# DMRC Stanford Hall

**DMRC Stanford Hall Stanford on Soar Loughborough LE12 5QW**

Date of inspection: 21-23 November 2023

## Defence Medical Services (DMS) inspection report

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, information given to us by the practice and patient feedback about the service.

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

# Contents

# Summary

## About this inspection

We carried out an announced inspection at DMS Stanford Hall on 21-23 November 2023.

**As a result of this inspection the service is rated as Good overall**

DMS are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of follow-up inspections that the CQC will complete at the invitation of the Director General in their role as the Defence Authority for healthcare and medical operational capability.

## Our inspection team

This inspection was undertaken by a lead CQC inspector. The team included three inspectors, regulatory officer and six DMS specialist advisors and a CQC specialist advisor.

**At this inspection we found:**

- The service had safe systems and processes to deliver safe care and treatment.
- Since the last inspection it was evident that significant changes and progress had been made towards embedding the governance vision of ‘business as usual’.
- A person-centred culture was embedded to ensure patients received quality and compassionate care to meet their individual needs.
- There was evidence across the DMRC of strong and passionate leadership, and a commitment to provide high quality services for patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The pain management team provided a holistic approach to managing a patient treatment plan.
- Patients received effective care reflected in the timeliness of access to appointments and reviews.

- Since the last inspection the psychological wellbeing service had implemented a single point of access (SPA) weekly meeting to discuss all referrals, caseload management and to allocate workloads to the team.
- The unit had implemented a policy on the management of challenging behaviours which has been widely disseminated across all clinical areas.
- The team have worked exceptionally hard to significantly reduce the waiting times for MTBI assessment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the Unit's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

**Recommendations**

- The inpatient wards should consider displaying posters with a laminated cover to ensure that it meets IPC standards.
- The unit should consider referencing to the most current resuscitation guidelines.
- The unit should consider further recruitment of a Rheumatologist consultant and nurse to meet demand for the service.
- The Unit should consider the recruitment of a further psychologist or occupational therapist to deal with the increasing waiting list for mild traumatic brain injury therapy (MTBI).
- The diagnostic and imaging service should consider displaying pregnancy posters in changing areas.
- The diagnostic and imaging service should consider installing assistance aids/bar inside changing cubicles.
- The diagnostic and imaging service should consider holding a register for simulated emergency scenarios for MRI evacuation of the patient.
- The diagnostic and imaging service should consider having a comforters and carers register to check for repeated attendances and monitor dosages.

## Background to Defence Medical Rehabilitation Centre

The Defence Medical Rehabilitation Centre (DMRC), Stanford Hall opened and started treating patients in October 2018. It replaced Headley Court as the Defence Medical Rehabilitation Centre in the country. Some of the current workforce transitioned from the old rehabilitation facility (Headley Court) in Surrey.

DMRC Stanford Hall is run by MoD, and it forms part of DMS. At the top of the chain of command is the Commanding Officer assisted by her professional staff which comprises of both members of the Armed Forces (in uniform) and civilians employed by the MoD.

The 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).

DMS promotes, protects, and restores the health of the UK armed forces to ensure that they are ready and medically fit to deploy globally. The DMS is staffed by circa 11,500 service personnel (8,000 regular and 3,500 reserves) and 2,600 civilian personnel and provides healthcare to circa 143,500 UK Regular Armed Forces personnel. (as of 9 November 2023: https://www.gov.uk/government/groups/defence-medical-services#rehabilitation-services).

Service personnel and civilians work side by side as medical, dental, and allied healthcare professionals and with other personnel with the relevant business and technical skills. The range of services provided by the DMS includes primary healthcare, dental care, rehabilitation, occupational medicine, community mental healthcare and specialist medical care.

The National Rehabilitation Centre (NRC), a new 70 bed NHS rehabilitation facility set to be built on the Stanford Hall Rehabilitation Estate near Loughborough, is currently under construction. The NRC should be open to patients by the end of 2025, and referral information will be available on the website closer to the date.
*(Source: www.thednrc.org.uk and https://www.nationalrehabilitationcentre.nhs.uk/)*

DMRC Stanford Hall provides the following clinical services in the form of inpatients, outpatients and residential rehab:

- Complex trauma, including prosthetics and orthotics
- Force generation- lower limbs, podiatry
- Force generation- spines and upper quadrant
- Force generation- specialist rehab
- Neurological rehabilitation
- Pain service
- Rheumatology
- Psychological wellbeing service
- Pharmacy
- Radiology

## Are services safe?

**We rated the Unit as GOOD for providing safe services.**

## Safe track record and learning

Staff received mandatory training in safety systems, processes, and practices. Training compliance was set at 100% for the unit. Mandatory training oversight data was held electronically for all staff; however, teams also held their own data locally in workbooks.

Mandatory training data was provided for the whole unit and broken down into specific staffing groups. This table below applies to the unit overall covering the period from 1st January 2023 to 7th November 2023. All training has a 100% completion target, however, on clarification we were informed that the target for compliance is 95%.12% of the training modules had a total compliance rate below 75%. The Civilian staff group have the lowest completion rate for their mandatory training.

| Staff group | Training module name | Target | Number of staff eligible | Number trained | YTD compliance % |
|---|---|---|---|---|---|
| All Exec | Freedom to Speak Up & Follow Up | 100% | 16 | 16 | 100% |
| Role Specific | Safeguarding Adults Level 4 | 100% | 4 | 4 | 100% |
| Role Specific | Safeguarding Children Level 4 | 100% | 4 | 4 | 100% |
| Clinical Staff | Data Security (Caldicott Level 2) | 100% | 189 | 187 | 99% |
| Role Specific | Safeguarding Adults Level 3 | 100% | 177 | 168 | 95% |
| Role Specific | Heat Illness Module 1 | 100% | 94 | 88 | 94% |
| Nursing/HCA | Sepsis | 100% | 61 | 57 | 93% |
| Staff with Patients Records Access | DMICP | 100% | 212 | 198 | 93% |
| Role Specific | Safeguarding Workshop | 100% | 177 | 165 | 93% |
| Role Specific | Safeguarding Children Level 3 | 100% | 173 | 161 | 93% |
| Role Specific | Freedom to Speak Up | 100% | 245 | 228 | 93% |
| All Staff | ASER System | 100% | 303 | 281 | 93% |
| Role Specific | Cold Injury Prevention Module 1 | 100% | 94 | 86 | 91% |
| All Staff | Basic Life Support | 100% | 303 | 276 | 91% |
| All Staff | Health & Safety | 100% | 303 | 276 | 91% |
| Role Specific | Safeguarding Adults Level 1 | 100% | 110 | 100 | 91% |
| Role Specific | Safeguarding Children Level 1 | 100% | 110 | 100 | 91% |
| All Staff | Security Fundamentals | 100% | 303 | 275 | 91% |
| All Managers | Freedom to Speak Up & Listen Up | 100% | 42 | 38 | 90% |
| All Staff | Information & Knowledge Awareness | 100% | 303 | 274 | 90% |
| Role Specific | Heat Illness Module 2 | 100% | 209 | 188 | 90% |
| All Staff | Healthcare Governance & Assurance | 100% | 303 | 271 | 89% |
| All Staff | Resilience and Wellbeing | 100% | 303 | 271 | 89% |
| Clinical Staff | Chaperone | 100% | 189 | 167 | 88% |

| | | | | | |
|---|---|---|---|---|---|
| All Staff | Infection Prevention & Control | 100% | 303 | 267 | 88% |
| Role Specific | Safeguarding Children Level 2 | 100% | 16 | 14 | 88% |
| All Staff | Records Management Awareness | 100% | 303 | 265 | 87% |
| All Staff | Prevent | 100% | 303 | 264 | 87% |
| All Staff | Display Screen Equipment | 100% | 303 | 263 | 87% |
| All Staff | Workplace Induction | 100% | 303 | 260 | 86% |
| All Staff | Protecting Personal Data | 100% | 303 | 257 | 85% |
| All Staff | Mental Fitness Brief | 100% | 303 | 253 | 83% |
| Role Specific | Safeguarding Adults Level 2 | 100% | 12 | 10 | 83% |
| All Staff | Business Continuity | 100% | 303 | 252 | 83% |
| Military Staff | Diversity & Inclusion | 100% | 121 | 98 | 81% |
| Role Specific | MCA/DOLS Update | 100% | 72 | 58 | 81% |
| All Staff | Fraud, Bribery & Corruption | 100% | 303 | 242 | 80% |
| All Staff | Active Bystander | 100% | 303 | 241 | 80% |
| All Staff | Manual Handling Awareness | 100% | 303 | 221 | 73% |
| All Staff | Office Safety Awareness | 100% | 303 | 218 | 72% |
| Role Specific | Cold Injury Prevention Module 2 | 100% | 209 | 147 | 70% |
| Role Specific | Patient Handling | 100% | 111 | 70 | 63% |
| Civilian Staff | Civil Service Expectations | 100% | 199 | 122 | 61% |

## All staff

All staff had the following mandatory training modules to complete as listed below, and then each specific staff group had additional modules.

From the training data covering the period between 1st January 2023 to 7th November 2023, the overall completion rate for all staff groups at the end of November 2023 was below the 100% target for all the selected mandatory training modules. Two out of the 19 modules (11%) achieved less than 75% completion rate (Manual handling awareness and Office safety awareness).

| Training module name | Target | Number of staff eligible | Number trained | YTD Compliance % |
|---|---|---|---|---|
| ASER System | 100% | 303 | 281 | 93% |
| Basic Life Support | 100% | 303 | 276 | 91% |
| Health & Safety | 100% | 303 | 276 | 91% |
| Security Fundamentals | 100% | 303 | 275 | 91% |
| Information & Knowledge Awareness | 100% | 303 | 274 | 90% |
| Healthcare Governance & Assurance | 100% | 303 | 271 | 89% |
| Resilience and Wellbeing | 100% | 303 | 271 | 89% |
| Infection Prevention & Control | 100% | 303 | 267 | 88% |
| Records Management Awareness | 100% | 303 | 265 | 87% |
| Prevent | 100% | 303 | 264 | 87% |
| Display Screen Equipment | 100% | 303 | 263 | 87% |

| | | | | |
|---|---|---|---|---|
| Workplace Induction | 100% | 303 | 260 | 86% |
| Protecting Personal Data | 100% | 303 | 257 | 85% |
| Mental Fitness Brief | 100% | 303 | 253 | 83% |
| Business Continuity | 100% | 303 | 252 | 83% |
| Fraud, Bribery & Corruption | 100% | 303 | 242 | 80% |
| Active Bystander | 100% | 303 | 241 | 80% |
| Manual Handling Awareness | 100% | 303 | 221 | 73% |
| Office Safety Awareness | 100% | 303 | 218 | 72% |

**Academic Department of Military Rehabilitation (ADMR).**

The ADMR team consists of eight personnel. The training data supplied for the ADMR team covering the period from 1st January 2023 to 7th November 2023 shows that 68% of the mandatory training met the 100% completion rate target (13 of the 19 mandatory training modules).

Role specific requirements within the team to complete Safeguarding Adults training level 2 and 3 was below target for completion at 75% and 50% and safeguarding children's level 2 module at 80% completion.

21% of training was at 75% completion or below.

| Staff group | Training module name | Target | Number of staff eligible | Number trained | YTD compliance % |
|---|---|---|---|---|---|
| Whole Team | Basic Life Support | 100% | 8 | 8 | 100% |
| Clinical Staff | Data Security (Caldicott Level 2) | 100% | 6 | 6 | 100% |
| Whole Team | Freedom to Speak Up | 100% | 7 | 7 | 100% |
| Whole Team | Freedom to Speak Up & Listen Up | 100% | 1 | 1 | 100% |
| Whole Team | Health & Safety | 100% | 8 | 8 | 100% |
| Whole Team | Healthcare Governance & Assurance | 100% | 8 | 8 | 100% |
| Whole Team | Infection Prevention & Control | 100% | 8 | 8 | 100% |
| Whole Team | Information & Knowledge Awareness | 100% | 8 | 8 | 100% |
| Role Specific | Safeguarding Adults Level 1 | 100% | 2 | 2 | 100% |
| Role Specific | Safeguarding Children Level 1 | 100% | 2 | 2 | 100% |
| Role Specific | Safeguarding Children Level 3 | 100% | 1 | 1 | 100% |
| Role Specific | Safeguarding Workshop | 100% | 4 | 4 | 100% |
| Whole Team | Security Fundamentals | 100% | 8 | 8 | 100% |
| Whole Team | Prevent | 100% | 8 | 7 | 88% |
| Role Specific | Safeguarding Children Level 2 | 100% | 5 | 4 | 80% |
| Whole Team | Protecting Personal Data | 100% | 8 | 6 | 75% |
| Whole Team | Records Management Awareness | 100% | 8 | 6 | 75% |
| Role Specific | Safeguarding Adults Level 3 | 100% | 4 | 3 | 75% |
| Role Specific | Safeguarding Adults Level 2 | 100% | 2 | 1 | 50% |

## Medical

The Medical team consists of 27 personnel. The training data supplied for the medical team covering the period from 1st January 2023 to 7th November 2023 shows 19% of training modules met the 100% target for completion.
The data highlights that not all staff are required to complete all four modules for both adult and child safeguarding training. It is a role specific requirement. The data shows a 100% completion rate for those required to complete safeguarding adults and safeguarding children, modules 1 and 4; however lower completion rates and under target for those required to complete training modules, 2 and 3 adults and children.
33% of training module completion was below 75%.

| Staff group | Training module name | Target | Number of staff eligible | Number trained | YTD compliance % |
|---|---|---|---|---|---|
| Role Specific | Safeguarding Adults Level 1 | 100% | 4 | 4 | 100% |
| Role Specific | Safeguarding Adults Level 4 | 100% | 3 | 3 | 100% |
| Role Specific | Safeguarding Children Level 1 | 100% | 4 | 4 | 100% |
| Role Specific | Safeguarding Children Level 4 | 100% | 3 | 3 | 100% |
| Clinical Staff | Data Security (Caldicott Level 2) | 100% | 23 | 22 | 96% |
| Role Specific | Safeguarding Workshop | 100% | 14 | 13 | 93% |
| Whole Team | Basic Life Support | 100% | 27 | 25 | 93% |
| Whole Team | Freedom to Speak Up | 100% | 14 | 12 | 86% |
| Whole Team | Security Fundamentals | 100% | 27 | 23 | 85% |
| Role Specific | Safeguarding Adults Level 2 | 100% | 6 | 5 | 83% |
| Role Specific | Safeguarding Children Level 2 | 100% | 6 | 5 | 83% |
| Role Specific | Safeguarding Adults Level 3 | 100% | 14 | 11 | 79% |
| Role Specific | Safeguarding Children Level 3 | 100% | 14 | 11 | 79% |
| Whole Team | Health & Safety | 100% | 27 | 21 | 78% |
| Whole Team | Information & Knowledge Awareness | 100% | 27 | 18 | 67% |
| Whole Team | Healthcare Governance & Assurance | 100% | 27 | 17 | 63% |
| Whole Team | Infection Prevention & Control | 100% | 27 | 16 | 59% |
| Whole Team | Prevent | 100% | 27 | 14 | 52% |
| Whole Team | Protecting Personal Data | 100% | 27 | 14 | 52% |
| Whole Team | Records Management Awareness | 100% | 27 | 13 | 48% |
| Whole Team | Freedom to Speak Up & Listen Up | 100% | 9 | 4 | 44% |

## Nursing

The Nursing team consists of 78 personnel. The training data supplied for the nursing team covering the period from 1st January 2023 to 7th November 2023 shows 43% of training modules met the 100% target for completion.
The data highlights (as with medical) that not all nursing staff are required to complete all four modules for both adult and children safeguarding training. The data shows a 100%

completion rate for those required to complete safeguarding adults' modules 1-4 and 100% completion for safeguarding children's modules 1, 2 and 4 with module 3 seeing a 94% completion rate, so just below target.
Overall, this cohort have higher rates of completion for their mandatory training requirements.

| Staff group | Training module name | Target | Number of staff eligible | Number trained | YTD compliance % |
|---|---|---|---|---|---|
| Clinical Staff | Data Security (Caldicott Level 2) | 100% | 73 | 73 | 100% |
| *Nb. Whole Team* | *Freedom to Speak Up & Listen Up* | *100%* | *13* | *13* | *100%* |
| Role Specific | Safeguarding Adults Level 1 | 100% | 1 | 1 | 100% |
| Role Specific | Safeguarding Adults Level 2 | 100% | 2 | 2 | 100% |
| Role Specific | Safeguarding Adults Level 3 | 100% | 69 | 69 | 100% |
| Role Specific | Safeguarding Adults Level 4 | 100% | 1 | 1 | 100% |
| Role Specific | Safeguarding Children Level 1 | 100% | 1 | 1 | 100% |
| Role Specific | Safeguarding Children Level 2 | 100% | 3 | 3 | 100% |
| Role Specific | Safeguarding Children Level 4 | 100% | 1 | 1 | 100% |
| Whole Team | Basic Life Support | 100% | 73 | 72 | 99% |
| Whole Team | Information & Knowledge Awareness | 100% | 73 | 71 | 97% |
| Whole Team | Records Management Awareness | 100% | 73 | 71 | 97% |
| Whole Team | Health & Safety | 100% | 73 | 70 | 96% |
| Whole Team | Infection Prevention & Control | 100% | 73 | 70 | 96% |
| Whole Team | Freedom to Speak Up | 100% | 60 | 57 | 95% |
| Whole Team | Healthcare Governance & Assurance | 100% | 73 | 69 | 95% |
| Whole Team | Prevent | 100% | 73 | 69 | 95% |
| Whole Team | Security Fundamentals | 100% | 73 | 69 | 95% |
| Role Specific | Safeguarding Children Level 3 | 100% | 68 | 64 | 94% |
| Role Specific | Safeguarding Workshop | 100% | 69 | 63 | 91% |
| Whole Team | Protecting Personal Data | 100% | 73 | 65 | 89% |

***Nb. Caveat*** – The DMS team confirmed that only 13 Nursing managers are required to complete the 'Freedom to speak up and Listen up' training; however, there is no drop-down option on their system to choose 'Nursing managers' so they choose 'whole team' which was the only suitable option and explains the discrepancy above (row 2).

**Rehabilitation**

The rehabilitation team consists of 116 personnel. The training data supplied for the rehab team covering the period from 1st January 2023 to 7th November 2023 shows only 11% of training completion met the 100% target; however, the remaining 89% of training completion rates were 90% or above.
As with medical and nursing, not all rehab staff are required to complete all safeguarding training modules for adults and children. Safeguarding adults and children's level 2 modules completion rates met the target of 100%; however, the number of staff required to complete this training was small when compared to those required to complete levels 1 and 3 for both these module types. It should be noted however, that the completion rates were not far off the target.

