Defence Medical Services

Northern Ireland Regional Rehabilitation Unit

Inspection Report

Regional Rehabilitation Unit
Aldergrove Barracks
Belfast
Northern Ireland

Date of inspection visit 1 & 2 March 2023
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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?	Requires improvement

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

We carried out an announced comprehensive inspection at Northern Ireland Regional Rehabilitation Unit (RRU) on 1 & 2 March 2023.

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. Where short comings were identified, there was no significant impact on the safety and quality of clinical care.

- There was a system for reporting and recording significant events.
- Essential systems, processes and practices were available to ensure 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.

However:

- We were concerned that not all incidents were being reported.
- There were some gaps in mandatory staff training.
- Recent staffing gaps meant that lead roles had been reallocated and accountabilities were not always in line with staff's current experience.

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.

- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities and updated them 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 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.

However:
- Use of outcomes and audit data was not optimal. Although patient outcome information was collected, results were not routinely collated or analysed at a local level. There was no systematic programme of regular audit reviewing quality of clinical care. This meant that the unit was unable to demonstrate that they routinely used information from outcomes and clinical audit to make improvements to the care delivered.

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 that they would understand their care and treatment.

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

- The unit uses information about the needs of the Population at Risk (PAR) within the Area of Responsibility (AOR) to inform how services are planned and delivered. We found they had a plan, which enabled them to meet the needs of the PAR, particularly those with complex needs, long-term or career-limiting conditions.
- Patients had timely access to initial assessment, diagnosis or urgent treatment in a way which suited them.
- The unit had a system for handling concerns and complaints.

We found that this practice required improvement in 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. However lines of accountability were blurred due to a number of

key staff being absent from post. Staff working within the service were doing the best that they could to ensure that responsibilities were clear and that quality, performance and risks were understood and managed, but there were gaps.

- Managers within the service worked hard to run the service and to ensure that patients' needs were met. However the post of OC was currently being covered by a locum who assumed no accountability for healthcare governance and was unable to line manage due to their locum status. Whilst all staff prioritised safe, high quality and compassionate care, some staff were being asked to assume accountability beyond their terms of reference.
- There was an inconsistent process for staff supervision / peer review. Some staff groups received regular formal peer supervision, but other staff groups did not have a formalised process.
- Staff and patients were encouraged to provide feedback using QR codes and this was acted on to make improvements to the service.
- 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:

- There was a comprehensive system for oversight of equipment maintenance which had been developed by the RTSA. Statements of needs were submitted promptly where required and the range and quality of equipment in the gym was excellent.
- The RTSA had tackled issues around cleaning standards and liaised directly with the contractor to ensure that improvements were delivered.
- We noted excellent interaction between RRU RTSA and ERIs practising within the 3 Primary Care Rehabilitation Facilities (PCRFs). To date, the RTSA had carried out 2 out of a planned 3 RTSA Advisory Visits. They had also made time to visit them in a more informal capacity ensuring full support as the ERI regional subject matter expert on exercise rehabilitation. The RTSA had undertaken peer reviews of ERIs within their region and provided comprehensive feedback to improve patient lesson delivery and performance. Furthermore, ERIs periodically came together and conducted Regional IST: a valuable opportunity to review working practices and share best practice within the peer group.
- There were visible QR codes in both buildings for patients to report any building faults or defective medical/gym equipment. Numerous places in the RRU existed for patients to provide feedback to the RTSA through QR codes and email. Patients gave excellent feedback about their experience and were fully involved in their care. We also noted that any patient or staff feedback was listened to and used to make improvements where possible.
- Staff feedback resulted in improved impact for patients. New flooring had been provided in the gym and a recent order for more gym equipment included rowers, calf raise machine and ski ergos.

Recommendations for improvement

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

- Establish clear lines of accountability for healthcare governance and line management of staff within the RRU.

- Ensure that terms of reference for individual staff sit in line with their experience and skillset. Where responsibilities extend beyond this, provide comprehensive training.
- Ensure that goals are set with all patients and that these are recorded in their patient record for comprehensive outcomes management.
- Ensure accuracy of and therefore utility of data to monitor patient outcomes. Routinely use these measures to identify areas for improvement in the service.
- Reference any best practice guidelines in consultation notes.
- Ensure that all staff groups can access peer review.
- Ensure that the hepatitis B status of all RRU staff is checked and recorded.
- Strengthen the induction programme to ensure it is in line with organisational policy
- Ensure all clinicians participate in clinical audit.
- Review the patient information displayed to ensure it is up-to-date.
- Re-introduce the multi-disciplinary team approach working with other PCRFs.
- Implement a local business plan to underpin the DMRP strategy.

Sean O Kelly
Chief Inspector of Hospitals

Regional Rehabilitation Unit – Northern Ireland

Detailed findings

Why we carried out this inspection

The CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare Regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections that the CQC will complete at the invitation of the DMSR in their role as the military healthcare Regulator for the DMS.

Background to the service

The Regional Rehabilitation Unit (RRU) is a defence regional facility which provides medical opinion and delivers treatment for patients with moderate musculoskeletal injuries. There are 13

RRUs across the UK. RRUs deliver intermediate care and provide the main conduit to secondary care rehabilitation. Each RRU supports a number of identified primary care rehabilitation facilities (PCRFs). This support ranges from the receipt of referrals through to providing advice with regards to clinical governance and delivery.

RRU NI provides coordinated clinical management and intermediate rehabilitation to a tri-service population within a defined geographical region – Northern Ireland.

