Defence Medical Services

# DMRC Stanford Hall

## Inspection Report

DMRC Stanford Hall
Stanford on Soar
Loughborough
LE12 5QW

Date of inspection visit 08-10 March 2022
Date of publication: 15 August 2022

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 | Requires Improvement |
| Are services safe? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Requires improvement |
| Are services well-led? | Requires improvement |

# Summary of findings

## Overall summary

We carried out an announced comprehensive inspection at Stanford Hall DMRC on 8-10 March 2022.

**DMS medical facilities are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently, military healthcare services are not subject to statutory CQC inspection and CQC has no powers of enforcement. However, DMSR (in consultation with DG DMS) has commissioned the CQC to undertake a comprehensive programme of inspections of all military primary and community healthcare services. This inspection programme enables us to inspect military healthcare services across the United Kingdom and overseas on behalf of DMSR.**

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

**We found that this practice was not safe in accordance with CQC's inspection framework**

- Essential systems, processes and practices were available to ensure patient safety but not all staff had mandatory training as required.
- Staff had training on how to recognise and report abuse, but they hadn't all completed it.
- The out-patient service did not always control infection risk well. Staff used equipment and some control measures to protect patients, themselves and others from infection, but this was inconsistent.
- The service did not always have enough staff to care for patients and keep them safe.
- Risks to patients who used services were not always assessed.

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

- Patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Relevant and current evidence-based best practice guidance had been identified and developed for defence rehabilitation services.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients and supported them to make decisions about their care. There was a strong team approach to multidisciplinary working within DMRC.
- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities as and when required.
- Staff sought patients' consent to care and treatment in line with legislation and guidance.

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

- Patients spoke positively about the care they received from the staff at the unit.
- Staff communicated with patients in a way that they would understand their care and treatment.

**We found that this practice was not responsive in accordance with CQC's inspection framework.**

- The Force Generation Unit was not performing well against set key performance indicators. There was no statistical information available on performance available after June 2021 due to a pause in Defence statistics.
- In diagnostics, referrals were often incomplete and of poor quality with omission of relevant patient history including previous imaging and results from other diagnostic tests.
- However, the service planned care to meet the needs of the population at risk, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment for medical care or out-patients.
- DMRC had a system for handling concerns and complaints. Action was taken to improve the service as a result of complaints.

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

- The service had a new overarching governance framework, which supported the delivery of the strategy and good quality care but needed embedding with teams.
- Information sharing between managers and staff relating to performance, incidents and complaints was limited. There was no evidence that lessons learned from investigations or findings from audits were widely shared with staff.
- Managers could not demonstrate how they monitored the effectiveness of the service as they did not fully complete the audit cycle. There were gaps in some governance systems and processes resulting in limited sharing of information about performance with staff.
- However, there was a clear vision for the DMRC and their priorities to improve the quality of care and treatment at DMRC had been set out.
- There was evidence across the DMRC of strong and passionate leadership, and a commitment to provide high quality services for patients.

**Recommendations for improvement**

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

**DMRC wide**

- Ensure all staff have mandatory training required for their role.
- Ensure staff have safeguarding training required for their role.
- Ensure there are adequate staff in roles to provide patient care.

- Ensure all staff have an understanding of their role and responsibility in regard to duty of candour.
- Ensure all staff are aware of the locations of resuscitation trollies and automated external defibrillators (AED).
- Provide a push pad entry system for pharmacy.
- Ensure that there are plans in place to replace essential equipment with no through life maintenance, for example pressure testing consumables.
- Record appraisal dates for all staff in addition to revalidation dates.
- Ensure learning from mortality and morbidity meetings is shared throughout the unit.
- Ensure dates of supervision for all clinical staff is recorded.
- Ensure staff receive feedback on funding applications for external courses.
- Ensure divisional and clinical workbooks are complete and have clear accountability of roles and responsibilities.
- Embed governance arrangements to ensure the flow of information between executive and patient facing teams.
- Ensure all Automated Significant Event Reporting (ASER) investigations are completed within the agreed timescales.
- Ensure that staff know how to report all incidents.
- Ensure all relevant staff have adequate adults and children disclosure barring (DBS) checks in place for their role or an adequate risk assessment.
- Ensure there is oversight of audit and quality improvement programmes and learning is shared.
- Increase support and training for middle managers to improve consistency of process and communication particularly with civilian staff.
- Promote and embed the Freedom to Speak up guardian (FTSUG) role.
- Ensure all civilian staff have the appropriate immunisations for their role.

**Force Generation Unit**

- Ensure staff have the appropriate chaperone training.
- Ensure that compliance of staff training in the use of equipment is recorded.
- Ensure risk assessments are carried out for procedures which carry a higher level of risk during rehabilitation.
- Ensure that goals are consistently documented in patient records and are specific, achievable, measurable and have a timeframe for completion.
- Review outcomes across the service to demonstrate impact of interventions provided.
- Ensure standardisation of access to in-service training for staff working in the Force Generation Unit.
- Ensure all staff document that they have reviewed a patient’s past medical history.
- Review the content of online material and sessions in response to patient feedback.
- Ensure communication to patients prior to courses is clear.

- Ensure all patients can access online sessions and have time to complete these sessions as part of their rehabilitation programme.
- Ensure patients can access services in a timely way through the service meeting key performance indicators (KPI).
- Ensure the service develops a recovery plan with clear targets to address backlogs.
- Review pathways of referral into the Force Generation unit to optimise outcomes with a focus on early return to service.

**Out-patients**

- Ensure that Compliance with sharps, bare below elbows and hand hygiene meet target compliance rates.
- Ensure that actions following learning from incidents are recorded and taken as soon as practicably possible.
- Consider carrying out routine audits of clinical records.
- Ensure it monitors compliance with guidance across the service.
- Ensure systems are in place to support staff to maintain competency in specialist areas.
- Ensure audit compliance to local guidance on prescribing.
- Consider support for typing clinic letters in the absence of the typist.
- Monitor appointments cancelled by the service and ensure they are rebooked as soon as possible.

**Medical care**

- Ensure that all staff are compliant with all mandatory training requirements
- Ensure that all staff have completed the appropriate level of safeguarding training
- Ensure that there are sufficient staff to provide safe care, treatment and rehabilitation
- Consider resolving ongoing environmental issues which impact on a patient's ability to move freely and independently around the unit
- Consider how it can address differences between staff groups to enable staff to work in more integrated ways. Nursing and therapy staff should work together better.
- Access to funding for both civilian and military staff should be more consistent.
- Ensure that there are effective and embedded governance processes that enable sharing of lessons learned from complaint and incident investigation, audit and feedback on care with all staff
- Ensure that audit and performance data is used to monitor and improve patient outcomes

**Diagnostics**

- Ensure that there are enough staff in post to manage the service effectively
- Consider implementing peer review of imaging between radiography staff

- Ensure that its digital imaging systems allow full access to all staff to access patient history and allow effective storage of images
- Ensure that the areas are clean and free from clutter at all times.
- Develop and implement key performance indicators.
- Ensure referrer information is fully completed to enable correct justification of exposures.
- Develop its own vision and strategy
- Ensure that all records required under IR(ME)R17 are in place and up to date

**Psychological Wellbeing Service**

- Consider the recruitment of a further psychologist or occupational therapist to deal with the increasing waiting list for mild traumatic brain injury therapy (MTBI).
- Consider recruiting to the consultant psychiatrist post to ensure that patient assessment and service gradings are not delayed.
- Ensure that staff are able to access the full range of training specific to mental health practice including training in risk assessment, managing challenging behaviour and the Mental Capacity Act.
- Review the policy on the management of challenging behaviour.
- Consider alternative approaches to communication via the tannoy system to reduce the disruption caused to the therapeutic environment when patients were undertaking therapy sessions.
- Ensure that the team are fully integrated into the wider DMRC service so staff can access the wider mental health focussed development training, support and networks.

# DMRC Stanford Hall

## Detailed findings

### Why we carried out this inspection

DMS medical facilities are not required to register with CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. Consequently, military healthcare services are not subject to statutory CQC inspection and CQC has no powers of enforcement. However, DMSR (in consultation with DG DMS) has commissioned the CQC to undertake a comprehensive programme of inspections of all military primary and community healthcare services. This inspection programme enables us to inspect military healthcare services across the United Kingdom and overseas on behalf of DMSR.

This was the first time that the Defence Medical Rehabilitation Centre (DMRC) has been inspected by the CQC. There is no directly comparable unit in the NHS or independent sector, as such the inspection utilised a bespoke hybrid methodology which largely encompassed the usual Defence Regional Rehabilitation inspection metholodgy and also included part of the NHS hospitals and independent health framework inspection methodology. DMRC will be re-inspected with the same methodology in-line with the CQCs usual re-inspection timelines.

### Background to the service

The Defence Medical Services (DMS) is made up of the Royal Navy Medical Service, Army Medical Service, the Royal Air Force Medical Service and the Headquarters DMS Group (HQ DMS GP). The primary role of the DMS is to promote, protect and restore the health of the UK armed forces to ensure that they are ready and medically fit to go where they are required in the UK and throughout the world. (Source https://www.gov.uk/government/groups/defence-medical-services).

Provision of general practice and occupational health services is the responsibility of Defence Primary Healthcare (DPHC). DPHC's purpose is to sustainably deliver and commission safe and effective healthcare, which meets the needs of patients and the chain of command. It provides primary healthcare, dentistry, rehabilitation and mental healthcare in the UK and overseas to service personnel and, where appropriate, their dependents. (Source https://www.gov.uk/government/groups/defence-medical-services).

Rehabilitation services are provided through a tiered network of Primary Care Rehabilitation Facilities (PCRF) and Regional rehabilitation units (RRUs) across the UK and Germany. PCRFs are unit/station based outpatient departments offering physiotherapy and exercise rehabilitation therapy. Patients with injuries that cannot be cared for at this level are referred to RRUs, to allow

rapid access to imaging services, podiatry and residential rehabilitation. This intermediate level of treatment nests between the PCRF and the DMRC at Stanford Hall

The Defence Medical Rehabilitation Centre (DMRC) provides a key element of the tiered Defence Medical Rehabilitation Programme (DMRP), delivering concentrated residential rehabilitation for complex musculoskeletal disorders and injuries (MSKI) including complex trauma, rehabilitation following neurological injury or illness, and in-patient care for joint and soft tissue disease. It also provides education and training in military rehabilitation and is the home of the Academic Department for Military Research (ADMR). (Source https://www.gov.uk/government/groups/defence-medical-services). The research centre was outside of the scope of this inspection unless referred to as part of the patient's rehabilitation pathway and treatment.

DMRC Stanford Hall opened and started treating patients in October 2018. It replaced Headley court as the main Defence medical rehabilitation centre in the country. The current workforce transitioned from the old rehabilitation facility (Headley Court) in Surrey.

DMRC Stanford Hall is run by Ministry of Defence (MoD) and it forms part of Defence Medical Services. At the top of the chain of command is the commanding officer (CO) assisted by his professional staff which comprises of both members of the Armed Forces (in uniform) and civilians employed by the MoD.

DMRC Stanford Hall provides the following clinical services:

- Complex Trauma
- Neuro Rehabilitation which includes mild Traumatic brain injury (mTBI) and Vestibular Rehabilitation
- Lower Limb Rehabilitation
- Spines and Upper Quadrant Rehabilitation
- Specialist Rehabilitation (lead on Covid Rehabilitation)
- Psychological Well-being Service
- Rheumatology Service
- Pain Service
- Radiology

The service is divided into three divisions providing clinical care, rehabilitation division, medical division (including diagnostics) and nursing division. Care is provided across two clinical groups; one out-patient based including the Force generation unit, pain management and rheumatology out-patients and diagnostics. The other is in-patient based and covers the in-patient rehabilitation split into complex trauma and neurology. The psychological well-being service (PWS) and pharmacy service also support DMRC across both in-patient and out-patient settings.

The Force generation unit for the purposes of this report is the main service. We also inspected pain management and rheumatology under out-patient's frameworks, diagnostics under a diagnostics framework, the psychological well-being service under a mental health framework and in-patient rehabilitation under medical care frameworks.

## Our inspection team

Our inspection team was led by a CQC inspector. The team included seven inspectors and five specialist advisors.

## How we carried out this inspection

Before visiting, we reviewed a range of information about DMRC. We carried out an announced inspection on 8-10 March 2022. During the inspection, we:

Spoke with approximately 96 staff, including consultants, physiotherapists, occupational therapists, podiatrists, nurses, exercise rehabilitation instructors (ERIs), administrators and officers. 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?

As DMRC Stanford Hall is a unique occupational rehabilitation facility providing in-patient and out-patient rehabilitation as well as specialist out-patient and diagnostics services we inspected the service as separate cores services. These core services were:

- The Force generation unit.
- Out-patients (covering rheumatology and pain services).
- Medical Care.
- Psychological Wellbeing Service.
- Diagnostics.

The Force generation unit, which had similar service delivery to the RRUs, was inspected in line with the RRU framework adapted for DMRC. Out-patients, medical care, psychological well-being service and diagnostics were inspected with frameworks specifically adapted for DMRC from CQC's independent health frameworks.

The main service provided by DMRC for the purposes of this report, was the Force Generation unit. Where our findings on the Force Generation unit – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the Force Generation unit. DMRC only collected some data at unit level rather than by team or core service and where this was the case the findings are presented in the Force generation report, however where recommendations are DMRC wide they are referred to as such within the recommendations made.

# Are services safe?

## Our findings

**We found that this service was not safe in accordance with CQC's inspection framework**

### Safe track record and learning

**There was a system for reporting and recording significant events. Essential systems, processes and practices were available to ensure patient safety but not all staff had mandatory training as required.**

- There was a system available for staff to report significant events, incidents, near misses and concerns and mechanisms for maintaining patient safety, the ASER toolkit. There were also other systems for reporting general data protection regulation (GDPR) incidents and health and safety issues. Staff did not always know which system to use and there was a risk some incidents or near misses were not recorded.
- No serious incident was reported by DMRC Stanford Hall between January 2020 and January 2022.
- The service provided mandatory training for staff in safety systems, processes and practices. Compliance targets for mandatory training were 95%. Mandatory training oversight data was held electronically for all staff, however teams also held their own data locally in workbooks.
- The training team had ultimate oversight of the mandatory training compliance and staff had training passports to record compliance and reminders to keep on track. Despite this only four out of 25 modules met the target of 95% for training.

| Training module name | Target | Number of staff eligible | Number of staff trained | YTD Compliance |
|---|---|---|---|---|
| First Aid At Work | 10px | 10 | 10 | 100% |
| Patient Experience Conf | n/a | 2 | 2 | 100% |
| DMICP | 95% | 216 | 210 | 97% |
| DIMP | 95% | 306 | 294 | 96% |
| Data Security Awareness (Caldicott L2) | 95% | 216 | 202 | 94% |
| ASER Login & System | 95% | 306 | 286 | 93% |
| Office safety | 95% | 306 | 284 | 93% |
| Resilience and Wellbeing | 95% | 306 | 277 | 91% |
| Basic Life Support (BLS) | 95% | 306 | 276 | 90% |

| Training module name | Target | Number of staff eligible | Number of staff trained | YTD Compliance |
|---|---|---|---|---|
| Security Fundamentals | 95% | 306 | 276 | 90% |
| H and S - Staff | 95% | 241 | 199 | 83% |
| Induction (WIP) | 95% | 308 | 257 | 83% |
| Healthcare Governance and Assurance | 95% | 306 | 240 | 78% |
| Business Continuity | 95% | 307 | 233 | 76% |
| Counter Fraud - staff | 95% | 241 | 183 | 76% |
| Mental capacity Act | 95% | 67 | 51 | 76% |
| IPC Covid | 95% | 306 | 230 | 75% |
| IPC Core | 95% | 306 | 222 | 73% |
| Patient Handling | 95% | 121 | 86 | 71% |
| Active Bystander | 95% | 306 | 214 | 70% |
| Inclusion in the Civil Service | 95% | 175 | 123 | 70% |
| Face It Fix It | 95% | 306 | 202 | 66% |
| H and S - manager | 95% | 65 | 41 | 63% |
| Counter fraud - manager | 95% | 65 | 37 | 57% |
| Annual Mental Fitness Brief | 95% | 306 | 172 | 56% |

- There were some difficulties in arranging face to face training due to Covid restrictions which was required for some modules, such as BLS and patient handling. ‘The face it fix it’ Diversity and inclusion (D and I) training and inclusion in civil service were new training courses in December 2021 so not all staff had been able to access training. Business continuity had also changed to a two-year requirement from a five year requirement.
- The service had comprehensive fire and environmental risk assessments in place. Staff knew where to find these if required and fire evacuation procedures had been rehearsed. There was also a risk assessment and standard operating procedure (SOP) in place for lone working. A disability access audit had been carried out in building one, 34 and 35 and horticultural therapy and were found to be fully compliant.

## Are lessons learned and improvements made when things go wrong?

**Action and learning were taken as a result of incidents which had occurred.**

- Once incidents had been identified, lessons were learnt, and action was taken to improve safety. Incidents and the outcomes were recorded in healthcare governance workbooks. Staff told us about learning from incidents that had changed practice, for example a recent code blue incident had led to training and changing of procedures.
- 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. No reported incidents at the unit had required the application of the duty of candour.
- There was a DMS wide duty of candour policy in place. Staff had some knowledge of duty of candour but could not explain when it should be applied and had limited understanding of their own roles and responsibilities.

- Risks from risk registers were shared at meetings on a weekly basis and action which had been taken to mitigate risks was discussed.
- There was a SOP for managing safety alerts and a designated lead was in place for clinical and non-clinical alerts, although one of these roles was gapped and being covered by a deputy. Safety alerts were sent to managers for review and feedback was requested and any action taken recorded.

## Keeping people safe and Safeguarding

**Most staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, but they hadn't all completed it.**

- Arrangements for safeguarding reflected relevant legislation and local requirements. Staff received safeguarding training to level two in line with national guidance with designated leads having level three training. Not all staff at the unit were compliant with safeguarding training and no training course met the target of 95%. The training was however only marked as compliant when face to face training had been completed and this had been delayed due to the Covid 19 pandemic. Designated staff at the service held level four safeguarding training and the safeguarding lead was the clinical director. Only one person had completed their level four training.

| Training module name | Target | Number of staff eligible | Number of staff trained | YTD Compliance |
|---|---|---|---|---|
| Safeguarding Adults level 1 | 95% | 104 | 87 | 84% |
| Safeguarding Adults level 2 | 95% | 69 | 63 | 91% |
| Safeguarding Adults level 3 | 95% | 128 | 105 | 82% |
| Safeguarding Adults level 4 | 95% | 4 | 1 | 25% |
| Safeguarding Children level 1 | 95% | 104 | 89 | 86% |
| Safeguarding Children level 2 | 95% | 69 | 64 | 93% |
| Safeguarding Children level 3 | 95% | 128 | 99 | 77% |
| Safeguarding Children level 4 | 95% | 4 | 1 | 25% |

- Not all staff were able to state what they would do if they suspected concerns of abuse, for example some staff could not identify the designated safeguarding leads. Staff who were able to identify safeguarding leads said they were approachable and knowledgeable.
- Staff had received training in the recognition of female genital mutilation (FGM) separate to safeguarding training. The numbers of staff who received this training was not supplied.
- The safeguarding lead post was gapped so the service was mitigating this by upskilling social workers and other professionals to level three training.
- Chaperone posters were displayed around the Force Generation unit. These highlighted the opportunity for patients to have a chaperone present for any appointments they attended. Consultants asked patients at each contact if they required a chaperone. Although, DPHC guidance was to provide chaperone training, bespoke DMS training was not available. Therefore, staff had accessed e learning for NHS staff whilst formalised training was sourced.

