Peninsula Community Health C.I.C

1-247215513

Urgent care services

Quality Report

During this inspection we visited the follow registered locations:

CQC Registered Location	CQC Location ID
Camborne and Redruth Community Hospital	1-303925581
Launceston Community Hospital	1-303946863
Newquay Hospital	1-303947227
St Austell Community Hospital	1-303962531
Stratton Hospital	1-303985486
Bodmin Hospital	1-303999240
Fowey Hospital	1-303926348
Helston Community Hospital	1-303946611
Liskeard Community Hospital	1-303946965

This service is also provided at the following registered locations which were not visited during the inspection:

CQC Registered Location	CQC Location ID
Falmouth Hospital	1-303926236
St Barnabas Hospital	1-303984801
St Mary's Hospital	1-303985084

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Date of inspection visit: January 21,22,23,28,29

Date of publication: 21/04/2015

Summary of findings

This report describes our judgement of the quality of care provided within this core service by Peninsula Community Health C.I.C. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Peninsula Community Health C.I.C and these are brought together to inform our overall judgement of Peninsula Community Health C.I.C

Summary of findings

Ratings

Overall rating for Urgent care services	Good
Are Urgent care services safe?	Good
Are Urgent care services effective?	Good
Are Urgent care services caring?	Good
Are Urgent care services responsive?	Good
Are Urgent care services well-led?	Requires Improvement

Summary of findings

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Overall summary

Overall rating for this core service Good |

Urgent care services were provided from 12 minor injury units (MIUs). These were nurse-led services for patients with minor health problems and injuries that were not serious and not likely to be life threatening. There were urgent care GP services being offered at three of the MIUs units, although the services were not yet providing a 24 hour service, seven days a week. Two of the three services were relatively newly established.

We inspected seven of the 12 MIUs provided by Peninsula Community Health C.I.C. During our visits we observed care and treatment and spoke with patients and staff. One of our experts by experience also spoke with patients visiting the Helston Community Hospital and Liskeard Community Hospital MIUs. We returned to Camborne and Redruth Community Hospital MIU and inspected Helston Community Hospital MIU during an unannounced visit on the evening of 29 January 2015.

Overall, urgent care and minor injuries services were good. There were reliable systems, processes and practices in place to ensure that patients were protected from abuse and avoidable harm. There were sufficient numbers of suitably trained and experienced staff on duty at all times. The units were visibly clean, hygienic and well organised, although the working environment provided limited space and storage in some units. Medicines were mostly safely stored, managed and administered, although there were two examples of where controlled drugs needed improved storage. There was sufficient safety equipment which was checked regularly. However, there was no clear system for triage in some of the units. There was also a lack of data and audit produced to ensure the organisation the services delivered were safe.

Treatment provided was effective. Staff responded quickly to patients in pain, prioritised more urgent patients, and arranged the urgent transfer of patients to an emergency department where necessary. There were competent staff who could access training and development to improve their skills. Staff worked well together and with other health and social care providers. Gaining consent for care was well understood and patients who could not provide valid consent were treated in their best interests. There was, however, a lack of data and audit produced to ensure the organisation the services delivered were effective.

Without exception, patients we met and who provided written feed-back told us staff were caring and kind and we observed this to be the case. Staff acted professionally and took care to provide individualised care for patients.

Services were responsive to the needs of patients. They were planned to meet the needs of all patients, including those who were vulnerable or had complex needs. Patients were almost always seen in less than four hours and over 90% were seen within two hours. At times some of the smaller MIUs were closed if the service was not able to provide safe staffing levels such as at times of staff sickness, but this was infrequent.

There was strong leadership of the units at local level and from senior management. Staff felt well supported and there was a positive, cohesive culture overall. The governance arrangements and systems to monitor and manage quality and performance did, however, require improvement. There was a lack of representation from the clinical lead nurse for urgent care and minor injury services at any of the provider's clinical governance forums. There was some quality and statistical data collected, but there was no evidence to demonstrate how it was used. Apart from data on attendances and waiting times, there was little evidence produced for the board to be assured the service was delivering safe and effective care. There was no supervision in place for MIU staff. This was a gap in ensuring frontline practitioners are well equipped and supported to discharge their safeguarding responsibilities.

Summary of findings

Background to the service

Background to the service

Peninsula Community Health C.I.C. (PCH) provided urgent care, minor injuries, and minor illness services in Cornwall and the Isles of Scilly. Services were provided to adults and children for both local residents and visitors to the area.

There were three locations providing urgent care services with GPs contracted by the organisation seeing walk-in patients on weekdays from 11am to 7pm and at some weekends. Services were provided at Camborne and Redruth Community Hospital, St Austell Community Hospital (since November 2014) and Liskeard Community Hospital (since January 2015). Where provided, X-ray departments were open on weekdays from 9am to 8pm and at weekends from 12pm to 6pm. These services were available at all hospitals with the exception of Fowey and Helston, and only on Wednesdays at St Marys, Isle of Scilly.

