Defence Medical Services

Cosford Regional Rehabilitation Unit

Inspection Report

Albrighton
Wolverhampton
WV7 3EX

Date of inspection visit: 19-20 November 2025
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, and information given to us from the provider and patients

Ratings

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

Summary of findings

Overall summary

Letter from the Chief Inspector of Hospitals

We carried out an announced comprehensive inspection at Cosford Regional Rehabilitation Unit on 19 and 20 November 2025.

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

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

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

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

- There was a system for reporting and recording significant events.
- The unit had suitable health and safety arrangements in place to ensure a safe service could be delivered.
- Risks to the service were recognised by the leadership team. The main risks outside of the unit's control had been escalated. A range of risk assessments were in place.
- Essential systems, processes and practices were available to ensure patient safety.
- Extensive safeguards were in place, including close working with the medical centre and the welfare team
- Staffing levels, skill mix and caseloads were planned and reviewed to ensure people received safe care and treatment at all times in line with relevant tools and guidance.
- There were effective arrangements to respond to emergencies and major incidents.

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

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

- Staff induction and training was complete and up-to-date.
- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the unit's patient record system and their intranet system.
- Staff sought patients' consent to care and treatment in line with legislation and guidance.

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

- Patient feedback about the service was positive.
- Interactions we observed between staff and patients were friendly and caring. Staff were helpful and courteous and treated patients with respect.
- Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during initial assessment and ongoing consultations to make an informed decision about the choice of treatment available to them.

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

- Patients had timely access to initial assessment, diagnosis or urgent treatment in a way which suited them.
- The unit had a system for handling concerns and complaints.

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

- There was a clear vision and a mission statement set out for the service, with quality and safety as the top priority.
- The service had an overarching governance framework which supported the delivery of the strategy and good quality care.
- An inclusive whole-team approach was supported by all staff who worked collaboratively to provide a consistent and sustainable patient-centred service.
- The team were committed to delivering the best care through a culture of constant learning and improvement.
- Staff were aware of the requirements of the duty of candour, (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).

Recommendations for improvement:

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

- Further develop the staff training programme to include recognising the deteriorating patient/sepsis and learning disability and autism.

- Continue to extend the clinical audit programme to incorporate quality improvement for the patient population and include all audits on the register.
- Ensure the podiatrist is included in the annual notes audits.
- Improve the visibility of patients sitting in the waiting room.

The Chief Inspector recommends to Defence Primary Healthcare:

- Support the unit and improve safety by installing Wi-Fi.

Toli Onon
Chief Inspector of Hospitals

Regional Rehabilitation Unit – Cosford

Detailed findings

Background to the service

The Regional Rehabilitation Unit (RRU) is a Defence regional facility that provides clinical assessment and treatment for patients with moderate musculoskeletal injuries. There are 12 RRUs across the UK, each delivering intermediate-level care and acting as the primary link to secondary care rehabilitation services. Every RRU also supports several designated Primary Care Rehabilitation Facilities (PCRFs), offering everything from referral management to advice on clinical governance and service delivery.

Access to RRU services is via referral from other Defence Medical Rehabilitation Programme (DMRP) services. On arrival, patients undergo an initial joint assessment in the Multi-Disciplinary Injury Assessment Clinic (MIAC), carried out by a doctor specialising in sport and exercise medicine and a clinical specialist physiotherapist.

Rehabilitation courses are provided for patients whose condition necessitates a period of intensive daily rehabilitation (such as post orthopaedic surgery). Patients may be referred for 2 weeks for rehabilitation with other patients who have a range of differing injuries to the upper and lower quadrants and spine.

Patients are expected to attend for the full duration and may stay either on-site or off-site. Alongside the structured programme, patients can also access one-to-one treatment as required.

A specialist podiatry service was available to provide a clinical biomechanical podiatry service to all entitled service personnel within the RRU catchment area.

Facilities include treatment rooms, a gym and cardiovascular area and access to the swimming pool on site.

Provision of specialist musculoskeletal opinion is delivered by a MIAC. This includes a Sports and Exercise Medicine Doctor (SEM) and a physiotherapist and can include an exercise rehabilitation instructor (ERI) when required. Clinical assessment at the RRU is delivered through the MIAC. The role of the MIAC is to determine:

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

The treatment plan may allow for patient management to be maintained at local level and preclude the need for secondary care or inpatient rehabilitation. The MIAC is a critical element of clinical assessment and planning in the DMRP. The MIAC will identify patient requirements and allocate appropriate early treatment based on clinical need, operational issues and individual circumstances. All patients being referred to the RRU for the first time should be seen in a MIAC. This is to ensure that there is an appropriate clinical plan for the patient and that the patient's case is being actively managed including interaction with relevant agencies. The MIAC clinicians are available to discuss individual cases prior to or after referral.