RRU NI takes its model of care from the Defence Medical Rehabilitation Plan in which clinical factors, service factors and local factors determine whether a patient can best be rehabilitated in a PCRF, RRU or Defence Medical Rehabilitation Centre (DMRC).
The RRU has four main roles:

1. Provision of specialist musculoskeletal opinion delivered by a Multidisciplinary Injury Assessment Clinic (MIAC). This includes a Sports and Exercise Medicine Doctor (SEM) and a physiotherapist and can include an ERI when required. Clinical assessment at the RRU is delivered through the MIAC.
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.

The treatment plan may allow for patient management to be maintained at local level and preclude the need for secondary care or inpatient rehabilitation.

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. 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. The MIAC clinicians are available to discuss individual cases prior to or after referral to MIAC.

Patients being referred to MIAC from PCRF clinicians are those that require further diagnostic services such as MRI and ultrasound scanning coupled with the greater knowledge of the MIAC Consultant and the B7 physiotherapist. They are patients who need a more definitive diagnosis and, if required, signposting to, for example orthopaedics or rheumatology.
PCRF physiotherapists also refer patients directly for a rehabilitation course – these do not require the diagnostic skills of MIAC. Similarly PCRF physios also refer directly to podiatry with no requirement for a MIAC appointment.

2.Provision of specialist podiatry assessment. Currently the service hosts a Band 7 Podiatrist who provides services both within the RRU and to patients referred from surrounding PCRF's. The aim of the specialist podiatry service 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.

3. Provision of intensive residential rehabilitation courses. This is for patients whose condition necessitates a period of intensive daily rehabilitation (such as post orthopaedic surgery). Patients may be referred for three weeks for rehabilitation on a 'trickle feed' course with other patients who have a range of differing injuries to the lower limb or spine. Rehabilitation sessions run in the mornings allowing patients who can to return to their units in the afternoon or to be accommodated on site at Aldergrove where travel is not possible.

4. Specialist outpatient injury assessment clinics (IACs) where treatment such as Extracorporeal Shockwave Therapy (ESWT) can be carried out.

Onward referral to other specialised centres can be arranged after MIAC, for example for MRI scan, ultrasound diagnostic scan, or orthopaedic opinion via the electronic referral system (eRS). This list is not exhaustive and can also include referral to DMRC for specialist advice and treatment of tendon injuries. There are links with local hospitals to access orthopaedic care, including private hospitals, both surgically and for MRI delivery.

The Regional Trade Specialist Advisor (RTSA) provides a regional, professional point of contact, conducting liaison visits with the PCRFs within region, and providing support and guidance. The RTSA also provides exercise rehabilitation instructor (ERI) mentoring in the region to all 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 medical centres and PCRFs.
Most patients referred to the RRU will have already received rehabilitation at their local PCRF, and following rehabilitation at the RRU, will be discharged back to the PCRF.
All patients referred 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.

Rehabilitation Referral Guidelines

Clinical Factors	• Moderate Injury • Requires intensive rehabilitation (daily) • Failure to respond to rehabilitation at PCRF level • Additional level of expertise
Service Factors	• Unable to continue to work in any capacity • Unable to continue work in specialist role (infantry, aircrew, PTI). • Temporary MES awarded
Local Factors	• No facility for local Rx available • Requires protected time for rehabilitation

The RRU is staffed by a service lead (OC- currently a locum who assumes partial accountabilities within the OC role), clinical specialist physiotherapy lead (currently Band 6 following the departure of the Band 7), physiotherapists, a locum MIAC doctors (8 hours per week), regional trade

specialist advisor (RTSA), exercise rehabilitation instructors (ERIs), a podiatrist and administrators.

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

Our inspection team

Our inspection team was led by a CQC inspection manager. The team included a further CQC 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 across 1 and 2 March 2023. During the inspection, we:

- Spoke with staff, including physiotherapists, exercise rehabilitation instructors (ERIs), administrators, the OC and the RTSA.
- Spoke 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
- Reviewed policies, complaints and ASER 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

There was a board in reception clearly stating the positive changes made to the RRU following patient requests and concerns. There were visible QR codes in both buildings for patients to report any building faults or defective medical/gym equipment. Numerous places in the RRU exist for patients to provide feedback to the RTSA through QR codes and email. A patient satisfaction questionnaire was sent out in June 2022 and 20 patients responded. 100% said that they were satisfied with their care and stated that they would recommend the service to their family and friends.

As part of our inspection, we also spoke with 4 individual course participants. They highly recommended this course to all injured Service personnel. They reported that the interaction between clinician and patient was outstanding and met their needs in terms of understanding their injury and how to resolve their physical difficulty. They benefitted from the daily routine of exercise therapy; something which isn't always possible at their unit. Small group numbers

provided greater clinician interaction and an opportunity for them to speak regularly about their current programme and about any concerns they may have. Some reported that they would prefer longer days and suggested lectures on nutrition, anatomy and other health related topics. Others felt the time allocated for daily rehab was sufficient. Some would prefer daily hydrotherapy as opposed to twice weekly to aid better physical movement for the rest of the day. Not all patients were aware of the quick response access to tutorials and presentations. Those who had used them, found them very informative. Patients commented that the MIAC offered a responsive and thorough assessment service. Patients told us they liked the small number of people attending the course as they had more enhanced supervision and easy access to equipment. Patients said they were included in the development of their goals and treatment plans. MIAC staff and course instructors were described as approachable, knowledgeable, friendly and supportive. They commented on the helpful QR codes in RRU reception for providing information on a variety of health related and change behaviour topics.

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 a system for reporting and recording significant events. Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER). The majority of staff were aware of the ASER process and had a log in to use the system. The training log showed ASER training was facilitated in 2019, 2021 and 2022. A recently recruited member of staff had not completed ASER training or received a log-in as required within their first week of their induction. An ASER log was maintained and it showed low numbers of reported incidents; 1 in 2021 and 4 in 2022. Lessons learnt were shared at the team meeting held on alternate Tuesdays and at the monthly clinical governance meeting.