There were 12 locations providing treatment for minor injuries, including sprains and strains, broken bones, wound infections, minor burns, minor head and eye injuries, insect and animal bites, and minor injuries to the back, shoulder and chest. The units were walk-in centres (no appointment needed) led by experienced nurses. Services were provided in most units seven days a week from 8am to 10pm (Helston 8am to 8pm) and 24 hours a day at two units: St Mary's Hospital on the Isles of Scilly, and Stratton Hospital in Bude.

At five of the minor injuries units, nursing staff provided minor illness treatment for conditions such as conjunctivitis, infections, colds and sore throats, and rashes. Minor illness services were provided at Stratton Hospital in Bude, Bodmin Hospital, Camborne and Redruth Community Hospital, Liskeard Community Hospital, and St Austell Community Hospital. These units were walk-in centres (no appointment needed) led by experienced nurses. Services were provided seven days a week from 8am to 10pm.

Both the urgent care and minor illness services were being provided under a pilot scheme funded by the Prime Minister's Challenge Fund. The pilot was running until the end of March 2015.

Attendance at the urgent care and minor injuries service fluctuated during the year and was higher during the summer holiday months. The units saw around 96,000 patients each year, of which around 25,000 were children aged 16 years and under.

Information about the provider

Peninsula Community Health CIC (PCH) provides NHS healthcare services to a population of almost three quarters of a million people in Cornwall and the Isles of Scilly. The demographics of Cornwall and the Isles of Scilly are broadly similar to England, although there is a slightly larger elderly population in Cornwall compared with England (6% higher in proportion). Deprivation in Cornwall and the Isles of Scilly is lower than the England average, although about 18.1% of Cornish children live in poverty. Life expectancy in Cornwall and the Isles of Scilly is slightly higher than the national average, standing at 79.5 for males and 83.5 for females compared with 79.2 and 83.0 nationally.

In 2013/14 there were 91,037 patients seen in the Minor Injury Units, physiotherapists carried out a total of 91,132 outpatient appointments, community nurses made 301,246 patient visits and there were 4,402 inpatient stays in community hospitals.

PCH provides the following core services:

- Community adults
- Community inpatients
- End of life care
- Urgent care services
- Children and young people's services

PCH has a total of 16 registered locations, including 14 hospital sites, a service located at an acute hospital A&E and community teams registered at the headquarters.

PCH was formed in 2011. The organisation has an income of about £88.8million, although was operating at a loss of £328,000 before tax as at March 2014. The service employs 2,104 staff across its services.

PCH community hospitals and community services have each been inspected twice since registration. At the time of this inspection all locations previously inspected were compliant.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams, Assistant Director of Governance, Bridgewater Community Healthcare NHS Foundation Trust

Team Leader: Mary Cridge, Care Quality Commission

The team included CQC inspectors and a variety of specialists: district nurses, a community occupational therapist, a community physiotherapist, a community children's nurse, palliative care nurses, a director of nursing, a governance lead, registered nurses, a community matron and two experts by experience who had used services.

Why we carried out this inspection

We inspected Peninsula Community Health CIC as part of our comprehensive community health services inspection programme.

Peninsula Community Health CIC is an independent organisation providing NHS services and therefore we used our NHS methodology to undertake the inspection.

How we carried out this inspection

During our inspection we reviewed services provided by Peninsula Community Health CIC across Cornwall and the Isles of Scilly. We visited community hospital wards, minor injuries units and outpatient clinics. We accompanied district nursing teams on visits to people in their homes where they were receiving treatment.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew, this included Health watch. We carried out an announced visit on 21 – 23 January 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We carried out an unannounced visit on 29 January 2015.

What people who use the provider say

We spoke with a range of patients and their families in the minor injuries units and we had 11 comment cards completed and left by patients or relatives/friends. Without exception patients were happy with the service. A number had used the service before and said the quality of the service was also good at that time. Patients we met said the longest wait they had experienced was 30 minutes, but all said they had expected to wait and were not concerned by that. A number commented that the waiting time increased in the summer months, but they all said they were given an idea when they arrived of how long the wait was likely to be.

Comments included: "the staff were fantastic…everything was brilliant", "excellent service and care all round including initial reception…prompt and caring attention 10/10", "staff treated me with great dignity and respect" The environment was impeccable. We were listened to and spoken to very well", "good

Summary of findings

service with excellent care and attention", "only used three or four times but brilliant every time. Seen within 30 minutes. Always clean and calm. Helped every time. Great caring staff."

Staff were described as "friendly", "fantastic", "always have a smile", and a patient who attended the unit at St Austell said "I would rather come here than anywhere else." We were also told about Bodmin by a local resident who said: "I have never heard a complaint about the service."

A patient at Stratton Hospital in Bude said: "I give them 10 out of 10. They couldn't really have done more and can't be faulted." A patient in Newquay said: "I didn't have to wait at all and they have not been rushed, just very thorough." In Launceston we observed staff cope with two emergency situations with calmness and professionalism. Patients in Helston MIU said staff were caring and kind and had seen patients promptly.

Good practice

We observed outstanding caring and professionalism from staff in Launceston Community Hospital MIU who were coping with two complex emergency situations and significant delays in arrival by the ambulance service. Staff were calm and sensitive to the distress of the patient, but also the relatives, while also having an inspection in progress.