Overall, this cohort have higher rates of completion for their mandatory training requirements.

| Staff group | Training module name | Target | Number of staff eligible | Number trained | YTD compliance % |
|---|---|---|---|---|---|
| Role Specific | Safeguarding Adults Level 2 | 100% | 2 | 2 | 100% |
| Role Specific | Safeguarding Children Level 2 | 100% | 2 | 2 | 100% |
| Clinical Staff | Data Security (Caldicott Level 2) | 100% | 89 | 88 | 99% |
| Whole Team | Health & Safety | 100% | 116 | 113 | 97% |
| Role Specific | Safeguarding Adults Level 1 | 100% | 25 | 24 | 96% |
| Role Specific | Safeguarding Children Level 1 | 100% | 25 | 24 | 96% |
| Whole Team | Information & Knowledge Awareness | 100% | 116 | 111 | 96% |
| Whole Team | Prevent | 100% | 116 | 111 | 96% |
| Role Specific | Safeguarding Adults Level 3 | 100% | 89 | 85 | 96% |
| Role Specific | Safeguarding Children Level 3 | 100% | 89 | 85 | 96% |
| Whole Team | Healthcare Governance & Assurance | 100% | 116 | 110 | 95% |
| Whole Team | Freedom to Speak Up & Listen Up | 100% | 18 | 17 | 94% |
| Role Specific | Safeguarding Workshop | 100% | 89 | 84 | 94% |
| Whole Team | Basic Life Support | 100% | 116 | 109 | 94% |
| Whole Team | Records Management Awareness | 100% | 116 | 109 | 94% |
| Whole Team | Security Fundamentals | 100% | 116 | 109 | 94% |
| Whole Team | Infection Prevention & Control | 100% | 116 | 108 | 93% |
| Whole Team | Protecting Personal Data | 100% | 116 | 106 | 91% |
| Whole Team | Freedom to Speak Up | 100% | 98 | 89 | 91% |

## Nursing Division

| Staff group | Training module name | Other - please specify | Target | Required frequency | Number of staff eligible | Number trained | YTD Compliance % |
|---|---|---|---|---|---|---|---|
| Nursing/HCA | Breakaway Trg | not mandated | n/a | n/a | 64 | 56 | 87.5% |
| Nursing/HCA | IV Meds | clinical Nurses | 100% | 3 yearly | 20 | 18 | 90% |
| Nursing/HCA | Oral Meds | clinical Nurses | 100% | 3 yearly | 20 | 18 | 90% |

Significant events

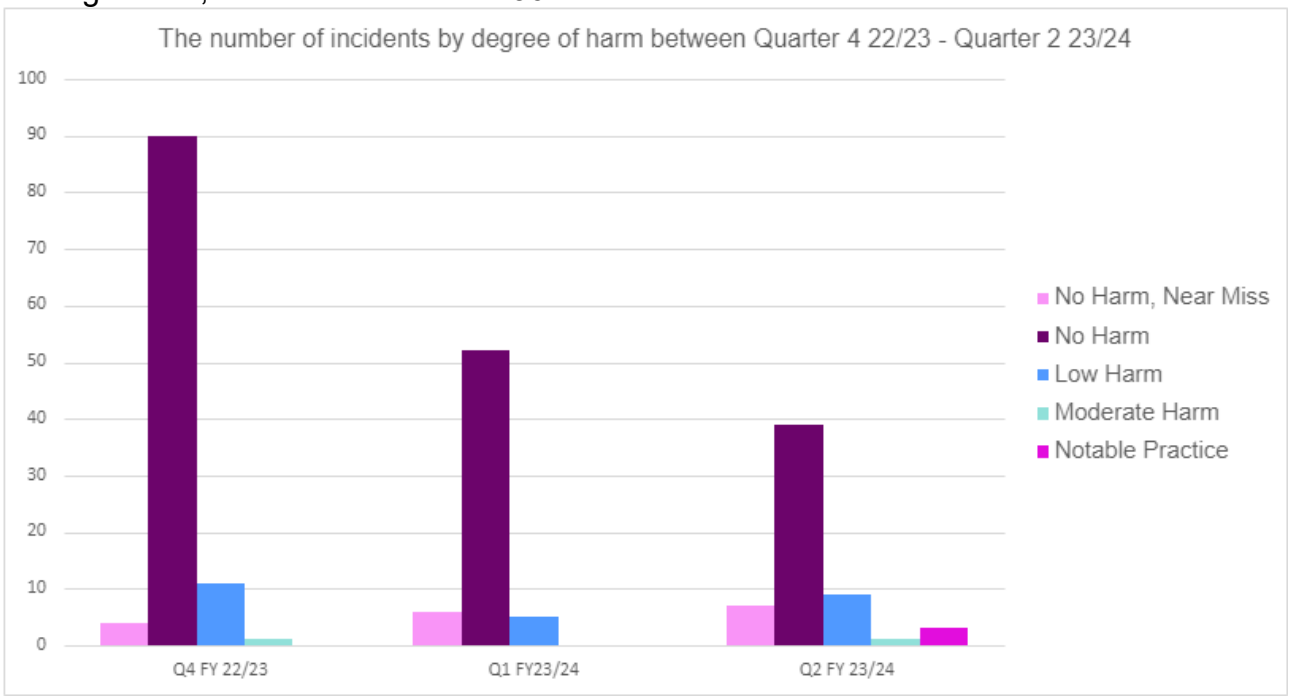
Significant events and incidents were reported through the electronic organisational-wide system (referred to as ASER). All staff were aware of the ASER process and had a log in to use the system. The training log showed ASER training was facilitated in 2022 and

2023. An ASER log was maintained, and it showed low numbers of reported incidents throughout 2022 to 2023. Lessons learnt were shared at the team meeting and monthly governance meetings.

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

No serious incident was reported by DMRC Stanford Hall between January 2022 and January 2023.

The total number of incidents recorded at DMRC in Quarter 4 of 2022/2023 compared to Quarter 1 of 2023/2024 decreased by 41%, from 103 to 61. There were also 59 incidents in Quarter 2 of 2023/2024. As shown in the graph below, most incidents resulted in “No harm”. So far in Quarter 3 of 2023/2024, there have been 21 incidents, 16 of which have resulted in “No harm”, 3 “Low harm” and 2 “Notable practice”. For each quarter, except for Quarter 4 of 2022/2023, the main incident category was “Clinical Administration/DMICP and Med IT”. In Quarter 4, the main incident category was “Resources/organisational management”, which accounted for 36 incidents.




*(Source: P7 DMRC SH ASER spreadsheet-CQC-OS)*

## Overview of safety systems and processes

The unit 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 throughout April and May 2023. A

management action plan had been developed from the findings of the audit and each action had RAG priority rating.

Essential systems, processes and practices were available to ensure patient safety. Arrangements for safeguarding reflected relevant legislation and local requirements. Staff understood their responsibilities and adhered to safeguarding policies and procedures. The service adhered to the Defence Primary Healthcare (DPHC) tri service safeguarding policies for adults, children, and young people. Safeguarding polices were in date and version controlled. Each policies had a clear flowchart and process to guide staff on how to escalate concerns. The policies included contact addresses and telephone numbers for the local safeguarding teams (both in hours and out of hours), and these were displayed across the service.

DMRC was accessed by 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.

All staff were Disclosure and Barring Service (DBS) checked and their professional registration and expiry date was reviewed. This ensured all staff at the unit were safe and fit to practice at the service.

## Risks to patients

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.

The code blue response was co-ordinated by the medical emergency team (MET) which consists of senior house officer out of hours (OOH), code blue nurse and healthcare assistant 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.

Staff knew the locations of the resuscitation trolley and the Automated External Defibrillators.

Workforce

The following staff whole time equivalent ( WTE) was reported by DMRC Stanford Hall. The data covered the period between February 2023 and October 2023. They have provided data for four teams including the Medical Division, Nursing Division, Rehab Division and HQ.

As of October 2023, the lowest fill rate across all four groups was 83% in the Medical Division and there is currently 87.5% fill rate across all four staffing groups.

**Medical Division**

| Month | Team | Staffing group | Planned staff - WTE | Actual staff - WTE | Fill rate (%) |
|---|---|---|---|---|---|
| Feb-23 | Med Div | Doctors, Radiographers, pharmacy, assurance team | 12 | 12 | 100% |
| Mar-23 | Med Div | Doctors, Radiographers, pharmacy, assurance team | 12 | 12 | 100% |
| Apr-23 | Med Div | Doctors, Radiographers, pharmacy, assurance team | 12 | 10 | 83% |
| May-23 | Med Div | Doctors, Radiographers, pharmacy, assurance team | 12 | 10 | 83% |
| Jun-23 | Med Div | Doctors, Radiographers, pharmacy, assurance team | 12 | 10 | 83% |
| Jul-23 | Med Div | Doctors, Radiographers, pharmacy, assurance team | 12 | 10 | 83% |
| Aug-23 | Med Div | Doctors, Radiographers, pharmacy, assurance team | 12 | 10 | 83% |
| Sep-23 | Med Div | Doctors, Radiographers, pharmacy, assurance team | 12 | 10 | 83% |
| Oct-23 | Med Div | Doctors, Radiographers, pharmacy, assurance team | 12 | 10 | 83% |

## Nursing Division

| Month | Team | Staffing group | Planned staff - WTE | Actual staff - WTE | Fill rate (%) |
|---|---|---|---|---|---|
| Feb-23 | Nursing Div | Nursing, HCA, medics | 57 | 50 | 88% |
| Mar-23 | Nursing Div | Nursing, HCA, medics | 57 | 50 | 88% |
| Apr-23 | Nursing Div | Nursing, HCA, medics | 57 | 48 | 84% |
| May-23 | Nursing Div | Nursing, HCA, medics | 57 | 54 | 95% |
| Jun-23 | Nursing Div | Nursing, HCA, medics | 57 | 51 | 89% |
| Jul-23 | Nursing Div | Nursing, HCA, medics | 57 | 55 | 96% |
| Aug-23 | Nursing Div | Nursing, HCA, medics | 57 | 50 | 88% |
| Sep-23 | Nursing Div | Nursing, HCA, medics | 57 | 47 | 82% |
| Oct-23 | Nursing Div | Nursing, HCA, medics | 57 | 53 | 93% |

## Rehab Division

| Month | Team | Staffing group | Planned staff - WTE | Actual staff - WTE | Fill rate (%) |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| Feb-23 | Rehab Div | AHPs | 47 | 37 | 79% |
| Mar-23 | Rehab Div | AHPs | 47 | 37 | 79% |
| Apr-23 | Rehab Div | AHPs | 47 | 37 | 79% |
| May-23 | Rehab Div | AHPs | 47 | 40 | 85% |
| Jun-23 | Rehab Div | AHPs | 47 | 40 | 85% |
| Jul-23 | Rehab Div | AHPs | 47 | 45 | 96% |
| Aug-23 | Rehab Div | AHPs | 47 | 42 | 89% |
| Sep-23 | Rehab Div | AHPs | 47 | 41 | 87% |
| Oct-23 | Rehab Div | AHPs | 47 | 40 | 85% |

**HQ**

| Month | Team | Staffing group | Planned staff - WTE | Actual staff - WTE | Fill rate (%) |
|---|---|---|---|---|---|
| Feb-23 | HQ | Administrative | 44 | 42 | 95% |
| Mar-23 | HQ | Administrative | 44 | 42 | 95% |
| Apr-23 | HQ | Administrative | 44 | 42 | 95% |
| May-23 | HQ | Administrative | 44 | 42 | 95% |
| Jun-23 | HQ | Administrative | 44 | 41 | 93% |
| Jul-23 | HQ | Administrative | 44 | 39 | 89% |
| Aug-23 | HQ | Administrative | 44 | 41 | 93% |
| Sep-23 | HQ | Administrative | 44 | 36 | 82% |
| Oct-23 | HQ | Administrative | 44 | 37 | 84% |

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

The vacancy data provided within the Provider Information Request (PIR) submission covers the date range from the 01 November 22 to 31 October 23 and was not broken down by staffing group.
The DMRC had a monthly average vacancy rate of 11%. (Over the same period, there were also 84 episodes of military personnel on external duty which did not fall under the 'vacant position' category and there are various reasons why these posts are vacant including moving temporarily to another unit, attendance at exercises/sporting events, conferences etc). June, September, and October saw the highest vacancy rates.

*The columns in blue were also included in the PIR return as examples of other reasons which would account for staff not being in post.*

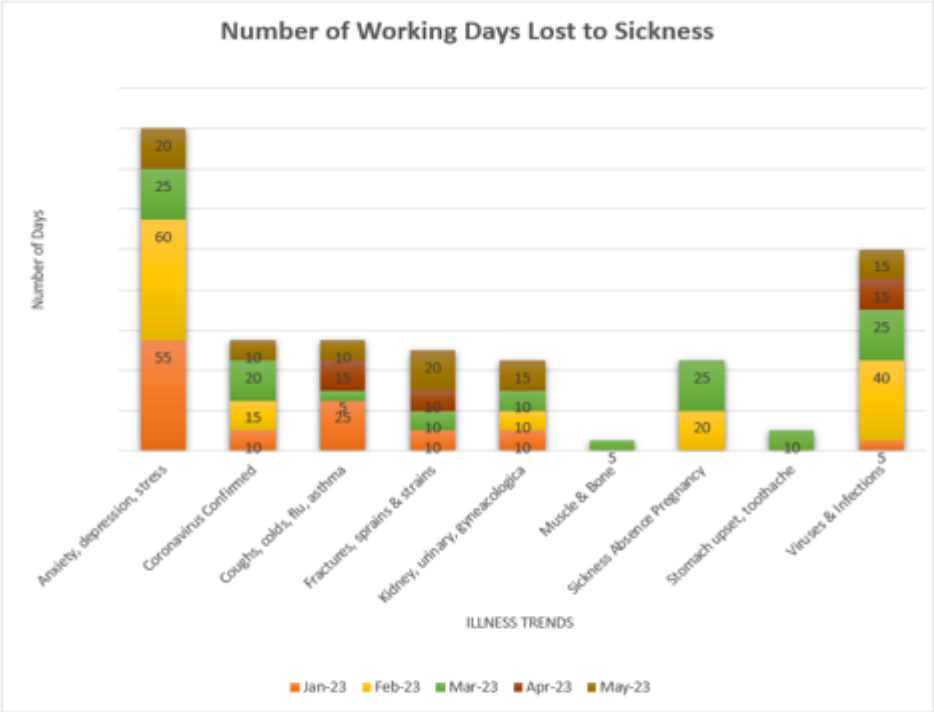
| Month | Total number of posts | Total number of WTE staff [Establishment] | Vacant positions | *Military deployed* | *Military duty external to unit (reason not included)* | Vacancy rate % |
|---|---|---|---|---|---|---|
| Nov-22 | 183 | 147 | 21 | *0* | *15* | 11% |
| Dec-22 | 183 | 147 | 20 | *1* | *15* | 11% |
| Jan-23 | 179 | 147 | 20 | *1* | *11* | 11% |
| Feb-23 | 179 | 148 | 20 | *1* | *10* | 11% |

| | | | | | | |
|---|---|---|---|---|---|---|
| Mar-23 | 179 | 148 | 19 | *4* | *8* | 11% |
| Apr-23 | 179 | 138 | 19 | *4* | *18* | 11% |
| May-23 | 179 | 154 | 18 | *6* | *1* | 10% |
| Jun-23 | 179 | 143 | 23 | *8* | *5* | 13% |
| Jul-23 | 179 | 145 | 17 | *6* | *11* | 9% |
| Aug-23 | 179 | 153 | 18 | *6* | *2* | 10% |
| Sep-23 | 179 | 157 | 23 | *5* | *-6* | 13% |
| Oct-23 | 179 | 158 | 23 | *4* | *-6* | 13% |
| **Total (annual)** | **2156** | **1785** | **241** | ***46*** | ***84*** | **11%** |

The DMRC explained that due to the fluid nature of the population, vacancies can change all the time. They have several vacant posts which they are waiting to fill across the board and due to a variety of different reasons for staff leaving the Unit and recording of these movements, it can be challenging to manage vacancy data.
*(Source: DMS provider information return – P8 Vacancies)*

## Sickness

Data provided by DMRC detailing civilian working days lost to sickness:




| | Average Working Days Lost by FTE by Month | | | | | |
|---|---|---|---|---|---|---|
| | **Jan-23** | **Feb-23** | **Mar-23** | **Apr -23** | **May-23** | **Jun-23** |
| DMRC | 0.93 | 0.88 | 0.77 | 0.24 | 0.56 | |
| HQ DMS | 0.77 | 0.64 | 0.72 | 0.53 | 0.60 | |
| UK Strat Com | 0.50 | 0.44 | 0.50 | 0.37 | 0.45 | |

Anxiety, depression, Stress accounted for the most days lost to sickness overall, occurring across the months of January, February, March, and May (160 days in total over four months).
***Sickness*** – It should be noted that 'long term sickness equates to a period of absence over 8 days.

*(Source: P19 Civil Service Sickness rates – Command Bd reports)*

**Long term sickness military staff group per month**
The data provided in the PIR covers the date range from 01 November 22 to 31 October 23 and was not broken down by days lost to sickness. The DMRC team confirmed they cannot access data in this way within their central systems and is managed on a team-by-team basis. The table below details the number of military staff off per month by staff type but does not confirm how many days each of the staff members were off sick each month, so it is not possible to provide these calculations. The annual sickness rate is based on staff numbers and not days lost.
The Nursing Division saw the highest number of staff off each month, long term sick equating to 66% of all staff sickness annually. Annually, the long-term sickness rate is 5% for all staff groups combined.
*Caveat: this table does not include all staffing groups that are within the DMRC (as per the PIR data return) so does not capture a full view of sickness across the site.*

| | | Staffing group (sum of LT sickness) | | | | |
|---|---|---|---|---|---|---|
| **Month** | **Total available staff (WTE)** | **Nursing Division** | **Rehabilitation Division** | **Headquarters** | **Total number LT sick per month** | **Monthly sickness rate %** |
| Nov-22 | 147 | 4 | 3 | 1 | 8 | 5% |
| Dec-22 | 147 | 5 | 3 | 1 | 9 | 6% |
| Jan-23 | 147 | 5 | 3 | 1 | 9 | 6% |
| Feb-23 | 148 | 7 | 3 | 1 | 11 | 7% |
| Mar-23 | 148 | 4 | 3 | 1 | 8 | 5% |
| Apr-23 | 138 | 9 | 3 | 1 | 13 | 9% |
| May-23 | 154 | 8 | 2 | 1 | 11 | 7% |
| Jun-23 | 143 | 5 | 2 | 1 | 8 | 6% |
| Jul-23 | 145 | 4 | 0 | 1 | 5 | 3% |
| Aug-23 | 153 | 4 | 0 | 1 | 5 | 3% |
| Sep-23 | 157 | 4 | 0 | 0 | 4 | 3% |
| Oct-23 | 158 | 4 | 0 | 0 | 4 | 3% |
| **TOTAL (Annual)** | **1785** | **63** | **22** | **10** | **95** | **5%** |

*(Source: DMS provider information return – P9 Sickness)*

## Turnover

The turnover data was provided for the date range 01 November 22 to 31 October 23. The information was broken down into three groups – two Military, assignments and termination and one Civilian, resignations. Military assignments were the highest reason for turnover annually making up 69% of all turnovers. June and December saw the highest turnover of staff. The annual turnover figure was 4% for all three groups.

| | | Military | | Civilian staff | | |
|---|---|---|---|---|---|---|
| **Month** | **Total available staff (WTE)** | **Military Assignments** | **Military Terminations** | **Resignations** | **Total turnover** | **% Turnover** |
| Nov-22 | 147 | 2 | 0 | 0 | 2 | 1% |
| Dec-22 | 147 | 15 | 1 | 0 | 16 | 11% |
| Jan-23 | 147 | 1 | 1 | 0 | 2 | 1% |
| Feb-23 | 148 | 2 | 1 | 0 | 3 | 2% |
| Mar-23 | 148 | 2 | 2 | 0 | 4 | 3% |
| Apr-23 | 138 | 4 | 2 | 0 | 6 | 4% |
| May-23 | 154 | 5 | 4 | 0 | 9 | 6% |
| Jun-23 | 143 | 8 | 5 | 1 | 14 | 10% |
| Jul-23 | 145 | 2 | 2 | 2 | 6 | 4% |
| Aug-23 | 153 | 8 | 1 | 0 | 9 | 6% |
| Sep-23 | 157 | 2 | 1 | 0 | 3 | 2% |
| Oct-23 | 158 | 2 | 1 | 0 | 3 | 2% |
| **Total (annual)** | **1785** | **53** | **21** | **3** | **77** | **4%** |

## Information to deliver safe care and treatment

The unit used a clinical system known as 'DMICP' (DMICP is the medical information system used throughout DPHC). Consultations were recorded directly onto DMICP except on the wards where, following each case, a record was scanned onto DMICP by way of a patient report form (PRF).