Accidents were reported using the Defence Unified Reporting and Lessons System (referred to as DURALS).

The RTSA monitored safety alerts via the Central Alerting System and was responsible for responding to safety notices.

Systems were in place to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The Regional Trade Specialist Advisor (RTSA) was familiar with the duty of candour. There had been one complaint relating to duty of candour which was managed appropriately and promptly.

Overview of safety systems and processes

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

Arrangements for safeguarding reflected relevant legislation and local requirements.
Staff understood their responsibilities and adhered to safeguarding policies and procedures. The local contact details for reporting a safeguarding concern was displayed in the waiting area. With the exception of a temporary member of staff in post for just 2 weeks prior to this inspection, all other staff we spoke with were aware of who the safeguarding lead was and how to report a concern.

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. A mandatory training database (that included this information) was maintained. Information was held electronically, and a check of the professional register or equivalent had been completed for all staff.

Vacancy rates were high but there were plans in place for recruitment and a locum had been employed to cover the physiotherapy vacancy.

Standards of cleanliness and hygiene were maintained. A cleaning schedule was in place for clinic rooms, the rehabilitation gym and swimming pool. Clinical areas were visibly clean at the time of the inspection. The RTSA was the infection prevention and control (IPC) lead, although they had not completed the required training for the role. The last IPC audit was completed in 2021. It identified fabric chairs and non-compliant sinks; these issues had been actioned. There was a comprehensive cleaning rota within the gym signed periodically throughout the day along with daily environmental cleaning from 08:30-09:00 hours. A cleaning schedule for the swimming pool was displayed.

Clinical waste and sharps were managed safely. Sharps boxes were used and disposed of in line with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. Clinical waste was disposed of in yellow bags which were placed in a locked clinical waste bin, for which there was a contract for regular removal.

Notices were displayed providing details of access to a chaperone. We were advised that patients were routinely offered a chaperone. However, there was no evidence in place to confirm which staff had received chaperone training.

There was clear information displayed about how safety, health, the environment and fire (referred to as SHEF) was managed at the unit, including a unit representative attending the station SHEF meetings. A fire risk assessment of the rehabilitation gym was undertaken in February 2022 with a suggested review timeframe in February 2023. We were not provided with evidence to confirm if this re-assessment had taken place. A fire evacuation checklist was in place and checks of firefighting equipment were carried out each week. The fire evacuation procedure was displayed.

The rehabilitation gym had recently been refurbished including new flooring and the purchase of new equipment. Patients were always supervised within the rehabilitation gym. This included a requirement to sign in/out of building. Typically 2 clinicians were on site whilst patients were undertaking rehabilitation. Over the last 12 months, they had had no more than 9 patients in attendance at any given time.

The RRU used the station swimming pool, the maintenance and monitoring of which was outside of their direct control. Chlorine checks were undertaken by a plant operator daily and 2 lifeguards were in attendance when RRU patients were undertaking hydrotherapy. Lifeguards had direct access to the guardroom via phone. There was a defibrillator in the located close to the pool.

The equipment care policy was reviewed in June 2022. Both the RRU main building and rehabilitation gym were well equipped with the latest equipment. Both areas had ample space for both patients and staff. An electronic inventory log was maintained and held information as to when maintenance had taken place for the equipment. Rehabilitation gym equipment had a unique identifiable marker and a history of maintenance. All physical training equipment has

been serviced and was next due for service in July 2023. All non-usable equipment was quarantined and was not accessible to patients. Periodic 'snap' inspections of medical equipment were carried out and signed by the RTSA.
The log was maintained by the unit RTSA and showed servicing was in date.

Portable electrical appliances were tested to ensure they were safe for use. Stickers on the equipment identified the checks had taken place.

Evidence was in place of equipment care training for staff. The RTSA maintained a log of when staff had received training on how to use each item of equipment.

Quick response codes were used were used to report faults with the building or equipment.

No medicines were stored in the RRU. The only medicines prescribed were a local anaesthetic and a steroid. These were prescribed by the consultant and collected from pharmacy. There were first aid kits, eye wash kits and blood spill packs available.

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 showed all clinicians were aware of best practice and NICE guidelines. We reviewed a range of patient records and they showed good compliance with minimum standards. All had documented consent, HPC, examination and a plan.

There was evidence of a MIAC DMICP consultation notes audit but there had been no audit of ERI course clinicians DMICP consultation notes in the last 12 months.

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.

RRU NI reported the following whole time equivalent (WTE) establishment staffing as of March 2023:

Staff group	Planned staff – WTE	Actual staff – WTE	Fill rate (%)
Regional Rehabilitation Officer (RRO)	1	1	100%
Physiotherapist B7	1	0	0%
B6 MIAC Physio (Locum) covering the B7	1	1	100%
Civilian physiotherapist B6	1	1	100%
Multi-disciplinary Injury Assessment Clinic (MIAC) consultant	8 hrs	0.2	100%
Podiatrist B7	8 hours	0.2	100%
Administrator E1	2	1	50%

Military Exercise Rehabilitation Instructor (ERI)	1	1	100%
RTSA	1	1	100%

In the planned absence of the RRO, the role was being covered by a locum RRO. A Band 6 had been recruited to a Band 7 post. However, their terms of reference were not reflective of their experience and grade. Whilst the staffing levels were sufficient to deliver clinical care, disruption to staffing was an issue. While staff had diligently worked to keep the service effective and safe, the governance regarding patient care had been limited in terms of supervision and audit. Furthermore, there was an unequal division of responsibilities in relation to governance. This had resulted in the RTSA working above and beyond what was required of their role. There was no cover available when the consultant took leave.