The staff team

Military Physiotherapist	1 Officer Command (OC) and 1 x 2nd in Command (2OC)
Military exercise rehabilitation instructor (ERI)	1
Regional Trade Specialist Advisor and lead (ERI)	1
Clinical Lead Physiotherapist	1 Band 8
Physiotherapist (civilian)	3 – 1 Band 6, temporary healthcare worker, 1 Band 7 and 1 Band 8 (MIAC visiting clinician)
ERI (civilian)	1 Band 5 temporary healthcare worker
Podiatrist (civilian)	1 Band 7
Doctor (civilian)	1 (GP with specialist interest)
Administrator	1

How we carried out this inspection

Before visiting, we reviewed a range of information about the unit. We carried out an announced inspection on 19 and 20 November 2025. During the inspection, we:

- Spoke with staff, including physiotherapists, exercise rehabilitation instructors (ERIs), the podiatrist, the administrator, the Regional Trade Specialist Advisor (RTSA) and the OC.
- Spoke with patients who were on courses or receiving treatment on the day of the inspection.
- Looked at information the service used to deliver care and treatment.
- Reviewed patient notes.
- Reviewed policies, complaints and ASER (organisational-wide system for reporting significant events) information.
- Observed the MIAC clinic.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Good

Are services safe?

Our findings

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

Safe track record and learning

A comprehensive unit-wide ASER (organisational-wide system for reporting significant events) log was in place that included the details of the team who undertook the root cause analysis for each incident reported, lessons learned, details of the meeting where the ASER was discussed and a closure date. ASERs were discussed at the healthcare governance meetings. Staff provided examples of ASERs and changes made as a result. A common example involved the fragility of the DMICP (electronic patient record system) and the frequent outages.

Staff understood their responsibilities to raise safety incidents via the My Safety system. The Regional Trade Specialist Advisor (RTSA) monitored safety alerts via the Central Alerting System and was responsible for responding to safety notices and sharing information with all staff.

Overview of safety systems and processes

The Multidisciplinary Injury Assessment Clinic (MIAC) doctor was the safeguarding lead for the unit, but in their absence the Medical Officer from the medical centre next door deputised. All staff were in-date for safeguarding training at a level appropriate to their role, clinicians had completed level 3 and administrative staff level 2. We discussed a recent event whereby a patient was referred to the welfare officer for support. There was a positive relationship between the Regional Rehabilitation Unit RRU staff and the medical centre with communication between them being reported as timely and effective.

Systems, processes and practices kept patients safe. All staff were Disclosure and Barring Service (DBS) checked; their professional registration and expiry date was reviewed by the Officer Command (OC). This ensured all staff at the unit were safe and fit to practice. A mandatory training database (that included this information) was maintained. Information was held electronically, and a check of the professional register or equivalent had been completed for all staff.

A chaperone policy was in place. The availability of a chaperone was displayed throughout the building and referenced in the patient information leaflet. Staff had received chaperone training in October 2025 and a list of available chaperones was displayed in all clinical rooms. Notices were displayed providing details of access to a chaperone.

Systems were in place to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology.

The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. We discussed an incident with the OC regarding an IT incident; we saw that the correct process had been followed and the patient informed.

Standards of cleanliness and hygiene were well maintained. A cleaning schedule was in place for clinic rooms and was visible for all staff in the shared office space. One of the physiotherapists was the infection prevention and control (IPC) lead, they had completed the required training for the role. The last IPC audits were completed in July 2025, covering all areas. No associated actions were required with all areas being found to be compliant.

Clinical waste and sharps were managed safely. There was a clinical waste bin that was shared with the medical centre, and each facility had its own log. Consignment notes were supplied to the unit and the correct number of bags and or sharps taken at each collection were accounted for.

There was clear information displayed about how safety, health, the environment and fire (referred to as SHEF) was managed at the unit, including a unit representative attending the station SHEF meetings. A fire risk assessment of the rehabilitation gym was in place, with it last being done in July 2025. Checks of firefighting equipment were carried out each week. The fire evacuation procedure was displayed and all staff were aware of the procedures to follow.