- DMRC was accessed 16 to 18-year old children on some occasions. Patients of this age were offered support from a family member whilst on site. Risk meetings also covered patients under 18 to discuss their care and put controls in place for their safety.
- The Force Generation unit 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. Equipment was stored tidily with some on designated racks and off the floor to assist adequate cleaning of the facilities.
- The hydrotherapy pool had a cleaner dedicated to the area daily and equipment was cleaned after each use and all areas of the pool had enhanced cleaning regimes in place. Pool chemical testing was carried by a contractor, any issues with chemical levels or cleanliness were escalated to the pool team and the pool was closed until the issue was rectified.
- The pool always had lifeguards on duty when the pool was in operation. The entrance to the pool area was by keypad and patients would not be able to access the area unattended. The main pool had a tape barrier in place when the lifeguard was not next to the main pool, This would not stop a patient entering the area alone but it was adjacent to an office which was manned at all times that the pool was operational.
- Arrangements for the maintenance and use of equipment ensured patient safety. Equipment was used, maintained and serviced in line with manufacturers' instructions. An electronic inventory log was maintained and held information as to when maintenance had taken place for the equipment at the Force Generation unit. The log showed servicing was in date.
- There was a clear process to manage faulty equipment in a timely way. Issues with equipment were discussed at the equipment care committee where updates on repairs were made. DMRC had several large pieces of equipment which did not have through life maintenance due to being gifted to the service. These were considered at the committee and where patient care was affected this was recorded on the risk register. Action was planned where environmental risks were on the risk register, for example, the administration area had no natural light and poor airflow. A works request had been submitted to install skylight windows and zoned lighting.
- There was no push pad automatic door opener situated outside pharmacy, to allow access for wheelchair users.
- The service provided pressure testing for lower limb conditions. This required specialist equipment which had no through life maintenance. The service was suspended due to equipment being unavailable and there was a backlog of patients. There had been a business case written to ensure ongoing supply of the consumable equipment and this was awaiting procurement.
- Staff only used equipment if they were fully trained in its use. There were local records of training in the pool area. Workbooks were also used to track staff training on equipment, although these were not all completed for all rehabilitation equipment and teams.
- The hospital had an infection prevention and control nursing officer (ICNO). Staff could discuss any issues around infection prevention and control with them. Staff were aware of who held this role.
- The service had implemented Covid 19 testing and track and trace scheme in line with government guidance. Patients attending Force Generation courses were required to do a lateral flow test on arrival and then take twice weekly tests throughout their stay.
- Despite having positive covid tests on site, no nosocomial infections of Covid had been recorded. A facility wide DHPC audit of personal protective equipment (PPE) had shown 100% compliance.

- DMRC carried out infection, prevention and control (IPC) audits for hand hygiene and bare below elbows (BBE). These were completed monthly and quarterly and were complete for the Force Generation department and at 100% apart from the last submission in January 2022 for BBE which was missing.
- The service used the defence medical information capability programme (DMICP) to store and access electronic patient records. This allowed staff to access patient records, in line with their role and the level of access they would require to view the information needed to treat the patient.
- Patient records were organised, up to date, shared and stored appropriately. We reviewed 10 patient records for patients attending the multidisciplinary injury assessment clinics (MIAC) and rehabilitation courses. Records included referral information, patient assessments, consent and treatment plans and were all complete. One set of notes contained abbreviations unidentifiable by another multidisciplinary (MDT) member.

### Monitoring risks to patients

**Risks to patients who used services were not always assessed. Staffing levels, skill mix and caseloads were planned and reviewed though there were a number of vacancies across different staff groups.**

- Risk assessments were not completed for all interventions which carried high risk such as acupuncture and pressure testing. These interventions posed risks to the patients undertaking them. Risk assessments were not in place for cardio-rehabilitation despite this being provided by DMRC.
- As of January 2022, the following staff whole time equivalent (WTE) was reported by DMRC Stanford Hall. There was a 78% fill rate across all staffing groups. Planned and actual staffing data was available for one-year period for staff in the medical and nursing division but only for one month for the rehabilitation division.

| Core Service | Staff group | Planned staff - WTE | Actual staff - WTE | Fill rate (%) |
|---|---|---|---|---|
| Medicine | Inpatient ward staff (RN, HCA, medic) | 96 | 70.9 | 74% |
| Force Gen | Military Physio | 19 | 13 | 68% |
| Force Gen | Civilian Physio | 22 | 17 | 77% |
| Force Gen | Military ERI | 20 | 20 | 100% |
| Force Gen | Civilian ERI | 7 | 7 | 100% |
| Force Gen | Service Manager | 2 | 2 | 100% |
| Force Gen | Occupational Therapist | 30 | 25 | 83% |
| Force Gen | Speech & Language Therapist | 2 | 1 | 50% |
| Force Gen | Recreational Therapist | 2 | 2 | 100% |
| Force Gen | Rehabilitation Assistant | 4 | 3 | 75% |
| Force Gen | Workshop technicians | 11 | 8 | 73% |
| Force Gen | Admin Support | 20 | 17 | 85% |
| Force Gen | Podiatrist | 2 | 1 | 50% |

| | | | | |
|---|---|---|---|---|
| Force Gen | Social Worker | 7 | 5 | 71% |
| Diagnostics | Radiographers | 4 | 2 | 50% |
| Diagnostics | Band 3 | 1 | 1 | 100% |
| Diagnostics | Admin | 3 | 1 | 33% |
| **Total** | **Total Staff** | **252** | **195.9** | **78%** |

Three staff roles had the lowest fill rate with 50% each, these are radiographers, speech and language therapist and podiatrist. Military physiotherapists were the next lowest at 68%.

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

### Vacancy

- The vacancy data was provided from the February 2021 to January 2022 for all core services apart from the rehabilitation division who only supplied data for February 2022. There was a 33% vacancy rate for all staff groups and 10% for nursing and 17% for medical/ dental. The highest vacancy was within the services for mental health.

| Core service | All staff | Nursing and Midwifery Registered | Medical and Dental |
|---|---|---|---|
| Diagnostics | 8% | | |
| Medicine | 28% | | 17% |
| MH - Mental health | 54% | | 1% |
| RRU | 27% | | |
| **Trust total** | **33%** | **10%** | **17%** |

From the data supplied, retrospective vacancy level for AHP staff could not be established for Stanford Hall. However, the figures below represented vacancies in February 2022.

| Staffing group | Number of vacancies |
|---|---|
| Military Physio | 6 |
| Civilian Physio | 5 |
| Military ERI | 0 |
| Civilian ERI | 0 |
| Service Manager | 0 |
| Occupational Therapist | 5 |
| Speech & Language Therapist | 1 |
| Recreational Therapist | 0 |
| Rehabilitation Assistant | 1 |
| Workshop technicians | 3 |
| Admin Support | 3 |
| Podiatrist | 1 |
| **Total** | **27** |

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

### Sickness

Breakdown by core service was not provided in the PIR. Sickness rates for military staff were provided but were unavailable for civilian staff.

| Staff group | Annual sickness rate % |
|---|---|
| Nursing Div. | 21% |
| Rehab Div. | 3% |
| Admin Div. | 3% |
| Bus Div. | 4% |

Sickness data supplied in the provider information request only covered May 2021 to December 2021 with nursing staff having the highest sickness rate.

*(Source: Staff analysis tool and DMS provider information return – P9 Sickness)*

### Turnover

The turnover data was provided for civilian staff for the period January 2021 to January 2022.

| Core service | All staff % | All staff - count of staff leavers |
|---|---|---|
| Outpatients | 2% | 1 |
| Medicine | 3.2% | 17 |
| MH - Mental health | 9.1% | 1 |
| Force Generation | 2.2% | 12.5 |
| Diagnostics | 4.5% | 1 |
| **DMRC total** | 4.2% | **32.5** |

The turnover figure only represented the civilian cohort.

*(Source: Staff analysis tool and DMS provider information return – P10 Turnover)*

- There were significant gaps in workforce for both military and civilian staff across the service. There were challenges recruiting certain Allied Healthcare professionals (AHPs) including Occupational Therapists (OTs), Social Workers, Podiatrists and Psychologists. This was thought to be because of a national shortage and the location of the unit being rural and the lack of accommodation availability.
- There were several gapped military posts, particularly Army OF2s. there was a plan in place to convert some of these posts to civilian and the CO had requested that military gaps were filled.
- 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 AED and there was also a resuscitation trolley in the out-patient department.
- One AED in the department had not been checked daily. We spoke to senior staff about this on site and this was addressed during the inspection.
- The service had a unit wide ‘code blue’ response to manage potentially life-threatening deterioration of patients or staff. This service was employed alongside putting out a 999 call to NHS services in the recognition that staff with additional training worked on site and could assist patients prior to the arrival of an ambulance.

- A recent incident had led to a review of this response service as there had been some confusion as to the location of the incident and the equipment available to staff and their knowledge of its location.
- The code blue response was co-ordinated from the in-patient staff as nurses were on duty out of hours (OOH) and had skills in life support. The staff providing the service were advanced life support (ALS) trained in daytime hours and may be intermediate life support (ILS) or ALS trained OOH. At the time of the inspection DMRC did not hold a central list of staff with ALS or ILS training. Following the inspection senior leaders confirmed this had been put in place.
- Not all staff knew the locations of the resuscitation trolley or the AEDs despite this being identified as a gap following the code blue incident and the locations being detailed within the resuscitation policy.
- To access medication on the resuscitation trolley, additional equipment was required which was not available on the trolley. We spoke to senior staff about this on site and this was addressed during the inspection.
- Clinical staff had commenced a morbidity and mortality meetings to review adverse events and incidents. Only one meeting had taken place and a log of adverse events had been made. This meeting needed embedding and we did not see how learning was shared with staff across DMRC.

### Assessing and planning for risk

**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 business continuity plan was specific to DMRC. The plan identified major threats to all aspects of service delivery, such as Force Generation, out-patients and in-patients and mitigation and management if an emergency or major incident occurred. The document provided guidance on alternative locations and outlined how the service would continue to run in an emergency.
- The COVID 19 pandemic posed a major risk for all business and services. The service had to adjust enable service continuity. The service had reduced numbers of patients to allow for social distancing. This was gradually being scaled back and backlogs addressed. During the recent vaccination programme the service had released staff to support clinics within the NHS at short notice.
- The service and leaders had considered the impact of increased activity due to any battle casualty increases. Plans were in place to maintain skills of staff and step up provision of services as and when required.

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

## Our findings

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

### Effective needs assessment

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

- Patient's needs were assessed, and care and treatment were 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 developed 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 Force Generation unit. Common guidelines and pathways documents were available for staff and patients to reference.
- The service had access to the equipment and facilities at ADMR, these included gait analysis, Computer assisted rehabilitation environment (CAREN). There were links in place to refer patients to use these as part of their rehabilitation programme and access to enrol patients in research trials if they met the criteria.
- The specialist rehabilitation team delivered long Covid rehabilitation. As this was a new service within DPHC, clinicians had developed guidance and were planning to share this with more local teams in PCRFs to commence rehabilitation for Covid patients there.
- 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.
- Goal setting was not always consistently documented within the clinical records and goals that were set were not always specific, achievable, measurable and had a timeframe for completion.
- Pain was assessed and managed according to each individual patient and patients felt their pain was managed well. Pain was assessed using a range of patient reported outcome measures (PROMS). Clinicians could select the most appropriate method for their patient group. PROMS were taken 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 (PROMS) were used for most patients attending the Force Generation unit. These outcomes were not routinely monitored across the service and there were challenges in the service's ability to demonstrate effectiveness.**

- PROMS and 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 could be patient specific to provide an objective measure associated with the patient's injury or specific to the intervention the patient was receiving. These were evident in 70% of the records we reviewed.
- Staff also followed patients up at various intervals to complete PROMS but this was not standardised across the service, some were at three months and others at six. The force generation unit was starting to collate these outcomes, but this was not embedded.
- Outcome measure audits had been carried out in the past but were time consuming due to a lack of a central data base of outcomes collected. There were plans in place for the Force Generation unit to audit outcome measures in March 2022. There was no benchmarking across the service or between services as outcome measures were not routinely scrutinised at service wide level.
- There were challenges in demonstrating effectiveness through outcomes measures in the Force Generation unit as patients were on short two or three week long courses. Patients were often at the end of their rehabilitation journey, having had rehabilitation at either PCRFs or RRUs. It was difficult therefore to show what had been achieved at the Force Generation unit as a stand-alone service.
- Leaders within the service were aware of these challenges and were looking at ways to try and address them. The Defence Covid Recovery service (DCRS) had implemented a comprehensive spreadsheet maps the outcomes of the DCRS which could be rapidly accessed by all DMRC staff and was seen as the way forward for all the Force Generation unit teams.

### Effective staffing

**Staff had the competencies and experience to carry out their role, which enabled them to optimise care and treatment for patents.**

- The overall appraisals completion rate at DMRC was of February 2022 was 97%. This was slightly below the 100% target. This did not include doctors who were appraised as part of the strategic command appraisal and revalidation process. DMRC did not keep records of medical staff appraisals so could not be assured they were completed in between revalidation periods.
- Staff had the right qualifications, skills, knowledge and experience to do their job when they started their employment, took on new responsibilities as and when required. A policy was in place for the statutory professional registration of healthcare professionals in the defence medical services. 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.
- Staff received in-service training to develop their knowledge and skills to optimise care and treatment for patients. Although the plan for the whole Force generation unit was not in place and face to face training had been delayed due to Covid 19 restrictions. Training sessions were happening but at various intervals and without standardisation.
- Newly appointed staff, locum staff and students were part of a mandatory induction programme.
- Supervision was held monthly including for permanent and locum staff. This was recorded in the individuals Continuing professional development (CPD) folders. Dates were also recorded in divisional workbooks but there were gaps the workbooks supplied. There was a supervision policy in place for all AHPs which stipulated at least two monthly supervision sessions should be carried out.

- Consultants received supervision through the mortality and morbidity meetings, although this meeting had only been held once and the process needed embedding. Junior medical staff received supervision at the beginning, middle and end of their four-monthly rotation. There were no records of dates of supervision for medical staff so the service could not be assured supervision had taken place.
- There was a process in place for DMRC to address performance issues or concerns for clinical staff, both qualified and unqualified. In the case of medical staff who had a responsible officer (RO), conducting their appraisal outside of DMRC, it was the manager's responsibility at DMRC to inform the RO of performance issues.
- There was opportunity for staff to apply for funding for external courses and there was oversight in place to review applications and approve or decline them based upon service need. Staff felt the process for applying for funding was complex and took a long time. Staff did not always receive feedback on funding decisions.
- Some staff were involved in peer reviews external to the unit across DPHC.
- Some allied health professional (AHP) staff did not feel their skills were being fully utilised at the unit. For example, there were delays in triaging as this was all done by consultants but could be picked up by specialist therapists. Also, only consultants could refer for diagnostics and not specialist therapists. This was out of line with practice with NHS settings where appropriately skilled AHPs can refer for diagnostics and triage.

### 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 Force generation unit 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 consultant and clinical lead physiotherapist held a joint MIAC clinic.
- Staff to patient ratios were good and staff reported work being satisfying as there was good MDT support.
- 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 record of the care and treatment of individual patients at the unit.
- In the clinical records we reviewed it was not evident that OT staff or ERIs had noted patient's past medical history although this was documented in the initial MIAC and physiotherapy notes.
- Some notes lacked detail of interventions carried out and would be difficult to hand over therapy interventions to other staff during or after a course.
- Patients received information prior the course to inform them about the treatment they would receive and what was expected. The guidance on Covid 19 testing for patients being admitted for in-patient care and the Force generation unit was different. Patients told us the information they received was not always clear and there had been occasions where patients had not been allowed on site as they had followed the wrong guidance. Where incorrect advice was sent to patients, an incident form would be submitted.

- Discharge plans and referrals onwards were clearly documented in the records. All services within DHPC used these records so PCRFs and RRUs could clearly see the plans following a course for their patients.

## 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.
- There was a consent policy for staff to follow. The policy included the consenting process and staff responsibilities regarding consent processes. The policy also displayed the rights of the patient in the consent process.
- Written consent was required for patients undergoing compartment pressure studies, although this was not operational at the time of the inspection. Consent forms were completed and scanned into the electronic system.
- Documented consent was obtained for treatments which involved a high level of risk. This was documented in patient records for patients who had undergone electromyography (EMG) studies, soft tissue injection, joint aspiration and injection, acupuncture, Grade 5+ spinal manipulations and Biodex isokinetic assessments.
- We reviewed 10 sets of patient records and found that verbal consent had been recorded in all treatment episodes.

# Are services caring?

## Our findings

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

### Kindness, dignity, respect and compassion

**Interactions we observed between staff and patients were respectful. Staff treated patients with compassion. 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.
- 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.
- There was a MOD wide diversity and inclusion plan which was followed by DMRC. There was also a statement from the CO promoting inclusion and zero tolerance to bullying and harassment.
- DMRC had a military liaison officer in post. Their role was to liaise between patients and staff treating them, on welfare issues and to input to all service improvements as a patient representative.

### 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 to ask questions and get support on a one to one basis.**

- Staff were able to form close professional relationships with the patients due to the nature of their work. Over the course duration, they were able to spend time talking to patients about their care, treatments goals and progress. Staff demonstrated a passion for their role and an encouraging, and supportive attitude towards patients.
- Patient survey results were collected and reviewed following each course in the Force Generation unit. Results showed that many respondents felt course delivery was good or excellent. Comments provided included ‘The level of instruction is exceptional’, ‘a world class facility where you are listened to and your injury is approached from all angles’ and ‘So much help all the time, amazing and confident moving forward’.
- Patients were mostly positive about their experience at the DMRC which reflected the outcomes of the patient satisfaction questionnaires completed by patients after finishing their rehabilitation.

- Patients were encouraged to be active partners in their care. Some patients found the content of the online material for remote sessions was unclear, this reflected written patient feedback. This had been recognised by the service but there were no plans in place to address the issue.
- Staff communicated with patients to make sure they understood why they were doing specific exercises. Patients told us they received one to one care from the course instructors to ensure patients were using the correct the technique and they took the time to explain things and modify treatment programmes when required to ensure rehabilitation and recovery chances were optimised.
- Patients told us there were opportunities for them to ask questions and be involved in their care and treatment. This helped to facilitate patients to take control and manage their rehabilitation independently with guidance from the staff.