The risk register was comprehensive with risks transferred to regional headquarters where appropriate. Risk assessments were developed by the RTSA and signed off by the SMO at Lisburn Medical centre. In addition, the clinicians facilitating courses used a dynamic risk assessment in the rehabilitation gym. It was signed daily as a competency check to oversee rehabilitation activity or a change in the planned timetable.

A risk assessment covered all aspects of provision of hydrotherapy in the swimming pool. The pool risk assessment was up-to-date. However, an old COVID-19 risk assessment (June 2020) was displayed and visible to users in the swimming pool reception area. The RTSA undertook monthly lifeguard training.

Oxygen and an anaphylaxis kit were brought to the RRU for injection clinics. Some staff were out of date for automated external defibrillator and basic life support training. We were advised training was planned. The Resuscitation Council UK guidelines on anaphylaxis was displayed.

Arrangements to deal with emergencies and major incidents

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

The unit had adequate arrangements to respond to emergencies and major incidents. A detailed business continuity plan was in place which was reviewed in June 2022.

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

- Rehabilitation was delivered in line with evidence based practice guidance on treating musculoskeletal conditions and provided a holistic approach to rehabilitation. The rehabilitation course timetable ran from 0900-1200hrs on a trickle feed system. Typically, 2-3 new patients commenced the programme each Monday and were likely to stay on the programme for up to 3 weeks. This system was working well for small numbers of patients and staff confirmed that the provision could be upscaled slightly if required. The component of the rehabilitation timetable was largely physical based but there was opportunity for clinicians to discuss pain and other non-physical subjects if required. This would be at the request of a patient. The rehabilitation programme was progressive and included military specific training.
- 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.
- Staff had access to best practice guidelines to inform the care and treatment they provided to patients. Staff followed assessment templates to ensure consistency and there were standard operating procedures (SOPs) to follow for procedures such as injection therapy. Specific guidelines had been produced to cover a range of conditions seen at the clinic, for example, the management of lower limb tendinopathy and the management of low back pain. The documents contained flow charts identifying specific care pathways. Each document identified specific clinical features which may be found for different presenting conditions and identified the approach to management of the condition which needed to be taken by the RRU. The document also identified red flag (serious pathology) which would need immediate attention and escalation if identified. References to the guidelines and evidence which had been used to develop the documents was also identified within the document.
- Policies were produced in line with and referenced national guidelines and evidence based, best practice.
- Pain was assessed and managed according to each individual patient. Pain was assessed using a visual analogue scale (a straight-line scale from 1 to 10 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. Patients attending the course told us that staff checked on whether they had any pain. They would suggest adapting their exercises or alternative or additional treatments or referral to the doctor to manage any pain experienced. There was a QR code in both buildings which provided a link to information which supported patients to

understand and manage pain. Patient reported outcome measures (PROMS) were used to measure changes in patients' pain throughout the course.

- All clinicians involved patients in modern digital approaches to rehabilitation programmes through "Rehab Guru" and the "Wattbike app". Should patients find difficulty in either app use, paper copies could be printed off.

Management, monitoring and improving outcomes for people

There was a limited approach to monitoring and benchmarking the quality of the service and outcomes patients received following an episode of treatment.

- Validated patient reported outcome measures (PROM) were used for all patients attending the RRU. All outcome data collected was entered into the patient's electronic healthcare record and we reviewed a number of these for individual patients using the service during the past 12 months. At patient level, outcomes information was available. However the RRU did not routinely use the measures to identify areas for improvement in their own service or benchmark against other units.
- The RRU routinely used two outcome measures:
    1. the MSK-HQ measure which is a generic, single musculoskeletal outcome measure that can be used throughout the healthcare pathway and covers patients with different musculoskeletal conditions and
    2. the FAA (*Functional Activities Assessment) which is used to assess which work tasks patients are able to safely undertake*
- There was a limited approach to monitoring and benchmarking the quality of the service and outcomes patients received following an episode of treatment. Project Apollo was a performance tool used to measure the progress of patients against set indicators. Indicator DHIR032 measured the percentage of care pathways at the RRU which showed improvement in validated outcome scores within the year. For RRU NI, 67% of patients had an improved FAA score in the past 12 months and 19% were shown to have an improved MSK-HQ score in the last 12 months. The MSK-HQ score was likely so low due to the majority of the outcomes scores being missing and so cannot be relied upon.
- The course clinicians deliver a combined assessment approach sharing the duties of subjective questioning and physical/objective testing. Both clinicians formed a plan for patients taking into consideration goals identified by the MIAC assessment. Not all patients go through the MIAC process: some are directly referred by the PCRFs to the course clinicians.
- Patients had their needs assessed, their care planned and delivered, and their care goals identified when they started treatment at the RRU. On the first day of the course, the patient would be assessed by the physiotherapist and ERI to identify their individual needs. On day two of the course, pre-course outcome measures would be completed, and goals set jointly between patients and staff. 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.
- We reviewed a selection of patient records and saw that for most (but not all), goals had been set with patients which outlined what they wanted to achieve through their treatment. Where goals had been recorded, these measures were patient specific to provide an objective measure associated with the patient's injury. These objective measures included a range of functional activity tests. Although the measures were repeated at the beginning and end of each patient's rehabilitation, there was no collation of these outcomes to evidence the unit's overall performance. There was also scope to reference any best practice guidelines in

consultation notes, to inform other clinicians involved in the care of the patient and the stage of recovery.