## 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.

# Are services effective?

**We rated the Unit as GOOD for providing effective services.**

## Effective needs assessment, care, and treatment

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 service. Common guidelines and pathways documents were available for staff and patients to reference.

## Effective staffing

The overall appraisals completion rate at Stanford Hall as of 6th November 2023 was 100% across all staff groups.

| Staff group | Number of individuals required (YTD) | Number of Staff who have received an appraisal (YTD) | Appraisal rate % |
|---|---|---|---|
| Military | 134 | 134 | 100% |
| Nursing Div | 43 | 43 | 100% |
| Rehab Div | 37 | 37 | 100% |
| Med Div | 8 | 8 | 100% |
| Admin Div | 9 | 9 | 100% |
| HQ | 4 | 4 | 100% |
| Bus Div | 4 | 4 | 100% |
| MPGS | 21 | 21 | 100% |
| QM | 2 | 2 | 100% |
| JSSERI | 6 | 6 | 100% |
| **GRAND TOTAL** | **193** | **193** | 100% |

*(Source: DMS provider information return – P17 Appraisals)*

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 DMS. 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.

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 and in the healthcare governance workbooks.

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.

## Coordinating care and treatment

All staff including those from different services were involved in assessing, planning, and delivering patients care and treatment. Joint assessments allowed care and treatment to be optimised for patients due to the provision of a more co-ordinated approach to management of the patient's condition for example, physiotherapists and ERIs jointly carried out initial patient assessments developing treatment plans for patients attending courses.

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 contemporaneous, multidisciplinary record of the care and treatment of individual patients at the unit.

Patients received clear information prior the course to inform them about the treatment they would receive and what was expected. This included information about the course programme, first day reporting instructions, and required clothing and equipment.

## Consent to care and treatment.

Staff understood relevant consent requirements and sought patients' consent to care and treatment in line with legislation and guidance. Staff had received training around the Mental Capacity Act and were clear on how this might be applied should a patient lack capacity.

There was a consent policy. The policy included the consenting process and staff responsibilities regarding consent processes. The policy also outlined the rights of the patient in the consent process.

We reviewed a selection of clinical notes and saw that consent had been appropriately sought and recorded in all cases.

# Are services caring?

**We rated the Unit as GOOD for providing caring services.**

## Kindness, 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.

## Involvement in decisions about care and treatment

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.

Patients were encouraged to be active partners in their care.

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.

Patients were extremely positive about their experience at the DMRC which reflected the outcomes of the patient satisfaction questionnaires completed by patients after finishing their rehabilitation.

# Are services responsive to people’s needs?

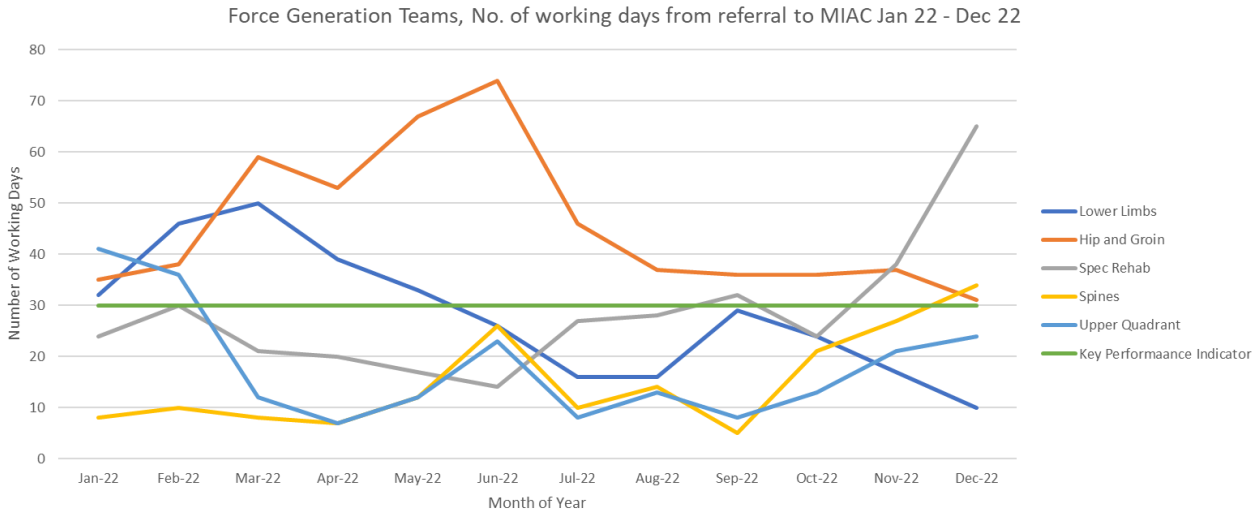
**We rated the Unit as GOOD for providing responsive services.**

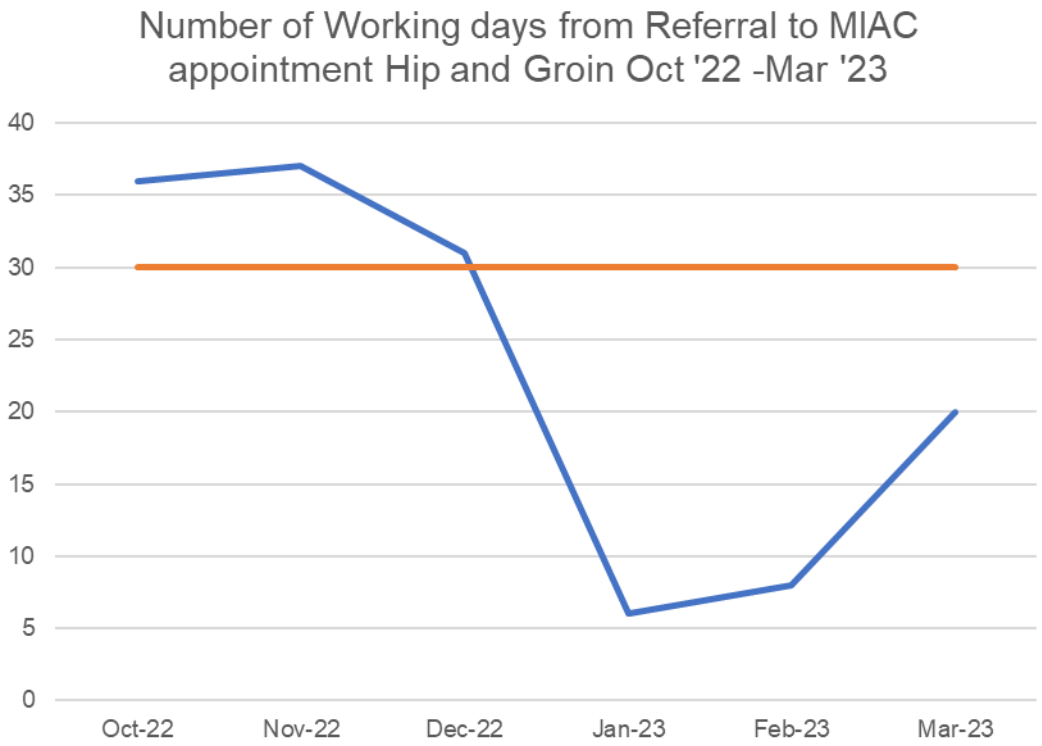
# Timely access to care and treatment

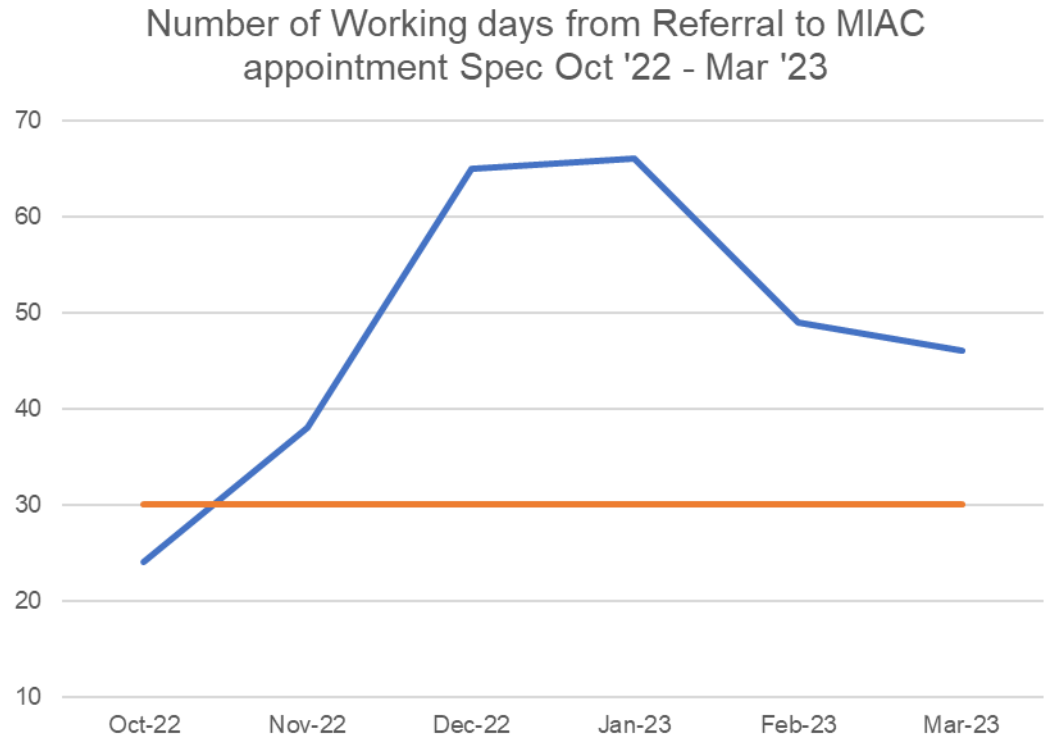
## Access to services from first referral

During 2022, the DMRC largely met the key performance indicator (KPI) of 30 working days from referral to multidisciplinary injury assessment clinic (MIAC) for Specialist Rehab, Spines, and Upper Quadrant. Throughout 2022, the number of working days from referral to MIAC for Hip and Groin consistently exceeded the KPI despite decreasing from a peak of 74 days in June 2022 to 31 days in December 2022. From additional data supplied the DMRC further reduced this and in March 2023 there were 20 days from referral to MIAC for Hip and Groin.

Towards the end of 2022, there was a notable increase in the number of working days from referral to MIAC for Specialist Rehab meaning the KPI was not met in November and December 2022. From additional data supplied, this was also the case for January, February, and March 2023.





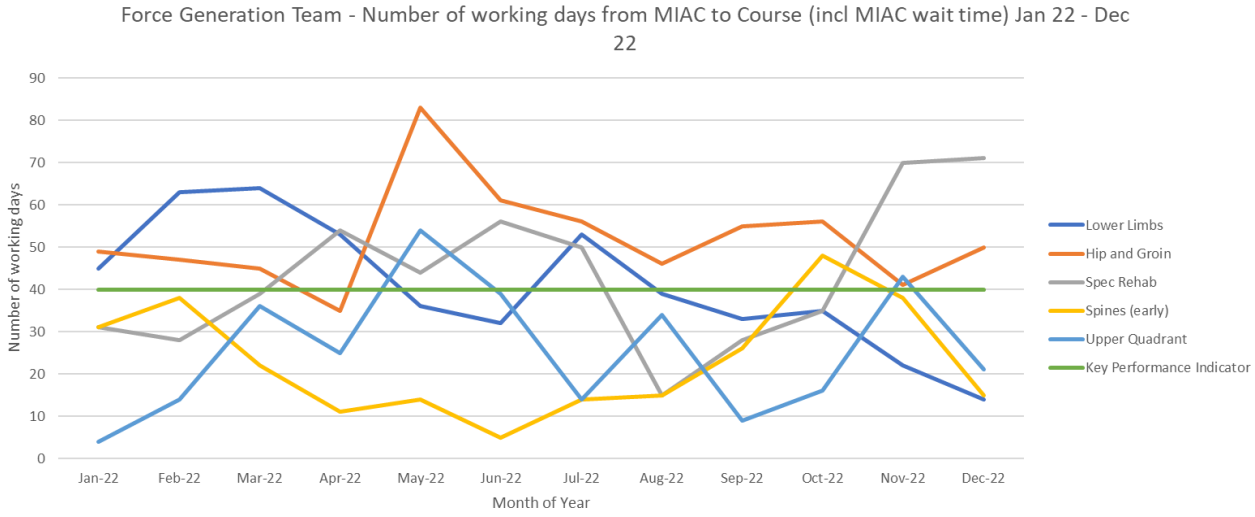



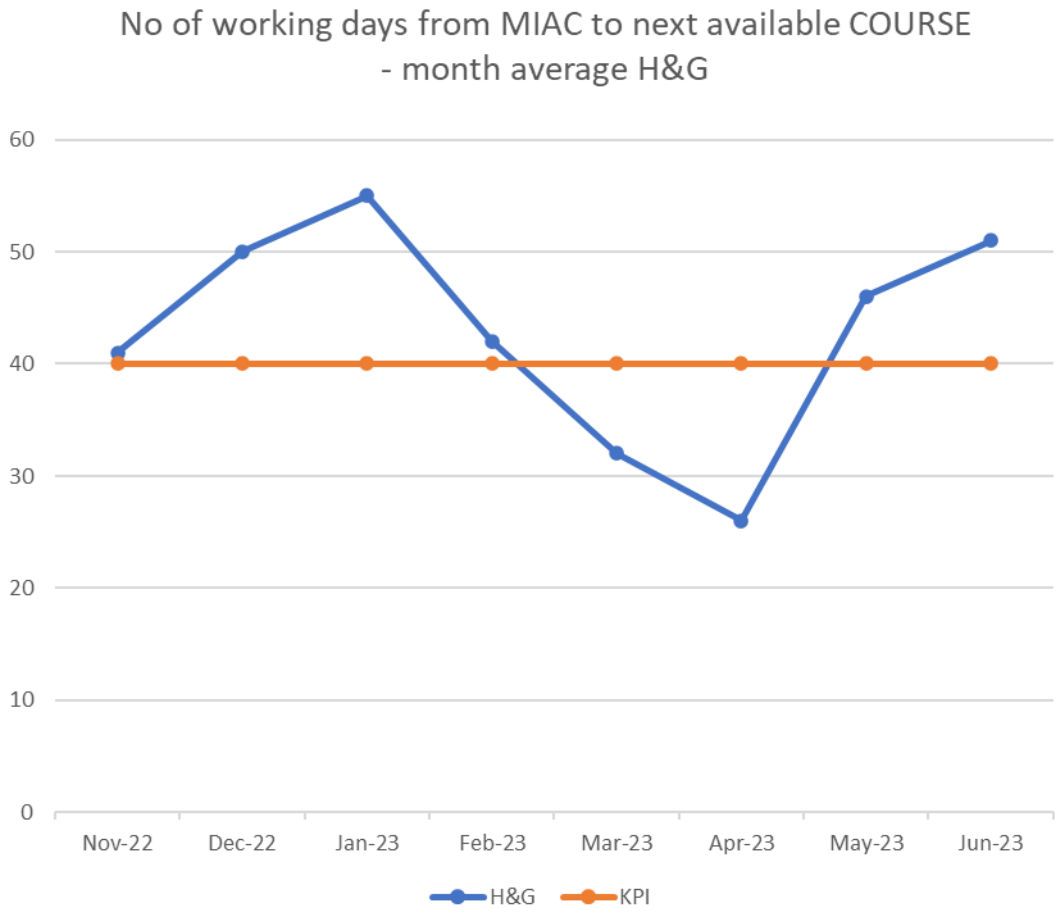

*(Source: P34 Referral to Access Force Gen and MTBI Stats Jun 22 – Dec 22 & P34 Referral to Access Force Gen and MTBI Stats Oct 22 – Mar 23)*

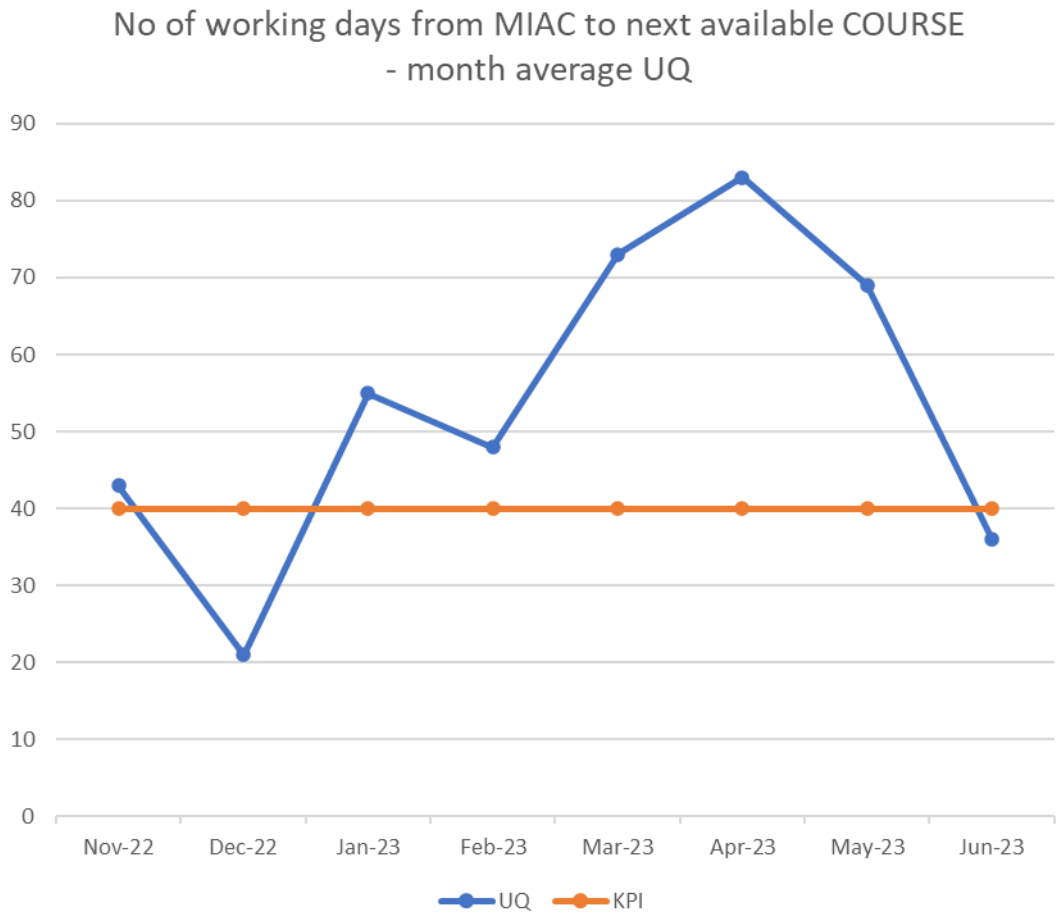
### Access to first offered course (including MIAC wait time)

Throughout 2022, Hip and Groin had the longest number of working days to first offered course. This was above the KPI of 40 days for 11 out of 12 months. From additional data supplied, this continued to rise before decreasing. In April 2023, the number of working

days to the first offered course was below the KPI (26 days) however, in June 2023 this had risen above the KPI to 51 days.
Towards the end of 2022, there was a sharp increase in the number of working days to the first offered course for Specialist Rehab with the number of days doubling from 35 days in October to 71 days in December 2022. From additional data the number of working days remained above the KPI in January 2023, in June 2023 it was below the KPI at 15 days.
The additional data supplied shows a generally increasing trend in the number of working days to first course offered for Upper Quadrant from late 2022 to April 2023. In June 2023 this had fallen below the KPI (good) to 36 days.




