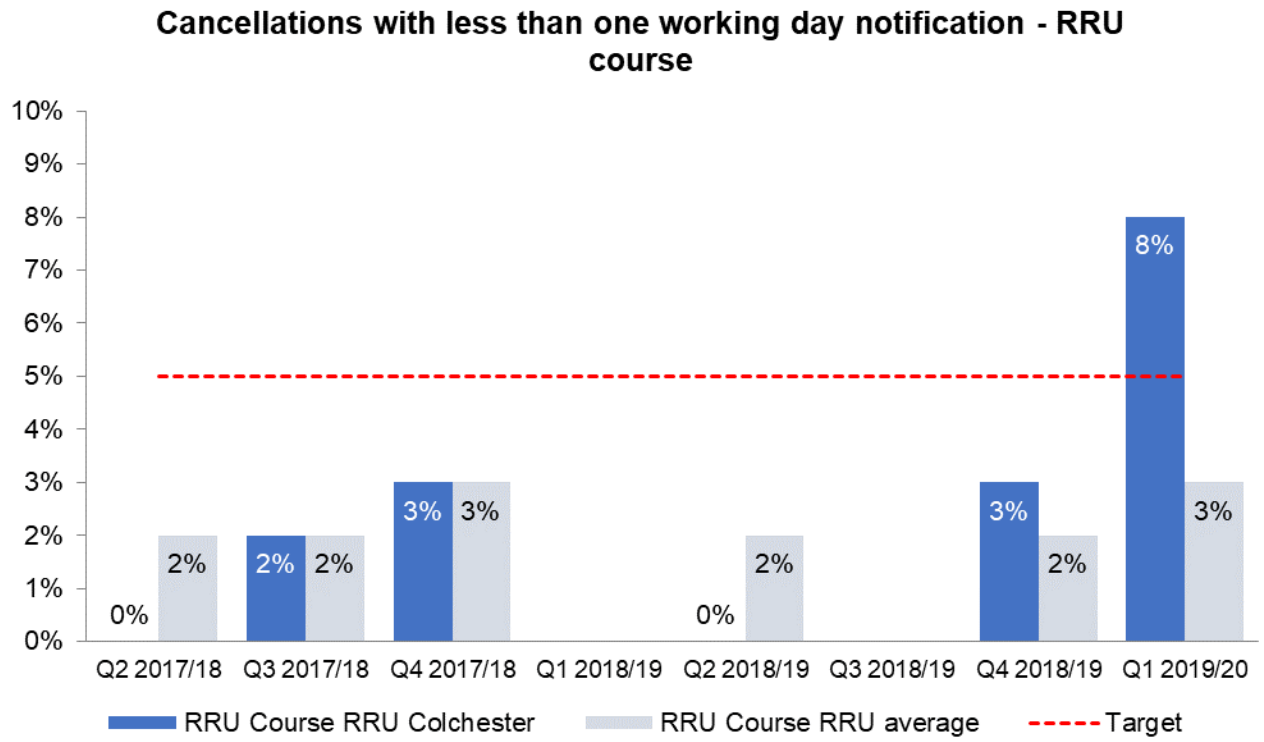


- The target for short-notice cancellation rates (cancellations with notice of less than one working day) is 5% or less.