- Staff ensured treatment was reviewed and optimised for patients, by reviewing goals and objective measures at each treatment session.
- An RRU audit programme for 2022/2023 was in place at RRU NI. However, greater input by ERIs was required in line with ERI terms of reference in order to support ERIs in the value of undertaking audits and assist in data collection and audit production.
- There were electronic up-to-date RRU Standing Orders (SOs) in relation to 'Patients Undergoing Treatment' and 'the use of the Gymnasium', but these need to be printed off for patients and placed on a patient notice board. The SOs on the notice board were not current as they were dated 2016.
- Information was available to support patients to manage their own health and wellbeing. A variety of presentations and tutorials were displayed for patients, accessible through quick reference codes. Examples of presentations included pain management, strength training, health promotion and diet and nutrition. No monitoring took place to determine the number of patients accessing these presentations.
- Information about heat illness, stress, smoking cessation and ensure good hydration were displayed.
- Four patients provided feedback to us on the day of the inspection. They highly recommended the rehabilitation course to all injured service personnel. They felt the interaction between clinicians and patients was outstanding and met their needs in terms of understanding their injury and how to resolve their difficulty. They told us that small group numbers provided greater clinician interaction. Some reported that they would prefer longer days and suggested lectures on nutrition and anatomy. Others felt the time allocated for daily rehabilitation was sufficient. Patients told us they would prefer daily hydrotherapy to aid better movement for the rest of the day. All patients commented on the helpful QR codes in reception for providing information on a variety of health related and change behaviour topics.
- One patient who responded to a post course survey in 2022, made free text comments around the excellent support they had received from staff running the course. They commented on the impact of their injury on their mental health and how staff had helped them to manage their anxiety. Physical and psychological wellbeing information was available for patients to access on patient notice boards e.g. Headspace.

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. However, training records required updating.

- A policy was in place for the statutory professional registration of healthcare professionals in the defence medical services (JSP 950 leaflet 5-1-5). This covered the requirement for professional registration, confirmation of registration on and during appointment, and a list of registered healthcare professionals who could be employed by the Ministry of Defence.
- Registered professionals were supported to meet the requirements of their professional registration. A register of staff professional registration was held which included HCPC and GMC registration numbers. We saw that all registered professionals had current registration. Staff undertook a number of work-based activities including training. We saw evidence of peer

review between ERIs in 2022, but this had not taken place across the physiotherapy team. This ensured they met the requirements of their continuing professional development.

- There was an in service training programme with quarterly sessions, although due to current staffing restrictions this programme had not been as expansive as it might be. Staff confirmed that they were not aware of how to access funding for external courses, although one of the physiotherapists had recently completed a strength and conditioning diploma which he financed himself.
- The recently appointed ERI had started to complete the Post Graduate Monitoring Programme (PGMP), required within the first 12 months in post.
- We spoke with individual staff and discussed the mandatory training they had received. This did not reflect what was recorded in the central training matrix.
- Due to the locum status of the current OC and gapped roles, day to day line management and formal appraisal arrangements were separate. The RTSA received formal appraisal from a staff member working in the Operations Rehabilitation DHRG Team and day to day line management was provided by the OC. However overall accountability for staff lay with the Regional Clinical Director for Scotland and Northern Ireland. Whilst we saw no evidence that these blurred line management arrangements were leading to any compromise in effective care, they may not be optimal for the staff concerned who were reporting to several different people.
- 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. There was a competency booklet that was completed by staff during the induction process which was signed off to evidence completion of induction activities. There were mixed views expressed regarding induction. Staff new to the unit had not completed elements of induction in line with policy. One member of staff had been given a verbal induction but on the day of the inspection there was no paperwork to support this. Following our inspection, the service told us that the paperwork had been located. On the other hand, staff recruited in 2022 described a detailed induction with the opportunity to add in elements they believed would be beneficial to providing good patient support. For example, the administrator had requested to attend the training on shock therapy so they could respond to basic questions patients may ask.
- We noted excellent interaction between RRU RTSA and ERIs practising within the 3 x Primary Care Rehabilitation Facilities (PCRFs). To date, the RTSA had carried out 2 out of a planned 3 RTSA Advisory Visits. He had also made time to visit them in a more informal capacity ensuring full support as the ERI regional subject matter expert on exercise rehabilitation. The RTSA has undertaken peer reviews of ERIs within his region and provided comprehensive feedback to improve patient lesson delivery and performance. Furthermore, ERIs periodically came together and conducted Regional IST which was a valuable opportunity to review working practices and share best practice within the peer group.

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.

- 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 inform them about the treatment they would receive and what was expected. This included information about the course programme, first day reporting instructions, and required clothing and equipment.
- RRU Northern Ireland engaged with local health providers. There were close links with civilian consultants from the local hospitals to which patients from the RRU were referred to access orthopaedic care. Patients could also be referred to independent hospital for scans and surgery if required. Links with Stanford Hall were established.
- Information needed to deliver effective care and treatment was available and accessible to staff in a timely way. Relationships with local PCRFs which referred patients to the RRU were particularly strong and where additional information was required, staff could quickly contact staff in primary care to discuss individual patients. Patients referred to the RRU were sent with individual exercise programmes developed by their local PCRF meaning staff at the RRU knew what rehabilitation they had been receiving. Referrals to the RRU were made on a FMed 7 form which provided full clinical details of each patient. Referrals lacking sufficient information were rejected and the referrer was contacted to discuss the reason for rejection, or to be asked to resubmit the referral with additional information if appropriate.
- Since the records system was a shared system, all previous health information and treatment approaches could be easily viewed by staff at 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.
- Patients benefitted from seamless care and effective handover. 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 outstanding goals and recommendations for further treatment.

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. Staff had received training around the Mental Capacity Act and were clear on how this might be applied should a patient lack capacity.
- There was a consent policy. The policy included the consenting process and staff responsibilities regarding consent processes. The policy also outlined the rights of the patient in the consent process.
- We reviewed a selection of clinical notes and saw that consent had been appropriately sought and recorded in all cases.
- Written consent was obtained for treatments which involved a level of risk. Patient records for patients which had undergone injection therapy contained a consent form identifying benefits, risks and contraindications of treatment.