### Patient and family support to cope emotionally with care and treatment

**Staff communicated with patients in a way that they would understand their care and treatment.**

- It was evident staff clearly understood the impact which patients care, treatment or condition had on their wellbeing.
- Patients were encouraged to link with other course participants while they were completing their rehabilitation. Patients had the opportunity to stay in accommodation on site, which provided them with the opportunity to socialise together during the course, during mealtimes, and in the evening.
- Patients told us some communication prior to course was confusing, such as Covid testing arrangements and joining instructions. The service was aware of these issues but did not have plans in place to address them.
- The service could access the support of the psychological wellbeing service which supported patients and families with adjustments to and managing with complex conditions.

# Are services responsive to people's needs?

## Our findings

**We found that this service was not responsive in accordance with CQC's inspection framework**

### Responding to and meeting patients' needs

**The service planned and provided care in a way that met the needs of people and the communities served.**

- The model of care provided across DMRC had changed in response to the Covid 19 pandemic. At the start of the pandemic, routine work was stood down. This was reintroduced but due to staff absence and social distancing at a reduced capacity.
- DMRC introduced a Covid recovery service for personnel without any additional resources. This involved some redeployment of staff across the service. The service was a residential rehabilitation course which has been delivered over 300 personnel.
- This service is now being evaluated and support been given to PCRFs to deliver post-covid rehabilitation in the most appropriate setting. This is reducing demand at DMRC in line with findings of the M-Covid research trial which is demonstrating the level of complex input for Covid patients is much lower than originally anticipated.
- DMRC had also adopted new tele-rehabilitation capability in response to the pandemic. This provided remote consultations which had also saved considerable travel and costs. The plan was to continue this approach beyond the pandemic for consultations which were clinically appropriate.
- Also due to the pandemic, some courses had been shortened from three to two weeks. In some cases, the first week was replaced by a remote online education package. Patients had fed back some issues with this as they were not all given time to complete the sessions and there were some issues with logging into the system. There were no plans in place to address this at the time of the inspection.
- Action had been taken from patient feedback about the specialist rehabilitation course being too short at two weeks and it was lengthened back to three.
- Clinical staff adapted their communication and advice with patients who may have limited reading ability. They also used online tools in a variety of languages for non-English speakers and at times had utilised support from colleagues to provide interpretation services.

### Access to the service

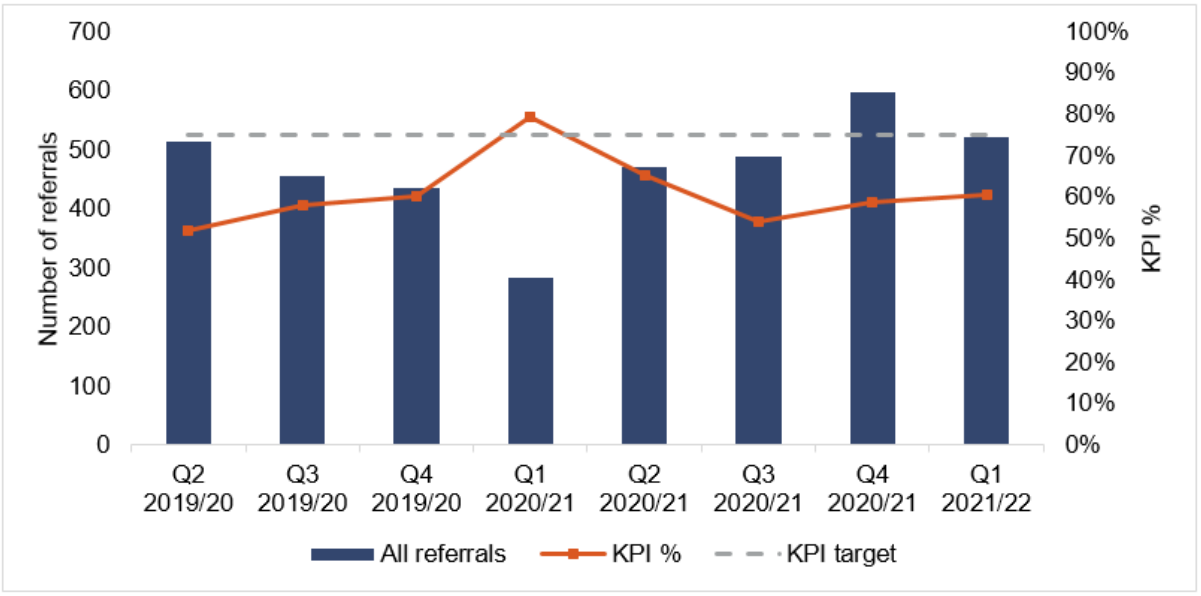
**The unit provided assessment and treatment services between 8am to 5pm Monday to Thursday and 8am to 2pm on Fridays. DMRC was not measuring performance against a range of KPIs, where information was available DMRC was not performing well against the set KPI.**

DMRC had limited information on access to the service. This was due to a pause in defence statistics from June 2021. No information was available on KPI performance from June 2021.

**Access to services for first referral**

DMRC Stanford Hall recorded 2,095 appointments between April 2021 and June 2021 with Outpatients accounting for 80% of the total appointments. For the same time period, this service achieved an overall performance figure of 61% for referrals with first appointment offered within 30 days. The target was 75%.

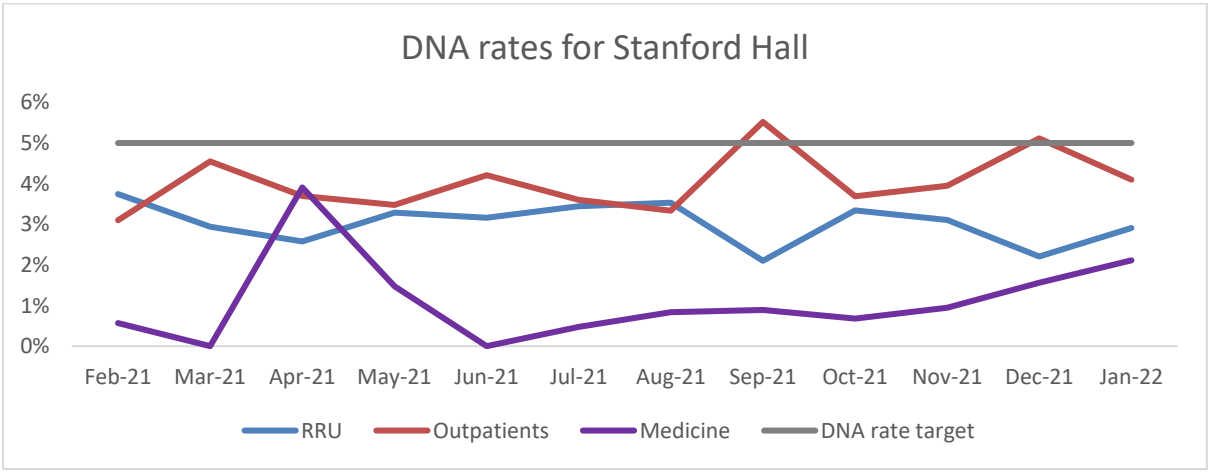
DMRC only met the 75% referral target once between Q2 2019 and Q1 2022.




*(Source: E1-P23 rehabilitation dashboard)*

**Attendance rates**

3% of all the overall appointments booked between February 2021 and January 2022 at DMRC were not attended or cancelled less than a day to the appointment (DNA). Most of these DNA's were from outpatients' referrals. The target for DNA was 5%.




*(Source: PIR P22 DNA rates)*

The highest DNA rates by clinic in the Force Generation unit were for the post Covid rehabilitation MIAC and spines MIAC both at an average of 4.5%.

- It was recognised that services at DMRC were based upon case mixes seen during conflict. Staffing had been redeployed to support post Covid rehabilitation, but the service had also seen an increased demand in the Force Generation unit as musculoskeletal conditions were more prevalent than major trauma. Each team across the rehabilitation division were reviewing capacity versus demand to try and address backlogs which had increased during the pandemic, but there was no formal recovery plan in place with targets.
- Waiting times were not equal across teams within the Force Generation unit even prior to the pandemic. Whilst teams were working to reduce their backlogs and increase capacity, they were hampered by ongoing Covid restrictions and staffing levels. Areas defined as 'pinch points' were specialist rehabilitation MIAC, admission to the Aspire rehabilitation course (a course for patients with ankylosing spondylitis) and lower limb rehabilitation courses, where either days to wait for the first appointment or numbers on the waiting list were highest. Due to the pause of Defence statistics this pressure was not reflected in any performance data produced by DMRC, however staff told us KPIs were not met.
- Senior leaders were aware of these access issues and were planning to address them through capacity planning with clinical staff and utilising AHPs with the skills to run clinics and triage.

### Listening and learning from concerns and complaints

**The unit had a system for handling concerns and complaints.**

**There were designated responsible people who handled all complaints in the unit. The complaints policy and procedures were in line with recognised guidance and DMS processes**. **Action was taken as a result of complaints being raised.**

- A new complaints process was in place for DMRC from January 2022. It had been identified that complaints were all handled previously by one officer in command who was non-clinical. The new process ensured complaints, depending on their nature, were passed to the most appropriate person to deal with them. For example, clinical complaints were passed to the clinical operational teams. This was to ensure complaints were managed at the lowest level possible and contained relevant information to answer the person's complaint.
- Concerns and complaints were listened, 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) which had been updated to reflect the new process in January 2022. This covered how the complaint was to be dealt with, including the stage of communication and investigation.
- Complaints were dealt with within target timescales. They were investigated and apologies were sent to the complainant. There had been four complaints across DMRC in 2021/2022.
- Informal complaints and compliments were recorded in divisional workbooks and were discussed at team meetings.

# Are services well-led?

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

# Our findings

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

### Vision and strategy

**There was a clear vision for the service and the priorities to improve the quality of care and treatment at the service had been set out.**

- There was a clear vision and mission statement set out for the service, with quality and safety the top priority. The mission statement for Stanford Hall DMRC was 'to deliver consultant led, safe and effective specialist interdisciplinary rehabilitation services to meet the needs of patients and Chain of Command'. This was underpinned by three strategic priorities. Firstly, to reset and recover from Covid lockdown restrictions through returning to pre-covid levels of capacity and continuing the work post-relocation of the service from Headley Court. Secondly, to continue to deliver agile and responsive patient services and improve healthcare governance, and thirdly to provide an excellent and safe working environment.
- These strategic priorities were underpinned by five objectives, to empower and invest in the workforce to deliver services for patients which are second to none, to recover and improve ways of working following Covid 19, to establish models and prepare for working with DNRC, to lead military rehabilitation and research within the DMRP and the DMS and to continuously improve through monitoring of clinical and non-clinical activity.
- The unit had a quality improvement programme with the aim of 'betterment' through structural and procedural improvement informed almost solely by feedback from staff and their lived experience.
- DMRC is a unique service and plans were in place for the service to respond to the needs of the wider DMS. There were plans in place to respond to future conflict situations as well as the provision of care to any military personnel referred to the unit in peacetime.
- During the Covid 19 pandemic, the service had responded to the needs of the military personnel by providing long Covid rehabilitation. In conjunction with its research arm, the service had identified that this service was better provided in more local teams and were supporting this provision within DPHC.
- Staff were positive about the vision and strategy and were able to articulate how their service contributed to wider aims. Staff told us they had been involved in consultations around strategy and were aware of the unit's objectives.
- The strategy at Force Generation unit level posed some challenges. It was easier in the more unique services to demonstrate impact through outcomes. It was also identified that there was a need for wider work across DPHC to develop best practice guidelines and referral pathways which optimised the unique consultant led, interdisciplinary approach of the unit. Staff and patients told us referrals were made at the end of their rehabilitation pathway when all other

avenues had been explored. This meant patients were often at the point of being discharged from service. It was felt that the service could do more to return personnel to service if the pathways were further developed.

- There was a clear IPC vision and strategy, with patient and staff safety paramount in the control of Covid 19 and other healthcare acquired infections.

### Governance arrangements

**The service had a new overarching governance framework, which supported the delivery of the strategy and good quality care but needed embedding with teams. This outlined the structures and procedures and ensured responsibilities were clear and that quality and risks were understood and managed. There were gaps in the oversight of performance data.**

- Since the move from DMRC Headley Court it was recognised that the unit's approach to healthcare governance was top down and there was a need to further integrate staff at all levels with the governance frameworks.
- 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. The service had completed the self-assessment in June 2021 and identified that governance framework improvements were required. A new framework for governance had been implemented in December 2021 having been delayed due to the Covid 19 pandemic.
- At executive level there was a Command Board which was held three times a year to align with the DPHC Command Board and a monthly executive meeting led by the Commanding Officer.
- From December 2021, Command Board structure would be strengthened with inputs from a quarterly Healthcare governance group and a quarterly Clinical delivery group (CDG). The CDG would be informed by two forums for out-patients and in-patients held monthly to review information at operational level.
- Command Board would cover risk, complaints, healthcare governance, research and audit and freedom to speak up outputs. This was a new process of oversight and needed embedding to ensure the flow of information from patient facing teams to executive level and back down the chain of command.
- The CDG was aiming to become more strategic in output in order to inform the Command Board. The meeting focuses on the clinical risk register, relevant statistics, issues that have reputational impact and clinical lessons identified/learnt.
- To facilitate the function of these groups there were leads for each of the five inputs, risk, complaints, healthcare governance, research and audit and freedom to speak up outputs.
- The unit was in the process of moving from the CAF system to the HAF system, but this had been delayed due to the CQC visit. Gaps identified from the CAF system were workbooks for all divisions.
- Workbooks covered all elements of the governance frameworks and it had been proposed they should be developed for each division of the service. However, there were also workbooks in use already within clinical teams that were well established and utilised by staff. There was a risk that there would be duplication or omissions of oversight in this system.

- This new governance framework was not yet embedded and across DMRC there was a lack of oversight and assurance around key areas including staffing levels and the impact of gaps, performance data and supervision and support of staff to maintain competence. Due to this the service was not at assured it was maximising its workforce capability and ensuring equal access to all patients using the service.
- Within the Force generation unit there were healthcare governance leads in each team who fed into the rehabilitation division and out-patient forums.
- It had been identified by DMRC that there were 60 ASERs still outstanding over a two-year period. This posed a risk that oversight and learning from incidents was not complete. It was also identified that further training on root cause analysis was required to ensure consistency of investigations.
- Clinical audits were taking place in the unit but there was no oversight or programme in place. Outcomes and learning were not shared, and audit cycle completion was not assured. Senior leaders had identified this and had put an audit and quality improvement lead in place to have oversight. It was unclear what was classed as an audit and what was a quality improvement programme and we saw no guidance or overarching aims of either programme.
- Risks were managed on a risk register and the service had developed this over the last two years. The second in command (2iC) managed non-clinical risk and to strengthen support to the clinical director it was suggested the officer in command (OC) rehabilitation division should manage clinical risk. Risks were allocated a risk owner with the commanding officer holding ultimate ownership of all risks. The clinical director owned clinical risk and risk ownership could be delegated from either level. Each risk also had an identified risk manager who would manage the risk and review the register on a monthly basis.
- Risk was managed at the lowest possible level with a risk scoring process in place. Risks could then either be terminated, tolerated, treated at the level of the risk manager or transferred to the commanding officer or higher where mitigations could not bring the risk into the other three categories.
- Staff were aware of the risks to the service and were able to explain these issues at all levels.
- Incidents were reported on the ASER system but depending on the type of incident it was also required to be reported elsewhere. Staff were not confident in how to report an incident and on occasions just raised issues at their usual meetings or with colleagues. This posed a risk that there was inadequate oversight at senior level of all the incidents across the service.
- The service had used the NHS IPC Board assurance framework (BAF) to bench mark its response to Covid 19 and provide the executive team with assurance of the control of Covid in the unit.
- Contracts with third party providers did not have one overarching governance process and the CO was working to formalise processes to bring contracts under one command.
- There was a lack of performance data oversight as Defence statistics was paused due to the implementation of Apollo. This was resulting in challenges in having oversight of and demonstrating activity levels. KPIs such as waiting time were still captured at local level and recovery from Covid 19 was being tracked.
- There had been a recent piece of work to implement SOPs in several areas and standardise these across the unit. Where previously SOPs had been duplicated in different areas, these were being reviewed and combined and leads put in place to ensure SOPs were appropriately ratified and not just going to one person for review. For example, managing DBS checks, OOH services, resuscitation and medicines management.

## Leadership and culture

**The managers in the service demonstrated strong leadership and they had the capacity and capability to run the service and ensure high quality care. It was clear they were passionate about their role.**

- Relocation to Stanford Hall and the Covid-19 pandemic forced the service to adopt a top-down approach. This was recognised by the senior team and several forums, processes and training courses were put in place to upskill the workforce. The aim was to return to a culture of devolved empowerment, where issues are dealt with by the appropriate person regardless of rank.
- There was evidence across DMRC of strong and passionate leadership, and a commitment to provide high quality services for patients. It was clear patients' needs were at the centre of the services delivered.
- Staff felt the current CO and their team were visible and approachable. The CO held a weekly briefing virtually with staff through the pandemic and this was well received. Staff reported the attendance at this briefing was increasing as it became an embedded communication process.
- Staff reported that while most leaders were open and approachable, this could be dependent upon individual leaders and not all teams had the same level of communication flow. Middle managers had identified the need for support and training as all civilian HR processes were only supported by online policies. This led to inconsistencies in the management of civilian staff. There were also challenges in lines of accountability where staff worked together across divisions in clinical teams but were line managed outside of the team. As OCs were on two to three-year assignments there were some concerns from staff that leadership of teams was turbulent.
- Staff told us that processes such as recruitment and applying for external courses were prolonged and convoluted. Adverts for specialist therapy roles were generic and difficult to navigate. Many posts were gapped, and we were told there were ongoing recruitment and retention issues for civilian staff since the move from Headley Court due to many civilian staff not relocating with the move. There was potential for this recruitment to become more challenging when DNRC becomes operational as it will be in direct competition for civilian staff.
- A tactical pause was planned for later in the year to focus on team building and resetting face to face working after the pandemic. The service had also established a health and wellbeing committee to address the ongoing impact of the pandemic and raise morale across the unit.
- The unit could not be assured all staff had adequate DBS checks in place. This was on an issues log but not on the risk register. Due to a previously gapped post there were gaps in monitoring out of date certificates and instances where the incorrect level had been applied for meaning staff only had adult or child clearance. They were delays in new staff having DBS checks and to mitigate this a risk assessment process had been put in place.
- There was a lack of assurance that civilian staff were appropriately immunised for their role by the contracted Occupational Health Service. This was on the risk register and had been transferred to DPHC.