The RRU was well equipped with the latest equipment. An electronic inventory log was maintained and held information as to when maintenance had taken place for the equipment. Rehabilitation gym equipment had a unique identifiable marker and a history of maintenance. All non-usable equipment was quarantined and was not accessible to patients. The last Land Equipment Audit (conducted in March 2024) identified that periodic ‘snap’ inspections of equipment had not previously been carried out at the appropriate intervals. However, we saw at this inspection that this was now in place and checks were undertaken monthly by the equipment lead. The log showed servicing was in-date. Portable electrical appliances were tested to ensure they were safe for use. Stickers on the equipment identified the checks had taken place.

The medicines management lead was the MIAC doctor. Medicines were held in a locked ambient temperature-controlled cabinet and routine temperature checks were carried out and recorded twice daily; a data logger was present for additional monitoring of temperatures. Whilst there were no temperatures recorded out of range, we discussed some extra measures to protect the accidental turning off on the fridge, including a do not turn off sign on the cabinet plug, this would add extra safety measures. We saw hard copy medicines logs were kept alongside the SOP and signature sheets for staff. Blank prescription forms were held in a locked draw in the MIAC room. After generation, prescriptions were filed with the dispensary at the medical centre. There were first aid kits, eye wash kits and blood spill packs available.

The service used DMICP to store and access electronic patient records. This allowed staff to access patient records in line with their role, to access the information required to treat the patient. Patient records we reviewed showed clinicians worked to best practice and NICE guidelines. We reviewed a range of patient records and they showed good compliance with standards. All had documented consent, examination and a plan. Annual notes audits had been carried out for all clinical staff with the exception of the podiatrist. Notes audits were recorded on the healthcare governance workbook.

The infrastructure was appropriate for the delivery of rehabilitation. The facility had air conditioning throughout all the physical training areas and clinical rooms ensuring satisfactory were maintained even in the hotter months. Wet Bulb Globe monitoring (a device that monitors temperatures) was used to monitor the environment to ensure it was safe for physical activity. Patients sitting in the

waiting area could not all be seen, so if they became acutely unwell staff may not be aware. The OC was proactively looking at how to manage this and it was recorded on the risk register.

Access to the service was through referral from medical centres and Primary Care Rehabilitation Facilities (PCRFs). Most patients referred to the RRU will have already received rehabilitation at their local PCRF, and following rehabilitation at the RRU, will be discharged back to the PCRF. All patients referred received an initial joint assessment by a doctor (a specialist GP trained in sports and exercise medicine) and a clinical specialist physiotherapist, in the MIAC located at the RRU. However, currently to cover sickness absence the facility was running more individual assessment clinics run by 2 physiotherapists.

Monitoring risks to patients

There was a good balance of well-trained civilian and military staff which afforded continuity of care. Whilst the team demonstrated a committed and flexible approach to completing tasks, there were concerns around resilience; in particular, the reliance upon temporary health workers (physiotherapist and ERI) for course outputs. Any reduction could lead to cancellation of courses. MIAC was only running with 1 doctor due to staff absence (since May 2025). The unit was pursuing the opportunity to develop staff through temporary managed progression (instead of locum staff covering gaps an internal member of staff temporarily fills the higher-grade role and request locum backfill for the internal staff member acting up). There had been a vacancy for 1 administrator since January 2025.

Course physiotherapists provided acupuncture to patients. There was an acupuncture standard operating procedure (SOP) and risk assessment in place that had been reviewed regularly and all staff were aware of. In addition, if patients were offered injection therapy, to ensure patient safety, there was access to an emergency trolley and all staff had completed training in anaphylaxis.

Arrangements to deal with emergencies and major incidents

Each staff member was issued an individual panic alarm and panic alarms were available within clinical rooms. There was no record of the alarms being previously tested but this was added to the monthly check list during the inspection and a test conducted.

All staff knew where the emergency medicines were located. We found medicines in the grab bag were appropriate, in-date, and were accompanied by a risk assessment. All staff had received updated training in emergency procedures, including basic life support, automated external defibrillator (AED) and anaphylaxis. An AED was available and all staff knew its location. Both clinical and non-clinical staff were familiar with the signs and symptoms of sepsis and but had not received formal training. Staff felt that formal sepsis training would be useful and this was being considered for the future.

A business resilience plan was in place and was reviewed annually.