No of working days from MIAC to next available COURSE
- month average H&G
60
50
40
30
20
10
0
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
H&G
KPI




*(Source: P34 Referral to Access Force Gen and MTBI Stats Jun 22 – Dec 22 & P34 Referral to Access Force Gen and MTBI Stats Oct 22 – Mar 23 & P34 Referral to Access Force Gen and MTBI Stats Nov 22 – Jun 23)*

### Attendance rates

Data provided showed that in September 2023, 1% (1) of inpatient (residential) appointments booked were DNAs. 0% of Inpatient (ward) appointments booked were DNAs. 7% (41) of Outpatient appointments booked were DNAs, the majority were for Lower Limbs (10) and Rheumatology (14).

*(Source: DMRC DNA Rates from Proj APOLLO-O)*

## Listening and learning from concerns and complaints

The service had a system for handling concerns and complaints. The service managed complaints in accordance with organisational policy and procedure.

Information was available to support patients in making a complaint if they felt the need to do so. Information regarding compliments, concerns, and complaints was displayed across the service.

Concerns and complaints were listened to, 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.

Data provided to us showed that the DMRC received 41 compliments since 30 April 2023 which were for the following reasons:

| Compliment Category | Number of Compliments |
|---|---|
| Quality of Care | 13 |
| Clinical Care | 11 |
| Staff Attitude | 8 |
| Staff Assistance | 6 |
| Visit Feedback | 2 |
| Other | 1 |

# Are services well-led?

**We rated the Unit as GOOD for providing well-led services.**

## Leadership and Culture

The managers in the service demonstrated strong and passionate leadership and they had the capacity and capability to run the service and ensure high quality care. It was clear patients' needs were at the centre of the services delivered.

A change in leadership had occurred prior to the inspection. The current Commanding Officer (CO) had only recently been appointed into post.

Staff felt the current CO and their team were visible and approachable. The CO held a monthly briefing meeting with all staff, and this was well received.

The CO and leadership team had an "open door" policy and all members of staff said they felt able to speak about personal circumstances or highlight areas of concern.

Staff were encouraged to have a voice and improved methods for reporting issues have been set up.

Huge efforts have been instigated to encourage unit-wide learning and sharing of information. Leadership training was offered at all levels.

## Vision and strategy

There was a clear vision and mission statement set out for the service, with quality and safety the top priority. The vision was to be recognised as a world leader in military rehabilitation and research, maximising the skills of dedicated integrated workforce, resulting in greater employability and deployability across Defence. The mission statement for DMRC (Stanford Hall) will deliver consultant led interdisciplinary collaborative teamworking environments which deliver safe, effective, and responsive specialist rehabilitation services to meet the needs of 'the patient' and the Chain of Command. This was underpinned by three strategic goal which focused on the people, quality improvement and our future. To achieve this the unit had a set of strategic objectives and clinical delivery group objectives.

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.

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.

## Governance arrangements

There was an effective governance framework to ensure quality, performance and risk were understood and managed. There was an overarching ministry of defence (MOD) corporate governance policy (JSP 525). This covered the structure of MOD governance, governance principle, roles and responsibilities, governance control processes and risk management processes.

We saw the unit had a comprehensive governance documentation and oversight system known as their governance workbook. The workbook had links to the risk register, quality improvement programme actions and progress, mandatory training compliance, professional registrations, complaints, incidents, standard operating procedures, and meeting minutes. All staff could access the workbook and were aware of the governance system through regular clinical meetings and healthcare governance meetings.

Service reviews were conducted for each clinical area to further build on improved governance and assurance awareness.

There was a programme of clinical and internal audit used to monitor quality and identify areas for improvement.

There were systems and processes to identify, manage and mitigate risks associated with the unit. Risks were recorded on risk registers. All risks were scored, and RAG rated and there were identified risk owners for each risk along with mitigations and planned actions.

## Continuous improvement and innovation

Continuous improvement was one of the service's strategic objectives.

There was a commitment to quality improvement. The service kept a log of quality improvement projects (QIPs) that had been completed. All QIPs were documented on the healthcare governance workbooks. The template enabled staff to set out the background to the project, the aims, and objectives, how it was completed, key findings and how it had changed practice. Further actions and the process for ongoing review of the quality improvement were also identified.

There was a commitment to ongoing learning by all staff. All staff were encouraged to attend the local and regional in-service training sessions which were both held regularly.

# Inpatient - Summary of this service

The in-patient service provides 24-hour clinical care for service personnel, in conjunction and support of their rehabilitation. Staff are key members of the interdisciplinary team and bring a wide range of experience and specialist skills to provide holistic individualised care to service personnel. This includes, nursing staff, medical staff, occupational therapy (OT), physiotherapy (PT), speech and language therapy, exercise rehab instructor (ERI), psychological wellbeing, prosthetics and orthotics, social work, recreational therapists, rehabilitation assistants, administration and clerical. Service personnel who are in-patients will be allocated to a ward, depending on their clinical support needs and level of interventions required. The speciality the patient is under the care of will either be complex trauma (CT) or neurological rehabilitation (NR) or occasionally dual care from both teams. As service personnel progress through their rehabilitation, they may move wards to best support their current needs whilst maintaining or promoting independence.

# Are services safe?

**We rated the service as GOOD for providing safe services.**

## Safety systems and processes

An overview of mandatory training compliance was stored electronically. The training team and line managers retained oversight of mandatory training progress for their workforce. Staff received an email prompt when their mandatory training required updating and staff

had training passports to record compliance and reminders to keep on track. Mandated training requirements were located on the healthcare governance workbook, once staff have completed training, certificates are provided to training link nurses or the practice development team who then update the training register.

The service adhered to the Defence Primary Healthcare (DPHC) tri service safeguarding policies for adults, children, and young people. Both polices were in date and version controlled. Each policy had a clear flowchart and process to guide staff on how to escalate concerns. The policies included contact addresses and telephone numbers for the local safeguarding teams (both in hours and out of hours), and these were displayed in the waiting areas and clinical rooms. Staff we spoke with during the inspection were fully aware of the policies and knew how to recognise and report a safeguarding concern.

The inpatients service had a designated safeguarding lead. The status of safeguarding and vulnerable patients was discussed regularly with the welfare team. In addition to informal discussion and the monthly clinical meeting, the needs of vulnerable patients were discussed at the monthly safeguarding meetings. Safeguarding concerns were discussed at interdisciplinary team meetings and reported where appropriate. Staff gave us examples of safeguarding and confirmed that action had been taken.

All staff we spoke with had received up-to-date safeguarding training at a level appropriate to their role. The data showed 100% completion rate for those required to complete safeguarding adults' modules 1-4 and 100% completion for safeguarding children's modules 1, 2 and 4 with module 3 seeing a 94% completion rate, just below target.

There was a chaperone policy in place and clinical staff had completed chaperone training. There were chaperone posters on display throughout the building. If a chaperone was requested, then this was documented in the patient`s notes.

Staff that we spoke with knew who the Infection Prevention Control (IPC) lead was and how to contact them. The service had a designated IPC link practitioner to provide support to staff and promote best practice in IPC. Staff had completed mandated IPC training. We observed during the inspection that staff followed infection control practises which included hand hygiene and bare below the elbows. Cleaning audits were completed quarterly, and the wards had achieved compliance. The environment was-clean and tidy. Staff told us during the inspection that they felt comfortable highlighting any IPC issues if required There were systems and policies in place for safely managing healthcare waste.

The wards had cleaners available 7 days per week between the hours of 08:00am to 16:30pm.

Environmental cleaning was provided by an external contractor. Twice yearly deep cleaning of the wards took place. Staff that we spoke with highly praised the cleaning staff stating that "nothing was too much trouble."

All patients were provided with their own room with ensuite facilities. Infections were monitored, and if identified were followed up by the IPC lead. For patients that posed an infectious risk information was shared with all staff during handovers. Signs with the appropriate IPC precautions required would be placed on the door to the individual patient's room. Personal Protective Equipment (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.

Cleaning cupboards were found to be clean with items correctly stored. Staff told us that there were no issues with obtaining kit and/or equipment. Both cleaning cupboards had access to Control of Substances Hazardous Health (COSHH) information for the cleaning products that were available. The Cleaning cupboards were locked securely, and the key was kept on the ward.

Curtains were dated and changed every 6 months or as required if soiled or dirty. Ward staff had oversight of when they were due to be changed.

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 equipment leads 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. The equipment support officer had oversight of all faulty equipment and had responsibility for reporting it and arranging repair. 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 storeroom on each ward which contained sufficient consumable items for clinical care such as dressings and PPE.

## Risks to patients

Staff that worked within the inpatients service were subjected to robust recruitment checks which included an enhanced Disclosure and Barring System (DBS) check. Medical, nursing and therapy staff had the required professional registrations and were in date. Most staff were up to date with their Hepatitis B vaccination. Some staff were non-responders this risk was logged on the divisional risk register. Individual risk assessment was completed and for non-responders and they were aware of actions if exposed.

There were sufficient nurses to meet the current population need on the wards. In the event of staff absences, the arrangements were for each ward to assist each other to provide cover to ensure safe staffing for patient ratio.

There were significant soft and hard staffing gaps across military and civilian staff within the nursing division. This will reduce the staffing workforce by 20%. This could result in unsafe staffing levels therefore there is a potential requirement to mitigate risk to reduce inpatient numbers to maintain suitable safe staffing ratios.

Staff received training in medical emergencies. All health care assistants (HCA) complete bedside emergency assessment training (BEAT) annually which covered anaphylaxis, basic life support, national early warning score (NEWS) and situation, background, assessment, recommendation (SBAR) and grab bag familiarisation. All staff recently completed a rehearsal of concept (ROC) drill scenario in the aquatic center. The resus team led this.

Resuscitation trollies were available on the wards. There were daily checks of items on the trolley such as defibrillator, suction unit were checked and completed. The trolley was locked with tamper proof tag in place. Medicines required in an emergency were available and were all in date. A grab bag was available on one of the wards and there was a second grab bag located at the control centre. This is a locked facility which is staffed 24/7 by the guard service. In addition, there were 10 defibrillator units across the DMRC and the locations of these was documented in the resuscitation policy. New staff members were made aware of the defibrillator locations during their induction.

We found that the grab bag had paperwork for scribing however it had not been updated since 2019 and it referred to resuscitation guidelines dated 2015 which were out of date.

We found on inspection that the resuscitation trolley was located away from the power socket leading to a trip hazard. This was highlighted as a risk during the inspection and staff moved the trolley nearer to the power supply. We were assured that the provider had responded effectively and reduced the risk.

Nursing staff had completed hot and cold injury prevention training and had achieved 100% compliance.

Nursing staff were required to complete sepsis in primary care training e-learning package. Data showed that 91% of staff had completed this.

## Information to deliver safe care and treatment.

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.

Blood tests were tracked on the specimen register and test results were given to the medical team. If urgent bloods were needed to be sent to the hospital, then military transport was available 24/7 and these were taken to an external host hospital. The IPC lead had access to the register and any abnormal microbiology results they would be notified of to take the appropriate action for example isolation of the patients if required. Staff told us that there are no issues with the labs and all results are returned.

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.

## Safe and appropriate use of medicines

The pharmacy team undertook ward visits and ward staff knew how to contact pharmacy to ask for advice or obtain supplies of medicines. The pharmacist regularly reviewed patients' medicines and administration records.

The pharmacist was involved in consultant ward rounds and multidisciplinary team meetings to provide guidance and support with prescribing and monitoring patients medicines.

Allergy statuses of patients were recorded on all medicine records seen. This meant that allergies were highlighted, and medicines could be prescribed safely.
Patient's weights were recorded on medicine records seen which is important for calculating weight-based medicines prescribing. However, one patient had the incorrect weight transcribed onto their medicine chart which was highlighted to the ward staff at the time and was corrected.

Documentation of medicines administration including routes of administration and specific times of administration were completed on the medicine records reviewed.

The use of patient group directions (PGDs) was limited to five locally agreed PGDs Ibuprofen, Paracetamol, Gaviscon, E45 and Chlorphenamine. Staff that were qualified to utilise PGDs had completed training which included Basic Life Support (BLS) and Automated External Defibrillation (AED) and were signed competent. We checked the PGD register that was on the nurse-led ward and found it was all in order. We were told a hard copy was kept in the dispensary.

## Track record on safety.

Measures to ensure the safety of facilities and equipment were in place. Risk assessments were completed and included both clinical and non-clinical risks. Fire risk assessments of the building were carried out annually and we saw evidence where necessary of an agreed action plan which set out corrective measures required for compliance in line with fire safety regulations. Staff were up to date with health and safety training which included fire safety training. Staff were aware of the fire evacuation plan and what to do in an emergency.

## Lessons learned and improvements made.

All staff had access to the electronic organisational-wide system for recording and acting on significant events and incidents. All incidents reported were logged through the Automated Significant Event Reporting System (ASER) system. They were discussed at the heads of department (HoDs) weekly meetings. These meetings were minuted and shared with staff for awareness via email. Staff told us that key headlines were also shared during ward meetings.

Data showed between April to October 2023 that there had been 14 ASER reports on Headley ward. This included clinical administration, medical device/equipment, medication Intravenous fluids (IV) and documentation. All 14 incidents were categorised as no harm or low harm.

Ward managers disseminated a weekly email to staff summarising any new ASERs reports. From the staff we spoke with, and evidence provided, it was clear there was a positive culture of reporting incidents. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements and learning made from the outcome of investigations.

Staff understood duty of candour. They were open, transparent and gave patients and families a full explanation if things went wrong.

There was a system and process in place for the service to receive and act upon any safety alerts relating to drugs and equipment. We saw that alerts were received, logged, and actioned from, Medicines and Healthcare products Regulatory Agency (MHRA), National Institute Clinical Excellence (NICE) & Department of Health (DoH).

# Are services effective?

**We rated the service as GOOD for providing effective services.**

## Effective needs assessment, care, and treatment

Staff followed up to date policies to plan and deliver high quality care in line with best practise and national guidance. Arrangements were in place to ensure staff had a forum to keep up to date with developments in clinical care and guidance included monthly clinical and healthcare governance (HcG) meetings.

There was a DMRC 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 monthly audits conducted by the ward audit links. This process provided a framework for measuring the fundamentals of 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 consultant led 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.

## Monitoring care and treatment

One of the medical consultants was the quality improvement lead. There is an annual audit programme with named leads for each audit. Detailed audit outcomes were provided. There was evidence of action plans in response to audit findings, so we were assured that managers and staff used audit results to improve patients' outcomes.

Outcome measures are used to measure effectiveness. For Neuro rehab patients the Canadian Occupational Performance Measure (COPM) is used and in CT – the IDT complete a form at the start of treatment and at each follow up. Some are patient reported and some condition specific and are used to monitor progression and set goals. Every patient has standard outcomes, review at 18 months. Return to Normal Living Index and

some injury specific measurements are also used. Outcome data was used as part of the service evaluation.

There is a working party to ensure care and treatment is in line with best practice guidelines. For example, in response to the NICE guideline for sleep identified training needs, a pathway was developed.

## Effective staffing

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 identified and appropriately met. This was uplifted according to the patient ratio and workload when needed. There were both military and civilian staff who had worked in a range of healthcare settings to enable them to develop appropriate skills.

Therapy staff were appropriately qualified and skilled to meet the needs of patients. Speech and language therapy (SLT) is part of the neuro rehabilitation service, the service had recently recruited an additional SLT primarily providing treatment for patients under the neuro rehab service. Referrals from the unit were made formally via DMICP to access support. Some patients may be signposted to their local NHS service if appropriate. There is a business case in progress for an additional post to meet the needs of the wider DMRC.

At the time of inspection provision for access to Nutrition and Dietetics (N & D) was limited due to staff absence. There was one inpatient with a tube feed requirement, but they were self-managing. There was access to offsite support via the wider MOD network.

We spoke with a range of OT staff including Neuro, CT, Spec rehab, lower limb, horticulture therapy, PWS and vocational OT’s all reported good access to learning opportunities, CPD and shadowing for learning.

All staff have access to an individual training budget which allows staff to exercise autonomy in identify training and development opportunities that also support the team and service objectives.

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.

The Consultants supervise the Royal College of General Practitioners (RCGP) General Practitioner (GP) Specialist Registrar (SpR) training. This is a four-month rotation and the Joint Royal Colleges of Physicians’ Training Board training for Sports and Exercise Medicine (SEM) for SpR, is for six to twelve months.

The junior doctors we spoke with commented very favourably about their time at DMRC and describe it as better than working for the NHS.

They receive a two-day induction followed by two weeks working in all the medical teams before being allocated to a specific team, with supervision from the relevant clinical lead. All doctors have structured learning three times a week as well as a weekly meeting with the clinical director. They reported that they had opportunities to contribute to positive changes during their rotation e.g. updating the admission documentation, update of SOP for managing pin site infections, development of handover/takeover sheet for patients transferred to local NHS Hospital in emergencies, this included information for NHS staff to understand level of care that can be provided at DMRC. Junior doctors reported that they were empowered to produce a PowerPoint presentation for future rotations and to update the junior MO handbook.

Currently there are 14 consultants in post, 8 military and 6 civilians. However, 2 posts are not covered due to absence. The Consultant body work with all aspects of the services provided by DMRC.

The Unit is looking to the development of new roles as well as filling gapped positions. The draft plans include reallocation of roles, review of job plans and TORs. There was good awareness of other factors impacting on potential plans such as governments cost savings and that recruitment of staff is proving more difficult in the Midlands than it was in Surrey.

There was a workplace Induction Programme (WIP) for all new staff. Nursing staff completed two weeks supernumerary ward orientation. All new staff were expected to complete a competency-based workbook and were signed off for procedures when competent. Staff told us that they had received a comprehensive induction to the unit and their assigned ward. They were given the opportunity to shadow colleagues before commencing their new role. The practice development team worked alongside staff to provide support and mentoring during their induction. All new staff are expected to complete their mandated training within three months of starting their position.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff groups we spoke with thought there was good provision and support for appraisal and supervision.

Staff had access to role specific training. For example, the IPC lead is completing a masters in IPC, the practise development team provided Intravenous therapy uplift training, and some military staff undertake regular placements with external NHS trusts and bring back shared learning to the unit.

## Coordinating care and treatment

There are consultant led weekly IDT meetings. These are attended by the full multidisciplinary team. Staff reported that since the last CQC inspection in complex trauma the format of the IDT had changed and was now more focused around patient goals, setting SMART goals that are shared with wider team. For neuro patients Goal Attainment Scaling (GAS) is undertaken on admission and every 6-8 weeks afterwards at treatment planning meetings.

Staff we spoke with from all disciplines reported that the IDT's, treatment planning meetings were well run, patient focused, and all felt they had a voice at the meetings and that their views and opinions were valued.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. The service had links with external organisations to provide additional training to the team.