## Seeking and acting on feedback from patients and staff

**Feedback was sought from patients to identify whether improvements could be made to the service. Feedback for the service was very positive and was shared with staff.**

- It was recognised by the senior team that morale was low in the unit following the move from Headley Court and then the covid 19 pandemic. There were a number of recognised challenges across the unit including accommodation, communication, IT and workforce gapping (civilian and military) which continued to impact morale.
- To address this the senior team had set up several initiatives; including a departmental managers forum to support line managers across the unit with procedures and policies, a coffee shop upgrade, a dragon's den event to allocate funding for welfare and amenities. There was also a training passport to assist staff to prioritise training and planning of events to support health and wellbeing. These were all new in place and needed embedding to impact upon morale.
- In 2020 a climate assessment report surveying staff highlighted concern in attitudes toward D and I, dignity and respect, and leadership and management. An action plan had been developed which included the roll out of diversity and inclusion training for staff, 'face it, fix it' training and establishing feedback loops for staff with concerns and mentorship. The service repeated the climate assessment this year.
- Another new initiative was the implementation of the role of the FTSUG. There was an identified lead and nine volunteer champions across a range of ranks and roles had been identified. Training was due to take place but had been postponed due to sickness. The FTSUG had begun to promote the role but there had been no up take yet. The aim was to manage issues raised at the lowest possible level but to report trends up to senior levels of the organisation for monitoring.
- An electronic questionnaire was used to gather views and experiences from patients following their treatment. Results were gathered centrally and then sent to the service to analyse. Staff told us they received feedback to their service if specifically mentioned, for example in hydrotherapy. Most feedback was very positive about the service.
- Patient feedback was discussed throughout the governance meetings framework up to Command Board. It was identified the central DPHC patient questionnaire had low up take and possibly wasn't appropriate for the patient group.

## Continuous improvement

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

- Continuous improvement was one of the service's strategic objectives.
- The service had responded to the recent Covid 19 pandemic and provided care and treatment for patients with long Covid. They had contributed to an ongoing research study for long Covid and they had evaluated their work and role.
- The service had led on IPC initiatives during the pandemic, leading the approach of DPHC in risk management and control. This had resulted in no outbreaks of Covid in patient groups.
- DMRC had access to state-of-the-art facilities and were able to provide innovative practice such as pressure testing in lower limbs, gait analysis, on site MRI and CAREN.
- The service was part of Defence Engagement which links overseas programmes with military healthcare staff. The service was engaged with Nepal on a long-term basis, Saudi Arabia who visited the unit to review the delivery of rehabilitation, Pakistan, Kenya and Ukraine. Military staff work alongside teams and through this maintain skills in delivery of care with limited resources.

- There was a programme in place for coaching and mentoring for supervisory and middle managers. It was in its infancy, but training was offered, and coaches already trained were identified to support the programme. The service had also reviewed its leadership training and was looking for other sources such as the NHS Leadership Academy (Edward Jenner Clinical Leadership Course), Defence Academy and the Army Leadership Academy.
- It had been identified by leaders that the route to external training was complicated, an analysis of barriers was to be undertaken to adjust internal processes before escalation to DPHC.

Defence Medical Services

# DMRC Stanford Hall

**Psychological Wellbeing Service**

# Are services safe?

## Our findings

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

### Track record on safety

- Since April 2021 there were four significant events recorded across the service. These had included a confidentiality breach, a delay in referring to another service and impact of staffing gaps. All events had resulted in low or no harm. Root cause analysis investigations had been undertaken where appropriate and were thorough. These provided evidence of learning and had led to improvements in practice. The team shared details of where an incident in 2020 had led to significant redesign in the way that the team operated and changes to processes for transfer of care to other services.

### Reporting incidents and learning from when things go wrong

- The team used the standardised DMS electronic system to report significant events, incidents and near misses. Staff received training at induction regarding the processes to report significant events and were aware of their role in the reporting and management of incidents.
- Significant events were discussed at monthly team meetings and weekly multidisciplinary meetings including the outcome and any changes made following a review of the incident. Learning and recommendations were noted within the minutes of these meetings. Staff were aware of learning from previous events and serious events that had occurred at other medical facilities.

### Assessing and managing risk to patients and staff

- The team undertook a thorough risk assessment for the patients they worked with and ensured these risks were shared with the wider service where appropriate. Patients at risk were reviewed by the multi-disciplinary team on a weekly basis. The team operated a process to share concerns with colleagues both within DMRC and in wider mental health services about specific patients whose risks had increased. This included risks due to safeguarding concerns.
- Where a known patient contacted the team in crisis, the team responded swiftly.
- Staff told us that the DMRC did not have a policy or guidance on the management of challenging behaviour and that they did not have access to training in de-escalation which was considered necessary. However, the DRMC confirmed the policy is under review.

- The Ministry of Defence had a policy for safeguarding vulnerable adults and the team had completed level 2 safeguarding training. Child protection training levels one to three were mandatory for DMS staff as appropriate to their role. At the time of the inspection staff had undertaken training as appropriate to their role. The team demonstrated an understanding of safeguarding principles and practice and had made safeguarding referrals where required. Safeguarding concerns were discussed at multidisciplinary team meetings and reported where appropriate.
- Business continuity plans for major incidents, such as security threat, power failure or building damage were in place and had been updated to reflect the risks in relation to the Covid 19 pandemic. Appropriate actions had been taken in response to the Covid 19 pandemic to mitigate the risk of infection to patients and staff and to ensure the service could operate safely. Where appropriate, staff had worked remotely to minimise risk however the team had continued to offer both virtual and face to face appointments as necessary throughout the pandemic.

### Safe and clean environment

- The team has sufficient space to undertake their work and meet with patients privately where required.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Hand wash facilities and hand gels were available, and staff adhered to infection control principles, including handwashing. Cleaning and infection prevention audits were undertaken, and the team's facilities were found to be clean throughout. Appropriate systems based on national guidance had been put into place to manage the risks associated with Covid 19. This included the accessibility and use of personal protective equipment (PPE), Covid testing, safe distancing measures and remote working.
- Equipment logs were in place. Equipment was found to be clean and had been serviced.
- Staff told us that the tannoy system within the building was frequently used and proved disruptive to the therapeutic environment when patients were undertaking therapy sessions. The management team had raised this with DMRC senior managers, but this had not been addressed.

### Safe staffing

- The clinical team totalled 15 individuals and consisted of medical, psychology, occupational therapy and nursing staff. The management team stated that there had been significant gaps in posts at the beginning on 2021 however they had worked hard to recruit to roles and had received additional resources since then. At the time of our inspection the clinical team was almost fully staffed against planned staffing. There were three vacancies for two nurses and a psychologist. A long-term locum covered the liaison nurse vacancy. Recruitment was ongoing for these posts. However, the team had a waiting list for mild traumatic brain injury therapy (MTBI) and told us that there was a need for a further psychologist or occupational therapist to address this. In addition, the consultant psychiatrist based within the team was taking a sabbatical which had impacted on patient's assessment and service gradings. Recently the team had been provided with virtual support from a consultant psychiatrist from another DCMH however this was not considered sufficient to ensure appropriate clinical oversight and medical governance. Following the inspection a psychiatrist had joined the team two days per week in addition to the virtual support.

- Across DMRC up to thirty-three training courses were classed as mandatory dependent on role. We saw that regular locum staff received training similar to permanent staff. At the time of the inspection overall compliance averaged 71% across DMRC although the PWS reported better compliance with key courses. However, staff told us that they were unable to access a range of training specific to mental health practice including training in risk assessment, managing challenging behaviour and the Mental Capacity Act.

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

## Our findings

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

### Assessment of needs and planning of care

- Clear treatment plans were in place for patients and were detailed, holistic and captured all relevant needs and risks. The team also contributed to the development of overall DMRC treatment plans.
- The PWS team had access to an electronic record system which was shared with therapists and the medical team and across other DMS healthcare facilities. However, the wards at DMRC used some paper records, meaning the team had to work hard to ensure that they had access to all appropriate information and to share their record of treatments undertaken for inpatients at the service. All care records we reviewed during this inspection were completed to a good standard.

### Best practice in treatment and care

- Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. NICE and other guidance was reviewed within team and governance meetings. Clinical records reviewed made frequent reference to NICE guidance. Staff told us of practices that met this guidance.
- The team employed psychologists, occupational therapists and nurses who were trained in a wide range of psychological treatments. Patients were therefore able to access a wide range of psychological therapies as recommended in NICE guidelines for depression, post-traumatic stress disorder (PTSD), acquired brain injury, neurological conditions and anxiety. Treatments included the use of cognitive behavioural therapy, cognitive analytical therapy, trauma focussed therapy, solution focused therapy, narrative exposure therapy and eye movement desensitization and reprocessing.
- The team undertook a wide range of diagnostic work including cognitive assessment, psychometric assessment and risk formulation. The occupational therapists at the team undertook a range of interventions to address sensory and functional needs, and activities to increase job readiness and independent living skills.
- The team delivered a wide range of therapeutic groups to prepare patients for psychological intervention and rehabilitation. These included groups for adjustment, anxiety management, resilience, stabilisation, acceptance and behavioural change.

### Skilled staff to deliver care

- The team consisted of a range of mental health disciplines working under the clinical leadership of a consultant psychologist. These included psychologists, occupational therapists and nurses.
- New staff, including locums, received a thorough induction. Development training, such as in cognitive behaviour therapy and EMDR, was available to staff. Some staff were undertaking additional academic qualifications financed by the service. However, some staff told us that they had lost places on external training due to delays in approval for funding.
- Additional bespoke training was delivered to the team at regular monthly sessions. This training was highly valued by team members. However, staff told us that they did not feel they had access to wider mental health focussed development training and support from DMS.
- Staff had support through weekly multidisciplinary, caseload management and professional development meetings. Staff were also involved in monthly team meetings.
- Staff confirmed that they had protected time for supervision and professional development and received regular supervision and caseload management. Records provided confirmed full compliance with clinical supervision and caseload management.

### Multidisciplinary and inter-agency team work

- Care and treatment plans were reviewed regularly by the multidisciplinary team in weekly multidisciplinary single point of access meetings. Patients at risk were also discussed in these meetings. We attended this meeting during the inspection and were impressed by how well this was managed and that all staff present had been effectively engaged in the decision making.
- The core function of the team was to provide equal opportunity to patients to access psychological management or mental health treatment as part of their overall rehabilitation process. Staff positively described the advice and support they would give to colleagues within the DMRC. The team was also working proactively to build links with and offer support to colleagues within wider DMS mental health services as patients were discharged from the DMRC. The team had recently recruited wellbeing champions from across the DMRC to promote mental health awareness and provided regular clinical supervision and education to the champions support this.
- The team worked in partnership with a range of services both within and outside the military. This included liaison with the NHS providers who are independent service providers of psychiatric beds. The team had a liaison nurse whose role it was to work with the NHS team to ensure effective care and discharge from the service.
- As an occupational health service, the team worked closely with a range of agencies to support military personnel to leave the Armed Forces. This role included access to employment, housing and welfare organisations including the Defence Medical Welfare Service and NHS Veterans Mental Health Transition, Intervention & Liaison Service (TILS). Where necessary, when handing care over on discharge of a patient from the services, the team met with the receiving NHS teams.

### Good practice in assessing capacity and consent

- Staff had not received specific training in the Mental Capacity Act however had received an update on the Mental Capacity Act in February 2022. All staff had awareness of the principles of the Act and the need to ensure capacity and consent.

- It is the individual healthcare professional's responsibility to assure capacity and gain consent and this should be considered on an ongoing basis. We found some evidence of capacity assessments in the records we reviewed. In line with the principles of the Act, staff assumed capacity unless there was evidence to suggest otherwise.
- In all records we reviewed we found records of consent to share information. A consent to treatment form had recently been introduced and we found records of consent to treatment in most records.

# Are services caring?

## Our findings

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

### Kindness, dignity, respect and support

- We saw staff that were kind, caring and compassionate in their response to patients. We observed staff treating patients with respect and communicating effectively with them. This included both clinical and administrative staff. Patients said that staff were kind and supportive, and that they were treated with respect.
- Staff showed us that they wanted to provide high quality care. We observed staff working extremely hard to meet the wider needs of their patients. Patients said that staff would help them to access all possible support that they could.
- Staff demonstrated that they were knowledgeable about the history, possible risks and support needs of the people they cared for. We saw staff working with patients to reduce their anxiety and behavioural disturbance.
- Confidentiality was understood by staff and maintained. Staff maintained privacy with people, who were asked if they would like their information shared with their relatives, within the chain of command and other bodies, including CQC. Information was stored securely, both in paper and electronic format.

### The involvement of people in the care they receive

- The team had informative leaflets explaining the service that was delivered. The team also provided access to a range of information regarding clinical conditions and treatments available to support the conditions. These were shared with patients routinely.
- The DMRC undertook patient experience surveys on an ongoing basis. Surveys were conducted for patients attending rehabilitation courses and in-patient admissions to the wards. Although the PWS was not identified as a separate service for the purpose of surveys the feedback on care provided was generally rated as good or excellent.
- The team confirmed that they involved patient's families within the patient's care where appropriate. Staff offered support and advice to family members including psychoeducation for carers

# Are services responsive to people's needs?

## Our findings

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

### Meeting the needs of all people who use the service

- The team could offer flexible appointment times during office hours.
- Remote appointments were available to outpatients meaning that patients could avoid lengthy travel to attend appointments.
- The team confirmed that they had access to interpreters should this be required.

### Access and discharge

- The team worked with patients prior to admission to the DMRC, during their inpatient stay and following discharge from the facility. Clear referral pathways were in place. Referrals were accepted from the multi-disciplinary injury assessment clinics (MIAC), mild traumatic brain injury therapy (MTBI) and neurological teams across DMRC and from external defence mental health teams. The team had developed a single point of access for all referrals. A duty worker was available each working day to review all new referrals. Routine referrals were clinically triaged by the duty worker to determine whether a more urgent response was required. All fresh cases were also taken to the weekly multidisciplinary single point of access meeting to ensure an appropriate response.
- Throughout the pandemic staff had mainly worked at home or remotely from the office where possible to minimise risk however the team had offered face to face appointments where necessary. The team had identified that patients had found virtual outpatient appointments extremely welcome as this had cut down on travel to appointments and had allowed greater flexibility. The team had also used this opportunity to offer more lengthy psychological interventions which previously would have entailed significant travel to and from the DMRC for outpatients.
- At the time of the inspection the team's active caseload was approximately 90 people.
- There was a waiting list of 50 patients for mild traumatic brain injury therapy (MTBI) due to a gap in a psychologist / occupational therapist post. However, there were minimal waiting times for all other treatments.

### Listening to and learning from concerns and complaints

- The team had a system for handling complaints and concerns. A policy was in place and information was available to staff. Staff demonstrated awareness of the complaints process and had supported patients to raise concerns.
- Information about how to complain was shared with patients and patient waiting areas had posters and leaflets explaining the complaints process.

- In the 12 months prior to our inspection there had been no formal complaints about the PWS and there had been seven written compliments about the service.
- Staff received feedback on complaints and investigation findings from cross DMRC during team meetings. We saw evidence of information sharing in meeting minutes.

# Are services well-led?

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

## Our findings

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

### Vision and values

- The Psychological Wellbeing Service leadership team told us of their commitment to deliver quality care and promote good outcomes for patients. The teams mission was: “To promote mental health and wellbeing as part of the rehabilitation process, to achieve optimal health within the service life or in transition to civilian life”.
- All staff we spoke with during this inspection were clear regarding the aims of the service and supported the values of the team.

### Good governance

- This new governance framework implemented by the DRMC in December 2021 was not yet embedded and across DMRC there was a lack of oversight and assurance around key areas including staffing levels and the impact of gaps and performance data. Due to this the DRMC was not assured that the PWS was maximising its workforce capability and ensuring equal access to all patients using the service. However, the PWS management team collated its own information about performance against targets and outcomes and had local processes to capture additional governance and performance information including incident, safeguarding and complaints data, training data and supervision logs.
- The PWS team had a monthly business and governance meeting which all staff attended. The meeting considered good practice guidelines, policy development, risk issues, learning from complaints and adverse events, team learning and service development. In addition, weekly multidisciplinary single point of access meetings considered areas of governance and practice.
- Local processes had been developed to deliver safe practice including procedures for managing referrals, risk and safeguarding.
- Work had been undertaken to capture learning from adverse events and had led to changes in practice.
- Partnership working with other parts of the DMRC and defence medical services, NHS and voluntary groups was very effective. The team actively engaged with stakeholders to gather feedback about the service and make necessary improvements.
- The common assurance framework (CAF), is a DMS structured self-assessment internal quality assurance process, which should form the basis for monitoring the quality of the service. The team contributed to the overall CAF for the DMRC.

- Risk and issues were reviewed monthly or as identified and logged on the DMRC risk and issues registers. The risk and issues logs included: a lack of psychiatric input, a shortfall in neuro psychology, and a waiting list for MTBI. The risks included detailed mitigation and action plans. All potential risks that we found at the team had been captured within the risk and issues logs or the common assurance framework.
- Environmental risk assessments were in place and included all relevant risks.

### Leadership, morale and staff engagement

- The management team consisted of a clinical lead who was the Consultant Psychologist and a manager who was the Consultant Pain Manager. Due to a gap in the military management role the Consultant Pain Manager had stepped into the role in April 2021. There was also a gap in the consultant psychiatrist role due to the postholder taking a sabbatical. The team had recently been provided with virtual support from a consultant psychiatrist from another mental health team however this was not considered sufficient to ensure appropriate clinical oversight and medical governance. Following the inspection, a psychiatrist had joined the team two days per week in addition to the virtual support.
- The distinct PWS team had been developed in July 2021, prior to this the staff had worked across a number of services at DMRC. The team told us that they were extremely positive about being brought together in to a single team and that this had helped to develop a clearer focus on mental wellbeing at the DMRC. The team also felt that it was positive to work closely with colleagues who were focussed on psychological wellbeing and that this provided positive peer support. The team were very positive about the leadership within the PWS. However, the team stated that while they felt part of the overall DRMC service they did not feel they had access to wider mental health focussed development training, support and networks within the wider DMS.
- We found that there was clear and accountable leadership at the PWS. All staff reported that morale was now very good at the team. Locums and administration staff supported this view and felt an integral part of the team. Staff reported that they felt supported by their colleagues and that the management team were approachable and highly supportive of their work.
- The team was almost fully staffed. Sickness and absence rates at the team were minimal.
- A whistleblowing process was in place that allowed staff to go outside of the chain of command. Staff also had access to a Freedom to Speak Up Guardian (FTSU). Staff mostly knew about the whistleblowing and FTSU processes and all stated they would feel confident to use these should they need to. There had been no formal reported cases of whistleblowing or bullying at the team in the previous year.
- All staff attended business and team meetings. Staff told us that developments were discussed at these meetings and they were offered the opportunity to give feedback on the service.
- Staff were positive about the service and felt this was making a positive difference to the quality of life of patients.

### Commitment to quality improvement and innovation

- A wide range of audits were undertaken by the team and the team undertook monthly caseload management reviews of all patient records.
- Staff told us that they were actively encouraged to engage in research and a number undertook research and lecturing roles within external universities.

- The team had made a number of positive changes at the service in response to significant events that had occurred previously.

# Are services safe?

## Our findings

**We found that this service was not safe in accordance with CQC's inspection framework**

### Mandatory training

**The service provided mandatory training in key skills to all staff and but not everyone completed it.**

- Nursing, medical and administration staff received mandatory training. Staff working in the out-patient department told us they were up to date with training, but unit wide figures showed that most training modules did not meet the target compliance.
- The mandatory training was comprehensive and met the needs of patients and staff.
- The training team monitored mandatory training and alerted staff when they needed to update their training.