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

Good

Our Findings

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

Effective needs assessment

Rehabilitation was delivered in line with evidence-based practice guidance on treating musculoskeletal conditions and provided a holistic approach. Patient's needs were assessed and care and treatment was delivered in line with current legislation, standards and other best practice guidance (BPG). We saw an audit had been completed in July 2025 against anterior cruciate ligament injury using BPGs, these were discussed with the team and recommendations had been made for improvement.

Staff followed assessment templates to ensure consistency and there were standard operating procedures (SOPs) to follow for procedures such as injection therapy. Specific guidelines had been produced to cover a range of conditions seen at the clinic, for example, the management of lower limb tendinopathy and the management of low back pain.

Patients being referred to Multidisciplinary Injury Assessment Clinic (MIAC) from Primary Care Rehabilitation Facilities (PCRF) clinicians were those that required further diagnostic services such as MRI and ultrasound scanning, coupled with the greater knowledge of the MIAC consultant and the physiotherapist. They were patients who needed a more definitive diagnosis and, if required, signposting to other specialities, for example orthopaedics or rheumatology. PCRF physiotherapists also referred patients directly for a rehabilitation course, these may not require the diagnostic skills of MIAC. Similarly, PCRF physiotherapists also referred directly to podiatry with no requirement for a MIAC appointment.

During MIAC consultations, the doctor and physiotherapist clearly explained their thoughts on the symptoms being experienced together with the options for treatment. Of note, the patient's own views were sympathetically listened to and time was consistently allowed. A course was recommended; this was clearly explained and the patient invited to get further details from reception on their way out. Discussion around pain management, discharge planning for course patients across MIAC and course clinicians took place throughout the week on ad hoc basis. Where possible and when relevant patients could be booked in for a Sports and Exercise Medicine Doctor (SEM) consultation for injection therapy (where appointments were available).

At Regional Rehabilitation Unit (RRU) Cosford, there was a Band 7 podiatrist who provided services both within the RRU and to patients referred from surrounding PCRF's. The aim of the

specialist podiatry service was to provide a clinical biomechanical podiatry service to all entitled service personnel within the RRU catchment area.

Management, monitoring and improving outcomes for people

Validated patient reported outcome measures (PROMs) were used for all patients attending the RRU. All outcome data collected was entered into the patient's electronic healthcare record, we reviewed a number of these for individual patients using the service and found goals set with patients outlining what they wanted to achieve through their treatment. Where goals had been recorded, these measures were patient specific to provide an objective measure associated with the patient's injury.

MSK-HQ measure, which is a generic, single musculoskeletal outcome measure was used throughout the healthcare pathway and covered patients with different musculoskeletal conditions including podiatry. The course clinicians delivered was a combined assessment approach sharing the duties of subjective questioning and physical and objective testing. Clinicians formed a plan for patients taking into consideration goals identified by the MIAC assessment.

An RRU audit programme was in place. Mandated audits had been completed but further clinical audits based on the patient population were limited. Specific audits would enhance patient care and could tailor further elements of staff training. The podiatrist conducted annual audits on provision of overseas podiatry support and there was a planned audit in the use of braces and the effectiveness for patients, although this was not in the audit calendar. We also saw evidence of the units staff climate survey including initiatives and outputs. We discussed recording these in audit or quality improvement logs so they could be shared.

Effective staffing

Newly appointed staff completed a mandatory induction programme. Clinicians were inducted by their peers; the induction programme included all aspects of health and safety as well as specific job-related responsibilities. There was a clear staffing structure and staff were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles, including staff who had lead roles for specific areas.

Mandatory training was recorded on the healthcare governance workbook which captured internal and external training. At the time of the inspection the log showed nearly all staff had completed their mandatory training, any gaps were because of mitigating circumstances such as sickness. Staff had not completed the training in how to interact appropriately with people who have a learning disability and/or autism, we discussed this with the OC and they felt this would be useful and agreed to action. Protected time was allocated for mandatory training.

Protected time was allocated for mandatory training. Staff said there was also informal ad hoc training conducted in small teams, for example, course development activity. Clinical staff were up-to-date with their continual personal development, revalidation and annual appraisal.

Coordinating patient care and information sharing

All staff at the RRU, including those from different services engaged 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 the 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 doctor and clinical lead physiotherapist held a joint MIAC clinic.