- Patients were supported to make decisions about consenting to care and treatment. Staff explained the risks and benefits of injection therapy to patients which enabled patients to make an informed choice about their treatment.

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.

- The DMS patient experience survey was in use and feedback between February 2021 and February 2022 showed there had been 23 responses and 22 patients were satisfied with their care. All patients confirmed that staff treated them with dignity and respect.
- There was adequate privacy within the RRU, however there was no single room within the gym. This has been raised and a statement of need with a proposal to change the kitchen into a clinical room.
- A chaperone policy was in place, but chaperones had not been trained. Staff told us that chaperones were routinely offered to patients but that this offer was rarely taken up.
- Several patients provided informative feedback to the inspection team. They all confirmed that staff treated them with respect and dignity and that they were well supported and motivated in their rehabilitation journey.
- 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 and we saw that these were noted in patient records.
- 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 treatment plans in response to patient feedback. Staff were supportive in their approach and motivated and empowered patients to fully participate in activities to their own ability and drive their own rehabilitation.
- Individual needs of patients and the occupational needs of their employment were considered when devising treatment plans. There was information displayed about how patients and staff could access support services. Information about the 'Mental Wellbeing First Aid Box' was displayed in the patient waiting area, including the contact details for various services.

- Staff demonstrated a helpful supportive attitude towards patients. We observed staff supervising patients to ensure safety and providing encouragement and motivation during the sessions. Patients reported that clinicians checked their understanding of exercises and explained how they would help their condition. Staff were described as flexible and understanding and explained how individual exercise programmes were adapted if patients were seen to be struggling or in pain.

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.
- We spoke with patients attending the course and they told us they felt involved in decision making about the care and treatment they received. They also said they felt listened to and supported by staff. They were given sufficient time during initial assessment and ongoing consultations to make an informed decision about the choice of treatment available to them. Care plans were personalised.
- Patients were encouraged to be active partners in their care. Patients on the course told us that they could discuss their treatment on a one to one basis with the course instructors at any time.
- 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 that the exercises would have optimum impact on the patient. We saw that staff also demonstrated equipment to patients to make sure they fully understood how to use it safely.
- 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.

- Staff understood the impact which patients care, treatment or condition had on their wellbeing. Patients confirmed that staff recognised any frustration and anxiety they were feeling due to their injury and showed understanding and consideration for their wellbeing.
- Patients were encouraged to link with other course participants while they were completing their rehabilitation.
- Staff responded to patients who were experiencing pain quickly and effectively and made adaptations to rehabilitation programmes or offered additional treatments in order to manage pain effectively.
- QR codes on the wall with educational materials allowed patients to educate themselves at convenient times. Physio and ERI's were available to clarify and discuss further information.
- Clinicians could signpost patients to various services including welfare, DCMH and the medical centre.

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. We found they had a plan, which enabled them to meet the needs of the PAR and this included those with complex needs, long-term or career-limiting conditions. The unit usually provided lower limb, upper quadrant, and upper limb speciality courses which patients attended for a period of three weeks for rehabilitation. The RRU in Northern Ireland provided Multi-disciplinary Injury Assessment Clinics (MIAC), Injury Assessment Clinics (IAC), Regional Podiatry Clinics (RPS) and RRU rehabilitation courses to a Population at Risk (PAR) of around 2500 (including 500 reservists). Courses were provided for patients whose condition necessitated a period of intensive daily rehabilitation. Up to 15 patients attended the course at any one time and received rehabilitation each morning and were then free to return to their unit or to remain on site at Aldergrove in the afternoons. This was course was delivered over three weeks and new patients could join each week. Patients were expected to attend for the duration of the course and could live on site or off-site at their unit. During courses, patients could also access one to one treatment if required.
- The podiatry clinic provided lower limb biomechanical assessment, assessment for and provision of custom-made orthoses, gait analysis, expert footwear/boot recommendations and prescription for custom boots when indicated.
- The MIAC was a multidisciplinary clinic delivered by an experienced physiotherapist and sports exercise medicine (SEM) Consultant. The clinic offered assessment, point of contact ultrasound scanning, injection therapy, and onward referral to specialist services e.g. pain clinic, pressure testing, imaging, orthopaedic referral. The clinic also acted as a point of contact for referrers in the region for clinical advice.
- MIAC records and recommendations contributed to occupational health review clinics where patients were facing career limiting conditions. MIAC clinicians liaised with patient's medical officers at the Medical Centre to discuss and recommend appropriate medical gradings.
- Patients had access to diagnostic imaging and some surgical procedures if required at a local independent hospital. Referrals could be made from doctors in MIAC and these were tracked by the administration team to ensure they were actioned in line with key performance indicators.
- Staff at the RRU could make recommendations to patient's medical officers at the PCRFs for referral to other appropriate services such as smoking cessation and mental health

support. They could also refer to DMRC for specialist opinions including rheumatology, peripheral nerve injury, compartment pressure testing, gait laboratory, Orthotist, pain clinic and specialist in-patient courses such as chronic regional pain syndrome.

- Services were planned to take account of the needs of different patients. The RRU and pool was accessible for people using a wheelchair. The team had identified that the main RRU building was not accessible to wheelchair users and a statement of need had been submitted for the remedial work to be done. There was an equality and diversity policy 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. As training records were not up to date, we were unsure whether all staff had completed equality and diversity training.