Staff encouraged patients to be actively involved in their care and treatment. Staff told us external trainers had visited the unit to provide one to one training to both staff and patients in catheter care and Percutaneous Endoscopic Gastrostomy (PEG) care and management. Other examples were given including the Spinal Injury Association and Headway who had attended the unit and provided teaching to patients and staff to assist in their treatment pathways.

## Helping patients to live healthier lives.

The inpatients department had a named lead and deputy for health promotion. There was a structured programme of health promotion activity with a yearly planner and calendar on the Healthcare Governance (HcG) workbook. There were notice boards displaying a range of health promotion information for patients.

Staff told us patients were encouraged to be involved in health promotion. Patients requested health promotion information related to their conditions. We noted during inspection that a spinal awareness month had taken place. A health promotion fair had taken place for both patients and staff to attend.

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 have a menu to choose from, the menu has a 4-week rotation. Patients can provide feedback on food via the 'did we impress today' QR code. The key themes are portion size, temperature, quality, and choice.  Any menu changes are made at a regional level through the defence infrastructure organisation (DIO). Patients do not have a direct

input in to the menus however any feedback is given to the DIO. As a result, there has been a significant uplift in funding. The additional funding has allowed for sourcing of better-quality supplies for example bread, snacks, and juices.

The catering service also provides a theme night once a month, patients pick the theme and feedback is positive.

There are kitchen facilities on the wards where patients can make a drink, toast, or have a snack, fridges are topped up regularly by the catering staff. The Quartermaster carries out a walk around 3 times a month, there is a weekly meeting with DIO, a helpdesk and food audit to maintain oversight.

## Consent to care and treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. This was recorded during their initial treatment planning meeting following admission. A review of patient notes evidenced that verbal consent was recorded and coded appropriately on electronic clinical records. Written consent was obtained for more invasive procedures in line with policy.

Staff told us they had received Mental Capacity Act (MCA) training. Data provided by the unit to evidence compliance with this training showed that only 76% of required staff in the nursing division had completed this training. This was below the compliance target rate. There was a plan in place to improve compliance.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. 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 gave good examples where mental capacity assessment had been required for patients and how an MDT approach was taken which included junior doctors input and escalation.

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.

Staff understood Gillick Competence and Fraser Guidelines and how to support 16- 18 years old who wished to make decisions about their care and treatment. Staff we spoke with understood Gillick competency and could give examples of when they had applied it

in practice. Gillick competency helps staff assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

# Are services caring?

**We rated the service as GOOD for providing caring services.**

## Kindness, respect, and compassion

Patients gave positive feedback about the service. Patients we spoke with were very complimentary about the care given, staff and the facility. The service had received numerous written and verbal compliments. The overriding theme was that staff were caring and professional.

The DMS patient experience survey is used to obtain feedback. Between October 2022 and October 2023 results showed there had been 123 responses and 96 patients rated their overall experience as outstanding. All patients confirmed that staff treated them with kindness and compassion. Results also showed that they felt involved in their care.

We were provided with numerous examples of when staff had gone ‘the extra mile’ to support vulnerable/at risk patients and/or to provide compassionate care that met the specific needs of the individual patient and their families.

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.

## Involvement in decisions about care and treatment

An interpreting service was available for any additional language requirement. Staff knew how to access and had used this service. Some of the staff spoke two to three languages so were utilised in an emergency. There was a list of service personnel who spoke second languages.

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.

There was a process to identify patients with caring responsibilities. This was assessed as part of the admission process so that the correct level of support and guidance could be given. Both patients and relatives could access welfare support on site.

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 had completed training on resilience and wellbeing. Data showed that 96% of staff had completed and had achieved above the compliance rate.

Patients can access the social worker team if required. They provide a wide range of help and support to patients with housing needs, benefits issues, mental capacity assessments, long term care needs assessments and help with transition from military to civilian life. Patients could be signposted to outside agencies such as charities for support.

## Privacy and dignity

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 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.

The DMS patient experience survey feedback between October 2022 and October 2023 showed there had been 123 responses. 106 respondents said that their privacy and dignity needs were maintained all the time.

Patients could request to see a clinician of a preferred gender.

# Are services responsive to people's needs?

**We rated the service as GOOD for providing responsive services.**

## Responding to and meeting people's needs

The unit had been set up to provide different specialisms of care on 3 wards. The unit used a dependency rather than condition model on the wards in order to provide a

transitional pathway of care for patients from full nursing dependency to self-management. This encouraged more efficient use of staffing.

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.

The Highground charity also provided bespoke horticultural therapy for individuals, working closely with the occupational therapy team on specific individual rehabilitation goals to support military personnel to return to active service or civilian life. Patient feedback is very positive, with expectations exceeded.

Staff advised us that they take part in team days. This was a mix of both military and civilian staff and enabled a better understanding of how service personnel become injured and how DMRC can assist in the care pathway of recovery.

The unit had a designated diversity and inclusion (D&I) lead who co-ordinates D&I work across the unit with support from D&I champions. They promoted inclusion, identify D&I issues, identify trends, share best practice, consider policy changes, and advised the commanding officer.

## Timely access to care and treatment

Referrals for inpatient admission to  neurological rehabilitation and complex trauma were able to be received from the Royal Centre for Defence Medicine, consultants in all NHS hospitals and medical officers at medical centres. Referrals for admission were triaged by the IDT  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 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 to meet the admission criteria.

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 at home with a home programme 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.

## Listening and learning from concerns and complaints

Within inpatients information was available to help patients understand the complaints system, including a QR code for patients to scan on the ward notice boards. We spoke with patients who confirmed they knew how to make a complaint.

The ward manager was the complaints champion. 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. Staff described the complaints process and confirmed that complaints and compliments were discussed at monthly team meetings.

There were compliments and complaint boxes around the facility which patients and staff can leave feedback anonymously.

All complaints, whether written or verbal, were recorded on the divisional workbook which could be accessed by all staff and actions and next steps were documented. Data showed from July 2023 to November the unit had received 10 complaints which related to low staffing numbers, staff morale and senior management being not approachable.

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.

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?

**We rated the service as GOOD for providing well led services.**

## Leadership, capacity, and capability

It was clear that the Officers Commanding (OCs) and service leads for complex trauma and neuro rehab recognised the value of working together across the different pathways to deliver the service. Staff we spoke with across all disciplines also report the importance of working together as a multi-disciplinary team to deliver the best patient experience.

The nursing division was led by an OC who was supported by a Deputy OC Nursing (DOCN) and a matron. Practice development nurses, clinical nurse specialists and a bed manager reported to the DOCN and matron. There were Officers in Command and 2ICs for each ward who reported to the matron and DOCN. Managers had completed various management and leadership training to ensure they had the skills for the role.

Consultants hold ultimate clinical and medicolegal responsibility for all patients, with consultant led rehabilitation for MIACs, residential and inpatient admissions. This includes liaison with external DMS and NHS consultants.

Staff reported during the inspection that the new leadership team seem engaged and approachable.

## Vision and strategy

The mission statement for DMRC is ‘to deliver consultant-led, safe and effective specialist interdisciplinary rehabilitation services to meet the needs of our patients and Chain of Command.’ To achieve this, all aspects of governance and assurance must be met and understood by all. The vision of the consultants we spoke with is to provide a world leading site of excellence which provides the best possible care for injured military. They strive to provide a level of rehabilitation beyond the level that the NHS is currently able to provide, to get their patients to the highest achievable function whether that is remaining in the military or transitioning into civilian life. As it is occupationally driven, this drives many of the end goals compared with the NHS. The consultants we spoke with described DMRC as a tertiary specialist centre for rehab which is unique in the UK. They felt that this uniqueness drives up the quality of care especially with the integration of medical expertise, physiotherapy, occupational therapy, psychological treatment, and pain specialists. What DMRC provides which is unique, is a wrap round holistic care package which includes Occupational Therapy, Pain specialists, Mental Health, and welfare support as well as the physiotherapy and rehab provided in the Regional Rehab Unit

Staff that we spoke with were aware of the vision and strategy.
The unit was passionate about the protection of the environment. There were many recycling bins including food recycling bins around the building.

## Culture

Leaders tried to ensure positive staff morale. However, due to the staffing gaps the unit were facing, some staff felt that more could be done to help provide a better life work balance. For example, for nursing staff changing shift patterns around long days. The leadership team recognised that staff gaps and sickness were difficult to manage, and there are additional challenges as a result of middle management sickness levels. Leaders were sighted on this, and the potential impact of staff burn out which could affect patient care. The unit was in the process of on boarding new staff members to fill the hard and soft staffing gaps, however this process was lengthy.

Staff told us that they felt supported by managers and that they worked well as a team. It was clear from patient feedback and from staff we spoke with there was a patient-centred

culture at the unit. The consultants we spoke with agreed that they have shared goals and described a friendly collegiate atmosphere.

All 13 senior nurses had completed freedom to speak up (FTSU) and listen up training with 100% compliance. All staff had access to FTSU and D&I champions. Staff told us they could raise concerns and said they felt listened to. There was a whistle blowing policy and staff were aware of how to access support if required.

There was an emphasis on staff wellbeing and safety. 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.

HighGround charity also provided lunchtime health and wellbeing sessions for staff which are well attended along with a one-day workshop.

Senior leadership team advised that all staff have access to health and wellbeing, friends and family days, social events, staff PT which is also opened to civilian staff. We were advised that staff can sign out kit and equipment for days off and annual leave such as camping kit and equipment or bikes at no charge.

Station Personnel Support Committee is held every 37 days. Unit Health Committees are to be held quarterly and will be chaired by the 2IC. In accordance with AGAI 57 all Army personnel who are on WISMIS (Wounded Injured and Sick Management Information System), on the vulnerable list or downgraded should be discussed every 28 days at a CMCR Commanders Monthly Case Review (CMCR). There is a welfare committee in place. Staff raised a concern that military staff within DMRC are not receiving the full support that is currently mandated.

Systems, processes, and policies are in place to support staff health and wellbeing, for long- and short-term sickness, return to work process and gradual return to work. There are some challenges around some differing approaches for military and civilian staff, but the leadership team had good oversight of all aspects of staff management and support including vacancy hotspots, recruitment, sickness absence. A dashboard was in place to facilitate this.

## Governance arrangements

Since the last inspection it was evident that significant changes and progress had been made towards embedding the governance vision of 'business as usual'. Staff reported that previously there was 'stove pipe/silo working', now from exec down and OC across all service there is a single approach, learning and plans are shared to meet objectives and develop services. Work strands for service reviews and management action plans, QIP and audit are better organised. All staff we spoke with had access to the Healthcare governance (HcG) workbook which included various registers and links such as the risk

register, ASER tracker, complaints, IT faults and cleaning issues log. A range of information was accessible though quick links from the HcG workbook. These included risk assessments, terms of reference (TOR), and the standard operating procedure index. The workbook was continually being developed. Staff were aware of the governance system through weekly team meetings and monthly governance meetings.

The consultants we spoke with had good oversight of risk and governance across the unit. Since the last CQC inspection there has been a drive to make governance and data collection part of the daily working routine rather than something that is done prior to inspections. This has led to an improved governance structure and much more collaborative work across teams and departments. This includes a weekly meeting every Monday morning where significant medical cases are discussed initially followed by a rolling agenda of looking at ASERs, risk, governance, audits etc. Meetings were reported as well attended with an average attendance of about 30 people across the Unit, a record of the meetings is maintained.

## Managing risks, issues, and performance

The service had established a governance structure that provided oversight of risk and the quality of service. There was a risk register and a retired risk register. Risk and issues were reviewed monthly or as identified and logged on the DMRC risk and issues registers.

The consultant group and leadership team had good awareness and oversight of concerns including:

- planned changes to DMICP that could impact on patient care for example repetition of tests and delays to the pathway.
- The establishment of the National Rehabilitation Centre (NRC), there are very real fears that this will be detrimental to the staffing within DMRC.
- The NHS is offering higher grade posts than the DMRC is able to and additionally the onboarding process for civil servants in the MOD is considerably slower compared to the NHS.
- Succession planning for consultants, a number of existing consultants are due to reach retirement age over the next 10 years. External factors impacting on this are change made by the General Medical Council, specifically in rehabilitation and rheumatology.

## Appropriate and accurate information

The service worked in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records, and data management systems.

## Continuous improvement and innovation

Continuous improvement was one of the service's strategic objectives. The inpatients service had a quality improvement lead (QIP) and a QI champion. There was a QIP register which detailed the current audits, service improvements and projects.

Significant improvements apart from the new infrastructure includes on site MRI and USS service with onsite radiologists who are often able to do imaging on the same day with rapid reporting. The pharmacy is much more robust and organised. All medical staff described a more integrated service with improved networking.

There is a more formalised interface between clinical care and academic research under one roof. The Professor of Rehab and Rheumatology works both in the clinical area and in the Academic Department of Military Rehabilitation, (ADMR). This leads to more flexibility to change delivery models. All consultants we spoke with agreed that by working cohesively clinical pathways have informed research and vice versa.

The inpatient services had commenced a wide-ranging quality improvement and service development programme (QIP) to improve co-ordination of nursing and rehabilitation activity to support the maturation of the DMRC Transitional Rehabilitation Model and to cement a culture of reintegration into inpatient rehabilitation activity. The project will launch with the establishment of a steering group to oversee the delivery of this QIP with the intention of completion in time to reflect, report and present at the Defence Rehabilitation Conference in Autumn 2024.

# Force Generation - Summary of this service.

## Background to Force Generation

Force Generation provides services for:

Spines and upper quadrant Inter Disciplinary Team (IDT) management of persistent back and neck pain and complex upper limb injury using a multi-faceted approach, including bespoke individualised residential rehabilitation courses.

Specialist rehab outpatient (OP) IDT management of chronic multi-systemic conditions using a multi-faceted approach, including bespoke individualised residential rehabilitation courses.

Lower limbs, podiatry OP IDT management of complex lower limb musculoskeletal Injury, including bespoke individualised residential rehab courses.
High performance clinic for early access to diagnosis and management opinion for service personnel in elite sports.

# Are services safe?

**We rated the service as GOOD for providing safe services.**

## Safety systems and processes

Training compliance was set at 95% for the DMRC. All staff had 12 priority mandatory training modules to complete which included safeguarding, data security awareness, health governance and assurance, health and safety, infection prevention and control, basic life support (including anaphylaxis and automated external defibrillator, information & knowledge awareness, prevent, protecting personal data (DIMP), records management awareness (DIMP), security fundamentals and freedom to speak up.

An overview of mandatory training compliance was stored electronically. The training team and line managers retained oversight of mandatory training progress for their workforce. Staff receive an email prompt when their mandatory training requires updating and staff had training passports to record compliance and reminders to keep on track.

The Force Generation team consisted of 116 service personnel. The training data supplied for Rehabilitation Division covering the period from 1st January 2023 to 7th November 2023 showed only 11% of service personnel had achieved 90% completion or above. However, this data was not specific to the Force Generation team.

The service adhered to the Defence Primary Healthcare (DPHC) tri service safeguarding policies for adults, children, and young people. Both polices were in date and version controlled. Each policy had a clear flowchart and process to guide staff on how to escalate concerns. The policies included contact addresses and telephone numbers for the local safeguarding teams (both in hours and out of hours), and these were displayed in the waiting areas and clinical rooms. Staff we spoke with during the inspection were fully aware of the policies and knew how to recognise and report a safeguarding concern.

Safeguarding was a role specific requirement and not all Force Generation staff were required to complete all safeguarding training modules for adults and children. Staff had received training at the appropriate level to their role.

Chaperone posters for patients and staff were displayed around the force generation unit. The staff poster had clear and detailed information on the expectations of staff undertaking the chaperone role. These highlighted the opportunity for patients to have a chaperone present for any appointments they attended. Staff asked patients at each appointment if they required a chaperone. If a chaperone was required, then this would be documented in the clinical records. Staff who were required to chaperone had received training.

Staff knew what to do in the event of a code blue response (when a patient needs immediate emergency medical attention) and they knew how to access resuscitation equipment including grab bags.

The force generation unit had suitable premises, facilities, and equipment. There was a wide range of equipment to aid patient`s rehabilitation and recovery. All Physical Training Equipment (PTE) had maintenance labels which showed when the next scheduled service was due. All other medical equipment that we saw had service labels which identified whether it was scaled and recognised by a FMED 1023. Non-recognised equipment was marked with the respective contractors' company sticker. The Equipment Support Officer (ESO) kept a spreadsheet which was Red/Amber/Green rated that showed when equipment items were due for service.

Force Generation had a clear equipment care system in place that included engagement with a significant number of other stakeholders to ensure that procurement, maintenance, calibration, servicing, spares, consumables, software, and disposal were all managed. They had established a scaled rehabilitation equipment list and continue to represent their specific requirements at the Defence Rehabilitation Equipment Committee (DREC), all of which represent high levels of diligence in this area.

At the previous inspection it was identified that improvements were needed for through life support (TLS) of equipment which had been gifted or gained through non-public means. There was now a process in place to manage sustainability and availability of equipment to support safe patient care. This was managed by a dedicated team.

All staff were properly inducted and competent in both the use and care of equipment. Equipment care leads kept a competency record for all staff. All new equipment came with Train the Trainer packages to ensure sustainability and effective use. Equipment spot checks were routinely conducted, recorded and issues were highlighted at the commanding officer monthly brief.

Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place, and this was signed off to confirm that cleaning tasks had been completed in line with the agreed frequency. Cleaning standards were monitored and at the time of inspection, the department was visibly clean. Cleaning audits data showed that for Q1,2 & 3 2023 compliance achieved was between 93% and 96%.

We reviewed hand hygiene and sharps management data for the period May to October 2023. Audits of the 'five moments for hand hygiene' were carried out monthly and results showed 100% compliance. Results of the monthly audit of sharps management also showed 100% compliance.

The hydrotherapy pool had a cleaner dedicated to the area daily and equipment was cleaned after each use. All areas of the pool had enhanced cleaning regimes. On the day of the inspection the pool area was clean and tidy.

The entrance to the pool area was protected by a keypad and patients were not able to access the area unattended. An external contractor managed the chemical testing and maintenance of the pool.

Lifeguards were present during all sessions. All rehabilitation staff including lifeguards knew what to do in the event of an emergency and could locate equipment including Automated External Defibrillator (AED) and spinal board. Staff were able to detail all exit routes and the assembly point should an evacuation occur. Space blankets and towels were available for evacuations. The lifeguard office held current Health & Safety Executive (HSE) information and key contacts for the current contractor that manages the pool.

The unit 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 through April and May 2023. A management action plan had been developed from the findings of the audit and each action had RAG priority rating.

## Risks to patients

Staff who worked within the unit were subjected to robust recruitment checks which included an enhanced Disclosure and Barring Service (DBS) check. All staff had the required professional registrations and were in date. Most staff were up to date with their Hepatitis B vaccination and there was a Hepatitis B register available to view. Some staff were non-responders; this risk was logged on the divisional risk register. Individual risk assessments were completed for non-responders, and they had been made aware of actions if exposed.

## Information to deliver safe care and treatment.

The unit 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 in order to treat the patient.

Patient records were organised, up to date, shared and stored appropriately. We reviewed 21 patient records for patients attending the multidisciplinary injury assessment clinics (MIAC) and rehabilitation courses. Records included referral information, past medical history, treatment plans, goals, outcomes and were all complete. All records were stored securely on an electronic system with password protected access.

## Lessons learned and improvements made.

All staff had access to the electronic organisational-wide system for recording and acting on significant events and incidents. All incidents reported were logged through the Automated Significant Event Reporting System (ASER) system.