### Safeguarding

**Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.**

- Nursing, medical and administration staff received training specific for their role on how to recognise and report abuse. Staff working in the out-patient department told us they were up to date with training, but unit wide figures showed that most training modules did not meet the target compliance.
- Staff could give some examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They acknowledged they would not always ask patients about protected characteristics.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns.
- Staff followed safe procedures for children visiting the service.

### Cleanliness, infection control and hygiene

**The service did not always control infection risk well. Staff used equipment and some control measures to protect patients, themselves and others from infection, but this was inconsistent. They kept equipment and the premises visibly clean.**

- Clinical areas were clean and had suitable furnishings which were clean and well-maintained.
- Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.
- Staff followed infection control principles including the use of personal protective equipment (PPE).
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.
- The service carried out IPC audits for hand hygiene (HH) and bare below elbows (BBE). These were completed monthly and quarterly and were complete for the Out-patient department. Compliance for BBE was at 67% and for HH at 80% which was below the target of 95%. BBE had been below target in November 2021 but then at 100% in December and HH had been below target for the past three months. The last sharps audit in January to March 2022 was also below target at 94%.
- In clinical areas we observed staff adhering to BBE in pain interventions clinic. The most local audit on display in the department showed HH at 100% compliance and BBE at 83%. Staff told us this was due to clinical staff not removing items such as watches.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

- Staff carried out daily safety checks of specialist equipment.
- The service had suitable facilities to meet the needs of patients' families.
- The service had enough suitable equipment to help them to safely care for patients.
- Staff disposed of clinical waste safely.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration**

- Staff responded promptly to any sudden deterioration in a patient’s health. The service also had access to the psychological well-being support (PWS) service if they had concerns about risks associated with mental health. Staff knew about and dealt with any specific risk issues.
- Staff completed risk assessments for patients on attendance for interventions, using a recognised tool, and reviewed this regularly. For example, the pain intervention clinic used an adapted WHO checklist which covered risks to the patient.
- Staff shared key information to keep patients safe when handing over their care to others and when informing patients about their care.
- The service had person of interest meetings, which were multidisciplinary case reviews. We were told oversight of medication and any issues with over medication would be discussed at these meetings.

### Staffing

- See Force Generation section for information under this sub-heading.

### Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.**

- Patient notes were comprehensive, and all staff could access them easily.
- When patients transferred to a new team, there were no delays in staff accessing their records.
- Records were stored securely on an electronic record. The records we reviewed were legible, clearly identified the patient and the staff member providing care.
- There was no routine audit of record keeping in place.

### Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

- Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.
- Medicine allergies or sensitivities was recorded on all medicine charts seen. This ensured that staff were aware and alerted to prevent the prescribing and administration of medicines causing allergic reactions.
- Medicine stocks were appropriately stored and managed in line with policy with access limited to authorised personnel only. Areas where medicines were stored, dispensed, prepared and administered were monitored and maintained. Medicines required in an emergency were available. Tamper evident seals were in use to ensure emergency medicines were readily available when needed and fit for use. Regular checks of emergency medicines and equipment were carried out by staff. Controlled drugs (medicines requiring more control due to their potential for abuse) and controlled stationery were managed and stored securely. Three monthly audit checks were undertaken. There were no discrepancies identified at the last audit (March 2022).
- Staff understood how to report a medicine incident or safety concerns following the service incident reporting policy. Reported medicine safety incidents were discussed at the medicine management committee meetings. Staff told us they received updates about errors or incidents. Staff were able to explain about some recent medicine incidents and the learning that had been undertaken.
- We were informed that there was a home care delivery risk for the provision and availability of some specialist pain medicines to treat inflammatory conditions (biologics). Systems and processes for obtaining these medicines was outside the management and control of DMRC, however it sometimes led to delays in patients receiving these medicines. This created a barrier which could potentially impact patients from receiving their prescribed treatment on time. DMRC had explored options to address this but this meant patients travelling regularly from across the country to DMRC or Medical officers (MOs) prescribing from more local facilities but this was not in line with prescribing guidance for MOs.

### Incidents

**The service managed patient safety incidents well. Staff recognised incidents and near misses and but did not always report them appropriately. Managers investigated incidents**

**and shared lessons learned with the whole team. Managers ensured that actions from patient safety alerts were implemented and monitored.**

- Staff told us about incidents which occurred, but they did not always report them appropriately. Staff raised some concerns and reported incidents and near misses in line with the service's policy, but this was not consistent. We were told about incidents which were not reported on the ASER system, but they were discussed between the team at local level.
- The service had one never event and one near miss. Managers shared learning about never events with their staff and across the service.
- Not all staff understood the duty of candour. They were open, transparent and gave patients and families a full explanation if and when things went wrong.
- Staff received feedback from investigation of incidents, within their service. It was not clear how wider learning was shared from incidents external to the service.
- Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback but there were some delays in the implementation of this. For example, a near miss for a wrong side intervention was recorded in August 2021, the action taken to address this was not recorded until February 2022.

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

## Our findings

**We don't rate the key question of effective within out-patients.**

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, there were DMRC guidelines for prescribing analgesics and managing neuropathic pain. These were based upon NICE guidance and had been approved by the Medicines Optimisation Advisory Committee in November 2020.
- Medication guidance was set out in the out-patient healthcare governance workbook with links to guidance for staff to follow. Clinical staff told us they focussed on reducing dependency upon medication wherever possible and promoted rehabilitation. Guidance was not audited by managers to ensure it was followed. The service was looking at auditing pain management interventions, but this was not complete.

### Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.**

- Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff prescribed, administered and recorded pain relief accurately.

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. They were planning to use the findings to make improvements and achieved good outcomes for patients.**

- Patient reported outcome measures (PROMS) were used within the service. In pain management, following an intervention, patients would receive a follow up call at three weeks. No standardised tool was used but patients were asked about changes in pain and function.
- Rheumatology used a standardised national outcome tool and staff told us outcomes were comparable to NHS outcomes for this patient group.
- Outcomes were not routinely monitored across the service or used to develop the service. The service had trialled local patient surveys, but these were too focussed on the Force generation unit, so uptake was low. The service was planning to develop its own patient survey.

### Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.
- Managers supported nursing staff to develop through yearly, constructive appraisals of their work. Medical staff were appraised externally to DMRC through the DMS General Medical Council (GMC) process.
- Managers supported staff to develop through regular, constructive clinical supervision of their work. Consultants had begun joint supervision sessions but only one session had been held. There were issues with staff maintaining competency, especially for clinicians who were delivering unique procedures within DMS and for non-medical prescribers. The service had documented this within an issue log and had accessed some clinical support from NHS colleagues, but it was not clear if this was an ongoing arrangement.
- Staff could access funding for external courses. They also attended regional meetings across DPHC for shared learning.
- Managers made sure staff attended team meetings or had access to full notes when they could not attend.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

- Patients could see all the health professionals involved in their care at one-stop clinics, including having diagnostics such as X-rays and sometimes same day MRI. Doctors and nurses ran concurrent clinics and consultants provided support through the clinic for all patients.
- Referrals were made into the service for interventions on DMICP, but these had not been analysed since 2020.

### Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

- Nurses had plans to run smoking cessation sessions as part of clinics. The service had relevant information promoting healthy lifestyles and support in patient areas.
- Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

- Staff gained consent from patients for their care and treatment in line with legislation and guidance.
- Staff clearly recorded consent in the patients' records. They did not always clearly document a discussion with patients about the treatment plan and its purpose.
- Key clinical staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, but unit wide figures showed not all staff were up to date with their training.
- Staff could describe and knew how to access policy on Mental Capacity Act.

# Are services caring?

## Our findings

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

### Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.
- Patients said staff treated them well and with kindness.
- Staff followed policy to keep patient care and treatment confidential.
- Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.
- Staff understood and respected some of the personal, cultural, social and religious needs of patients and how they may relate to care needs.

### Emotional support

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.**

- Staff gave patients and those close to them help, emotional support and advice when they needed it.
- Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.
- Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

### Understanding and involvement of patients and those close to them

**Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.**

- Staff made sure patients and those close to them understood their care and treatment.
- Staff talked with patients, families and carers in a way they could understand.
- Patients and their families could give feedback on the service and their treatment and staff supported them to do this.
- Staff supported patients to make informed decisions about their care.
- Patients gave positive feedback about the service.

# Are services responsive to people's needs?

## Our findings

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

### Service delivery to meet the needs of local people

**The service planned and provided care in a way that met the needs of the communities served. It also worked with others in DMRC and DPHC to plan care.**

- Managers planned and organised services, so they met the changing needs of the population at risk. During Covid, clinics for patients at risk of deterioration or patients who needed medication reviews continued. The service made use of virtual clinics and continued to do so which meant patients could be assessed without travelling into DMRC.
- The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and diagnostic tests on one visit to DMRC. Sometimes the MRI scanner was not available on the same day, but the site had facilities to offer overnight accommodation, so patients were asked to bring an overnight bag.
- Facilities and premises were appropriate for the services being delivered.
- Staff could access emergency mental health support during operational hours for patients with mental health problems.
- Managers monitored and took action to minimise missed appointments. There was a text reminder service in place for patients.
- Managers ensured that patients who did not attend appointments were contacted.

### Meeting people's individual needs

**The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

- Staff did not routinely ask about protected characteristics. They did ask routinely about home circumstances and picked up where reasonable adjustments needed to be made.
- Patients were given a choice of food and drink to meet their needs.

### Access and flow

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**

- Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

- Managers worked to keep the number of cancelled appointments to a minimum.
- Between April 2021 and June 2021, this service achieved an overall performance figure of 62% for referrals with first appointment offered within 30 days. The target was 75%. The DNA rate for out-patients was an average of 2% with the highest DNA rate in the rheumatology MIAC clinic at 9%.
- The rheumatology service had a considerable backlog of patients following the Covid pandemic despite seeing patients who were at risk of deterioration through this time. To address this, surge clinics were held, and additional nurses had been recruited and upskilled to order diagnostics and prescribe and this had led to much improved access times.
- The waiting time for a rheumatology appointment for routine patients was six to eight weeks and urgent patients were seen within a week. The waiting time for pain management was two weeks but patients could be seen sooner. For pain intervention clinic waiting times were four to six weeks. This demonstrated much better access times compared to the NHS, but this increased the risk of increased referrals from across DPHC as referrers to the service were able to choose between DMRC and NHS services. The service was not seeing an increase in referrals at the time of the inspection but clinical leaders recognised this risk.
- The service did not collect data when patients had their appointments or treatments/operations cancelled at the last minute. There were no targets to make sure appointments were rearranged as soon as possible.
- Staff supported patients when they were referred or transferred between services. Most referrals were made on DMICP, so clinic letters were not typed. Where referrals were made outside of DMS the service had one typist who had limited capacity. On occasions, consultants were typing their own referrals which risk delays in patients being referred.

### Learning from complaints and concerns

- See Force Generation section for information under this sub-heading.

# Are services well-led?

## Our findings

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

### Vision and Strategy

- See Force Generation section for information under this sub-heading.

### Governance arrangements

- See Force Generation section for information under this sub-heading.

### Leadership and Culture

- See Force Generation section for information under this sub-heading.

### Seeking and acting on feedback from patients and staff

- See Force Generation section for information under this sub-heading.

### Continuous improvement

**Staff were committed to continually learning and improving services**

- The pain working group were delivering virtual lectures in pain management across DMRP.
- See Force Generation section for information under this sub-heading.

# Are services safe?

## Our findings

**We found that this service was not safe in accordance with CQC's inspection framework**

### Mandatory training

**The service did not provide mandatory training in key skills to all staff or make sure everyone completed all mandatory training requirements.**

- Staff did not all receive and keep up to date with their mandatory training and compliance with completion of these was inconsistent. The target for compliance with mandatory training requirements was 95%; this was not met in 17 out of the 25 mandatory training topics.
- Although the mandatory training programme was comprehensive and met the needs of patients and staff, we saw that compliance was inconsistent. Staff followed training requirements set out in the DPHC mandated training policy. Training data for the inpatient service was recorded in a divisional workbook. The Nursing division workbook showed data for registered nurses, healthcare assistants and medical staff compliance with training. Compliance ranged from 21% (for 'Face it Fix it' training) to 97% (for Data Security Awareness). Doctors, nurses and healthcare assistants told us they were not all up to date with mandatory training due to a lack of time and capacity for protected time to complete training sessions.
- Each ward had an individual who acted as a training link and who had oversight of a training compliance database. The link person sent an email to any staff members who were due to update mandatory training modules. However, this system had not been successful in ensuring all staff maintained up to date with mandatory training requirements.
- Clinical staff were not required to routinely complete training on recognising and responding to patients with mental health needs.

### Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to recognise and report abuse. However, not all staff had completed the appropriate level of safeguarding training.**

- Nursing staff, medical staff and healthcare assistants had not all received training specific for their role on how to recognise and report abuse. The Nursing division workbook showed that compliance with safeguarding children level three training was 52% and compliance with

safeguarding adults' level three training was 47%. Managers at DMRC recognised this was a concern and were working to improve this.

- No staff within in the division were trained to level four at the time of our inspection, although leaders said there was a plan to train some staff up to this level. Following our inspection we were told that an inpatient consultant had completed the level four adults safeguarding training.
- Staff knew how to recognise safeguarding concerns and were able to give examples of how they would identify adults at risk of, or suffering, significant harm. Staff knew there were named social workers who acted as a key point of contact for specialist safeguarding advice. The social workers in the interdisciplinary team screened every new patient for any safeguarding concerns. Staff also had access to specialist safeguarding leads within DPHC for additional advice and support.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff were aware of their responsibilities. Information about how to raise a safeguarding concern was displayed on a board in each of the ward offices.
- The unit had a chaperone policy and there were posters advising patients of their right to request a chaperone widely displayed around the unit.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

- Ward areas were clean and had suitable furnishings which were clean and well-maintained. Patient rooms had wipeable furniture and were cleaned regularly in accordance with a cleaning schedule by cleaning contractors. The ward manager could identify any issues with the standard of cleaning with the cleaning team, but they reported that they were very happy with the quality of cleaning provided. All clinical storerooms were well organised and clean, and free from items and boxes on the floors. The sluice was clean and organised. All patient bathrooms were en-suite and were cleaned to a high standard.
- The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning schedules were colour coded to identify the frequency of cleaning each area required. Logs of cleaning tasks were kept, and these were fully completed. Cleaner supervisors audited compliance with cleaning schedules monthly and fed back any concerns to cleaning staff. Clinical cleaning quality improvement tools were completed quarterly by ward staff which assessed cleanliness of ward communal areas, patient bedrooms and bathrooms, treatment rooms and sluices. Examples of completed clinical cleaning quality improvement tools provided showed that there was between 89% and 99% compliance on each ward. Any areas of reduced compliance had identified actions to rectify issues.
- Infection prevention and control (IPC) quality improvement tools were completed monthly on each ward by staff in the nursing division. The tool was designed to identify compliance with IPC practices and to identify IPC risk within DMRC Stanford Hall. Examples of completed IPC quality improvement tools provided showed that compliance was between 98% and 100% on each ward.
- Staff followed infection control principles including the use of personal protective equipment (PPE). PPE was readily available in various sizes outside each patient bedroom. There were sufficient hand washing facilities and hand gel stations available. Staff were observed using these regularly and appropriately. Hand decontamination technique posters were displayed

within the ward areas. Hand hygiene and appropriate use of PPE were part of the standards assessed through the use of the IPC quality improvement tool. Staff were bare below the elbow in clinical areas and did not wear stoned jewellery in line with the unit IPC policy.

- There was specialist IPC advice and support available from the divisional OC, clinical director, named IPC leads, the microbiologist, and the Defence DIPC.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff completed cleaning and decontamination care bundle reviews on clinical equipment on each ward. Examples of completed care bundle reviews showed there was full compliance with each element. All re-usable and shared equipment was routinely cleaned as part of pre-user 373 checks, and whenever equipment had been used.
- All patients were required to complete COVID-19 screening prior to admission to reduce the risk of cross infection or outbreak. On admission to the unit, patients had to complete a PCR test and remained in isolation in their room until a negative result was received. All inpatients and staff participated in a track and trace system and completed twice weekly lateral flow tests. Any patients taking weekend leave were required to complete a PCR test on their return and remain in isolation until they received a negative result. There was one patient testing positive for COVID-19 during our inspection and staff had taken appropriate action to isolate the patient and known close contacts of the patient in line with guidance.
- Visitors were not allowed to enter the wards. Any visitors had to be pre-booked in through DMRC and patients with visitors used communal spaces to meet to reduce the risk of cross infection.
- The service had a focussed screening approach for MRSA. This was used in line with local risk assessments to ensure that patients who had been identified as previously MRSA colonised or infected were tested and managed appropriately. The service did not provide any data on Clostridium difficile or Methicillin-resistant Staphylococcus aureus infection rates, but staff told us there had not been any cases for the past five years.
- There were care bundles and staff observation audit tools to ensure that the insertion and ongoing management of peripheral vascular devices, central vascular devices and urinary catheters was safe and complied with IPC guidance. Infection rates for invasive devices were monitored but were rare within the population at risk. Completed audit tools for the management of invasive devices were not available due to the low numbers of patients with these devices in situ. Staff told us catheters and cannulas were removed when no longer needed in line with national and local DPHC guidance.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the design of the environment was not suitable to meet the needs of all patients all of the time.**

- The available inpatient facilities comprised of 224 beds, with 100 of these beds being for use by patients attending the Force Generation service. Beds were split across five available wards although only three wards were in regular use. At the time of our inspection, wards had been combined into one as there was both reduced capacity due to staffing and reduced demand on beds. There were 14 complex trauma patients and 12 neurology patients on the ward at the time of our inspection. In addition, there was one ward for more independent patients which was staffed by healthcare assistants. There was capacity for 28 patients on this ward, although at the time of our inspection there were only five patients on this ward. The ward staffed by healthcare assistants was open from Sunday afternoon to Friday afternoon only as patients returned home at the weekends.