Access to the service

- Consultant facilitated MIAC clinics ran on Tuesday and Thursday mornings 0830-1230. There was a 3 week wait for the clinic. The consultant held an injection clinic once every 3 weeks. An Aeromedical urgent slot was available with the consultant each week. If the slot was not utilised then a MIAC appointment was offered to a patient on the waiting list. The podiatrist facilitated a clinic once a week (8 hrs on Tuesdays) and the current wait time was 1-2 weeks. The wait time for a rehabilitation course was 4-5 weeks. The unit worked with the patient to accommodate their employment schedule. If a patient needed to attend a course urgently then the unit would explore whether this could be facilitated.
- The administrator managed referrals to other services and had clear failsafe systems in place both for sending referrals and monitoring their progress, including 'red flag' or urgent referrals. The Defence Patient Tracking System (DPTS) was used to track referrals and included an alert facility. As DPTS it does not link with DMICP, a separate folder was maintained of referrals sent. The administrator checked DPTS several times a day. Referrals to hospital were coordinated through MPAC, the defence administration cell. Delays for referrals for surgery had been reported through the ASER system. However, the consultant confirmed that these waits were equitable to the rest of the UK.
- We were advised that failure to attend appointments was not tolerated. Non-attendance was documented in a patient's record on DMICP. The administration team would attempt to call any patient who did not attend to check they were aware of their appointment and would book a second appointment if required.
- The RRU did not routinely record appointments that had to be cancelled by the RRU and staff did not think that this would occur regularly enough to deduce any trend.
- The targets for accessing services were monitored by the RRU and at the time of this inspection were being largely met. Staff told us that the main wait was for MIAC and this was due to the doctor's limited hours of 8 hours a week. There had been a recent application to increase this to 12 hours. One slot was kept available at all times to meet the requirements for aeromedical evacuations (to ensure urgent patients were seen in a timely fashion). Seven aeromedical patients had been seen in the past 12 months and all were seen within 5 days of landing as there is a MIAC aeromedical slot reserved every Thursday.

Patient Requirement	TARGET	ACTUAL
MIAC URGENT referral & Aeromeds	within 5 days	5 days
MIAC Routine	within 20 days	28 days

Podiatry Routine	within 20 days	11 days
Rehab Assessment	N/A	18 days
Rehab Course	N/A	19 days

- Feedback from patients resulted in changes to how the service was planned, developed and delivered. There were 'you said, we did' boards displaying information about how the delivery of courses had been adapted in response to comments made by patients.

Listening and learning from concerns and complaints

The unit had a system for handling concerns and complaints.

- The unit had a system for handling concerns and complaints. The RTSA managed complaints in accordance with organisational policy and procedure.
- Information was available to support patients in making a complaint if they felt the need to do so. Information regarding compliments, concerns, and complaints was displayed in the unit.
- Concerns and complaints were listened and responded to and used to improve the quality of care. There was a policy available to provide guidance for staff about complaints made about healthcare services provided by the defence (JSP 950 leaflet 1-2-10). This covered how the complaint was to be dealt with, including the stage of communication and investigation. The policy stated informal verbal complaints would initially be dealt with locally with the aim of an initial response within two working days. The complaints investigation should then be completed within 15 working days and the medical complaints manager should meet the complainant within five working days of the investigation being finished. A decision letter to the complainant should then be sent within another five working days of the meeting.
- All concerns raised were investigated by the OC and RTSA. Initially a conversation was held to gain more information about the concerns raised and to attempt to reach a local resolution where possible. Where local resolution was not possible, concerns were progressed to written complaints which were handled in line with the complaints policy. There had been no recent complaints submitted to the service.
- Information was available to support patients in making a complaint if they felt the need to do so. QR codes were available for patients to use to directly feedback to the RTSA.
- There was a board in reception clearly stating the positive changes made to the RRU following patient requests and concerns. There were visible QR codes in both buildings for patients to report any building faults or defective medical/gym equipment. Numerous places in the RRU existed for patients to provide feedback to the RTSA through QR codes and email.
- Patients using the service were surveyed in 2022 and when asked whether they felt that staff would listen to their comments and complaints, 100% confirmed that they did.

Are services well-led?

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

Requires improvement 

Our findings

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

Staff working within the service were doing the best that they could to ensure that responsibilities were clear and that quality, performance and risks were understood and managed, but there were gaps.

Vision and strategy

- The vision for RRU NI was to achieve excellence in patient care, targeted rehabilitation and so support patients to return to their work role. The strategy is to do this was via good communication with PCRFS and Units.
- The overarching mission statement for the RRU was 'To sustain and improve the operational effectiveness of service personnel by provision of high-quality targeted rehabilitation, accelerating the return of injured personnel to their optimal physical capacity, while influencing their psychological and social health.' 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.
- There was a specific strategy and operational guidance for the defence medical rehabilitation programme (DMRP), which had been developed centrally. This 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 overall strategy of the DMRP was to maximise the number of service personnel who were medically fit for role. At the time of this inspection the RRU did not have a local developmental business plan to support achievement of the central strategy.