We reviewed incident reports (ASER's) submitted for the Force Generation unit for quarters 1, 2 and 3 for 2023. There were 3 purple reports for good practice and 19 other reports, all categorised as low harm. Evidence showed that incidents were reviewed and closed in a timely manner.

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.

Lessons had been learnt in the management of a cardiac patient inpatient. An ASER highlighted the safety issues linked with treatment of a neuro (damage to the nerve system) patient who had not followed the cardiac rehab pathway. Changes from the ASER now ensured that neuro patients were treated and supported by a Cardiac Lead from Spec Rehab. This provided an excellent example of inter-team support to meet patient needs.

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.

# Are services effective?

**We rated the service as GOOD for providing effective services.**

## Effective needs assessment, care, and treatment

Patients' 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 followed professional standards of practice and followed national guidelines for care and treatment such as NICE guidelines.

Rehabilitation was delivered in line with evidence-based practice guidance on treating musculoskeletal conditions and provided a holistic approach to rehabilitation. Courses provided exercise and education sessions which included health promotion and wellbeing information. The rehabilitation courses were based on best practice guidance and had been written centrally. The courses were standardised across Defence Primary Healthcare (DPHC) with specified mandatory elements although the delivery of these elements could be modified in each unit to suit the resources available.

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.

Following the inspection findings in relation to PROMs in 2022 a project to review the effectiveness of a system to collate and monitor patient outcomes had commenced. The pilot programme ran from May 2023 to October 2023. At the time of the inspection the pilot evaluation data was not yet available.

A service evaluation was completed for specialist rehab between January and April 2023 which identified outcomes by comparing patient data at admission, at 6 weeks and at 6 months post discharge. The approach used Joint Medical Employment Standards (JMES)(this is the means of categorising employability, Functional Activities Assessment score (FAA) and Canadian Occupational Performance Measure (COPM) score (measures client-perceived changes in occupational performance over time). Improvements were seen in occupational outcomes (JMES) with 77% of patients back to service at 6 months post admission. COPM scores demonstrated that at 6 weeks post admission 61% of patients showed a clinically significant improvement in their perceived ability to perform activities that they had identified as problematic. 94% showed an improvement overall in their perceived ability to perform activities that they identified as problematic. 77% of patients showed a clinically significant improvement in their satisfaction with performing problematic activities. 94% overall showed an improvement in their satisfaction with performing problematic activities.

The unit had produced a Cardiac Rehabilitation (CR) Standard operating procedure (SOP) aligned to British Association for Cardiovascular Prevention and Rehabilitation (BACPR) which ensured staff were trained and prepared to best support the needs of CR patients.

## Effective staffing

Staff had the right qualifications, skills, knowledge, and experience to do their job when they started their employment and when they 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.

Registered professionals were supported to meet the requirements of their professional registration. A register of staffs' professional registration was held which included health and care professions council (HCPC) and general medical council (GMC) registration numbers. We saw that all registered professionals had current registration. Staff undertook a number of work-based activities including training.

Managers supported staff to develop through yearly, constructive appraisals of their work. All staff within the rehabilitation division that we spoke with had received an appraisal within the last year. Staff appraisals rates were 100%.

There was a Workplace Induction Programme (WIP) for all new staff.

All Force Generation staff 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 Exercise Rehabilitation Instructors (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 Multi-disciplinary Injury Assessment Clinic (MIAC). 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.

Inter Disciplinary Team (IDT) meetings occurred weekly. IDT meetings involved the whole team to review progress to discharge against set goals, and general welfare and support of the patient. The IDT also helped to risk assess activities for the patient and decide on fitness to return home at weekends. Treatment Planning Meetings (TPMs) occur between the whole team ensuring that every facet of treatment was considered.

Staff engaged with Primary Care Rehab Facilities (PRCF) to ensure that continuity of treatment and aftercare was maintained. Staff used the FMed 14 for discharge summaries plans which outlined the patient treatment plan and onwards referrals were clearly documented in the records. All services within DHPC used these records so PCRFs and Force Generation staff could clearly see the plans following a course for their patients.

## Consent to care and treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. This was recorded during their initial treatment planning meeting. A review of patient notes evidenced that verbal consent was recorded and coded appropriately on electronic clinical records. Written consent was obtained for more invasive procedures in line with policy.

Staff told us they had received Mental Capacity Act (MCA) training. Data provided by the unit to evidence compliance with this training showed that only 81% of staff had completed this training. This was below the compliance target rate. There was a plan in place to improve compliance.

# Are services caring?

**We rated the service as GOOD for providing caring services.**

## Kindness, dignity, respect, and compassion

Patients said that they felt safe, and that staff provided excellent care.

Patients gave positive feedback about the service. Data from the patient experience survey results showed that many of the respondents that attended the Individual Programme, Strength Training, or Group Therapy sessions rated their delivery as “Excellent” or “Good.” Most people said that the sessions were “Very” beneficial to their recovery. Most respondents who attended the Mobility and Flexibility, Hydrotherapy or CV sessions rated their delivery as “Excellent,” and most people felt that they were “Very” beneficial to their recovery.

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.

It was evident staff clearly understood the impact that a patient’s care, treatment, or condition had on their wellbeing. Staff recognised how problems with physical health and fitness could affect patient’s mental health. Staff gave examples of when they had signposted individuals to additional support services to support their full recovery.

Staff supported patients to manage their emotional needs and understood how working in a high-pressured environment could affect engagement with rehabilitation and jeopardise their ability to make a full recovery from injury.

## Involvement in decisions about care and treatment

Staff were able to form close professional relationships with the patients due to the nature of their work. Over the course duration of eight days, they were able to spend time talking to patients about their care, treatments goals and progress. Staff showed an encouraging, and supportive attitude towards patients.

Patients were encouraged to be active partners in their care. Treatment goals were agreed between staff and patients and were regularly reviewed and updated as required. Patients on the course told us that they could discuss their treatment on a one-to-one basis with the course instructors at any time.

Staff communicated with patients to make sure they understood why they were doing specific exercises. We observed staff clearly demonstrate exercises to patients and take the time to explain the relevance of the exercise and how this would benefit the patient. Staff took the time to correct the technique used by patients to ensure that the exercises would have an optimum impact on the patient's rehabilitation. We saw that staff also demonstrated equipment to patients to make sure they fully understood how to use it safely.

There were opportunities for patients to ask questions and be involved in their care and treatment. There were positive interactions between staff and patients, and we saw that staff were all approachable and explained everything well. Staff answered questions appropriately when patients asked them. This helped to facilitate patients to take control of managing their rehabilitation independently with appropriate guidance from the staff. Each patient group had an identified physiotherapist and ERI for the duration of the course. These clinicians were their first point of contact during the course.

A patient outlined how impressed they were in how the orthopaedic surgeon and the DMRC Consultant had communicated to ensure that the treatment plan was seamless. It was also obvious how the IDT communicate and ensure that treatment is 'joined up'.

Patients were impressed with the education that they were given to manage and understand their condition. Examples that were given were the course lectures, support during group therapy sessions and discussion with their IDT.

Patients were asked about the structure, content, and practicality of their workbooks. All patients said that it was worthwhile and pitched at the right level.

Staff demonstrated a helpful supportive attitude towards patients. We observed staff supervising patients to ensure safety and providing encouragement and motivation during

the sessions. Patients reported that ERIs checked their understanding of exercises and explained how they would help their condition. Staff were described as flexible and understanding and explained how individual exercise programmes were adapted if patients were seen to be struggling or in pain.

# Are services responsive to people's needs?

**We rated the service as GOOD for providing responsive services.**

## Responding to and meeting people's needs

Force Generation provided spines and upper quadrant (SUQ), lower limbs (LL) and specialist rehab specialty courses which patients attended for rehabilitation. Courses ran between 1- 3 weeks and were provided for patients whose condition necessitated a period of intensive daily rehabilitation. Service personnel were accommodated onsite and provided with a schedule of activity and appointments on their arrival.

The unit provided Multi-disciplinary Injury Assessment Clinics (MIAC), Injury Assessment Clinics (IAC), high performance clinic, pressure testing and tendinopathy clinic.

The podiatry clinic provided lower limb biomechanical assessment, assessment for and provision of custom-made orthoses, gait analysis, expert footwear/boot recommendations and prescription for custom boots when indicated.

There were 'you said, we did' boards displayed prominently within the force generation patient waiting area. The board was current with the last review/input date visible. The service has used patient feedback to make changes to service provision. Some examples include:

Lower Limb service

*'Would like orientation to unit and introduction to camp facilities*. In response the welcome brief was revised and the lead ERI provides unit walk round.

"*Having an extra week on course would be beneficial and allow us to consolidate our IP and rehab plan".* In response the course timetable was reviewed and have designed a 3-week model which will be trailed in January 2024

"*Too much white space on timetable*". Educational video links along with self-directed study has been placed in the timetable. Additional cardio-vascular and rec therapy sessions have been introduced.

"*The patient workbook could be better and can be laborious to complete*". The patient workbook has been reviewed across the teams to link better with course structure and associated workshops

Specialist Rehabilitation service

*"We would appreciate having group sessions e.g. potted sports which caters for everyone".*

Have introduced a 'Group Recreation' session on Wednesday of week 1 allowing time

For individuals on the course to meet each other and complete a group task within the team'.

"*The session ran back-to-back and this tiring. Would benefit from a break".* Have scheduled breaks throughout the course allowing for pacing strategies to be implemented and recovery gained.

'*Physical structuring of joining instructions could be more user friendly'.* Joining instructions improved across all Force Generation teams, more concise and easier to read.

*"Nutrition – nothing on nutrition which is key to recovery".* Nutrition lecture introduced in week 2 of course.

The service development plan indicates that FG Teams aim to display this electronically in the future.

## Timely access to care and treatment

Force Generation provided assessment and treatment services between 8am to 5pm Monday to Thursday and 8am to 2pm on Fridays.

During 2022, DMRC largely met the key performance indicator (KPI) of 30 working days from referral to multidisciplinary injury assessment clinic (MIAC) for Specialist Rehab, Spines, and Upper Quadrant. Throughout 2022, the number of working days from referral to MIAC for Hip and Groin consistently exceeded the KPI despite decreasing from a peak of 74 days in June 2022 to 31 days in December 2022. From additional data supplied, DMRC had further reduced this and in March 2023 there were 20 days from referral to MIAC for Hip and Groin.
Towards the end of 2022, there was a notable increase in the number of working days from referral to MIAC for Specialist Rehab meaning the KPI was not met in November and December 2022. From additional data supplied, this was also the case for January, February, and March 2023.

Throughout 2022, Hip and Groin had the longest number of working days to first offered course. This was above the KPI of 40 days for 11 out of 12 months. From additional data supplied, this continued to rise before decreasing. In April 2023, the number of working days to the first offered course was below the KPI (26 days) however, in June 2023 this had risen above the KPI to 51 days.

Towards the end of 2022, there was a sharp increase in the number of working days to the first offered course for Specialist Rehab with the number of days doubling from 35 days in October to 71 days in December 2022. From additional data the number of working days remained above the KPI in January 2023, in June 2023 it was below the KPI at 15 days. The additional data supplied shows a generally increasing trend in the number of working days to first course offered for Upper Quadrant from late 2022 to April 2023. In June 2023 this had fallen below the KPI (good) to 36 days.

In September 2023, 1% (1) of force generation appointments booked were DNA's.

## Listening and learning from concerns and complaints

Within force generation information was available to help patients understand the complaints system, including posters and a QR code for patients to scan on the unit. Within Force Generation information was available to help patients understand the complaints system, including posters and a QR code for patients to scan on the unit. We spoke with patients who confirmed they knew how to make a complaint. Patients were able to give feedback directly to staff at the end of a course or in the patient.

All compliments whether written or verbal, were recorded on the divisional workbook which could be accessed by all staff and demonstrated the great work that they were doing.

# Are services well-led?

**We rated the service as GOOD for providing well led services.**

## Leadership, capacity, and capability

The rehabilitation division was led by the OC for Rehabilitation Division supported by service managers and team OCs.

Staff were committed to providing a high standard of safe care and spoke positively about the services they provided.

## Vision and strategy

There was a mission statement set out for the rehab division, which was to deliver an accessible, evidence-informed responsive rehabilitation service underpinned by relevant diagnosis, with the aim of maximising the functional and recovery potential of service personnel. It aimed to be person-centred, and outcome focussed utilising a biopsychosocial approach, delivered by an empathetic and accountable interdisciplinary team.

## Culture

Staff reported that leaders were open and approachable.

It was clear from patient feedback and interviews with staff there was a patient-centred culture at the unit. Staff described how the leadership team promoted an inclusive and open-door culture with everyone having an equal voice, regardless of rank or grade. Staff said they would feel comfortable raising any concerns and were familiar with the whistleblowing policy. Staff were given the opportunity to express their views at meetings.

## Governance arrangements

All staff had access to the rehab division Healthcare governance (HcG) workbook which included various registers and links such as the risk register, ASER tracker, complaints, IT faults and cleaning issues log. A range of information was accessible through quick links from the HcG workbook. These included risk assessments, terms of reference (TOR), and the standard operating procedure index. The workbook was continually being developed and was managed by the rehab division. Staff were aware of the governance system through weekly team meetings and monthly governance meetings.

## Managing risks, issues, and performance

The service had established a governance structure that provided oversight of risk and the quality of service. There was a risk register and a retired risk register. Risk and issues were reviewed monthly or as identified and logged on the DMRC risk and issues registers.

There was one risk relating to Force Generation on the unit risk register relating to lack of consultant workforce across DMRC, impacting patient care delivery in Force Generation as well as resilience to service and staff. Mitigations were in place, actions identified and reviewed regularly.

## Appropriate and accurate information

The service worked in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records, and data management systems.

## Continuous improvement and innovation

Force Generation had identified future development plan which included evaluation of all courses.

Staff told us about the introduction of a facility/equipment booking system, so that patient care is not restricted to a specific area and that further facilities can be utilised (project due to be introduced start of January 24 – coordinated by the TCWO).

DMRC have now performed ‘roadshows’ with the Force Generation Team so that PCRF staff are educated and informed on the role that they perform to ensure that the patient pathway is fully supported.

# Outpatients - Summary of this service

The outpatient service provides clinics for pain intervention and the Defence rheumatology service. Services were provided 0800-1700 hrs Monday to Thursday and 0800-1300 on Friday.

# Are services safe?

**We rated the service as GOOD for providing safe services.**

## Safety systems and processes

Medical, nursing, health care assistants and administration staff received mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. All staff could access the staff database and record their own training. Protected time for mandatory training was made available to all staff.

The service adhered to the Defence Primary Healthcare (DPHC) tri service safeguarding policies for adults, children, and young people. Both polices were in date and version controlled. Each policy had a clear flowchart and process to guide staff on how to escalate concerns. The policies included contact addresses and telephone numbers for the local safeguarding teams (both in hours and out of hours), and these were displayed in the waiting areas and clinical rooms. Staff we spoke with during the inspection were fully aware of the policies and knew how to recognise and report a safeguarding concern.

All staff we spoke with had received up-to-date safeguarding training at a level appropriate to their role. The outpatients service had a chaperone policy and clinical staff had completed chaperone training. There were chaperone posters on display throughout the building. Pain team records audit showed poor compliance with recording around chaperone, some improvement noted from May to October, actions had been identified to address, further audit planned post inspection.

There was a dedicated lead for infection prevention and control (IPC) for the department, and they had completed appropriate training. The service carried out IPC audits for hand hygiene (HH) and sharps management. These were completed monthly and quarterly. Compliance in HH was 100%. During the inspection we observed all staff adhering to bare below the elbows (BBE) in line with policy.

We reviewed the last six months of sharps audit data for the outpatient's department, they had achieved 100%.

Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place, and this was signed off to confirm that cleaning tasks had been completed in line with the agreed frequency. Cleaning standards were monitored and at the time of inspection, the department was visibly clean.

Cleaning audits were completed quarterly, and the department had achieved compliance. Clinical waste was appropriately managed and disposed of safely.

## Information to deliver safe care and treatment.

Within the outpatient's department the process for the management of referrals was good. External referrals were received from a number of sources including the regional rehabilitation unit (RRU), medical centres, or a primary care rehabilitation facility (PRCF). Once the referral was received by the referrals clerk this was logged and then sent to the relevant consultant to triage. Once accepted, they then sent a task to the referrals administrator to schedule an appointment with the patient if appropriate. An appointment tracker was kept and was held in a limited access folder on the electronic system which was password protected. Peer review of electronic consultation records was undertaken using a consistent methodology of 20 sets of patient records selected at random for review. Nursing and senior healthcare assistant records were also peer reviewed. A meeting with the Individual took place to review the records and discuss their findings.

## Safe and appropriate use of medicines.

Allergy status of patients was recorded on all medicine records seen. This meant that allergies were highlighted, and medicines could be prescribed safely. Patient weights were recorded on medical records seen which is important for calculating weight-based medicines prescribing.
A team of specialist pain nurses undertook online, telephone and face to face consultations with patients. They reviewed patients' medicines history and formed a plan of treatment which may or may not include pain relief medicines. We observed one telephone consultation which was in depth and involved listening to and working with the patient to form a plan to manage their pain. The patient was given time to explain their symptoms and how they felt. The advice on risks and benefits given was clear with an

opportunity for follow up questions. This was handled with care, sensitivity and understanding.
Staff prescribed, administered, and recorded pain relief accurately. Staff assessed and gave pain relief in line with individual needs and best practice. Patient survey results showed that 76% of patients said that their pain was managed effectively.

## Track record on safety.

Within outpatients there was an established system for monitoring and recording the servicing of all clinical and non-clinical equipment. The senior healthcare assistant was the lead for outpatient equipment care and there was a notice board in the corridor with information showing full compliance.

Consumables were ordered though a dedicated team. There were concerns raised by staff regarding the length of time it took to receive ordered goods and often the incorrect items were sent as replacements. This had been reported to the equipment support officer (ESO).

## Lessons learned and improvements made.

All staff had access to the electronic organisational-wide system for recording and acting on significant events and incidents. All incidents reported were logged through the Automated Significant Event Reporting System (ASER) system. They were discussed at the practice meetings.

From speaking with staff and evidence provided, it was clear there was a positive culture of reporting incidents. Both clinical and non-clinical staff gave examples of incidents reported through the ASER system including the improvements and learning made because of the outcome of investigations.

Staff understood duty of candour. They were open, transparent and gave patients and families a full explanation if things went wrong.

# Are services effective?

**We rated the service as GOOD for providing effective services.**

## Effective needs assessment, care, and treatment

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 best practice guidance had been identified and developed for defence rehabilitation services and was used to direct how services, care and treatment were delivered. Specific guidelines had been produced to cover a range of conditions seen at the clinic. These guidelines determined the necessary assessments and treatments required for specific conditions. Staff had access to best practice guidelines, to inform the care and treatment they provided to patients.

The outpatient clinical staffing consisted of consultants, nurse specialists, healthcare assistants and administration team. Within the outpatient department there were two clinics, the pain clinic and rheumatology. Upon arrival the patient was seen by the appropriate clinician after which if bloods were needed to be taken, they would be seen promptly by the Senior Healthcare Assistant.

## Effective staffing

Medical and nursing staff had the appropriate skills for their role and were working within their scope of practice. Clinical staff kept up to date with their own continual professional development and revalidation requirements. Performance appraisals were conducted by line managers for all staff. Internal and external training sessions were available for all staff. For example, the Advanced Nurse Practitioner had undertaken the ‘Explain Pain’ course. Staff could access funding for external courses.