We witnessed outstanding caring and warmth shown to a child patient in St Austell Community Hospital MIU. Afterwards, the patient said their treatment had been "brilliant" and they added "I now want to be a nurse when I'm older."

There was a strong emphasis on supporting and developing staff with excellent access to training and development in the MIUs. All staff were enabled and encouraged to maintain and improve their knowledge and develop new skills.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve:

- Develop an effective governance framework for urgent care and minor injuries services, including a comprehensive assurance system to monitor and report on activity, performance, quality, safety and effectiveness. The service must maintain a service level risk register and escalate serious risks to a corporate risk register.

Action the provider SHOULD take to improve:

- Ensure there is a system for giving feedback to staff consistently for reported concerns and incidents.
- Ensure there are written prompts for staff to enable them to consider any suspicion of abuse of vulnerable adults patients when making initial assessments. The prompts should extend to enable staff to also consider if there is a child who might be at risk in the care of a patient visiting the unit.
- Ensure all medicines are stored in accordance with legal requirements and the provider's medicines management policy. This includes controlled drugs and other medicines stored inappropriately.
- Ensure information about and access to Newquay Hospital MIU for both patients and the ambulance service is clear at the entrance.
- Ensure the environment in St Austell is reviewed for health and safety.
- Ensure patients are able to have private conversations, their records are kept securely and their confidentiality protected in Launceston and St Austell MIUs.
- Ensure that patients waiting to be seen in Newquay Hospital MIU are visible and adequately monitored to ensure they are safe at all times.
- Take steps to maintain staff's skills and confidence in units where patient attendance is low.
- Ensure there is a system of safeguarding supervision in place for MIU staff to ensure frontline practitioners are well equipped and supported to discharge their safeguarding responsibilities.

Peninsula Community Health C.I.C

Urgent care services

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good

Are Urgent care services safe?

By safe, we mean that people are protected from abuse

Summary

The urgent care services and minor injuries units had in place reliable systems, processes and practices to ensure that patients were protected from abuse and avoidable harm. There were sufficient numbers of suitably trained and experienced staff on duty at all times. The units were visibly clean, hygienic and well organised, although the working environment provided limited space and storage in some units. Medicines were mostly safely stored, managed and administered, although there were two examples of where controlled drugs needed improved storage. There was sufficient safety equipment which was checked regularly. However, there was no clear system for triage in some of the units. There was also a lack of data and audit produced to ensure the organisation the services delivered were safe.

Incident reporting, learning and improvement

- Staff were open and honest about incidents. Nursing staff described what constituted an incident and why they would report them. Reportable incidents included patient trips, slips and falls, patients self-discharging or not waiting, violence or aggression towards staff or other people, staff shortages, errors or near misses with patient treatment or safeguarding alerts. Staff said they reported incidents so the organisation knew when something untoward had happened, or there was a near miss. There was, however, not much confidence among staff as to whether this information was used in the wider organisation to improve of change services.
- Staff had a varied experience of getting feedback or seeing improvements arising from incidents. Some staff said they received good feedback from any relevant incidents where feedback was appropriate, but others felt feedback was not routine or consistent. Most of the nursing staff said they felt they had been or would be informed at staff meetings if incident trends had been identified. However, none could recall any specific examples.
- There were changes made following serious incidents which had identified shortcomings in the service. For example, a serious incident had led to a review of all paediatric protocols, delivery of training in paediatric life support for all nursing staff, emphasis in training on recognition of the sick child; and the creation of the Devon and Cornwall Paediatric Emergency Care Forum.

This forum was chaired by the nurse consultant lead for MIU for PCH. The group met quarterly and included representatives from both Treliske Hospital in Truro and Derriford Hospital in Plymouth.

Safeguarding

- There were reliable systems in place to protect vulnerable people from abuse. Each unit we visited had information displayed for staff with flowcharts about how to progress concerns. Staff knew of their responsibilities for reporting concerns to the provider leads for safeguarding vulnerable adults and children, and the local authority. Staff said the provider leads for safeguarding would contact the appropriate local authority for any patients or possible vulnerable dependents of patients. This included those who lived out of the county of Cornwall. For patients in the county of Cornwall and some parts of neighbouring Devon, the PCH computer system had access to information about known vulnerable children and adults. This extended to information about patients who were frequent attenders in hospital, and this information would be used to consider if a safeguarding referral or alert was needed.
- All the nursing and health care staff we met were trained to know what constituted abuse, to recognise signs and act upon them. Staff gave examples of concerns they had raised in the past. One member of the nursing staff gave a particularly good example of how they checked with the local authority as to how a safeguarding concern for a child had been managed.
- There were checklists within paediatric patient assessments covering any suspicions of abuse and what to do with any concerns. There were, however, no prompts for considering any abuse of vulnerable adult patients or dependents in the adult assessment notes. Staff said they would record any comments in the free text section, but agreed the focus fell mostly on children and not vulnerable adults or dependents.