- The design of the environment was not always appropriate for all patients receiving care. All patients were cared for in single en-suite bedrooms which had adjustable height beds, an armchair, over-bed table and a bedside locker. In addition to en-suite shower facilities, there were bathrooms containing baths integrated with a range of mobility and lifting aids. These baths were not in use at the time of inspection due to the risk of patient infection from bath contamination. New baths were on order but there was no time scale for their installation.
- It was recognised that the design of the environment had some flaws that had not yet been addressed. For example, patients who used wheelchairs had to negotiate outward opening doors. Once patients had pressed the keypad to activate the door opening, they had to quickly retreat out of the way as the doors opened towards them. Any patient in a wheelchair with limited ability to use their arms was unable to go out of the ward without being accompanied. This was due to the position of the door keypads being at a height that meant they were unable to access them. This limited their independence as they had to be accompanied by someone who could activate the keypad to open the door.
- Patients all had call bells by their bed, which staff made sure were within reach. Staff responded quickly when called.
- Equipment was safe to use and well maintained. Staff followed equipment care directives and carried out daily service user safety checks of equipment. FMed 373 documents were completed in line with policy for all equipment used by staff. All electrical equipment checked was in date for servicing. Any equipment that was faulty or overdue for service was kept in a quarantine area and clearly labelled to ensure it was not used by staff. There was a Warrant Officer equipment lead on site who had overall responsibility for equipment maintenance. Each division had a named team lead who managed equipment maintenance for that area and ensured it was serviced regularly and in accordance with policy. Specialist maintenance contracts were in place for specific equipment such as plinths and hoists. There were monthly equipment meetings led by the Quarter Master (QM) who was the unit equipment officer. The QM had oversight of all faulty equipment and had responsibility for reporting it and arranging repair. There was some equipment that had been gifted to the unit which did not have a contract for through-life care. Statements of requirements were in the process of being produced to identify suitable maintenance options for these pieces of equipment.
- Staff were trained in the safe use of equipment as part of their induction to the unit. There were regular workshops to upskill staff in safe use of any new pieces of equipment.
- The service had enough suitable equipment to help them to safely care for patients. There were sufficient large care items such as hoists and pressure mattresses. In addition, there was a well-stocked clinical store room on each ward which contained sufficient consumable items for clinical care such as dressings and spare PPE.
- Resuscitation trolleys were available on each ward and were checked regularly. There were daily checks of items on the trolley surface such as the defibrillator and suction unit. The emergency medicines were stored in a tamper proof drawer on the trolley. There was a temperature logger in the trolley drawer to monitor the storage temperature of the emergency medicines. Staff monitored the temperature daily and understood what actions to take if the temperature was outside of the recommended range. The medicines drawer was secured with a tamper-evident tag. The tag number was recorded alongside the earliest expiry date of any equipment. The log of the tag and expiry date was checked weekly and the tag was broken, and equipment replaced before the expiry date was reached. One ward area also had a grab bag and there was a second grab bag held at the main gate. This meant that emergency equipment was available to be taken to the site of any emergency within the unit. In addition, there were 10 defibrillator units across the DMRC and the locations of these was documented in the resuscitation policy. All new members of staff were made aware of the defibrillator locations during their induction.

- Staff disposed of clinical waste safely. Staff placed all clinical waste in orange bags and the cleaning contracting service was responsible for emptying the orange bags into a yellow bin held in the secure cleaning cupboard on each ward. Each bag was labelled with the ward name, the date and time, and the unit postcode. This meant waste could be tracked back to the unit if required. The external waste storage compound was not secure and did not meet regulation standards and this was highlighted on the unit risk register. In mitigation, a system had been developed where the facilities manager removed the clinical waste from the wards to coordinate with the collection day and time of the external waste management contractor. Waste that was collected for was counted and signed out. This meant that clinical waste was not left in an unsecured environment and waste was managed safely.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

- Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Routine observations were not required to be completed due to the nature of the patient group. Patients were only admitted to the wards if they were medically stable. Observations were, however, completed for all patients on antibiotics or any patient feeling unwell. These were recorded on a National Early Warning Score (NEWS) chart and staff followed NEWS guidance to identify how frequently to repeat observations and when to seek medical attention. Staff were aware of the risk of sepsis and followed a sepsis standard operating procedure in the event of suspected sepsis in a patient.
- Staff felt supported by the wider medical team when escalating issues or concerns about patients. Consultant medical staff were available on site Monday to Friday 9am to 5pm and were available on call 24 hours a day seven days a week. Consultant staff were required to be within a one hour drive of DMRC so that they could attend the unit if required. Junior doctors were available on call 24 hours a day seven days a week. Junior doctors were required to be within 30 minutes of DMRC but also had the option to stay on site in accommodation. This meant there was always a duty doctor available who could provide rapid assessment and treatment for any deteriorating patients. If any patient became suddenly acutely unwell a ‘code blue’ call was put out and staff who were trained in immediate and advanced life support attended the patient. All ward staff were required to be trained to a minimum basic life support level and registered nurses to immediate life support standards. The ward sister and doctors were required to be trained in advanced life support. However, data provided in the nursing divisional workbook showed that not all staff were up to date with the required level of life support training. This meant that deteriorating patients who suffered a cardiac arrest may not receive optimal emergency care. However, due to the lack of facilities to support medically unwell patients, there was a policy to phone an emergency ambulance and arrange transfer to a local acute hospital if patients became acutely unwell.
- Staff completed risk assessments for each patient on admission and reviewed them weekly or when appropriate. All patients had risk assessments completed for falls, pressure, malnutrition, manual handling and venous thromboembolism (VTE) on admission. There were specific risk assessment tools for each type of risk, and these followed national guidance. Falls risk and Waterlow scoring were repeated weekly. Malnutrition scores and manual handling plans were updated when appropriate, for example, if their condition changed or they were identified as high risk. Patients who scored high risk for any risk factor had the assessment repeated weekly. Each patient’s risks were considered individually and were reviewed and updated as and when appropriate. VTE risk assessments were documented on patient medication charts and all other risk assessments were held in a secure cabinet. Risk assessments were not

added to the main record system (Defence Medical Information Capability Programme (DMICP)) until the end of the patient episode of care. Where risks were identified, staff completed management action plans to identify care and treatment tasks required to reduce the risk.

- The service had access to specialist mental health support if staff were concerned about a patient's mental health. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.
- Shift changes and handovers included all necessary key information to keep patients safe. Handover template documents were used for sharing information at each shift change to ensure all staff had up to date information necessary to provide safe care.
- All patients were discussed in a weekly interdisciplinary team meeting and a record of discussions was documented in the electronic patient record on DMICP. This meant that a patient's referring medical officer and staff at their local Primary Care Rehabilitation Facility (PCRF) had access to all their care treatment records from Stanford Hall when they were transferred or discharged. Consultants in complex trauma and neurology worked closely with PCRFs and RRUs to make decisions about appropriate timings for transfer of care. Rehabilitation plans were held on DMICP meaning patients could continue their same rehabilitation programme on transfer to their local rehabilitation facility.

### Staffing

**The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels where possible but some staffing roles were not able to be filled due to circumstances out of their control.**

- Staffing data was provided for the nursing division as a whole and covered registered nursing staff, healthcare assistants and medical staff. This data was not broken down by staff type. The service did not have enough staff to keep patients safe. The nursing division had a planned WTE of 96 staff. This included registered nurses, healthcare assistants and medical staff. From February 2021 to January 2022, the average number of actual staff in post was 74.9 WTE. Staffing was identified as a risk on the unit risk register. Staffing issues were a result of both hard gaps due to deployment and sickness. In September 2021 the complex trauma and neurology wards were merged into one ward to try and tackle the staffing challenges. The two wards were still merged at the time of our inspection but there were plans to return to two separate wards imminently.
- Staffing data for Allied Health Professionals working in the nursing division was provided as part of the rehabilitation division as a whole. The inpatient therapy teams sat outside of the nursing division but there were staff in the rehabilitation division who delivered inpatient therapy.
- Managers told us that nurse staffing levels were improving following a recent civilian recruitment drive. Staffing issues were also alleviated by the approval of use of agency staff to fill military gaps.
- Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift. Planned staffing for the combined complex trauma and neurology ward was dependent on the number of patients. At the time of our inspection there were 26 patients in total and planned staffing was two registered nurses plus two healthcare assistants (HCA) on each shift for each speciality. There was an accepted minimum staffing level of three registered nurses and two HCA staff across the ward on each shift if staffing was short. If there were patients of higher dependency staffing levels would be increased to

manage this. On the healthcare assistant led ward planned staffing was dependent on the number of patients. At the time of our inspection there were six patients on the ward and planned staffing of two HCAs on each shift. All wards operated a two shift system of days and nights of 12 hour shifts each.

- Ward managers, clinical leads and the matron monitored nurse staffing levels and moved staff between wards where necessary. In addition, ward managers and clinical leads could cover clinical shifts if staffing was short. Managers told us that if staffing could not be safe then training courses and adventure training would be cancelled to ensure sufficient staff were available to cover clinical shifts. Off duty staffing rotas were completed six weeks in advance so managers could identify if there were any anticipated gaps. There were monthly off duty meetings between clinical leads and ward managers and staffing issues could be escalated to the matron who could make decisions about requesting additional agency staff to fill any anticipated gaps such as long term sickness.
- The service had high vacancy rates. Managers told us that they held between 15% and 20% gapping of military staff at any one time. They reported that each individual military service did not always see the unit as a priority to send staff to cover deployment gaps.
- The service had high sickness rates. Data provided in the nursing divisional workbook showed that out of a total 290 permanent staff days available each month, from May to December 2021 there was an average of 61 sick days. This equated to a staff sickness rate of 21%. Managers explained that the high sickness rates were impacted by the ongoing COVID-19 pandemic.
- The service did not provide data about rates of bank and agency nurses used on the wards.

### Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

- Patient notes were comprehensive, and all staff could access them easily. There was a mixture of electronic and paper records. DMICP was used to record patient reviews by doctors, ward rounds, interdisciplinary team meeting discussions and specific investigations such as blood tests. Nursing interventions such as risk assessments and fluid balance charts were recorded on paper and scanned into DMICP when the patient was discharged or transferred.
- Any paper records were stored securely in a locked trolley which the nurse in charge on shift held the key to and provided access on request.
- Records we reviewed were succinct, clear, dated, timed and signed and written in a professional manner.
- When patients transferred to a new team, there were no delays in staff accessing their records as all information about previous and ongoing care was stored on DMICP which was accessible to staff in patient's local PCRFs.

### Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

- Staff followed systems and processes to prescribe and administer medicines safely. A pharmacist provided advice to optimise the best use of medicines and a pharmacy technician supported the management of medicines. There was an effective decision-making process for prescribing medicines. For example, guidance and advice on prescribing medicines for treating

patients with neuropathic pain had been approved by the Medicines Optimisation Advisory Committee (November 2020).

- Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. A self-administration medicine (SAM) policy was in place and risk assessments were undertaken to determine the level of support required. However, the current risk assessment tool did not fully take into consideration both the patient's capacity in understanding how to manage their medicines and their physical ability to take their medicines. We were informed that there was a gap in the risk assessment tool which had already been identified by the service. We were shown a draft version of an additional risk assessment which was due to be discussed at the next medicine management meeting.
- People who were able to do so were empowered and supported to manage their own medicines to maximise their independence. Patients who could, took responsibility for collecting their own medicines from pharmacy when the doctor had written their prescription. Each room had a lockable medicines cupboard and patients who were able to manage their own medicines signed to take responsibility for the key. This meant they could independently administer their own medicines.
- Staff completed medicines records accurately and kept them up to date. Medicine allergies or sensitivities was recorded on all medicine charts seen. Patient weights were recorded on medicine charts which was important to determine the correct dose of certain medicines.
- Staff stored and managed all medicines and prescribing documents safely. Medicine stocks were appropriately stored and managed in line with policy with access limited to authorised personnel only. Areas where medicines were stored, dispensed, prepared and administered were monitored and maintained. Keys to medicine cupboards were held by authorised staff or by patients for their own medicine bedside locker following a risk assessment. Medicines required in an emergency were available. Tamper evident seals were in use to ensure emergency medicines were readily available when needed and fit for use. Regular checks of emergency medicines and equipment were carried out by staff. Controlled drugs (medicines requiring more control due to their potential for abuse) and controlled drug stationery were managed and stored securely. Three monthly audit checks were undertaken. There were no discrepancies identified at the last audit (March 2022).
- Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The pharmacist checked and reviewed patients' medicines whilst in hospital and ensured the medicines were correct at the point of discharge.
- Staff learned from safety alerts and incidents to improve practice. Staff understood how to report a medicine incident or safety concerns following the service incident reporting policy. Reported medicine safety incidents were discussed at the medicine management committee meetings. Staff told us they received updates about errors or incidents. Staff were able to explain about some recent medicine incidents and the learning that had been undertaken.

### Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not widely share lessons learned with all staff. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

- All staff knew what incidents to report and how to report them. All staff had access to the ASER system for reporting incidents. A log was kept on the nursing divisional workbook of all ASERs reported.
- Staff raised concerns and reported incidents and near misses in line with DMSR policy. Incidents were graded according to their level of harm. Data for the 19 reported incidents from October 2021 to January 2022 showed that all incidents had been graded as low or no harm. Nine of the incidents reported related to medication, six related to clinical administration, two related to patient behaviour, one related to clinical procedures and one about documentation.
- The service had no never events on any wards.
- Staff understood the duty of candour. They explained that they would be open and transparent and would give patients and families a full explanation if and when things went wrong. Staff gave an example of one incident when Duty of Candour had needed to be applied. They explained how an apology had been given to the patient and an investigation had been carried out to identify learning.
- Managers investigated incidents thoroughly. There was a system to monitor the progress of incident investigations. The incident log held on the divisional workbook identified responsible individuals for each incident investigation, updates and incident status, timeframes for completion and the final outcome. Where medication incidents had occurred, managers completed a root cause analysis (RCA). Findings of these were used to identify any required actions to reduce the risk of similar incidents.
- Staff did not always receive feedback from the investigation of incidents once outcomes had been identified. Managers told us that incidents were discussed at heads of department meetings and there was a top down approach to investigating them. However, they described a new process just implemented for the clinical quality manager to attend handover and share incident outcome information with staff. All staff had access to the ASER log through the divisional workbook. Managers said where RCAs were completed, findings were shared with staff by email. However, there was no embedded process for sharing incident outcome feedback with staff meaning there was no opportunity for discussion of the issues so staff could understand them and identify appropriate changes and improvement.
- Staff met to discuss the feedback and look at improvements to patient care. Where incidents had resulted in learning and actions, managers and staff reviewed the need for a quality improvement project to make positive changes. Individual staff took responsibility to lead on these projects and embed learning and change in practice.
- Safety alerts were managed through a hierarchical process and relevant information was cascaded down from the clinical quality manager to ward managers and on to ward staff.

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

## Our findings

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

### Evidence-based care and treatment

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

- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. DMRC is a consultant led unit managed by DPHC who provided guidance for staff to follow to deliver evidence based care. Each professional group of staff had profession specific standards and guidelines which they followed. Nursing staff completed care bundles on admission which were based on national guidance for harm free care. All policies followed were centralised DPHC policy documents to ensure a consistent approach across all rehabilitation services. Additionally, the inpatient team had developed some local standard operating procedures for interventions that were unique to the inpatient service. For example, a protocol for monitoring blood glucose levels had been developed for diabetic patients based on NICE guidelines.
- There was a DPHC standard operating procedure for admission and discharge documentation which was based on national guidance and professional standards of practice. This ensured that all patients at DMRC were assessed using standardised processes and that documentation was consistent and of high quality. Benchmark standards had been identified for admission and discharge documentation and these were assessed through six-monthly audits conducted by the clinical nurse leads. This process provided a framework for measuring the fundamentals of nursing care against best practice guidance.
- Comprehensive and holistic assessments of patient's physical, mental and social needs was provided. At interdisciplinary team (IDT) meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. IDT meetings followed a template for discussing patient's care which included review of patient's mood and psychological wellbeing and any family issues or concerns, alongside their physical health. All patients were discussed at the IDT weekly. Consultants assessed all patients on admission and saw them for review as part of a weekly ward round. All patients had their own bespoke rehabilitation prescriptions which were reviewed as part of the IDT and ward round process and updated as the patient progressed.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.**

- Staff made sure patients had enough to eat and drink, including those with any specialist nutritional requirements. Patients were offered a choice of hot food which they chose from a menu each morning. Meal choices catered for patients with special dietary requirements such as vegan or Halal meals to ensure patient's cultural needs were met. There were protected meal times for each meal and patients were encouraged to take their meals in the communal dining room where possible. All staff were clear about which patients required support with eating and drinking. Named staff were identified to provide this at each meal time. In between

meals there was access to snacks such as fresh fruit, and patients had access to bread and a toaster. Hot and cold drinks were available for patients to self-serve 24 hours a day.

- Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The Malnutrition Universal Screening Tool (MUST) was completed on admission for all patients and reviewed weekly for any patient identified as being at risk. Care plans were completed for patients at risk which included regular weight checks, completion of fluid and nutrition charts and referral to the dietitian for specialist support.

### Pain relief

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

- Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used an initial pain assessment tool with patients on admission and pain scales were used to reassess levels of pain every 12 hours. Where pain was identified as an issue, staff communicated with the medical team to request a pain review. Patients with complex pain could be referred to the specialist pain service for further assessment and pain management advice.
- Patients received pain relief soon after requesting it. Some patients who were assessed as being able to independently self-administer their medicines could access their prescribed pain medication as required from the locker in their room. Patients requiring support with their medicines were able to access prescribed pain medication from nursing staff promptly on request.
- Staff prescribed, administered and recorded pain relief medicines accurately using individual medicines charts for each patient. Any required pain relieving medicines were prescribed by doctors on patient's medicine charts. The charts were signed by staff to record the dose and time of pain relieving medicine administered.

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. However, although there were audit schedules, there was not a consistent approach to sharing and learning from audit findings. We were not assured that systems were in place to use routine audit findings to make improvements and achieve good outcomes for patients.**

- Managers and staff planned to carry out a programme of repeated audits to check improvement over time. The nursing division had an annual schedule of audits with named leads for each audit. Planned audits included aspects of care provision such as IPC, records, medicines management and mandatory training. The schedule enabled recording of when planned audits were completed and the audit outcome score. However, the schedule showed that not all planned audits had been completed.
- Detailed audit outcomes were not provided so we could not be assured that outcomes for patients were always positive or met expectations. There was no evidence of action plans in response to poor audit findings so we could not be sure that managers and staff used audit results to improve patients' outcomes.
- Specific outcome measures were used on an individual patient basis to review individual progress with treatment plans. A range of outcome measures were used on inpatient admission such as anxiety scores, psychometric assessment, injury severity scores, activities

of daily living measures and patient reported outcome measures. However, although these were repeated after an episode of care to measure individual patient progress, they were not collated to review the overall effectiveness of care delivery to the patient group as a whole. Managers told us that there were no measurable standards set for achievement of care delivery to specific patient groups.

- There was no evidence of routine sharing of audit findings with staff on the wards. Clinical lead nurses had the responsibility for completing audits. Most ward staff were not aware of current audits being undertaken and were not actively involved in the audit process.
- There was no evidence that audit findings and patient outcome measures were routinely used to improve the delivery of patient care and treatment.

### Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

- Nursing staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There was a skill mix of registered nurses and healthcare assistants on the wards to ensure patient needs were able to be identified and appropriately met. There were both military and civilian staff who had worked in a range of healthcare settings to enable them to develop appropriate skills.
- Medical staff worked as a team of consultants and junior doctors to meet the needs of patients. Junior doctors said they had unique learning opportunities at DMRC to further develop specialist skills.
- Managers gave all new staff a full induction tailored to their role before they started work. Both nursing and medical staff described how they had received a comprehensive induction to the unit and the ward they were working on. This included the opportunity to shadow colleagues before they fully took on new roles. For military staff who rotated through the unit, there was a cross over period where new staff worked alongside existing staff to enable them to develop the skills and confidence required for the role.
- Managers supported staff to develop through yearly, constructive appraisals of their work. All nursing and healthcare assistant staff we spoke with had received an appraisal within the last year. There was a system for annual appraisals for all staff with a mid year review of objectives. A log was kept of staff appraisals which showed that 100% of staff in the nursing division were in date for their appraisals. The appraisal process gave staff the opportunity to discuss training needs with their line manager. However, the appraisal process for medical staff was different; doctors who were appraised as part of the strategic command appraisal and revalidation process. DMRC did not keep records of medical staff appraisals so could not be assured they were completed in between revalidation periods
- Clinical supervision was available to nurses and healthcare assistants. Group sessions were offered monthly to all staff across the nursing division but were not mandatory. Staff could also request a one to one supervision session with the ward manager if they wanted to discuss particular issues or concerns. Physiotherapists, Occupational Therapists and ERIs received support from professional lead advisors who they could request supervision sessions from. There was a gapped professional lead advisor post for social workers at the time of our inspection, but they usually had access to this support. All therapy staff have access to supervision through a cascade system within the teams, which was documented locally and confidentially between supervisee and supervisor. In addition, physiotherapists used peer review and joint working as a further method of continuing professional development.