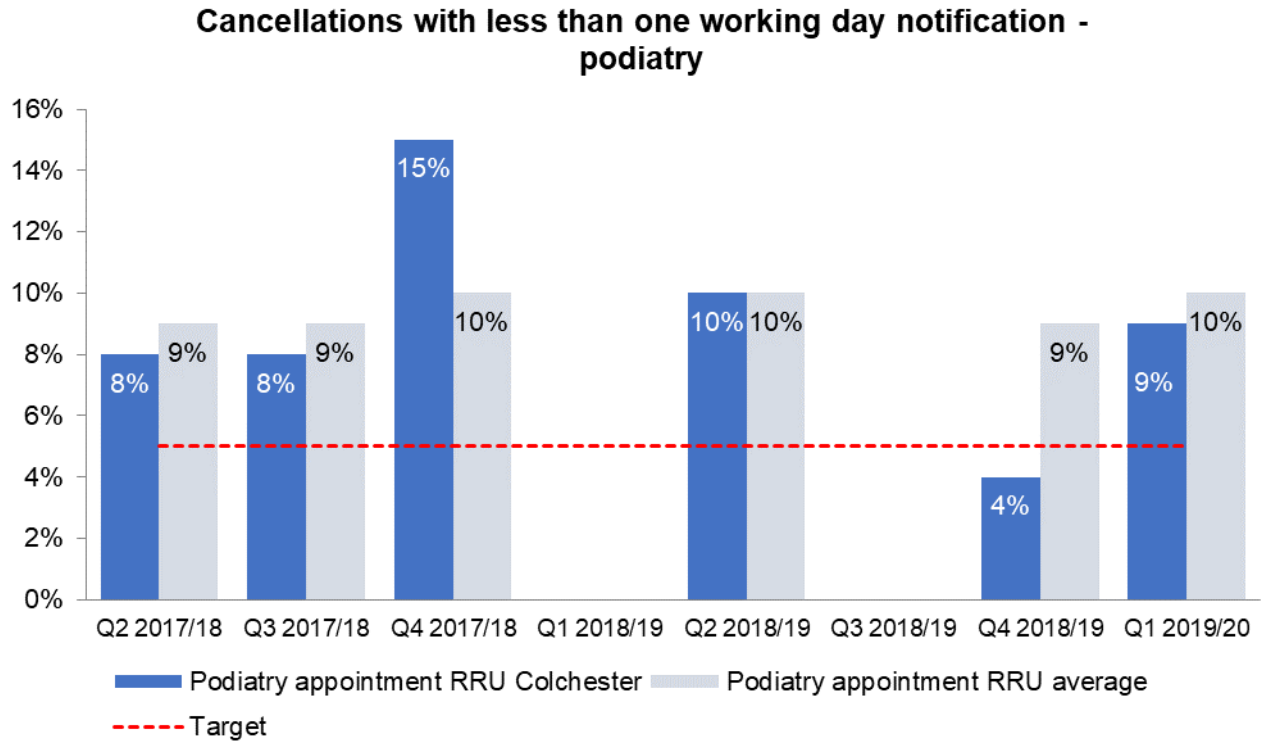
- From quarter 2 2017/18 to quarter 1 2019/20 the MIAC short notice cancellation rate at RRU Colchester ranged between 6% and 11%. The cancellation rate was higher than the 5% target and similar to or higher than the RRU average across the whole of the period.

- There was no data available for any of the RRUs in quarters one and three of 2018/19 as the dashboards were being reconfigured. Data for quarter 2 2019/20 was not available at the time of inspection.



- The RRU course short notice cancellation rate at RRU Colchester was similar to or better than the RRU average across most of the period. However, in the latest two quarters of data, the cancellation rate for the unit increased and was notably higher than both the target and RRU average in quarter 1 2019/20.

- There was no data available for any of the RRUs in quarters one and three of 2018/19 as the dashboards were being reconfigured. Data for quarter 2 2019/20 was not available at the time of inspection.



- The podiatry appointment short notice cancellation rate at RRU Colchester was worse than the target in five quarters of available data from quarter 2 2017/18 to quarter 1 2019/20. In the most recent quarter, 9% of podiatry appointments at RRU Colchester were cancelled at short notice. This was similar to the RRU average of 10%.
- There was no data available for any of the RRUs in quarters one and three of 2018/19 as the dashboards were being reconfigured. Data for quarter 2 2019/20 was not available at the time of inspection.
- 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 classed as urgent of 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. Staff told us the communication between themselves and the PCRFs was good and they would discuss any queries about referrals openly.
- 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.
- 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. This was in line with the DNA (Did Not Attend) standard operating procedure, dated August 2019.
- Patients had access to fast track diagnostic imaging for identifying and monitoring diseases or injuries, if required, at a local private 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. A verified equality and diversity policy was available 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.

- We saw clear signage around the RRU and posters displaying a variety of advice and signposting patients to other services.
- A poster detailing interpretation services was clearly visible in the administrative area and signposted patients how to access the service in different languages.

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. The unit had a complaints policy dated November 2019. This covered how the complaint was to be dealt with, including the stage of communication and investigation.
- From January to November 2019, the RRU received two complaints, one regarding the facilities and the other regarding a delay in an appointment. We reviewed one of the complaints and it was processed within fifteen days, in line with the complaints policy.
- Information was available to support patients in making a complaint if they felt the need to do so. The procedure to make a complaint was available for patients in the RRU. Also, information was also provided as to how to make a complaint in the patient's course booklet.
- The RRU provided a copy of its compliments register with 37 compliments received from January to November 2019. The majority of compliments, 19 (51%) were regarding staff.

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 not well-led in accordance with CQC's inspection framework

Vision and strategy

- The mission statement for RRU Colchester was set out for the service, with quality and safety the top priority. The mission statement for the RRU was 'to provide a collaborative and whole person approach to defence rehabilitation.'