Medicines management

- Medicines were well managed and, with two exceptions, stored appropriately and securely. All medicines were kept in locked cupboards and most of these were located in offices or areas away from patients. Keys were supervised by staff and kept in locked cupboards when not in use. We checked the record books for stocks of controlled drugs and these were recorded accurately and clearly. In all units, medicines requiring cold storage were refrigerated and safe temperatures were checked and recorded daily. In January 2015 the provider reported an incident to us relating to possible failures of the cold storage of vaccines at St Austell MIU. This related to a period in the second half of 2014. Satisfactory action had been taken to address issues around refrigeration temperatures and their checking and recording.
- Medicines were prescribed and administered safely. The provider used Patient Group Directions (PGDs). These are written and approved instructions for the supply or administration of medicines to groups of patients who may not be individually identified before treatment. The PGDs in use in the MIUs had been produced under guidance of Royal Cornwall Healthcare Trust, the director of nursing and pharmacist at PCH, and Kernow Clinical Commissioning Group. This enabled nursing staff to administer, prescribe and supply medicines from an approved stock to presenting patients. All the PGDs were signed and dated when authorised (1 May 2013) and there was a date for their expiry (30 April 2016). We checked 12 of the medicines in stock in three MIUs and found all had authorised PGDs.
- Medicines were administered and prescribed in safe doses. Staff were trained to use weight and age charts to determine the amount of medicine to prescribe to children. There were up-to-date British National Formulary guides alongside the medicines for both adults and children. Medicines and dressings were available specifically for children. Each medicine cupboard we saw had guidelines for the prescription and administration of safe levels of paracetamol to children in accordance with their age and weight. Staff asked patients and recorded if they had any allergy or intolerance to any medicines.
- There were medicines for use if a patient had an allergic reaction. Each MIU we visited had an emergency anaphylaxis kit and other items for treating events such as hypoglycaemia or asthma attacks.
- There were few incidents reported which related to medicines. One incident relating to low stocks reported in October 2014 had been investigated and the matter resolved. An action plan showing how to address any recurrence of this problem in future was shown on the incident report.

Safety of equipment

- The units had appropriate equipment to keep people safe. Each had recognised equipment for use for both adults and children. The resuscitation trolley had equipment for children and oxygen/suction kit had child-sized attachments. There was a portable defibrillator, a portable suction machine, portable oxygen, and, in most of the units we visited, provision of piped oxygen for patients. Where there was not piped oxygen, the units had appropriate cylinder provision. All equipment was checked regularly as required and the checks were recorded. We saw these checks had been done daily or weekly in line with policy. We checked one resuscitation trolley thoroughly and found all the equipment was present and correct and the trolleys were locked to prevent tampering. We saw the defibrillator machine was charged and ready for use and the portable oxygen was full. There were also portable 'grab bags' for use if staff needed to attend patients outside or close to the unit.
- The equipment used in the units was used correctly by trained staff and was serviced and maintained. Each unit had the same resuscitation equipment following approved guidance used consistently at each service. Staff would therefore find the same equipment in each unit and in the same place. Equipment was serviced in rotation and staff said the NHS external provision for maintenance and servicing of medical devices and equipment was responsive to any requests for repairs. Staff said equipment rarely failed, although it was occasionally borrowed by other departments, as we observed in Bodmin MIU when a piece of equipment was not working elsewhere in the hospital.

Safety of the environment

- The units were safe for patients and staff to enter and leave, although there were some access problems for ambulance personnel and patients at Newquay. Units were generally clear of clutter. There was limited storage space and staff were doing their best to provide a safe environment for patients, carers and staff. Areas of concern around the environment from the units we visited were:
  - The ambulance entrance door at Newquay MIU was locked to emergency ambulance crews arriving. When nursing staff were attending a patient they had to interrupt their treatment to admit ambulance personnel. If one of the ambulance crew went back to their vehicle, they would have to be admitted again. This happened on two occasions during our morning visit to Newquay when the nursing staff needed to remain with their patient.
  - Patients and visitors, including those attending outpatient appointments in the X-ray department in Newquay Hospital, were using the ambulance entrance to exit the hospital. If a patient was exiting who needed time to proceed (for example, patients with crutches/sticks or using a wheelchair) they were potentially obstructing the emergency ambulance crew.

Records and management

- Records were completed well. There was an electronic system for capturing and recording statistics and data about the patient and paper records for more specific treatment information. We looked at a sample of paper records for recent patients of each of the units we visited. Most were fully completed with the information available from the patient. We saw some records were missing pain scores in one unit, but most were completed when the patient was first seen by the receptionist. The hand written notes described how the patient presented, described their treatment, if any, and were completed well. They were clear, legible and accurate.
- Records were stored to protect patient's confidentiality. Records were mostly in locked or supervised offices where there was no access to unauthorised people. Security of records in St Austell Community Hospital was less satisfactory. There was very limited space or private areas in this unit. Patient records were in unlocked filing cabinets next to the nurses' desks where patients were triaged. Patients were also triaged in an area which was not private and where conversations could be overheard. There were times when the unit would have been unsupervised and there was a risk to the security of patient records.
- Records of visits and treatment were sent to a patient's GP or other social/clinical professional such as school nurse or case worker. If the patient attended for something considered as sensitive, where the GP or other professional did not need to know the detail of the visit, then the visit was reported but not the reason for the visit. There was, however, no system or indicator in place to be able to confirm information had been produced and sent.