- Managers made sure staff received any specialist training for their role. Practice development nurses worked with nursing staff to support their learning and development needs. Nurses completed self assessments of their competency levels with a range of core competencies identified in a knowledge framework document. Staff were supported in achieving the required competency levels by the practice development nurses and clinical leads who led clinical skills training sessions
- Staff were given the time and opportunity to develop their skills and knowledge. In addition, external providers visited the unit to provide specialist training sessions such as a spinal study day, intravenous medicine updates and management of stomas. The ward had an education board which was updated monthly by a member of nursing staff. The board provided a display of key information to share with all staff and a brief training session by the nurse who had developed the board that month.
- Junior doctors said they found the working environment very supportive and had easy access to the consultants for advice, support and supervision. They had protected time to complete continuous professional development activities such as attending specialist clinics and in-house training twice a week.
- However, it could be difficult for staff to access funding to undertake external courses specific to their professional roles. Military nursing staff could apply for funding for specialist training but told us the process was long and often unsuccessful. Managers explained that a training needs document had to be submitted in advance for the year ahead. Upcoming relevant courses were not always known about in advance so were not always able to be identified on the training needs request. If courses weren't listed on the training needs document, then staff could not access funding to attend these courses. Civilian staff could apply for course funding through DPHC and there were currently two civilian nurses undertaking Masters degree programmes.
- Managers did not always make sure all staff attended team meetings. Staff meetings at ward level were not routinely held in the service. Where meetings were held minutes were not routinely recorded, meaning staff did not have access to full notes when they could not attend meetings. Leaders told us that the lack of consistency in staff meetings at ward level had been recognised and was being addressed. However, therapy staff did routinely attend team meetings within the rehabilitation division; minutes of these meetings were taken and shared with staff.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

- Staff held regular and effective interdisciplinary meetings to discuss patients and improve their care. There was a strong multidisciplinary approach to care and rehabilitation across the unit. The multidisciplinary team (MDT) included doctors, nurses, therapist, exercise rehabilitation instructors, psychologists and social workers. The team followed a template to facilitate a holistic discussion about each patient's care. Decisions about ongoing care and treatment were made jointly as a team. Plans were then discussed with patients during the ward round to ensure they were involved and agreed with plans for their future rehabilitation.
- There was, however, a disconnect between the nursing and therapy staff on the ward, with therapy being seen as an activity that happened off the ward. Patients attended therapy sessions in the designated gymnasium areas or hydrotherapy pool. It was not routine for nursing staff to accompany patients to their therapy sessions. Nurses told us that therapy was not embedded into the daily ward activities. There were some therapy activities which took place on the ward for those patients who were more dependent. Therapists sometimes

involved nurses in this therapy, for example, teaching nurses how to use standing frames in order that patients could continue to use them over the weekend. Managers recognised that communication and joint working between nursing and therapy staff could be improved. They described the nursing division as running alongside the rehabilitation division rather than the two divisions being fully integrated in their approach to patient care.

- Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Please see the PWS report for more detailed findings of mental health support available to inpatients.
- Medical staff completed a mental health assessment with patients on admission. If mental ill health concerns arose with a patient, the MDT could refer to the psychological welfare service for additional support. The service could arrange for transfer out to a more appropriate setting for any patients experiencing an acute mental ill health crisis.
- Patient care was consultant led and they attended the IDT meetings and led the ward round. Consultants were therefore always up to date with a patient's progress and able to adapt their care plan accordingly.

### Seven-day services

**Some, but not all, key services were available seven days a week to support timely patient care.**

- There was seven day access to medical cover with the junior doctors providing on call cover 24 hours a day seven days a week. Most new patient admissions happened on Mondays and patients were clerked in by the junior doctor. Consultants aimed to review patients on the day of admission or within 24 hours at most. Consultants were available on an on call rota for advice and support to the junior doctors and nursing team.
- Staff could call for support from other disciplines, including Allied Health Professionals, pharmacy and diagnostics. However, all services were not available 24 hours a day, seven days a week. Therapy staff, pharmacy and diagnostic staff provided input to the wards from Monday to Friday only and not at weekends. Leaders explained that there was no requirement for therapy to be available seven days per week as rest periods needed to be factored in during the intensive rehabilitation programme. Weekends were often used to facilitate home or family visits which was a fundamental part of the rehabilitation approach.

### Health promotion

**Staff gave patients practical support and advice to lead healthier lives.**

- The service had relevant information promoting healthy lifestyles and support on wards. There were notice boards displaying a range of health promotion information for patients.
- Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Any specific or additional support needs for patients were identified during the admission process.
- National priorities such as smoking cessation were supported. Some of the nursing staff were trained in smoking cessation support and if patients were interested in this, support could be provided. Patients who wished to start on the programme were supported with nicotine replacement products provided on prescription from the ward doctor.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.**

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff were experienced in working with patients with complex injuries which may impact on their capacity to provide consent. If there was any concern about a patient's capacity to provide consent, nurses would ask the team to complete a capacity assessment.
- Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff asked patients for permission to perform personal care tasks or rehabilitation. Doctors were observed asking for consent to assess patients during ward rounds. We saw that consent to care and treatment was documented in patient records.
- When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Each patient's capacity to consent was recorded during their initial treatment planning meeting following admission. Capacity was reviewed as necessary during interdisciplinary meetings and a best interests decision making process was undertaken by the team where patients could not provide consent. The whole team, including the patient's family, carers or friends would be involved in the decision making process.
- Staff made sure patients consented to treatment based on all the information available. We observed doctors taking time during the ward round to explain different treatment options to patients, including risks and benefits of these, so that patients could make an informed choice.
- Staff told us they had received Mental Capacity Act (MCA) training. However, data provided by the unit to evidence compliance with this training showed that only 62% of required staff in the nursing division had completed this training.
- Staff fully understood the Deprivation of Liberty Safeguards (DoLS) process and used it for any patients who were unable to consent to being an inpatient in the service. They used appropriate documentation to apply for DoLS when required. Staff knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

# Are services caring?

## Our findings

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

### Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. Patients were encouraged to be as independent as possible, but staff made it clear that support was readily available as required. Patients were happy to approach staff when assistance was required. We observed appropriate and respectful conversations between staff and patients. Staff built up a rapport with patients quickly. The consultant had a good rapport with patients during the ward round which made them feel relaxed and reassured.
- There were displays of staff photographs with names and roles on each ward to help patients familiarise themselves with those staff involved in providing their care.
- Patients said staff treated them well and with kindness. They described staff as ‘very caring and supportive’. They said that staff understood their needs and communicated with them well. One patient said all staff provided good care and were very skilled in their roles.
- Staff followed policy to keep patient care and treatment confidential. Ward round conversations were held with patients in individual rooms to maintain confidentiality. All records of patient care were kept securely to maintain confidentiality.
- Patient privacy and dignity was respected. All personal care tasks were carried out in patients individual en-suite bedrooms. Having single occupancy rooms ensured patient’s privacy and dignity was always maintained.
- Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Patients explained that staff took time to understand their needs and personal goals and worked together with them to improve their recovery. All patients had an individualised rehabilitation timetable which detailed all their multidisciplinary treatment activities based on the goals they had agreed with staff. Doctors were keen to understand the impact of a patient’s condition on both their work life and general well-being. Ward round conversations focused on what the patient wanted to achieve from their inpatient stay.

### Emotional support

**Staff provided emotional support to patients to minimise their distress. They understood patients' personal, cultural and religious needs.**

- Staff gave patients help, emotional support and advice when they needed it. There were a range of wellbeing and mental health services that staff could signpost patients to. Staff supported patients to manage their emotional needs and understood how emotional trauma and distress could affect engagement with rehabilitation and jeopardise a patient’s ability to

make a full recovery from injury. All staff attended a training session on wellbeing, resilience and stress as part of the DPHC mandated training.

- Staff responded to patients who were experiencing pain quickly and effectively. Patients requiring pain relieving medicines could access these without delay. Exercise programmes were adapted when patients were in pain and staff demonstrated empathy and understanding of the impact of pain on patients. One patient gave an example of how staff had provided very good pain management for their subluxed shoulder.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. These were respected during their inpatient stay and patients could access special diets or multi faith prayer facilities if required. All patients and staff had access to padres and world faith chaplains for support.
- Staff communicated with patients in a way that they would understand their care and treatment. They used language they could understand rather than jargon and checked patients understanding of what had been said.
- Patients told us there was good fatigue management built into the rehabilitation programme. Staff recognised that patient's experienced fatigue as a result of their condition and made sure there were sufficient opportunities to rest between rehabilitation activities.

### Understanding and involvement of patients and those close to them

**Staff supported patients to understand their condition and make decisions about their care and treatment. However, patient's family and carers were not widely involved in decisions about their care.**

- Staff made sure patients understood their care and treatment and took time to explain all planned care and treatment to patients. Treatment planning meetings were held with patients soon after admission to discuss and agree the planned programme of care and rehabilitation. After each weekly interdisciplinary team meeting, patients had individual ward round appointments with the consultant to discuss their care. This was an opportunity for patients to ask questions about their rehabilitation and future plans for care and treatment. However, friends and family were not actively involved in treatment planning as visitors were not allowed on the ward at the time of our inspection. This was since DMRC had been designated a Covid secure site. There was some restricted visiting allowed outside of clinical areas by pre-arrangement. Although visiting was restricted, family were contacted when discharge planning conversations were held in interdisciplinary meetings to ensure their views were considered.
- Staff supported patients to make informed decisions about their care. Patients were at the centre of all decisions made about their care. On a daily basis, patients who required support with care were encouraged to make choices about how and when this was delivered. Patients were given control over their day to day care choices. Consultants took time to explain the different treatment options so that patients fully understood the impact of different choices and could make a decision based on all the available information.
- Patients and their families could give feedback on the service and their treatment. Clinical leads told us that all patients were invited to complete friends and family style feedback after each admission. This data was returned to the clinical quality manager who reported it to the Headquarters for Defence Medical Services in a bi-annual Governance, Performance, Assurance and Quality report. However, this report was not routinely shared with ward staff or matrons and clinical leads. Return rates for the feedback questionnaire were low. Data provided from February 2021 to February 2022 was based on feedback by nine inpatients. Feedback was overall very positive, and all nine patients said they would recommend the

service to their friends and family. Seven of the nine patients rated their experience at DMRC as excellent and the other two rated it as good.

- Patients gave positive feedback about the service. Patients we spoke with were very complimentary of the care given, the facility, and the resources available. They were very pleased with the time available for them to discuss their condition and rehabilitation with staff. They felt they had easy access to consultants when they had specific medical concerns. All patients were very complimentary about the holistic and multidisciplinary approach to rehabilitation. Patients felt the service was very caring and staff were dedicated to helping patients achieve their maximum potential.

# Are services responsive to people's needs?

## Our findings

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

### Service planning and delivery to meet the needs of the population at risk

**The service planned and provided care in a way that met the needs of the population at risk. It worked with other facilities in the wider DPHC system and NHS to plan care.**

- Managers planned and organised services so they met the changing needs of the population at risk. The number of beds used could be flexed in accordance with demand. There was the capacity to open a total of 224 beds if necessary. Since the unit had opened, there had been a change in the focus of injury type. There were reducing numbers of battle injuries and increased non-combat injuries. There was also a need to provide rehabilitation from Covid-related illnesses. The unit was able to increase or decrease the amount of beds and wards open in order to match the specific demand on the services.
- The unit had been set up to provide different specialisms of care on separate wards. There was a ward for patients with neurological disorders and one for patients with complex trauma injuries. In addition, there was a healthcare assistant led ward for more independent patients who no longer required specialised care. There was a plan to further adapt the inpatient service delivery to better meet the changing needs of the population at risk. A dependency model was planned where patients would be grouped on wards according to the level of dependency of the care and treatment requirements.
- Facilities and premises were appropriate for the services being delivered. There were adequate numbers of beds all provided as single use en-suite rooms. There was a wide range of state of the art rehabilitation facilities in dedicated gymnasiums and the hydrotherapy area. Individual clinic rooms were available for confidential assessments and consultations.

### Meeting people's individual needs

**The service was inclusive and took account of patients' individual needs and preferences. They coordinated care with other services and providers.**

- Staff recognised when patients had additional communication support needs. For example, when a patient had difficulty understanding as English was not their first language, the doctor used analogies and diagrams to aid their understanding of their care options. Interpreting services were also available if required. Speech and Language Therapists supported patients with communication difficulties as a result of their illness or condition. They worked with patients and ward staff to ensure appropriate communication tools were used where required to enable patients to be understood and understand.
- Wards were designed to meet the needs of patients living with disabilities. Corridors and doorways were wide enough to accommodate wheelchair users and there were keypads on doors to enable automatic opening.

## Access and flow

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to arrangements to admit, treat and discharge patients were in line with service targets. Staff coordinated transfer of care with other services and providers.**

- Patients were able to access inpatient beds for rehabilitation in line with targets set. The latest data for waiting times for inpatient admission was provided for the period from April 2021 to June 2021. This showed that 80% of complex trauma admissions and 100% of neurology admissions were within 30 working days of the date of decision to admit. These met the target which was 75%. There was a combination of factors that limited clinical capacity at the time of our inspection, including social distancing restrictions and staffing availability across nursing and therapy teams. Staff told us that capacity to admit inpatients was usually dictated by therapist capacity which was limited. For example, at the time of our inspection, the Occupational Therapy team had capacity for up to 12 neurology patients.
- Referrals for inpatient admission for neurological rehabilitation were able to be received from the Royal Centre for Defence Medicine, consultants in the NHS and medical officers at PCRFs. Referrals for admission for complex trauma rehabilitation were triaged by the consultants and either streamed to an MDT review clinic or directly for admission. Staff at the unit held weekly admissions meetings to review all referrals. Doctors, nurses, therapists, and the bed manager attended these meetings in order to make admission decisions. All new referrals were reviewed for appropriateness and previous admissions were discussed to agree an appropriate timescale for patients to be admitted. Patients needed to be medically stable before they were admitted to DMRC and to have completed all their acute episode of care treatment in order to meet the admission criteria. All referrals were discussed at each weekly meeting to review their readiness for admission.
- Managers monitored waiting times to make sure patients could access services when needed and within agreed target timeframes. Waiting times for inpatient admission were reported to the Directorate of Defence Rehabilitation who collated them in a dashboard of performance information for all defence rehabilitation facilities. The dashboard was shared with all defence rehabilitation facilities.
- There was flexibility in how inpatient rehabilitation was delivered. Patients usually had a cycle of admissions for rehabilitation, starting with an initial admission for six weeks of assessment. Following this in complex trauma, cycles of three week admissions and three weeks rest were planned. However, all patient admissions were tailored to meet individual needs and if patients required longer admission periods this was accommodated. Patients would remain as inpatients for as long as they required care.
- Managers and staff worked to make sure that they started discharge planning as early as possible. Discharge planning conversations were started on the day of admission. Treatment planning meetings held at the point of admission to the unit set out expectations for length of stay for patients. Patients had a named keyworker who communicated any discharge plans discussed during treatment planning meetings to ensure patients were involved in their discharge planning.
- Staff planned patients' discharge carefully, as most patients had complex needs. The interdisciplinary team considered patient's physical and mental health needs and social care needs when planning for discharge from the inpatient service. They ensured that all care, support and equipment was in place before patients were discharged home.

- Staff supported patients when they were referred or transferred between services. Patients were fully involved in interdisciplinary team decisions around their transfer of care or discharge from the unit. There were meetings between NHS providers and Stanford Hall to facilitate patient's transfer of care back to the NHS. There were strong links between RRUs and PCRFs and there was regular communication about patient's progress and ongoing rehabilitation needs when they were discharged from the unit. Patients who required a particular level of care were not discharged into civilian life unless an appropriate level of care could be provided by other services. This was achieved through close liaison between the consultant and external agencies such as the civilian GP, the patient's clinical commissioning group and NHS armed forces commissioning. This process could be lengthy but patients were not transferred or discharged until all appropriate care was in place.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared outcomes with patients. However, learning from complaints was not always shared widely with staff.**

- Patients, relatives and carers knew how to complain or raise concerns. Patients were given information about how to complain during the admission process.
- The service clearly displayed information about how to raise a concern in patient areas. There was an information board on each ward which gave advice on the complaints process.
- Staff understood the policy on complaints and knew how to handle them. There was a designated member of staff who was the lead for patient complaints. They were supported by ward managers who acted in complaints champions roles. There was a local complaints policy which referenced and followed the DMS policy for complaints. The policy clearly outlined roles and responsibilities for managing the complaints process.
- Managers investigated complaints and identified any themes. A log of all complaints was recorded on the divisional workbook. All complaints were investigated by a named lead and findings were recorded which included actions taken and lessons learnt. Staff aimed to complete investigations within 15 working days.
- Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Letters to acknowledge receipt of complaints were sent to patients within two days. Following investigation there was a meeting to review findings and then a decision letter was sent to the patient with the outcome and findings of the investigation.
- Managers did not widely share feedback from complaints with staff. However, learning identified was used to improve the service. All complaints, whether written or verbal, were recorded on the divisional workbook which could be accessed by all staff. Senior staff took responsibility for complaints investigations, but ward staff did not always receive information about outcomes of complaints investigations; this was recognised as a gap. It was planned to use staff meetings and handovers to routinely share any learning from complaints with all staff. Clinical leads explained that Quality Improvement Projects (QIPs) had been completed when learning was identified from complaints investigations. They gave examples of when QIPs had led to actions to embed learning and make service improvements.

# Are services well-led?

## Our findings

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

For more detailed findings on well-led please see further information in the Force Generation Unit section.

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.**

- The nursing division was led by a commanding officer who was supported by a deputy divisional OC (DOCN), a clinical quality manager and a matron. Practice development nurses, clinical lead nurses and a bed manager reported to the DOCN and matron. There were Officers in Command and 2ICs for each ward who reported to the clinical lead nurses. Managers had completed various management and leadership training to ensure they had the skills for the role.
- Staff felt that managers at divisional level were visible and approachable. They described how they regularly visited clinical areas and made time to check in with ward staff.