## Helping patients to live healthier lives.

The health promotion displays were comprehensive, clear, and positioned strategically to target the most relevant cohort of patients. For example, extensive information was available about arthritis, osteoarthritis, pain, and pain-relieving medicines. Nurses ran smoking cessation sessions as part of clinics. Staff assessed each patient’s health at every appointment and provided support for any individual needs to live a healthier lifestyle.

## Consent to care and treatment.

Staff had a good understanding of the Mental Capacity Act (2005) and how it would apply to the patient population.

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Clinicians advised us that implied consent was accepted for basic procedures such as the taking of blood pressure. Written consent was taken for more intimate examinations.

Staff clearly recorded consent and the treatment plan in the patients record.

# Are services caring?

**We rated the service as GOOD for providing caring services.**

## Kindness, respect, and compassion

Throughout the outpatient department we observed staff being courteous and respectful to patients in person and on the telephone. Patients said staff treated them well and with kindness.

Patients could access the welfare team and various support networks for assistance and guidance. Information regarding these services was available in the waiting areas and the clinical staff were fully aware of these services to signpost patients if required.

The last patient survey, undertaken between October 2022 and October 2023, showed 100% (of the 108 patients asked) said they were treated with kindness and compassion.

The Defence Medical Rehabilitation Centre Benevolent Fund is a volunteer led charity that provided funding to support holistic, occupational, and social integration opportunities for serving military patients at Stanford Hall that were not provided by public funding.

As part of the patient's rehabilitation journey, it was essential that in coming to terms with their injury patients regained their confidence in being able to attend social gatherings and able to engage in day-to-day activities that reflected their normal lives. The process of allocation of funds was monitored by a committee who in liaison with DMRC Stanford Hall staff who ensured the equipment, and activities were clinically relevant and enhanced the patient's rehabilitation and function.

## Involvement in decisions about care and treatment

An interpreting service was available for any additional language requirement. Staff knew how to access this service.

## Privacy and dignity

All patients we spoke with stated that they were confident that the staff would keep information about them confidential. Consultations took place in clinic rooms with the door closed. Patients were offered a private room if they wanted to discuss something in private or appeared distressed. The waiting room was large and seating sufficiently away from the reception desk and there were televisions to mask any conversations held at the reception desk.

All staff we spoke with had completed the Defence Information Management Passport training which incorporated the Caldicott principles.

# Are services responsive to people's needs?

**We rated the service as GOOD for providing responsive services.**

## Responding to and meeting people's needs

The rheumatology service consisted of consultants, clinical nurse specialists, and administrators. Physiotherapists, exercise rehabilitation instructors, and occupational therapists from Spines and Upper Quadrant provide support for the delivery of the inpatient rehabilitation course. The rheumatology team saw any patient serving in the military with a rheumatological condition. This could range from very complex conditions to more routine inflammatory/ non-inflammatory illness. The team had developed specialist interest services with national level expertise.

Managers planned and organised services, so they met the changing needs of the population at risk. During Covid, patients at higher risk were sent letters to advise them to obtain a vaccination and to use the letter of evidence of eligibility.

The service made use of virtual clinics and continued to do so which meant patients could be assessed without travelling into DMRC. For example, if a patient was based overseas and had been referred to rheumatology they could be examined 'by proxy' with a doctor or physiotherapist using a video consultation service. This allowed the patient to be seen without delay.

Patients needing a rheumatology appointment were seen face to face in the first instance. Following that they were given the choice of face to face follow up or a telephone review.

Patients had access to the rheumatology team for advice. This was via email through to a group mailbox which is checked and actioned during working hours.

## Timely access to care and treatment

Outpatient working hours were 0800-1700 hrs Monday to Thursday and 0800-1300 on Friday.

During 2023 there were 308 new patient referrals to the rheumatology service. Waiting time for a rheumatology appointment for new patients' assessment was fourteen weeks

and urgent patients were seen within four weeks.  All military referrals were accepted. 75% of patients for follow up appointments were face to face due to patient choice.

Due to the nature of the caseload all patients require ongoing reviews which adds to the workload. The team felt that they would benefit from an increase in workforce by at least one consultant and one nurse. The service was actively recruiting to fill this position.

Pain Service Figures for 2023 showed that there were 253 referrals received and 216 accepted and 37 rejected. Waiting times for an appointment were dependant on need. The average time for a first appointment was 11 days. During November and December 2023 there were 15 cancelled appointments due to staff sickness or training. These appointments were rebooked within the week.

The current consultants are specialists in Rheumatology and Rehabilitation. The GMC now states that Rheumatology specialists must have another medical subspeciality rather than rehabilitation. There are concerns that this will impact on the specific requirements for the military population when they are looking to replace the current team in the future.

The team felt that there was good communication with other teams within DMRC and referrals have been simplified using electronic system without the need to write formal referral letters.

Patients were able to access diagnostics such as X-rays and sometimes same day MRI.

The Spine and Upper Quadrant team provides a regular 2-week inpatient rehabilitation course on behalf of Rheumatology for patients with Axial Spondylopathy , a chronic inflammatory arthritis (there are approximately 220 cases in the military). This type of course is only provided by one other unit in the UK. Outcomes are audited with a very favourable outcome both objectively and subjectively by the patients. On average this condition is diagnosed several years earlier in military patients which leads to a better long-term outlook.

An outpatient appointment could be cancelled and rebooked with reasonable justification up to 3 working days in advance.

The Do Not Attend (DNA’s) rate for outpatients was on average 7% mostly in Rheumatology.

Patient feedback was positive about the service.

## Listening and learning from concerns and complaints

Within the outpatient department information was available to help patients understand the complaints system, including a QR code for patients to scan in the waiting room. We spoke with 3 patients who confirmed they knew how to make a complaint. Staff described

the complaints process and confirmed that complaints and compliments were discussed at monthly team meetings.

# Are services well-led?

**We rated the service as GOOD for providing well led services.**

## Leadership, capacity, and capability

The balance of civilian and military clinical input provided the best possible care for patients. The service had a strong leadership strategy and vision that all staff championed. Staff reported feeling supported within their roles and listened to when suggesting change or raising concerns.

The team were committed to delivering the best care through a culture of constant learning and improvement. DMRC Stanford Hall had a well-established training ethos. It supported learners in a variety of trade groups including doctors, nurses, and medics, which ensured teaching and learning was always a high priority.

## Vision and strategy

The vision across the service is to be recognised by those we serve as a world leader in health and healthcare policy and advice, medical operational capability, and military healthcare.

The service was passionate about the protection of the environment. There were many recycling bins including food recycling bins around the building.

## Culture

A responsive and patient-centred focus was clearly evident with this ethos embedded in everyday practice. All staff described an approachable and supportive leadership team that was committed to ensuring cohesion, equality, and inclusion. It was clear from discussions with staff that their contributions to the development of the service were valued. All staff attended the outpatients' meetings where they could put forward suggestions or raise concerns.

All staff we spoke with described a culture that was inclusive with an open-door policy with everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns. We interviewed a cross section of staff, and all told us that it was a happy place to work and

that they could rely on their work team to discuss and mitigate any concerns they faced. They spoke about colleagues who were supportive, compassionate, and caring.

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information, and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We were provided with examples of when duty of candour had been applied.

## Governance arrangements

There was an effective governance framework to ensure quality, performance and risk was understood and managed. We saw that there was a comprehensive governance documentation and oversight system, which was referred to as the workbook. All staff had access to the workbooks. We reviewed the governance workbook which included audit schedule, quality improvement program and actions, risk register, divisional risks and issues, mandatory training compliance rates, and complaints. Staff were aware of the governance system through weekly team meetings and monthly governance meetings.

## Managing risks, issues, and performance

Risk registers were held centrally and were accessible to staff. 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.

## Appropriate and accurate information

The service worked in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records, and data management systems.

Clinical meetings were held weekly and provided a forum for effective discussion and shared learning.

## Engagement with patients, the public, staff, and external partners

Options were in place for patients to leave feedback about the service including information in the practice leaflet. All feedback was collated and discussed at the practice meetings every month. Quick Review or QR codes were used throughout the service to capture patient feedback.

## Continuous improvement and innovation

The Academic Department of Military Rehabilitation (ADMR) provided a central hub for clinical rehabilitation research within Defence. Departmental staff conducted an evolving clinical research programme designed to meet the needs of UK Defence, it's clinical practitioners and injured population with an aim to provide high level clinical research evidence that influenced clinical care and thereby contributed to the force readiness of the UK armed forces.

The ADMR mission was "to advance the scientific basis of rehabilitation medicine in order to maximise the number of personnel fit for operations ".

ADMR research priorities were subject to ongoing review and informed by higher level DMS priorities with recent research activity focussed on trauma rehabilitation, COVID-19 recovery and outcomes and musculoskeletal injury (MSKI) rehabilitation.

**Trauma Rehabilitation & Outcomes**

The Armed Services Trauma and Rehabilitation Outcome (ADVANCE) study is a 20-year research programme investigating the long-term medical and psychosocial outcomes of UK military personnel who sustained combat trauma. The baseline and 3-year follow-up data collection with 1200 participants is now complete and the first mental health and cardiovascular outcomes published in high impact scientific journals including The Lancet (psychiatry). ADVANCE is globally the only longitudinal cohort study evaluating the effect of combat trauma on a range of health indicators in military personnel. The study will therefore provide evidence that will influence future healthcare of combat and major trauma patients.

Clinically relevant findings are fed back to DMS clinicians including primary care providers and have led to changes in rehabilitation care pathways. Clinically relevant results have also been reported to NHS England.

**COVID-19 recovery and outcomes**

The Military COVID (M-COVID) study reporting the outcomes and recovery status of UK armed forces personnel following COVID-19 has provided an understanding of the impact and complications of coronavirus on the UK military population.

**Musculoskeletal injury (MSKI) rehabilitation**

Current MSKI research activity includes three large, pan-defence randomised controlled trials (RCT) providing the highest level of research evidence available. The 3 studies

investigating non-arthritic hip pain, joint tendinopathy and the utility of new treatments including blood flow restriction (BFR) therapy.
The MILO study investigating hip pain has provided evidence to support both inpatient MDT rehabilitation for this condition as well as outpatient physiotherapy led rehab.
The BE-FIT study showed no evidence for the frequently used injectable therapies (specifically large volume injection and corticosteroid) in chronic tendinopathy which has influenced care pathways of service personnel with chronic tendinopathy (a common lower limb MSKI).

**Collaboration across Defence**

The formation of a Research and Clinical Innovation directed, ADMR led, defence MSKI research themed working group strengthened collaborative links to the Defence Science and Technology Laboratory (Dstl), Institute of Naval Medicine (INM) and Army Health Branches. With an emphasis on translational research designed to achieve optimal impact, departmental staff are also leading innovative research exploring the introduction of Artificial Intelligence (AI), Virtual Reality (VR) and mirror therapy into Defence rehabilitation practice. ADMR and DMRC research capability is enhanced through strong collaborations with world leading universities and the availability of state-of-the-art advanced technologies including a 30-metre biomechanics performance laboratory (BPL) and computer assisted rehabilitation environment (CAREN) VR trainer.

**Clinical Service**

In 2023 the defence biomechanical assessment service (DBAS) was introduced to provide both inpatient and outpatient biomechanical screening capability for patients referred from DMRC and the regional rehabilitation units (RRU). This is in addition to the CAREN virtual reality assessment and rehabilitation sessions offered to DMRC inpatients.

# Psychological Wellbeing Service - Summary of this service

## Background to Psychological Wellbeing Service

The Psychological Wellbeing Service (PWS) delivers a specialist clinical service that supports the wellbeing and mental health of service personnel to support their physical rehab and help enable them to achieve optimal health within the service life or transition to civilian life.

# Are services safe?

**We rated the service as GOOD for providing safe services.**

## Safety systems and processes

The service adhered to the Defence Primary Healthcare (DPHC) tri service safeguarding policies for adults, children, and young people. Both policies were in date and version controlled. Each policy had a clear flowchart and process to guide staff on how to escalate concerns. The policies included contact addresses and telephone numbers for the local safeguarding teams (both in hours and out of hours), and these were displayed in the waiting areas and clinical rooms. Staff interviewed during the inspection were fully aware of the policies and knew how to report a safeguarding concern.

Each service had a link to a safeguarding lead and safeguarding team champions had been implemented since the last inspection. Safeguarding team champions provide support to DMRC senior safeguarding team and support staff and signpost staff with safeguarding activity.

The status of safeguarding and vulnerable patients was discussed regularly with the welfare team. In addition to informal discussion and the monthly clinical meeting, the needs of vulnerable patients were discussed at the monthly unit health committee meetings. Safeguarding concerns were discussed at interdisciplinary team meetings and reported where appropriate.

Safeguarding training levels one to three were mandatory for staff as appropriate to their role. At the time of the inspection staff had undertaken training appropriate to their role. The team demonstrated an understanding of safeguarding principles and practice and had made safeguarding referrals where required. Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. DBS checks were renewed every five years for military staff and three years for civilian staff. There were chaperone posters on display throughout the building.

Staff that we spoke with knew who the Infection Prevention Control (IPC) lead was and how to contact them. The service had a designated IPC link practitioner to provide support to staff and promote best practice of IPC. Staff had completed mandated IPC training. We observed during the inspection that staff followed infection control practises which included hand hygiene and bare below the elbows. Cleaning and infection prevention audits were undertaken, and the environment was found to be clean and tidy. There were systems for safely managing healthcare waste supported by a policy.

Equipment logs were in place. Equipment was found to be clean and had been serviced.

Since the last inspection the use of the public address system within the building had reduced to minimise any disruption to the therapeutic environment, however, was unlikely to be eradicated due to health and safety regulations.

## Risks to patients

Staff that worked within the service were subjected to robust recruitment checks which included an enhanced DBS check. Medical and nursing staff had the required professional registrations and were in date. Staff were up to date with their Hepatitis B vaccination and there was a Hepatitis B register available to view.

The team completed a risk assessment of each patient that were on their caseload and ensured that any risks identified were shared with the wider service where appropriate. Patients at risk were reviewed by the MDT 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.

The service had implemented a policy on the management of behaviour that challenges, which has been widely disseminated across all clinical areas.

## Information to deliver safe care and treatment.

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 and neurological teams across DMRC and referrals from course admission and complex trauma.

The service had implemented single point of access (SPA) weekly meeting to discuss all referrals, caseload management and to allocate workloads to the team.  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 new cases were also taken to the weekly multidisciplinary single point of access meeting to ensure an appropriate response.

At the time of the inspection the team’s active caseload was 98 (combined PWS and the mild traumatic brain injury service (MTBI). MTBI were co-located with PWS at the time of inspection. The MTBI team have worked exceptionally hard to significantly reduce the waiting times for  assessment and at time of inspection there were approximately 20 MTBI patients on the waiting list.

During 2023 there were 212 referrals to the PWS. The average wait for their first appointment was ten working days dependant on patient need.

## Track record on safety.

Measures to ensure the safety of facilities and equipment were in place. Risk assessments were completed and included both clinical and non-clinical risks. Equipment checks, including the testing of portable electrical appliances were in-date. Fire risk assessments of the building were carried out annually and we saw evidence where necessary of an agreed action plan which set out corrective measures required for compliance in line with fire safety regulations. Staff were up to date with health and safety training which included fire safety training. Staff were aware of the fire evacuation plan and what to do in an emergency.

Business continuity plans for major incidents, such as security, safety, environment, and IT were in place.

We saw in clinical areas patient call bells and emergency alarms for staff to summon assistance in an emergency.

There was a system and process in place for the service to receive and act upon any safety alerts relating to drugs and equipment. We saw that alerts were received, logged, and actioned from, Medicines and Healthcare products Regulatory Agency (MHRA), National Institute Clinical Excellence (NICE) & Department of Health (DoH).

Data showed that between November 2022 and November 2023 PWS has reported four ASERs. This included Information technology (IT) outage issues and a Caldicott confidentiality breach. All four incidents resulted in no harm. All staff interviewed knew how to submit an ASER. Investigations that had been undertaken where appropriate and were thorough. These provided evidence of learning and had led to improvements in practice. Staff that we spoke with could give us examples of this.

## Lessons learned and improvements made.

There was a system and policy for recording and acting on significant events and incidents (referred to as ASER). This was supported by a standard operating procedure (SOP). Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

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.

# Are services effective?

**We rated the service as GOOD for providing effective services.**

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 were reviewed within the team and at 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 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 include the use of cognitive behavioural therapy, trauma focussed therapy, solution focused therapy, narrative exposure therapy and eye movement desensitization and reprocessing. There are plans, when capacity allows due to gapped positions, to increase use of therapeutic groups which will be a great benefit for patients and patient flow.

The MDT undertake a wide range of diagnostic work including cognitive assessment, psychometric assessment, and risk formulation. The occupational therapist (OT) undertakes a range of interventions to address sensory and functional needs, and activities to increase job readiness and independent living skills.

One MTBI clinician described outcomes for patients following the service intervention as resulting in above 80% returning to duty, which is an exceptional example of the benefits of the occupational service being provided and the rationale for recruiting more staff to enhance the service.

## Effective staffing

New staff received a thorough induction. Development training, such as in cognitive behaviour therapy and Eye Movement Desensitisation and Reprocessing (EMDR), was available to staff, and staff were aware of the process in order to apply for further and additional clinical training.

Staff confirmed that they have protected time for supervision and professional development and received regular supervision and caseload management, although evidence obtained through interview is that this protected time for some is becoming compromised due to capacity issues. Records provided confirmed full compliance with clinical supervision and caseload management.

Staff told us that they received support through weekly MDTs, caseload management, clinical supervision, and professional development meetings. Staff were also involved in monthly team meetings.

Mandatory training compliance was monitored by the training team and staff had training passports to record compliance and received email reminders to keep on track.

There was role-specific training which included Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS) updates, Risk and Mental Fitness Brief. All staff were 100% compliant.

Staff appraisals rates were 100%.

The clinical team totals 15 Clinical and admin staff and consisted of medical, psychology, occupational therapy, and nursing staff although some posts are currently gapped (hard and soft).

The management team stated that there continue to be significant gaps in posts which was impacting on the ability of the team to deliver the full range of the service.

At the time of the inspection there were 4 vacancies: 2 nursing gaps, a psychologist, and a psychiatrist. The risk associated with the psychiatrist vacancy was mitigated with cover that was being delivered remotely from the department of community mental health (DCMH).

Despite the gapped posts the team have been able to reduce the waiting list for mild traumatic brain injury therapy (MTBI).

## Coordinating care and treatment

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 MTBI service offers both virtual and face to face including patient courses. Virtual treatments of benign paroxysmal positional vertigo (BPPV) include teaching the patient to perform the Epley manoeuvre. This is done with a number of precautions to ensure that the patient is safe, including that the patient has someone with them.

## Helping patients to live healthier lives.

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 inpatient care and treatment. 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 and high ground charity.

## Consent to care and treatment.

Medical and nursing staff understood the requirements of legislation and guidance when considering consent and decision making. A review of patient notes evidenced that verbal consent was recorded and coded appropriately on the electronic system. Consent recording formed part of peer review and audits were carried out.

# Are services caring?

**We rated the service as GOOD for providing caring services.**

## Kindness, respect, and compassion.

Staff treated patients with kindness, respect, and compassion. 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 told us that staff were kind and supportive, and that they treated them 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 told us that staff would support them to access all support that they could.

There was evidence that all staff across the team were extremely committed, compassionate and professional in their approach to both patients and each other. There was clear evidence of staff always striving for excellence.