Cleanliness, infection control and hygiene

- There were systems and processes in relation to infection prevention and control to keep patients safe. All the nursing and health care staff we spoke with were aware of hand-washing policy and protocols and we observed good hand washing techniques and practice. Hand washing audits were done on each unit by the infection control link nurse. Results were not always displayed for patients to see, but we did see two audits on a notice board where the results were 100%. Two of the link nurses we spoke with described how they would conduct the audit, and this was a good, thorough process. We observed good and appropriate hand washing techniques. There was personal protective equipment available for staff which included disposable gloves of different sizes and aprons.
- The units were visibly clean and well organised as space permitted. All the units we visited were visibly clean, including in the hard to reach areas. Floors, fixtures and fittings were clean and well cared for. Some of the units were in better condition from a decorative and maintenance perspective, and these were easier to keep clean. In the older units which had not been refurbished for some time, there was some peeling paint and chipped surfaces, but the units were kept clean. There were some oxygen masks in Camborne and Redruth MIU that were not wrapped, making them vulnerable to cross infection.
- Clinical waste was managed in accordance with safe practice. All the units we visited had arrangements for the safe collection, removal and storage of clinical waste, including sharp instrument boxes and specific bins to segregate waste.
- The organisation reported to the board upon issues and data in relation to infection control. The most recent report we were shown (October 2014 for quarter two 2014/15) reported no concerns in relation to MIUs and no incidents or accidents relating to infection control.

Mandatory training

- Mandatory training courses were fit for the purpose of working in a minor injuries unit. The nursing staff we spoke with told us they were all up to date with their mandatory training or it was just due for an update. The staff said the courses were developing from being computer-based online courses to more face-to-face training. This was a development staff said they appreciated as the training was more meaningful and gave them the opportunity to ask questions and interact. Staff said the courses were relevant and were updated for new information.
- The provider was not able to supply data to show how the specific staff working across MIUs were up to date with their training. The information was only available showing staff by the hospital they were based at, and not the service they provided. We can only therefore report that, as at the end of November 2014, there was a varied achievement of training targets for the whole organisation. Infection control had the lowest ratio with only 76% of staff from a target of 84% being up to-date. In equality and diversity, 96% of staff were up to date and 95% were up to date with health and safety training. Of the seven mandatory training subjects, four were below, two exceeded, and one was on target.

Assessing and responding to patient risk

- Patients arriving at MIUs were responded to in accordance with the urgency of their complaint. As each patient arrived the receptionist, a nurse or healthcare assistant, would meet them and take some brief details of their injury or illness. If a patient talked about certain symptoms, such as chest pains, abdominal pain, breathing difficulties, or confusion following a head injury, they would get urgent attention. While we were visiting two of the MIUs we observed a calm and professional but urgent response to symptoms of this nature.
- Most patients were triaged shortly after arrival on the unit. The provider had a protocol to triage all patients within 15 minutes of their booking in. However, there was no specific system to ensure this happened when units were busy, and no evidence to show the target was being met. Initial assessment (or triage) should be done by a member of the nursing or healthcare team. This enables patients to be seen with a priority intended to prevent further deterioration, receive appropriate pain relief, be sign-posted patients to more appropriate services, or provided with reassurance. Notes from the triage session were added to the assessments notes, along with the name of the member of staff who had provided the triage. This member of staff would then make sure any patient who needed to be seen more quickly was attended to in a timely way. There was no evidence collected to demonstrate what percentage of patients were seen within 15 minutes and no target

percentage of patients for staff to achieve. The patient records we saw suggested most patients were seen within the required timescale and this was an embedded practice with most staff. However, not all units we visited were clear about their triage pathway and were not able to show how they were performing.

- When the reception area for the unit was closed (mostly in the evenings and at weekends) there was some risk to patients from not being visible to staff. In Newquay Hospital, for example, patients had to ring an intercom at the hospital entrance for attention from the MIU nurses when the reception was closed. Firstly, the signs instructing patients to do so were small and not easy to see on arrival. Staff had made their own signs to try and improve this which were larger and could be placed more prominently. Secondly, if the nursing staff were with other patients in the unit's treatment room (which were all enclosed rooms), we found they were not always able to hear the intercom (which rang in their office). Thirdly, once the patient was admitted into the waiting room, registered, and asked to wait, they were then not otherwise visible to the nursing staff. If a lone patient became unwell, it might take time for them to be discovered. It was difficult to get the attention of nursing staff as the door leading into the treatment area was secure. Patients or relatives could therefore not summon staff when needed. This issue was not reported on the provider's risk register, although staff said it had been raised on numerous occasions. This had been addressed to an extent in Stratton Hospital, Bude, as there were CCTV cameras in a number of areas which were not visible from the main treatment room.