Governance arrangements

The service had an overarching governance framework, which supported the delivery of the strategy and good quality care. This outlined structures and procedures to be followed. Due to leadership capacity, responsibilities were not always clear and there was scope to broaden the impact of quality improvement work and to ensure that all risks were captured 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 NI were systematic and reflected best practice. We saw the unit had a 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 was a healthcare assurance framework (HAF) assessment which was a live document used to support the delivery of good quality care. It was based on the five CQC domains of safe, effective, caring, responsive and well led. We reviewed the information held within this and were able to directly tie the evidence held there with our own key lines of enquiry.
- There were systems and processes to identify, manage and mitigate risks associated with the unit. RRU NI maintained a comprehensive register of risks that could affect the RRU and its staff and patients. The risk register was reviewed regularly by the unit leads. The risk was rated for likelihood of impact and probability it would occur. 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 decision was recorded as to whether a reach risk should be Treated, Tolerated, Terminated or Transferred. 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.
- There were 24 active risks identified on the RRU risk register which all 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. Each risk was RAG rated to give a severity score and an associated risk control approach. We saw that there was one risk rated as medium (no sinks in some treatment rooms) with the rest being rated low or no risk. We noted that a risk had been added in 2018 around incomplete Hepatitis B status records for staff working the RRU. This risk had still not been mitigated at the time of this inspection in 2023. Risks that were no longer applicable were retired from the risk register.
- There was a 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. However links to several of the most recent audits were missing and so we could not review this work. There was scope to expand the quality improvement approach taken by the RRU to cover more clinical areas in 2023.
- There had been less opportunity to conduct Multi-Disciplinary Team (MDT) meetings with other PCRFs since a significant change in staffing levels. The RTSA had undertake an annual formal review of Services carried out by ERI PCRFs to ensure compliance was met.
- There was a limited approach to monitoring and benchmarking the quality of the service and outcomes patients received following an episode of treatment. Project Apollo was a performance tool used to measure the progress of patients against set indicators. Indicator DHIR032 measured the percentage of care pathways at the RRU which showed improvement in validated outcome scores within the year. For RRU NI, 67% of patients had an improved FAA score in the past 12 months and 19% were shown to have an improved

MSK-HQ score in the last 12 months. The MSK-HQ was likely so low due to the majority of the outcomes scores being missing and so cannot be relied upon.

- 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 areas related to governance were discussed, which included safety and quality issues such as incidents, training, risks, infection prevention control, equipment updates staffing 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.
- The RTSA, OC and administrator often met informally on a daily basis to discuss and address any pertinent issues. Discussions with gym staff took place on most afternoons. Any decisions were then discussed at Monday staff meetings and recorded.
- Recent significant changes in staffing had meant a reallocation of secondary roles and responsibilities. Staff were adjusting to this and appraising themselves of who were the leads in the organisation. We reviewed the terms of reference and job descriptions for key staff within the service and noted lines of accountability were not always appropriate and in line with the skills and experience of the individual staff member. Where staff had not previously undertaken healthcare governance work and were being asked to lead in this 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.

- Leadership capacity at this RRU had been recently reduced due to gaps in some key staff roles. The RTSA, locum OC and their wider team had been willing to step up and cover these gaps as best they could in the available time. Safe, high quality and compassionate care was prioritised at all times. Nevertheless, accountabilities were blurred at times (it was not entirely clear who was leading on healthcare governance). Line management responsibilities had been allocated to staff outside the RRU as locums cannot appraise staff within the military system. For the most part, staff had the skills, knowledge and experience to carry out their roles effectively, but we noted that some staff's terms of reference included lead responsibilities for areas where they had no experience and training plans were not in place to address this. Throughout the inspection, the reliance on the delivery focus and pragmatic approach of the RTSA was very clear. The RTSA was due to leave the service in March 2023 and there is potential for this loss of 'hands on' attitude and skill to have a detrimental impact on a service which already has gaps in local know how.
- Support was available to the RRU in Northern Ireland from both the Regional Clinical Director and also from Operations Rehabilitation DHRG. We spoke with these individuals and discussed their input with staff working in the RRU and their contribution was appreciated and valued.
- It was clear from patient feedback and interviews with staff there was a patient-centred culture at the unit. Staff described how the leadership team promoted an inclusive and open-door culture with everyone having an equal voice, regardless of rank or grade. Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. Staff were given the opportunity to express their views at meetings.

- 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 felt respected and 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. 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.

Seeking and acting on feedback from patients and staff

- RRU NI had gathered patient feedback in 2022 to gather views and experiences of patients using the service. This asked a variety of questions and included the Friends and Family test and the mandated DPHC variants. Questions were focused on meeting individual needs, confidentiality, dignity and respect, feeling listened to and involved, convenience of appointments and whether patients would recommend the service to family and friends. The latest results showed high levels of satisfaction. Feedback collected was used to adapt and develop the way services were delivered. The service was able to provide examples of when they had acted on patient feedback to make improvements.
- 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 raised feedback points on a daily basis and these were formally recorded in the next weekly staff meeting. Examples of improvement following staff feedback included the gym staff suggesting that new flooring was required and a recent order for more gym equipment including rowers, calf raise machine and ski ergos.
- 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.

- There was a comprehensive system for oversight of equipment maintenance which had been developed by the RTSA. Statements of needs were submitted promptly where required and the range and quality of equipment in the gym was excellent.
- The RTSA had tackled issues around cleaning standards and liaised directly with the contractor to ensure that improvements were delivered.
- We noted excellent interaction between RRU RTSA and ERIs practising within the 3 x Primary Care Rehabilitation Facilities (PCRFs). To date, the RTSA had carried out 2 out of a planned 3 RTSA Advisory Visits. They had also made time to visit them in a more informal capacity ensuring full support as the ERI regional subject matter expert on exercise rehabilitation. The RTSA has undertaken peer reviews of ERIs within his region and provided comprehensive feedback to improve patient lesson delivery and performance. Furthermore, ERIs periodically came together and conducted Regional IST: a valuable opportunity to review working practices and share best practice within the peer group.

- There were visible QR codes in both buildings for patients to report any building faults or defective medical/gym equipment. Numerous places in the RRU existed for patients to provide feedback to the RTSA through QR codes and email. Patients gave excellent feedback about their experience and were fully involved in their care. We also noted that any patient or staff feedback was listened to and used to make improvements where possible.
- Staff feedback resulted in improved impact for patients. New flooring had been provided in the gym and a recent order for more gym equipment included rowers, calf raise machine and ski ergos.