Staff had the information they needed to deliver effective care and treatment to patients. Each member of staff had access to the electronic records system which held a contemporaneous, multidisciplinary records of the care and treatment of individual patients at the unit. Patients referred to the RRU were sent with individual exercise programmes developed by their local PCRF, meaning staff at the RRU knew what rehabilitation they had been receiving. 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.

All course clinicians ensured they completed a discharge summary for patients with pertinent points from the course, summarising the patients progress and goals. This information was shared with referrers to facilitate treatment continuity by keeping the patients notes and DMICP updated.

The RRU engaged with local health providers. There were close links with civilian consultants from the local hospitals to which patients from the RRU were referred to access orthopaedic care. Patients could also be referred to independent hospital for scans and surgery if required.

Consent to care and treatment

Staff understood relevant consent requirements and sought patients' consent to care and treatment in line with legislation and guidance. There was a consent policy in place, this included the consenting process and staff responsibilities. The policy also outlined the rights of the patient in the consent process. We reviewed a selection of clinical notes and saw that consent had been appropriately sought and recorded in all cases. Written consent was obtained for treatments which involved a level of risk. Patient records for patients which had undergone injection therapy contained a consent form identifying benefits, risks and contraindications of treatment.

Good

Are services caring?

Our findings

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

Kindness, dignity, respect and compassion

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

As part of the inspection, we received feedback about the service from 68 comment cards completed by patients. All were positive about the experience of treatment and care. Of note, there was a theme of patients complimenting the unit staff on providing clear and thorough explanations of the courses and treatment.

We saw the results of the last Defence Primary Healthcare patient questionnaire 2025 (January to July), there were 105 responses.

- 97% were able to access healthcare easily.
- 94% were satisfied with their healthcare.
- 84% said they would know how to submit feedback. To improve this action taken was to display the complaints policy, update the complaints leaflet and have a dedicated patient feedback board.
- Course content, 80% very satisfied, 20% satisfied.
- Knowledge and confidence to manage injury, 72% very satisfied, 27% satisfied.
- Level of progress with injury, 54% very satisfied, 41% satisfied.
- Did joining instructions provide all of the information required for attendance on the course? 100% said yes.

All patients asked said staff made them feel at ease patients including introducing themselves, explaining their position, being friendly and warm towards them and treating them with respect. They confirmed that staff let them tell their story in their own words, not interrupting, rushing or diverting them.

Individual needs of patients and the occupational needs of their employment were considered when devising treatment plans. There was information displayed about how patients and staff

could access support services. There was a health information board in the waiting room that gave information of a wide range of topics including sleep, menopause and mental health.

Staff understood that patients undergoing treatment could cause low mood and affect their wellbeing. Prior to patients attending Multidisciplinary Injury Assessment Clinic, a notes review was conducted and anything which had been highlighted was passed onto course clinicians so they were aware prior to the course starting.

Patients were given information to support their treatment and general wellbeing, this included lectures and a talk as part of their induction brief. Patients were made aware that if they had any concerns, they could let the staff know and it would be dealt with discreetly. Patients were given information on management of stress and also signposted to services that could support them.

Care planning and involvement in decisions about care and treatment

We spoke with patients attending the course and they told us they felt actively involved in decisions about their care and treatment. They said staff listened to them, offered support, and provided sufficient time during both initial assessments and ongoing consultations to help them make informed decisions about the treatment options available. Care plans were personalised.

Patients were encouraged to be active partners in their care. Those attending the course told us they were able to discuss their treatment on a one-to-one basis with instructors at any time.

Staff communicated clearly with patients to ensure they understood the purpose of specific exercises. We observed staff demonstrating exercises and explaining their relevance and expected benefits.

Each patient was assigned a physiotherapist and exercise rehabilitation instructor (ERI) for the duration of the course. Patients told us they valued this individual attention, as it allowed them to build a strong rapport with staff who became familiar with their needs. This enabled staff to tailor care and treatment to each patient’s specific circumstances.

Patient and family support to cope emotionally with care and treatment

Staff demonstrated a good understanding of how patients’ care, treatment, or condition could affect their overall wellbeing. Patients told us that staff were quick to recognise any frustration or anxiety related to their injury and responded with empathy and consideration.

Are services responsive to people's needs?

Good

Our findings

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

Responding to and meeting patients' needs

Information about the needs of the population was used to inform how services were planned and delivered. Relevant stakeholders were involved in planning services; these were flexible and reflected patient choice. The Officer in Command (OC) of the Regional Rehabilitation Unit (RRU) hosted quarterly Teams calls for the Primary Care Rehabilitation Facility (PCRF) heads of departments and quarterly regional in-service training delivery for PCRF and primary care staff.