Staffing levels and caseload

- Most units operated with two sisters/staff nurses at all times if there were times when insufficient staff were available then the MIU would be closed for a period of time until sufficient staff were on duty. There were also trained paramedics working on regular bank shifts at a number of the units (who have been referred to within the nursing team throughout this report). The smaller units at Fowey and Helston were staffed by registered nurses, but they were not dedicated to the MIU. Each staff group was supervised by a senior sister/staff nurse who looked after two units and worked between the units accordingly. A vacancy had recently arisen for a senior sister/staff nurse at Newquay Hospital. This had been filled and the new nurse was due to start shortly. In the meantime the hospital matron was providing support. Each unit had a trained health care assistant covering certain shifts and roles. Although staff on most units said they could almost always get cover with experienced staff at short notice, there was an example of one unit running without two experienced nurses on the day prior to our visit. Nursing staff said this was unusual, but in this case it had not been reported as an incident.
- There was a good skill mix of experienced and trained staff. The nursing staff were either trained to sister/staff nurse level, with further qualifications in minor injuries and illnesses, or were band five nurses in the process of completing their specialist training before being promoted to band six (sister or staff nurse). The healthcare assistants (HCA) had specific roles, and some were trained to triage and treat certain patients. We met one HCA on duty who was experienced, knowledgeable and clearly a valued member of the team.
- There was limited use of agency staff. PCH mostly used a bank system provided by an external company. The bank staff were usually regular staff. They included PCH's own staff who were prepared to work additional shifts (as many were part time) and paramedics from the local ambulance trust who were trained to provide treatment for minor injuries and illnesses.

Managing anticipated risks

- The units were able to manage most anticipated risks. On occasion there was unplanned staff absence due to sickness, for example. If the unit could not cover the shift with an appropriate replacement, the unit would be closed. Any closure would need to be authorised by a senior member of the organisation. Once this had been done, there was a process for informing interested parties, including the emergency services, local GPs, the media, and placing an announcement on the PCH website.
- There was no change to service provision to meet seasonal demand, but almost all patients were seen within a target time of two hours (65% target) and four hours (95% target) at most. In December 2014, 95% of all patients were seen within two hours and 99.9% of patients within four hours. In the busiest month of last year (July 2014) 92% of patients were seen within two hours and 99.9% of patients within four hours. The

majority of the units had limited space and treatment rooms, and putting additional staff on duty may not have improved the situation, but statistics showed the service was managing this anticipated risk.

Major incident awareness and training

- There was a major incident policy with a description and action card for staff roles. Each MIU had a copy of the policy as it related to a major incident and the nursing staff knew how and when they could be involved. There had been a major incident drill and review with staff from the Devonport naval base involving the MIU clinical lead.
- There were plans for dealing with epidemics or public health risks. Each unit had an 'Ebola box' which had been prepared with information for use if a patient presented with signs of this virus. Each unit had a room with a toilet identified for use in isolation before a patient exhibiting signs of this and any other infectious disease could be transferred. Staff knew how to respond and had been trained accordingly.
- Any suspected illness trends would be reported. Any developments or increases in numbers of patients presenting with an illness, such as influenza, or suspected food poisoning, would be escalated to senior management for onward reporting.

Good

Are Urgent care services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

Treatment provided was effective. Staff responded quickly to patients in pain, prioritised more urgent patients, and arranged the urgent transfer of patients to an emergency department where necessary. There were competent staff who could access training and development to improve their skills. Staff worked well together and with other health and social care providers. Gaining consent for care was well understood and patients who could not provide valid consent were treated in their best interests. There was, however, a lack of data and audit produced to ensure the organisation the services delivered were effective.

Evidence-based care and treatment

- The MUIs had protocols and pathways for providing care for presenting illnesses and injuries. This included minor injuries and minor illnesses (in the units where this service was provided) for both adults and children. The protocols and pathways were based upon guidance from relevant best practice and predominantly the National Institute for Health and Care Excellence (NICE). Those we reviewed were relevant and appropriate to patients attending the units. However, they were not dated to show when they had been produced; were not signed by an appropriate clinical person/team; and there was no date for when they should be reviewed.

Pain relief

- Assessing pain and offering analgesia was part of the triage process and treatment for patients. We observed nursing, health care and reception staff asking patients when they arrived if they were in any pain. Patients were asked to score their pain on a scale of 1-10 and this was recorded on the electronic patient record.
- Children were assessed differently for pain. In Bodmin MIU staff told us about pain scores for children. Younger children were given a picture of various 'smiley' faces and asked which face would describe their pain or how they felt. If a child was too young to say or did not want to say, staff would use the FLACC scale assessment. This was used for children between two months and seven years and assessed a patient's 'Face, Legs, Activity, Crying and Consolability' for signs of pain.
- The MIUs had a range of different pain relief medicines. Nursing staff would follow the protocol for giving pain relief. They would ensure they checked first with patients if they had already taken any pain medication before administering further pain relief. Staff said giving pain relief quickly was important as it helped when they examined a patient in pain if the pain had lessened and the patient was more relaxed.

Technology and telemedicine

- Most of the MIUs had access to digital X-ray facilities. Nursing staff were able to order digital X-rays for upper and lower limbs and were trained to read them. If a patient came to the unit with a suspected fracture and the X-ray facilities were not available, nursing staff would assess the possible severity of the fracture. For more serious fractures needing urgent attention, staff would ask the patient to attend a facility with an X-ray available, or the nearest accident and emergency department. If staff decided a patient could wait until the following day, the patient would be asked to return and given advice about managing the injury in the meantime.
- There was back-up for staff from specialised personnel. If one of the nursing team was unsure about interpreting an X-ray, they could refer the patient to one of the acute hospitals for review by a radiographer or consultant. Otherwise, all the digital X-rays were cross-checked by a qualified radiographer within 48 hours. If staff had missed something or misdiagnosed a patient, the radiographer would contact the unit and the patient would be contacted for further treatment and advice. Staff said this happened infrequently, but the provider was not gathering evidence to show the frequency of errors and whether there were any trends developing.