We saw extremely positive feedback from patients.

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.

## Involvement in decisions about care and treatment

A translation service was available for any additional language translation requirement. Staff knew how to access this service.

## Privacy and dignity

Patient`s privacy and dignity were respected. Clinic room doors were closed during consultations.

All staff we spoke with had completed the Defence Information Management Passport training which incorporated the Caldicott principles. Staff followed policy to keep patient care and treatment confidential.

# Are services responsive to people's needs?

**We rated the service as GOOD for providing responsive services.**

## Responding to and meeting people's needs

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.

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 impact that reductions in the workforce were likely to have on the ability to deliver groups sessions and enhanced care packages was recognised by all staff and is indicative of their consistent commitment to delivering high quality, bespoke care that would result in effective outcomes for patients.

## Timely access to care and treatment

The team could offer flexible appointment times during office hours. There was a duty clinician rota in operation that ensured there was adequate specialist support available to both patients when required.

Remote appointments were available to outpatients preventing patients having to undertake lengthy journeys to attend appointments.

## Listening and learning from concerns and complaints

The team had a system and process 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 patients waiting areas had posters and leaflets explaining the complaints process.

In 2023 there have been no formal complaints about the PWS, there have been a number of verbal and written compliments about the service.

# Are services well-led?

**We rated the service as GOOD for providing well-led services.**

## Leadership, capacity, and capability

The PWS leadership and management team was led by a consultant nurse who was guided by two consultant clinical advisors (one psychological and one psychiatric).

We found that there was clear and accountable leadership at the PWS. All staff reported that morale was now very good in 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.

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.

## Vision and strategy

The Psychological Wellbeing Service leadership team told us of their commitment to deliver quality care and promote good outcomes for patients. The team’s 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".

## Culture

Staff told us that the culture was inclusive with an open-door policy and everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns. Staff also had access to a Freedom to Speak Up Guardian (FTSUG). There had been no formal reported cases of whistleblowing or bullying within the team.

The service had developed strong links with the welfare team, pastoral support, and Chain of Command. Systems were in place to safeguard vulnerable personnel and ensure co-ordinated person-centred care for these individuals.

Staff were positive about the service and felt this was making a positive difference to the quality of life of patients.

## Governance arrangements

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.

All staff had access to the Psychological Wellbeing Service Healthcare governance (HcG) workbook which included various registers and links such as the risk register, ASER tracker, duty of candour log, IT faults and cleaning issues log. A range of information was accessible though quick links from the HcG workbook. These included risk assessments, Terms of References (TOR`s), and the standard operating procedure index. The workbook was continually being developed and was managed by the PWS manager.

## Managing risks, issues, and performance

The service had established a governance structure that provided oversight of risk and the quality of service. There was a risk register and a retired risk register. Risk and issues were reviewed monthly or as identified and logged on the DMRC risk and issues registers. All current issues logged at time of inspection relate to workforce gaps (Consultant Psychiatrist and Nursing) and insufficient capacity to meet demand (Neuro Psychology)

The PWS Manager reported that there was a service review planned for December 2023 during which she was positive that any residual structural issues would be remedied to ensure outputs of the service were rationalised and best use of resource available was allocated to where the priorities fell.

## Appropriate and accurate information

The service worked in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records, and data management systems.

## Engagement with patients, the public, staff, and external partners

Partnership working with other parts of the DMRC, and defence medical services, NHS and voluntary groups appears very effective and the role of the DMRC PWS and Neuro Psychology capability was well understood across stakeholders.

## Continuous improvement and innovation

The service had a comprehensive and an effective audit programme that was integral in driving improvement.

Quality improvement was recognised as a priority team output involving the entirety of the team. There was evidence of recent audit findings related to reflective practice in Neuro and CT and evaluation of the Senate and long-term conditions groups.

One of the team has been actively involved in conducting research in 2023 with publication of findings in the Journal of Head Trauma Rehabilitation.

Quality Improvement Programmes also included sharing learning outside of DMRC with roadshows to share best practise with medical centres and primary care rehab facilities (PCRF) about the management of MTBI.

# Diagnostic Imaging - Summary of this service

# Is the service safe?

**We rated the service as GOOD for providing safe services.**

## 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.

The mandatory training was comprehensive and met the needs of patients and staff. All staff could access the staff database and record their own training. Protected time for mandatory training was made available to all staff.

Staff working with radiation had completed the appropriate training dependant on their grade. All staff completed a yearly update on Ionising Radiation Medical Exposure Regulations/Radiation training in line with regulations.

## 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. All staff we spoke with had received up-to-date safeguarding training at a level appropriate to their role.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service adhered to the Defence Primary Healthcare (DPHC) tri service safeguarding policies for adults, children, and young people. Both polices were in date and version controlled. Each policy had a clear flowchart and process to guide staff on how to escalate concerns. The policies included contact addresses and telephone numbers for the local safeguarding teams (both in hours and out of hours), and these were displayed in the waiting areas and clinical rooms. Staff interviewed during the inspection were fully aware of the policies and knew how to report a safeguarding concern.

Relevant recruitment checks had been completed for all staff. These included a disclosure and barring service (DBS) check and professional registration checks.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were aware of female genital mutilation (FGM) and Child sexual exploitation (CSE) and told us these subjects were covered in their safeguarding training.

The service had a chaperone policy and clinical staff had completed chaperone training. There were chaperone posters on display throughout the building.

Staff followed safe procedures for children visiting the service/department. There was a secure swipe access-controlled door through to the imaging area which meant other

people could not wander into the controlled area such as the Magnetic Reasoning Imaging (MRI) scanner.

## 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.

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 Environmental cleaning was provided by an external contractor. A written cleaning schedule was in place, and these were signed off to confirm that cleaning tasks had been completed in line with the agreed frequency. Cleaning standards were monitored and at the time of inspection, the department was visibly clean.

Cleaning audits results for October 2023 were displayed in reception area and demonstrated they had achieved 100% for hand hygiene, bare below the elbows (BBE) and sharps.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed during the inspection that staff followed infection control practises which included hand hygiene and bare below the elbows.

There were sanitising stations and hand gel available throughout the department.

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.

We observed staff cleaning equipment after patient contact and labelled equipment to show when it was last cleaned.

## 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 provided magnetic resonance imaging machines (MRI), X-ray, dual-energy X-ray absorptiometry (DEXA) and ultrasound diagnostics. We saw the commissioning documents for the imaging machines. The service had service and maintenance contracts in place.

The service consisted of a staffed reception area and waiting area which was wheelchair accessible. All imaging areas, corridors and rooms were wide and spacious.

Controlled areas and areas of restricted access had clear signage and additional safety features such as key swipe entry.

There were emergency assistance call bells in all patient areas, including consultation rooms, treatment rooms, and diagnostic imaging areas. Staff confirmed that, when emergency call bells were activated, they were answered immediately.

The design of the environment followed national guidance. We saw an in date copy of their ionising radiation local rules which included what was expected of staff and details of the medical physics expert (MPE), the radiation protection supervisor (RPS) and the radiation protection advisor (RPA). We saw in the X-ray room there was copy of the local rules which was in date. The local rules describe procedures for using PPE and shielding, controlled area entry, use of the radiation equipment, use of personal monitoring devices and quality assurance testing.

The service was easy to find and was clearly signposted for patients.

Staff carried out daily safety checks of specialist equipment. We saw evidence that daily assurance checks were carried out. 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 manufacturers guidance. There was an asset log for equipment which was held centrally.

A resuscitation trolley was available within the department. There were daily checks of items on the trolley such as defibrillator, and suction unit were completed. The trolley was locked with tamper proof tag in place. Medicines required in an emergency were available and were all in date.

At the time of the inspection the resuscitation trolley was in the Fluoroscopy room. We highlighted to the provider that we had concerns around this and asked them to review where it is located to ensure that it is accessible in the event of an emergency. The provider agreed to review, discuss with the resuscitation officer, and update the resuscitation protocol. During the inspection the provider moved the resuscitation trolley into the main corridor on our recommendations.

Staff had completed competencies in using equipment and there was an equipment competency checklist.

There was a system and process in place for the service to receive and act upon any safety alerts relating to drugs and equipment. We saw that alerts were received, logged, and actioned from the Medicines and Healthcare products Regulatory Agency (MHRA), National Institute Clinical Excellence (NICE) and the Department of Health (DH).

The service had suitable facilities to meet the needs of patients' families. The service had accessible toilet facilities which were fitted with an emergency call alarm to summon assistance in an emergency.

There were spacious accessible changing rooms where patients were able to change into a patient gown for their scan, however we would have expected the changing rooms to be fitted with assistance aids/bars.

The service had enough suitable equipment to help them to safely care for patients. There were radiation warning signs outside any areas that were used for diagnostic imaging. Imaging treatment room no entry signs were clearly visible and in use throughout the department at the time of our inspection.

MRI local safety rules were in place and reflected best practice. There was signage in place which detailed the magnet strength and safety rules. The MRI scanner was fitted with emergency buttons which stopped scanning and switched off power to the magnet. The service used equipment supplied by the manufacturer which was classed as magnetic resonance (MR) safe (a piece of equipment that has no known hazards in all MRI environments). Additional equipment that was not supplied by the manufacturer and used within the MRI environment was risk assessed and labelled as MR safe, MR conditional or MR unsafe in line with MHRA safety guidelines for magnetic resonance imaging equipment in clinical use (2015).

Staff disposed of clinical waste safely. Clinical waste was appropriately managed and disposed of 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. Staff were all trained in basic life support (BLS). Staff knew to commence Cardiopulmonary Resuscitation (CPR) until the resuscitation team attended. The service had an emergency resuscitation protocol and staff told us they had practised the MRI patient evacuation procedure; however, we did not see documented evidence of this.

Staff completed risk assessments for each patient on admission/arrival, using a recognised tool, and reviewed this regularly, including after any incident. The service used The Society of Radiographers' "Pause and Check" system. Pause and Check consisted of the three-point demographic checks to correctly identify the patient, as well as checking with the patient the site to be imaged, the existence of previous imaging and for the operator to ensure the correct imaging modality was used. We observed staff checking to make sure that the patient was the right person having the right scan at the right time by staff asking their full name, address, and date of birth in line with the patient identification policy.

To prevent unnecessary exposure of an unborn child to ionising radiation and in accordance with Royal College of Radiologists guidelines, all females between the ages of 12 and 50 and receiving an examination of anatomical areas between the diaphragm and

the knees were asked about the possibility of being pregnant. Staff asked patients last date of menstrual period and followed the 10 day/28 day rule to ensure that all reasonable measures are taken to minimise the risks associated with potential foetal irradiation during the medical exposure of women of childbearing age.

All patients undergoing an MRI scan completed an MRI safety questionnaire before scanning took place. We observed staff reviewing the form after completion and verbally checking questions again with the patient as an additional safety check. Questions included asking whether the patient had a pacemaker if they were pregnant or if they had shrapnel injuries.

The service had an imaging reporting policy which included communication of critical, urgent, and unexpected significant radiological findings.

The service had a policy to identify the deteriorating patient.

## Staffing

The service had enough staff. Managers regularly reviewed and adjusted staffing levels where possible and gave staff a full induction.

Staffing consisted of a Head of Department, MRI radiographers, radiographers, research radiographers, health care assistant and administrators.

The service had six radiologists that reported on scans and prepared reports mostly offsite. The radiologists did attend onsite when they had an ultrasound clinic list.

The service outsourced to a radiologist based at another location to review scans and prepare reports for neurological brain scans.

The service told us that radiographers could contact a radiologist for advice during out of hours. Staff we spoke to confirmed this.

The service was fully staffed and had no vacancies.

## 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.

All requests were entered onto the radiology information system (RIS). The service ensured imaging requests were appropriate and included the relevant information to allow for requests to be justified in accordance with Ionising Radiation (Medical Exposures) Regulations (IR(ME)R).

Patient request forms we reviewed included all the required information, medical history, and clinical indication for the scan.

The department used electronic systems to store imaging details and scan reports. These systems were only accessible with a personal login which restricted access.

Reporting was undertaken by a mix of in-house radiologists and external outsourced radiologists. The service stored images on a Picture Archive Communication system (PACS). All imaging could be shared, facilitating service personnel's onward care, enabling joint care with the external NHS.

## 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. 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 knew what incidents to report and how to report them.

All staff had access to the electronic organisational-wide system for recording and acting on significant events and incidents. All incidents reported were logged through the ASER system. This was supported by a standard operating procedure (SOP). Staff received feedback from investigation of incidents, both internal and external to the service.

Staff told us that they had reported an incident with the Dual Energy X-ray absorptiometry (DEXA) scanner which had been intermittently cutting out between scans. This was identified as a potential radiation risk to patients if it failed during the scan. This incident was notifiable to CQC and had been reported.

There had been no radiation safety incidents in the last 12 month prior to inspection.

Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

Staff understood duty of candour. They were open, transparent and gave patients and families a full explanation when things went wrong.

# Is the service effective?

**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.

The Radiation Protection Advisor (RPA) had completed the annual radiation protection authority report. This report found the service to have good compliance and recommendations from the last report had been acted upon.

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 (LDRLs). There was also a programme of local audits in place to monitor radiation safety This included auditing local radiation dose reference levels for comparison to national levels (NDRLs) to ensure radiation doses were kept as low as reasonably practicable.

Staff had access to radiation protection supervisors, a radiation protection advisor, and a medical physics expert.

## Nutrition and hydration

Patients had access to a water dispenser located in the reception area.

Due to the nature of the service, nutrition was not provided.

## 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.  Audits were completed across the service including diagnostic reference level audits.

A recent audit of MRI safety and quality was carried out. 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 with no issues identified.

The service had recently commenced peer review of imaging of lateral knee x-rays.

## 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. All radiographers were registered with the Health and Care Professional Council (HCPC) and were required to complete continuous practice development to meet their professional body requirements. Staff were required to renew their membership every two years and we saw that all radiographers had successfully renewed their membership.

Managers gave all new staff a full induction tailored to their role before they started work. New staff received a thorough induction.

Managers supported staff to develop through yearly, constructive appraisals of their work. Completion rates for appraisal was at 100%.

Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Clinical staff were required to complete continued professional development (CPD) to meet their professional body requirements.

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

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 multidisciplinary meetings to discuss patients and improve their care. There was evidence of good multidisciplinary team working between staff to delivery patient services. Meetings were held weekly.

## Key services

Key services were available to support timely patient care.

The service was available for patients: Monday to Thursday from 08:30am to 17:00pm and Friday 08:30am to 13:00pm.

## Health promotion

The service had relevant information and support in patient areas. Posters were on display in the waiting room and around the department which included sign posting information for individuals with mental health and stress issues, information on your Xray test, information regarding anonymised use of imagery for teaching and research, zero tolerance aggression and violence towards staff, pregnancy, safeguarding and patient chaperone information.

## 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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff understood that if a patient lacked the ability to understand or provide informed consent to an examination to stop and contact the referrer. This was in line with regulations and best practise.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff followed standard operation procedures for imaging investigations involving the use of ionising radiation on individuals of childbearing potential. Staff understood the importance of obtaining informed consent from the patient. Staff made sure patients consented to treatment based on all the information available. Where written consent was required, staff clearly recorded consent in the patients' records.

Staff had completed and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

# Is the service caring?

**We rated the service as GOOD for providing caring services.**

## 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. We observed all members of the team introducing themselves to the patient and told them who would be looking after them during the scan.

Patients told us that staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential. Discussions with patients took place in consulting rooms to ensure privacy and confidentiality.

## 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. During inspection radiographers were observed communicating with patients over the scanner intercom providing reassurance and providing updates as to how long the scan would take.

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. Staff understood at times it may be necessary for a patient to have a carer or comforter to be present during a medical examination using ionising radiation. The risks, benefits, dosage must be explained, and consent recorded on the carers and comforters consent form. This process was supported by a SOP. The team explained that there had been no requirement to date to use carers or comforters and therefore there were no records of such.

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

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

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.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.  The service had copies of the electronic patient satisfaction survey for patients to complete which was available via URL link and QR Code.

We saw that patients gave positive feedback about the service.

# Is the service responsive?

**We rated the service as GOOD for providing responsive services.**

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

The service planned and provided care in a way that met the needs of service personnel. 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. Provisions for disabled people were available including disabled access, disabled accessible toilets, spacious reception area and all treatment rooms and theatre on the ground floor. There was also free parking onsite.

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.

Managers ensured that patients who did not attend appointments were contacted.

## 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.

Patients were given ear defenders and ear plugs in line with MHRA guidelines when undergoing an MRI scan.

The service provided disability access for patients with limited mobility.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us that this could be arranged in advanced of their consultation if required.

## Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment 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. The service did not provide any KPI data on the day of the inspection, although this was provided retrospectively.

A walk-in service was available for X-ray examinations.

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.

Managers worked to keep the number of cancelled appointments to a minimum.

## 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 lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns. Within the diagnostic department information was available to help patients understand the complaints system, including a QR code for patients to scan in the waiting room.

The service clearly displayed information about how to raise a concern in patient areas. Patients waiting areas had posters and leaflets explaining the complaints process.

Staff understood the policy on complaints and knew how to handle them. 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.

# Is the service well-led?

**We rated the service as GOOD for providing well led services.**

## 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 Head of Department reported to the Radiologist Clinical lead for clinical issues and then OC Medical Division as an organisational chain of command.

Staff knew the management arrangements and their specific roles and responsibilities.

The management team were described by staff as approachable, open, and honest. The service was described by staff we spoke with as a lovely environment to work in.

## Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The service had recently formalised a vision which aimed to deliver world-class, responsive, patient centred diagnostic imaging and image guided clinical interventions, in support of UK Defence clinical rehabilitation and research. To achieve this, they had a strategic plan to work towards achieving the vision.

## Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided

opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us that the culture was inclusive with an open-door policy and everyone having an equal voice, regardless of rank or grade. All were familiar with the whistleblowing policy and said they would feel comfortable raising any concerns. Staff also had access to a Freedom to Speak Up Guardian (FTSU). There had been no formal reported cases of whistleblowing or bullying within the team.

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.

## Governance

Leaders operated effective governance processes throughout the service and with partner organisations. 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.

There was an effective governance framework to ensure quality, performance and risk was understood and managed. We saw that there was a comprehensive governance documentation and oversight system, which was referred to as the ‘workbook’. All staff had access to the workbooks. We reviewed the governance workbook which included audit schedule, quality improvement program and actions, risk register, divisional risks and issues, mandatory training compliance rates, and complaints. At the time of this inspection, key performance indicators were not in place to monitor and evaluate the service. We were however advised, post inspection, that indicators had been introduced.

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.

## Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had established a governance structure that provided oversight of risk and the quality of service. There was a risk register and a retired risk register. Risk and issues were reviewed monthly or as identified and logged on the DMRC risk and issues registers. All current issues logged at time of inspection relate to medical device/equipment and information technology (IT)

Business continuity plans for major incidents, such as security, safety, environment and IT were in place, and actions for staff to take in managing this disruption efficiently.

The service had a service level agreement for the provision of the Radiation Protection Adviser (RPA) and Medical Physics Expert (MPE).

## 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.

The service worked in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records, and data management systems.

The service uploaded diagnostic images on a secured electronic portal for staff to 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.

Clinical meetings were held weekly and provided a forum for effective discussion and shared learning with the team.

## Learning, continuous improvement and innovation

Leaders encouraged innovation and participation in research.

The service aimed to promote a positive culture of research and innovation. The service participated in quality improvement projects (QIPs). The service was starting a QIP on improving how patients are safety checked for MRI.