The RRU engaged with Defence Healthcare Recovery Group (DHRG) headquarters through fortnightly meetings and termly governance meetings. This also provided opportunity to engage with other OC RRUs. Additionally, course, podiatry and administrative working groups were attended by relevant staff.

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

The Multidisciplinary Injury Assessment Clinic (MIAC) was a multidisciplinary clinic delivered by an experienced physiotherapist and sports exercise medicine (SEM) Consultant. The clinic offered assessment, point of contact ultrasound scanning, injection therapy, and onward referral to specialist services, for example the pain clinic, pressure testing, imaging and orthopaedic referral. MIAC records and recommendations contributed to occupational health review clinics where patients were facing career limiting conditions. MIAC clinicians liaised with patient's medical officers at the medical centre to discuss and recommend appropriate medical gradings.

Specialist outpatient injury assessment clinics (IACs) where treatment such as Extracorporeal Shockwave Therapy (ESWT) (a non- invasive treatment using high energy sound delivered through the skin to stimulate healing) could be carried out. Onward referral to other specialised centres could be arranged after MIAC, for example for an MRI scan, ultrasound diagnostic scan, or orthopaedic opinion via the electronic referral system (eRS). This list was not exhaustive and could also include referral to Defence Medical Rehabilitation Centre for specialist advice and treatment of tendon injuries. There were links with local hospitals to access orthopaedic care, including private hospitals, both surgically and for MRI delivery.

An Equality Access Audit as defined in the Equality Act 2010 was completed annually. Any points identified were discussed and put onto the issues register.

Access to the service

All patients were electronically referred to MIAC via the electronic health record (eHR) with the reason for referral and the working diagnosis being clearly stated. Upon receipt of the referral, the detail was checked and accepted if it met the criteria. If the referral was accepted onto the caseload, it was acknowledged and confirmed to the referring unit. The referral would then be forwarded to a consultant and or lead physiotherapist within 7 days of receipt. Following triage, if a referral has been accepted, the triaging clinician would add a consultation to the eHR stating the approximate wait for an appointment. All referrals were tracked by the administrator.

Availability was good with approximately 10-12 consultant facilitated MIAC clinic appointments available each week. If a slot was not utilised then a MIAC appointment was offered to a patient on the waiting list. The current wait time for access to the MIAC clinic was 10 working days, 1 working day if it was urgent. The podiatrist facilitated a clinic once a week and the current wait time was 12 working days. The wait time for a rehabilitation course was 7 working days. The unit worked with the patient to accommodate their employment schedule. If a patient needed to attend a course urgently then the unit would explore whether this could be facilitated.

Listening and learning from concerns and complaints

The OC was the lead who handled all complaints. Complaints were managed in accordance with Defence Primary Healthcare policy complaints policy and local procedure. The complaints procedure was displayed in the practice leaflet, on daily orders and on a noticeboard in reception. There had been 1 complaint received in the past 12 months this related to a missed telephone appointment. We saw that the complaint had been fully investigated and the patient was given an explanation and an apology.

Are services well-led?

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

Good 

Our findings

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

Vision and strategy

The vision for Regional Rehabilitation Unit (RRU) Cosford reflected that of Defence Primary Healthcare which was:

> *"To provide safe, effective healthcare to meet the needs of our patients and the Chain of Command to support force generation and sustain the physical and moral components of fighting power".*

The strategy was to achieve this via strong interdisciplinary collaboration through good communication with Primary Care Rehabilitation Facility (PCRF), and units, facilitated by regular visits and liaison with teams across the region. This was also fostered through patient-centred care, adherence to best practice and monitoring of long-term outcomes to ensure patient outcomes were optimised.

The overarching mission statement for the RRU was:

> *"to sustain and improve operational effectiveness of Armed Forces personnel through the provision of high-quality targeted rehabilitation that accelerates return to duty."*

Staff we spoke with were clear that their remit was to support patients to benefit from the best possible healthcare outcomes which, in turn, supported operational capability.

Rehabilitation was delivered to patients through an integrated multi-disciplinary approach. There was clear engagement and strong and inclusive support between the unit and Defence Healthcare Recovery Group (DHRG) headquarters.

The unit was working hard to improve the protection of the environment. They actively promoted the need to recycle and there were many recycling bins around the building. They were also trying to reduce paper wastage by using electronic records and turned off all electrical items.