Outcomes of care and treatment

- The number of patients who re-attended for unplanned further treatment was low. The provider had a target for

unplanned re-attendance of less than 5%. In the period from April to December 2014, the average number of patients re-attending the units was just below 3%. The provider was not able to show what the main reasons for re-attendance were, but nursing staff said it was often pain management, changing wound dressings, and further advice for patients or carers.

- Care provided to patients produced good outcomes, although evidence for this was mostly from feedback from patients and a low re-attendance rate. There was no data or evidence otherwise gathered to demonstrate to the organisation that the units provided good outcomes for patients. Patients we spoke with and written comments we received were, without exception, showed that patients were satisfied with the outcome of the care and treatment they had received. Feedback to the provider from patients was very positive.
- There was a follow-up service to assess the minor illness service. While the pilot for the minor illness service was running, reception staff were calling patients the day after their visit to check if they had received a good service or had any remaining concerns about their health or wellbeing. This was done again at seven days. Responses were captured and would form part of a report on the outcome of this pilot service. Results so far were good and patients were happy with the service they had received and the outcome of the treatment.

Competent staff

- The MIUs were staffed with well trained and experienced reception, nursing and healthcare staff. Each unit, with the exception of the small units in Fowey and Helston (and St Barnabas, Saltash which was closed) had established that two service-specific trained band five or sisters/staff nurses would be on duty at all times. Nurses were funded by the provider at band six (sisters/staff nurses). When a vacancy arose, the provider would look to employ either a band six or a band five nurse. If a band five nurse was appointed, they were fast-tracked through the two approved MIU modules, and if successful, were then promoted to a band six post. Nursing staff were enabled to update their core skills on elements of the modular courses each year. Staff treating children and young people had received specific training to care for and treat children. There was one health care assistant in each unit at certain times and with specific roles. They were required to manage stocks and stores, check equipment and trained to apply dressings and some plastering of fractures. Reception staff were trained to meet patients and carers and obtain and record certain information and offer reassurance.
- The provider was not able to supply data to show how the specific staff working across MIUs were up-to-date with their annual performance review. The information was only available showing staff by the hospital they were based at, and not the service they provided. We can therefore only able to report that as at the end of November 2014, staff were not meeting trust targets for performance reviews. The target was 100% but only 74% of staff had met with their line manager in the previous 12 months to discuss and review their performance. Most of the staff we met said they had a review in the last year, although some senior nursing staff said they had dropped behind with this due to work pressures.
- Staff were supervised during any training and development and in daily practice. The service had a clinical lead manager (nurse consultant) who visited all the units on a regular basis and worked clinically. Clinical practice was supervised and any areas for improvement were highlighted and re-evaluated at a later date. The minor injury modular training was delivered by the nurse consultant, who was an accredited trainer. The modular training also had practical hands-on training elements, which were supervised by the nurse consultant.
- Staff were trained to deal with life threatening emergencies. All nursing staff were trained to deliver intermediate life support (ILS) to both adults and children and in acute illness management. Health care assistants and administration staff were trained in basic life support. All nurses, including those who worked bank shifts, were required to be up-to-date in ILS for both adults and children.
- Staff were supported at induction and in practice. Nursing staff worked alongside GPs in the urgent care centres and were supportive to them with induction and learning. We spoke at length with a GP working in session at St Austell MIU. The GP was knowledgeable and experienced in dealing with the patients coming for urgent care and minor injuries. They said the nursing staff team had been supportive and generous with their time and experience as this new service was being

Good

Are Urgent care services effective?

embedded. All the nurses we spoke with were enthusiastic about the GP sessions and felt they provided shared learning and development opportunities.

- There were staff with additional skills taking 'link' roles to support colleagues in their area of expertise. Areas included infection prevention and control, dementia, learning disabilities, and paediatrics. Staff were responsible for certain training and audit of these aspects of care and practise. They were enabled to attend training and development courses to ensure their knowledge was up-to-date.
- Some arrangements at the MIUs meant staff were not given regular exposure to patients and presenting conditions. Three of the MIUs were small with few attendances each year. One of these (Fowey) was described by a number of nursing staff as more of a 'first aid' service. It had not issued any medicines to patients in the nine months from April to December 2014. The unit at Helston was not fully staffed at all times and although staff were trained in minor injuries, they could be rostered to work on the ward. The other unit (St Barnabas, Saltash) was currently closed due to staff retiring and not yet being replaced. So, although these nursing staff were trained to the same level as others in the busier units, they were treating very few patients. They were not having as regular interactions as staff on other units or keeping up their skill set and confidence.