- It had SEED binding principles:

Success- through patient centred goals, sustainable development and organisation
Employable- Return to role, improve deployability and improve capability of service staff.
Empower-Can do attitude, positive experience and educate
Deliver-Evidence based practise, self-effective care and specialist care.

- Staff had contributed to the mission statement and it was clear from speaking to staff and their interaction with patients, they had a clear understanding of the importance of providing high quality, personalised rehabilitation to patients.
- 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 the development of a peripatetic clinic in Kent to meet requirements of patients who were in that area.

Governance arrangements

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

- There was an effective governance framework to ensure quality, performance and risk were understood and managed. There was an overarching ministry of defence (MOD) corporate governance policy (JSP 525). This covered the structure of MOD governance, governance principle, roles and responsibilities, governance control processes and risk management processes. The policy was not specific to the RRU but provided context and guidance about how MOD governance processes worked.
- Governance arrangements at RRU Colchester were systematic and reflected best practice. We saw the unit had a comprehensive governance documentation and oversight system, which was referred to as the workbook. All staff could access the workbook and all staff were aware of the governance system through weekly team meetings and monthly governance meetings.
- We reviewed the governance workbook which included the risk register, quality improvement programme actions and progress, mandatory training compliance, professional registrations, complaints, incidents, standard operating procedures and meeting minutes.
- There were clear arrangements providing good oversight of safety, quality and risk at the RRU. There was a monthly team meeting at which all aspects of safety and quality were discussed.
- The RRU had a daily morning meeting, where staffing was reviewed any immediate issues and a plan of what everyone was doing for the day was discussed. We saw a morning meeting which was brief, but effective in ensuring everyone was aware of their tasks for the day and any immediate issues could be addressed.
- The unit had a monthly staff meeting, where information from the station executive meeting was shared, staff checked the diary for the next two weeks, areas related to governance were discussed, which included incidents and patient feedback. We saw minutes of meetings which indicated this was occurring regularly. Staff told us they felt these meetings were a whole team affair and everyone was engaged and participated in discussions.
- Healthcare governance meetings were held every month. Standing agenda items were incidents, risk register, action plan review, standard operating procedure review,

mandatory training review, equipment updates, infection control, Caldicott and quality improvements.

- There were systems and processes to identify, manage and mitigate risks associated with the unit and a risk register meeting was held monthly. The service had a risk register which was reviewed regularly by team leaders. All staff could add a risk to the register. The risk was rated for likelihood of impact and probability it would occur. Each risk was reviewed to check the likelihood of it happening was kept a low as possible. Staff we spoke with were engaged with the risk management process, the risk register and told us they were involved in discussions about solutions. This was in line with the RRU's risk management standard operating procedure, dated August 2019
- We saw the risk register and each risk was given a category and rated on impact and likelihood. The original rating was documented and the category was reviewed in line with actions taken regularly. Management plans and mitigating actions had been identified to manage the risk. A responsible person had also been designated to oversee and manage the risks.
- A common assurance framework (e-CAF) assessment was a live document used to support the delivery of good quality care. 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. We were unable to look at the RRU's e-CAF at the time of inspection because of an issue with the information technology systems.
- 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. In addition, staff had completed an audit to review the efficiency of the peripatetic clinic which had been recently established in Kent.
- 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 clinical governance, complaints, infection, prevention control and equipment care.

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 three months at the time of our inspection, had skills knowledge and leadership skills from role held across their military career. Staff

spoke very highly of the leadership from the service lead and how they were supported and empowered to develop their knowledge and skills.

- 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 how committed they were working to improve the quality of care by developing the knowledge and skills of the local PCRFs and supporting them to evolve. The regional in-service training events 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.
- 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. There was a whole team ethos of ‘equal voice’ regardless of rank.
- Communication within the RRU was good, both informal and through team meetings and staff had nominated roles and responsibilities, with time allocated to fulfil these roles. Leaders supported staff development with regular appraisals and staff supported on another with peer reviews and in-service training.
- Staff told us about social events and team buildings events, which were well attended. 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.
- Feedback was collected and used to adapt and develop the way the course ran. For example, the waiting area for patients was changed following feedback. On completion of a course, all patients completed an end of course evaluation patient feedback questionnaire.
- 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 involved in developing the mission statement of the RRU.
- 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.

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, clinical governance, RRU infrastructure /gym/equipment, training and miscellaneous.
- The service carried out regional assurance visits, some were informal, some advisory, some were for clinical advice, but all were focussed on continuous learning and improvement at all levels within the service.