Governance arrangements

There was a range of standard operating procedures (SOPs) in place for all key processes and these were kept under review.

There were clear arrangements providing good oversight of safety, quality and risk at the RRU There was a monthly team meeting at which all aspects of areas related to governance were discussed, which included safety and quality issues such as incidents, training, risks, infection prevention control, equipment updates staffing and patient feedback. We saw minutes of meetings which indicated this was occurring regularly. Staff told us they felt these meetings were a whole team affair and everyone was engaged and participated in discussions. Additional to this there was a thorough rotation of a range of meetings in place to ensure effective communication and information sharing. This comprised of:

- Weekly management meetings
- Fortnightly Officer Command (OC) and RRU headquarters meeting
- Monthly governance meetings
- Monthly continual personal development and in-service training
- Monthly mandatory training
- Quarterly course review meeting, regional PCRF heads of departments and the Defence Healthcare Recovery Group headquarters governance meetings.

There was a healthcare assurance framework (HAF) assessment which was a live document used to support the delivery of good quality care. It was based on the five CQC key questions of safe, effective, caring, responsive and well-led. We reviewed the information held within this and were able to directly tie the evidence held there with our own key lines of enquiry.

Known risks were captured on the risk register. The key risk for the service related to having no Wi-Fi in the building. In event of an outage there was a risk of losing electronic notes access, the cancelling of clinics and phone reviews. Some workarounds were in place but these were not failsafe (for example the use of a dongle, a small portable device that plugs into a computer to provide it with wireless internet connectivity) and SIM cards. This was last chased with Defence Primary Healthcare (DPHC) in March 2024 and the request was rejected.

There was a programme of clinical audit used to monitor quality and identify areas for improvement. An audit log was maintained which identified which audits were to be completed, how often, when they needed to be reviewed and who was responsible for the audit. However, there was scope to expand the quality improvement approach taken by the RRU to cover more clinical areas and use this to pinpoint any training needs.

Leadership and culture

From patient feedback, interviews with staff, a review of patient records and outcomes/outputs for patients, we confirmed holistic and person-centred care was key to the principles of the unit. Staff understood the specific needs of the patient population and organised the service to meet those needs. Staff were complimentary of the culture within the RRU at Cosford. Communication was positive and effective amongst the team, clinical updates and guidance were shared and team cohesion was consistently evident.

Seeking and acting on feedback from patients and staff

A staff climate survey was conducted in January 2025; 14 staff were sent the survey and 10 responded. Following the survey and considering staff thoughts and opinions a review of working practices took place, an improved use and monitoring of white space across the team was

introduced with more focus on improving work life balance and improved workload balance across the team. This had been picked up by DHRG who planned to implement it across all RRUs.

Course patients reported a strong sense of psychological safety. They felt empowered to give open feedback. They reported that the course content and staff delivering the course were excellent. The content of the course has been refined based on patient feedback and underpinned with strong sport science principles. The programming was notably well thought and patient focussed.

Feedback from patients resulted in changes to how the service was planned, developed and delivered. There were 'you said, we did' boards displaying information about how the delivery of courses had been adapted in response to comments made by patients. For example, there was reported to be limited availability of the leg press machine due to command, the RRU ordered a second machine for patients to use. Other patients asked for more cardiovascular exercise on the courses, this was added to the programme.

Any feedback was discussed with the team following the course and was used to review and modify course structure and content, for example increasing hydrotherapy lessons. Feedback was also collected on the outpatient clinic; there were 57 positive responses. Overall patients said they felt listened to, felt included in their care planning, said staff were caring, compassionate and positive.

Continuous improvement

We found a number of examples of innovation and quality improvement projects that included:

- Continuing course development; reduced for a 3-week model pre-DHRG (2022) to reformed 2-week model (2023 onwards), the course had continuously improved amid patient feedback and evidence obtained from the course staff.

The RRU were also part of centrally driven initiatives including

- Service development opportunity, this was a trial of using band 8 physiotherapists in Multidisciplinary Injury Assessment Clinic to cover the consultant.
- Radiology pilot (2024) leading to full redirection of all imaging from 2025, saving significant cost by the use of DMRC MRI scanner rather than referring via the Fastrack contract therefore reducing overall spending.
- Extending Pain Intervention Service to RRUs – injection trial commencing in January 2026 for 6 months to support rehabilitation delivery.