### Vision and Strategy

**The unit had a vision for what it wanted to achieve and a strategy to turn it into action. There was a divisional vision and objectives.**

- There was a clear vision and mission statement for DMRC as a unit with three strategic priorities. These were underpinned by unit objectives. The nursing division had developed a local vision and objectives which supported those of the unit.
- Staff were aware of the vision; we saw posters with the local vision statement displayed. Staff had been involved in the development of the vision statements within the division.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. However, there was a notable division between military and civilian personnel.**

- Staff described the OC for the nursing division as very supportive. All staff feel proud to work at DMRC; some staff had requested to work there and all staff we spoke with were happy to have been posted to this location. Staff said that it was a very rewarding place to work.
- There was a hierarchical system of support where junior staff could seek support from senior clinical staff and senior staff could seek support from managers and leaders.
- There was an emphasis on staff wellbeing and safety. There was a health and wellbeing committee who provided education and health promotion activities across the unit. There was

good welfare support to staff including access to a padre, an employee assistance helpline and access to the unit's grounds, gymnasium and pool facilities at lunchtimes or after work.

- Staff could raise any concerns and said they felt listened to. There was a whistle blowing policy and staff were aware of how to access support if required.
- Staff and managers recognised that there were some cultural differences between military and civilian personnel. This was resulting in some strained working relationships between the two staff groups which was impacting on morale for some staff.

### Governance

**Leaders did not always operate effective governance processes. Although there was a programme of audit, there was no system for sharing audit findings and using them to improve practice. Feedback from incident and complaint investigations was not widely shared with ward staff. However, there were systems in place for managers to regularly meet, discuss and learn from the performance of the service.**

- There were a range of DPHC policies based on national guidance which staff followed at DMRC. In the nursing division there was a first look folder where new SOP's were printed and available to all staff. There was a process for staff to sign to say they had seen and read the documents. NICE guidance was provided via the DPHC newsletter which all staff had access to.
- There were a range of clinical governance meetings at unit level. Within the nursing division there was an inpatient forum led by the officer commanding for the nursing division. Departmental managers met as a group across the divisions to review processes, share knowledge and collaborate. Information from both these forums fed into command board meetings and Healthcare Improvement and Quality committee meetings. These unit level meetings reviewed governance issues including e-CAF domains, risks, staffing and complaints.
- There was a nursing divisional workbook which covered all elements of the governance frameworks and was available electronically for all staff to view.
- There was a programme of local clinical audit which was led by senior nursing staff. Ward staff were not routinely involved in the audit process. Audits completed were a data collection exercise but there was no completion of the audit cycle to demonstrate that findings were used to drive improvement. There was no process for routinely sharing audit findings with ward staff and most staff we spoke with were unaware of what audits took place on their ward. There was no consistent process for sharing other performance information with ward staff. Findings from complaint and incident investigations was only shared with staff on an ad-hoc basis. There was a new process being developed to provide a mechanism for sharing this information with staff, but this was not yet fully embedded.

### Management of risk, issues and performance

**Leaders and teams did not always use systems to manage performance effectively. However, there were processes to identify and escalate relevant risks and issues with identified actions to reduce their impact.**

- Overall service performance information was recorded in the nursing division workbook, such as incidents, complaints, and training compliance. There were systems in place to monitor and record these. However, clinical performance data, for example about harm free care, was not routinely collated, recorded or reported. Although there were care bundle review tools available, results from completion of these were not routinely audited and shared. This meant

that there were not embedded systems to monitor and share clinical performance within the division.

- Everyone had a responsibility for risk management. When staff identified a clinical risk they highlighted it to management leads who reviewed the risk and added it to the divisional workbook. The officer commanding was the risk owner for clinical risks and worked with the relevant ward manager to assess, score, mitigate and monitor any identified clinical risks. All actions to manage risk were logged on the divisional workbook. At the time of our inspection there were five active risks on the divisional risk register. As everyone had access to the divisional workbook, all staff were aware of key risks. Risks were reviewed and discussed at departmental managers meetings.

### Information Management

- See Force Generation report for information under this sub-heading.

### Engagement

- See Force Generation report for information under this sub-heading.

### Learning, continuous improvement and innovation

- See Force Generation report for information under this sub-heading.

# Are services caring?

## Our findings

**We found that this service was not safe in accordance with CQC's inspection framework**

### Assessing and responding to patient risk

**There were processes in place to ensure the right person received the right imaging procedure or radiological scan at the right time. However, some documentation was missing and referred to previous IR(ME)R legislation.**

- The service checked three points of identification and used the society of radiographers pause and check guidance. The department had employer's procedures as required by IR(ME)R 2017 and these were reviewed and updated by the lead radiographer and the medical physics expert. However, there were some documents with incorrect references to previous legislation and three of the required documents were not present.
- Patient questionnaires were used to ensure they did not have metal implants or shrapnel before they were safe to enter the MRI scanner.
- The service had a policy designed to identify the deteriorating patient and guidance for escalating treatment and care.
- The service had an imaging reporting policy which included communication of critical, urgent and unexpected significant radiological findings.
- The service had named staff fulfilling the essential roles of radiation protection advisor (RPA), medical physics expert (MPE), and radiation protection supervisor (RPS). Staff said the RPA and MPE were readily accessible online or through over the telephone for providing radiation advice.

### Safeguarding

**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.**

- Staff had training on how to recognise and report abuse and they knew how to apply it.
- All staff had completed safeguarding adult and children levels one and two training. One of the clinical leads had completed safeguarding level three training. Staff had a good understanding of when they would need to report a safeguarding concern.
- We reviewed the service's safeguarding policy, this detailed what to do in the event of a safeguarding concern and reflected the service's obligations under safeguarding legislation.

- There were processes in place to ensure the right person received the right imaging procedure or radiological scan at the right time. The service checked three points of identification and used the society of radiographers pause and check guidance.

### Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

- Staff received and kept up to date with their mandatory training. Training was delivered as a mix of face to face and e-learning modules.
- We were assured that staff working with radiation had appropriate training in the regulations, radiation risks, and use of radiation. Staff could provide evidence of training and were aware of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 Employers Procedures. No specific IRR or IR(ME)R training was given to staff but during overseas deployment training was given predominantly on occupational radiation protection.

### Staffing

**The service did not have enough staff. Managers regularly reviewed and adjusted staffing levels where possible but some staffing roles were not able to be filled.**

- Staffing figures provided prior to the inspection were not consistent. Planned versus actual staff in post as a February 2022 demonstrated a 50% gap in actual staff numbers. However, vacancy information to the end of January 2022 indicated just one WTE vacancy in radiology for an admin staff member.
- We were told by some staff that it was a challenge to be able to recruit diagnostic staff into the service.

| Core Service | Staff group | Planned - WTE | Actual - WTE |
|---|---|---|---|
| Diagnostics | Radiographers | 4 | 2 |
| Diagnostics | RDA Band 3 | 1 | 1 |
| Diagnostics | Admin | 3 | 1 |
| **Total** | **Total Staff** | **8** | **4** |

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

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

- The service had infection prevention and control (IPC) policies and procedures in place which provided staff with guidance on appropriate IPC practice; for example, communicable diseases and isolation.

- Staff followed infection control principles including the use of personal protective equipment (PPE).
- We observed staff to be compliant with best practice regarding hand hygiene, and staff were noted to be bare below the elbow. There was access to hand washing facilities. We observed staff washing their hands using correct hand hygiene techniques before, during and after patient contact.
- Hand sanitiser gels were available in reception and in all rooms. Information charts about hand hygiene were displayed throughout the service. The service met National Institute for Health and Care Excellence (NICE) QS61 statement 3: People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care.
- Subject to quarterly audits looking at clinical and waiting areas. Results from clinical cleaning audits were all compliant (90% or over) with the exception of the imaging department in quarter 3 where issues were identified related to debris and dust on floors, ledges and limescale on some taps.

| Department | Quarter 1 | Quarter 2 | Quarter 3 |
|---|---|---|---|
| Imaging | 96% | 95% | 89% |

*(Source: DMS provider information return – P9 Clinical cleaning audit)*

- Sharps disposal bins (secure boxes for disposing of used needles) were located across the service which ensured the safe disposal of sharps, such as needles. They were all clean and not overfilled. We saw labels were correctly completed to inform staff when the sharps disposal bin had been opened.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

- The service had enough suitable equipment to help them to safely care for patients.
- The design, maintenance and use of facilities and premises prevented patients from avoidable harm.
- Maintenance and use of equipment protected patients from avoidable harm. Equipment we looked at had an up-to-date service record which provided information on when an item was due to be serviced. Quality assurance tests were routinely carried out in line with professional body guidance.
- There were arrangements in place to restrict access and control the area where there was ionising radiation or high magnetic fields. We saw warning signs on the door which explained safety rules.
- Resuscitation equipment was readily available and easily accessible. We saw daily and weekly checks were carried out which confirmed the equipment was safe and fit for use. There were procedures in place for the transfer of a patient from the MRI scanner in the case of a medical emergency.
- Equipment used in the MRI department was clearly labelled to show where it was safe to take into the scanning room in line with MHRA guidelines.

- Equipment procurement was managed by primary defence services and not radiology. Staff told us equipment procurement was not overseen by radiology specialists and for this reason the best equipment for the service was not always procured.

### Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

- Records were stored securely.
- Patient notes were comprehensive, however staff told us that patient's previous medical history was sometimes difficult to access remotely and could only be accessed by the radiology lead locally.

### Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

- Medicines were rarely used by the service. We found medicines to be stored securely and in date, and the administration of medicines recorded in both the patient records and in the log of medications. The service did not store or administer any controlled drugs. Medicines were administered and secured in accordance with the medicines policy of the provider.

### Incidents

**The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

- Staff raised concerns and reported incidents and near misses in line with the service's policy.
- Staff received feedback from investigation of incidents, both internal and external to the service.
- Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where appropriate.
- Staff told us they completed an incident form for every adverse incident, clinical and non-clinical, accident or near miss.
- There was evidence that changes had been made as a result of an incident investigation. For example, following a local IT failure.
- Where a patient received an accidental or unintended dose of radiation advice was sought from the MPE. No incidents had occurred requiring notification to the CQC of patient radiation exposures in the previous 12 months.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

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

## Our findings

**We don't rate the key question of effective in Diagnostic services**

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.
- We reviewed policies, procedures and guidelines produced by the service. These were based on current legislation, national guidance and best practice, these included policies and guidance from professional organisations such as National Institute for Health and Care Excellence (NICE), as well as the Royal College of Radiologists and the Society and College of Radiographers (SCoR).
- Referral guidelines were available online to staff requesting imaging. The guidelines adopted were evidence-based guidance and best practice.
- Staff were aware of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17). There were local rules (IRR) and employer's procedures in place IR(ME)R) which protected staff and patients from ionising radiation.
- An audit of radiation protection arrangements was carried out at the service by the radiation protection adviser. The audit reviewed the service's departmental procedures, protocols and practices against the legislative requirements and associated guidance. and found the service to have good compliance overall with minor gaps which had associated actions.
- The provider's policies and procedures were subject to review by the radiation protection advisor (RPA) and the medical physics expert, in line with IR(ME)R 2017 requirements. The service applied the Public Health England guidance on National Diagnostic Reference Levels when setting their local DRLs. There was also a programme of local audits in place to monitor radiation safety.
- Senior staff informed us that the quality of imaging referrals was not always sufficient due to the omission of clinical information. This meant staff were not always able to justify the exposure effectively.

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

- The service participated in clinical audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and these were monitored appropriately.
- Radiation doses patients received were audited on a two-yearly basis. Results were compared to national diagnostic reference levels.

- There was no peer review of imaging or any formal double reporting, however, the managers received feedback from radiologists concerning image quality where appropriate. Radiologists did participate in audit within their own NHS trust. Opportunities for error audits and feedback were limited at DMRC due to the lack of availability of previous imaging and low rates of repeat imaging.

### Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.
- Managers gave all new staff a full induction tailored to their role before they started work.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.
- Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.
- Managers made sure staff received any specialist training for their role.
- All eligible staff had had their professional registration checked every six months. All radiographers were registered with their professional body, the Health and Care Professions Council and met the standards to ensure delivery of safe and effective services to patients.
- Clinical staff were required to complete continued professional development (CPD) to meet their professional body requirements.
- We were assured staff working with radiation had appropriate training in the regulations, radiation risks, and use of radiation. Staff were aware of the Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17).
- The lead radiographer received training on the equipment by the applications specialists, who cascaded the training to other staff. Records seen on inspection demonstrated adequate training had been carried out.

### Multidisciplinary working

**Staff worked together as a team to benefit patients. They supported each other to provide good care.**

- There was good multidisciplinary team working between staff to delivery patient services. However, this was sometimes more challenging depending on the seniority of the individuals and whether they were military or civilian. Some staff we spoke with stated they were not always able to challenge more senior staff when being asked to manage demand and work as a team.

### Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Patients were consented correctly prior to their procedures, and information was available about procedures.**

- Scan safety consent forms were completed by all MRI patients prior to their scan, to record the patients' consent. These also contained patients' answers to safety screening questionnaires.

- Procedures were in place to support staff in providing information to patients on the benefits and risk of ionising radiation before their examinations. Posters and written material were also available to support patients in making decisions.
- Verbal consent was obtained for X-ray and DXA examinations.

# Are services caring?

## Our findings

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

### Compassionate care

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

- Staff followed policy to keep patient care and treatment confidential.
- Staff understood the impact that patients' care, treatment and condition had on wellbeing.

### Understanding and involvement of patients and those close to them

**Staff ensured that patients were involved in decisions about their treatment.**

- A procedure was in place to support the optimisation of radiation doses to carers or comforters who accompany patients during examinations.
- Staff communicated with patients, so they fully understood their care and treatment options. Patients were actively involved in their care, and this was reflected in the patient records we reviewed.
- Patients were given time to ask questions before and after their scan and staff provided clear information in a way that was easy to understand.

# Are services responsive to people's needs?

## Our findings

**We found that this service was not responsive in accordance with CQC's inspection framework**

### Service delivery to meet the needs of local people

**The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.**

- Facilities and premises were appropriate for the services being delivered. There was sufficient comfortable seating, toilets and a water fountain.
- The service provided planned diagnostic treatment for patients on referral.
- Patients were provided with appropriate information about their visit including an explanation of procedures, frequently asked questions, and directions to the waiting area of the service.

### Meeting people's individual needs

**The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers but referral quality was an issue which impacted upon the capability of the service.**

- Senior staff informed us that referrals were often incomplete and of poor quality with omission of relevant patient history including previous imaging and results from other diagnostic tests, this meant we were not assured that imaging could not always be undertaken in a timely manner.
- There was sufficient space in the examination rooms for staff and patients to move and for scans to be carried out safely.
- Visitors had access to water in the waiting areas. They also had access to information about the service.
- Patients were given ear defenders and/or ear plugs in line with MHRA guidelines when undergoing an MRI scan.
- The service provided disability access for patients with limited mobility.

### Access and flow

**People could access part of the service when they needed it and received the right care promptly. However, there were delays due to staff availability for MRI scans.**

- A walk-in service was available for X-ray examinations. However, staff told us at times the demands for these X-rays compromised other clinics due to staff availability.

- MRI and DXA examinations were by appointment only. The waiting time for an MRI scan is up to two weeks due to staffing availability for the service.

# Are services well-led?

## Our findings

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

For more detailed findings on well-led please see further information in the Force Generation Unit report.

### Vision and Strategy

**The service did not have a vision for what it wanted to achieve or a strategy to turn it into action, developed with all relevant stakeholders.**

- The service outlined their aims and objectives in their statement of purpose. Their aim was to provide high standards of diagnostic imaging to meet the needs of referrers and their patients.
- The service did not have a specific vision or strategy document. Staff were able to articulate what they wanted the service to be and how they wanted to achieve this. However, nothing had been formalised into a vision and strategy.
- Senior staff discussed business development and strategy and the way in which they planned to expand the service but this was not recorded.

### Governance

**Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

- The service was overseen by a defence radiology specialist board. We saw evidence of the board ratifying local procedures.
- The medical physics service undertook a radiation protection specific regulatory audit two-yearly. In November 2020, 11 minor recommendations were made to improve regulatory compliance with radiation regulations.
- The service had systems to monitor the quality and safety of the service. The use of audits, risk assessments and recording of information related to the service performance was to a high standard. The service completed regular clinical audits and adapted service delivery in response to the results or outcomes.
- The provider disseminated information to staff in team meetings or through email. These included minutes of meetings, updated or new policies, changes in legislation or best practice, and service developments.
- Staff were clear about the governance structure in the organisation through team meetings and stated they were confident the systems in place supported the delivery of clinical care.

### Leadership and Culture

**The managers in the service demonstrated strong leadership and they had the capacity and capability to run the service and ensure high quality care. It was clear they were passionate about their role.**

- The service had a clear management structure where the registered manager had responsibility for administrative running of the service, and clinical leads were responsible for day to day running of appointments and clinical areas. Staff knew the management arrangements and their specific roles and responsibilities.
- We observed members of staff interacting well with the leadership team during the inspection. Management of the service appeared to be approachable.
- The service had a service level agreement for the provision of the Radiation Protection Adviser (RPA) and Medical Physics Expert (MPE).
- The service held weekly radiology team meetings chaired by the lead radiographer, we saw evidence that these were well attended. Monthly MDT radiology meetings were held and attended by consultants and the radiology team.
- Most staff told us they felt supported, respected and valued by the management, though as noted above some staff felt they were unable to challenge senior staff. Staff stated that they could approach the managers about concerns if they needed to, and that they felt comfortable reporting incidents to them.
- Staff were proud of the work they carried out. They enjoyed working at the service; they were enthusiastic about the care and services they provided for patients.
- There was good communication in the service from managers. Staff stated they were kept informed by various means, such as through team meetings and emails.

### Management of risk, issues and performance

**Whilst there was a local risk register and business continuity policy in place, KPI was not in place, and systems issues presented risks regarding access to patient clinical history and imaging.**

- The service had a local risk register.
- There were some KPIs in place for imaging around reporting turnaround times however, we were told that there had been discussion of additional KPIs during team meetings.
- On inspection we were told that the imaging storage platforms and information management system did not interface well. This caused difficulty in accessing previous patient clinical history.
- DMRC external Images acquired were imported onto the MoD PACS via the image exchange portal, however not all patient images were consistently uploaded to the PACS system if they were acquired and presented to the service on a compact disc. This led to previous patient imaging not always being made available.
- The service had a business continuity policy, which included specific plans for the service. The plans included specific scenarios (such as electricity failure or building restriction), and actions for staff to take in managing this disruption efficiently.

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

- We observed good practice from staff in relation to information management.

- Relevant information for the running of the service, such as policies and team meeting minutes, were available for all staff to access.
- The service uploaded diagnostic images on a secured electronic portal for access to service staff and those with remote access. The system was also able to provide reports to NHS services, which meant results of diagnostic scans could be shared efficiently with NHS providers.
- Senior staff informed us they were General Data Protection Regulation (GDPR) compliant and that patient information was managed in line with data protection guidelines and legislation. Staff had received training on information governance as part of their mandatory training.

### Learning, continuous improvement and innovation

**Leaders encouraged innovation and participation in research.**

- The service offered same day scanning for patients along with the possibility of same day reporting, with a consultant radiologist available upon request to discuss findings with referrers if diagnosis was needed quickly.
- The service was not operating at full capacity. Senior staff told us their plans of expanding the MRI service with additional staffing and more clinical capacity.