Multidisciplinary working and coordination of care pathways

- There was a good approach to working with other services and professionals. Nursing staff described contact with social services when they had concerns about a patient or carer. GPs were contacted when a patient on their list had attended the unit, as were school nurses when the patient was in school, and the health visitor if one was involved with the patient or family. There was a good relationship with the accident and emergency (A&E) departments in the local acute hospitals. Staff could talk with A&E staff if they wanted to follow up a patient who had been transferred. A&E staff would also contact staff at the MIU if they felt a referral or transfer had been inappropriate or ill judged. These events would be reviewed by the nurse consultant lead for MIU and discussed with the member of staff for learning, and then shared, if appropriate with the wider team for future reference.
- Staff had access to medical advice for non-emergency situations. PCH had an internet-based system to request consultant advice from Royal Cornwall Hospital in Truro. Nursing staff would request consultant advice on a website for this purpose. The consultant on call would carry a bleep, and would call the MIU staff as soon as possible to provide direct advice.

Referral, transfer, discharge and transition

- Patients were transferred appropriately. Care and treatment protocols described clearly when a patient's presenting condition was such, or deteriorated to a level, where emergency care was needed. Nursing staff were also guided by their experience and training. While we were at two of the units we visited, patients arrived with conditions that required a transfer to the A&E department under the patient protocol. Staff ensured the patients were safe and provided appropriate treatment while an ambulance was called.
- Patients were formally registered on arrival and discharged on departure. This process was to ensure there was a formal process for admitting a patient and getting all the right information. At the other end of the treatment session was a discharge process for the patient. This was to make sure all information about treatment, advice given, or medicines administered or prescribed was recorded into both the electronic record system and the paper record. Any referrals or information for other providers was processed also at this time.
- Nursing staff were able to make some further referrals to other services. This included X-ray, the mental health crisis team, the falls team, and patients were signposted to services such as the drop-in physiotherapy services which were available at Bodmin, Newquay and Helston hospitals.

Availability of information

- Staff had access to relevant patient information. The computer system used held patient records which gave staff some information. This included how often the patient had attended the unit or other units in the local area. If they were a returning patient, there would be information about their GP, what they had attended with before, and their personal details. Staff would check this information was still current when the patient was registered.

Good

Are Urgent care services effective?

- Staff had access to other information to deliver effective care. Each unit had a 'library' of certain medical and technical books. This included medicine information, including the most up-to-date British Medical Formulary for both adults and children. There was also information on infection prevention and control, information for use in an emergency or major incident, and pathways and protocols for treatment.

Consent

- Consent was sought from patients or parents/guardians in line with legislation and guidance. The nursing staff and the GP we met had an excellent working knowledge of the law as it related to consent. Staff were aware that as the treatment they were providing was not high risk, they did not need written consent and verbal or implied consent was acceptable. Staff said patients were told what staff proposed to do and were able to ask any questions before treatment took place. There was, however, no specific area on the assessment record for staff to record or confirm decisions and conversations around consent. Consent to share information with other health and social care providers was not sought actively by staff or recorded on the assessment record.
- Consent provided by or for children was sought in accordance with legislation. The nursing staff and the GP we spoke with had excellent working knowledge of the guidance for gaining valid informed consent from a child. Staff knew that young people of age 16 and 17 were presumed to be able to provide their own consent under the MCA 2005. Staff knew the legal guidelines which meant children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (often called 'Gillick competent'). Otherwise, consent would be sought from the child's parent or guardian with input from the child. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.
- Staff understood and used the provisions of the Mental Capacity Act 2005 when an adult patient did not have the ability to provide valid informed consent. Staff described how they would consult with the patient's family or someone else appropriate if the person did not have the mental capacity to give consent in order to help them reach a 'best interests' decision. If there was no one, the provider had links with independent mental capacity advocates. However, given the treatment needed usually required quick attention, staff would attempt to talk with the patient's GP, social worker, or contact a member of the family or care worker. Staff were often able to involve one of the hospital-based medical staff for input. Staff said treatment was then provided in the best interests of the patient. There was, however, no specific prompt in the assessment form to record how staff proceeded with patients unable to provide valid informed consent.
- Staff had a good awareness of the Deprivation of Liberty Safeguards (DoLS). Staff said although there were no likely circumstances where they would need to apply for a licence to deprive a person of their liberty within their service, they needed to be aware of the provisions of this aspect of the Mental Capacity Act 2005. This would be in order to recognise when a person attending might be deprived of their liberty in another setting. Staff said it was possible a patient might attend an MIU who might be deprived of their liberty in a care home. If this happened, staff would alert their adult safeguarding lead.

Good

Are Urgent care services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

Without exception, patients we met and who wrote comments told us staff were caring and kind. We observed this along with professionalism and individualised care for patients from all those staff we met.

Dignity, respect and compassionate care

- Patients were treated with kindness and compassion. We observed this from the staff we met, including receptionists and health care assistants. Without exception, the patients we met said staff were caring and sensitive. One patient spoke of how staff were empathetic with the pain they were experiencing, and another said (of a previous visit to the particular unit) staff had made sure the patient was able to get home safely and had support at home.
- Not all the MIU environments had the best arrangements to ensure patient confidentiality. In Launceston and St Austell MIUs there were no or limited spaces to have private conversations with patients. As with the other units, primarily due to space, there was no dedicated triage room and patients were often spoken with in the waiting area or in the main body of the clinical area. Stratton, Bodmin, Camborne and Redruth, and Newquay MIUs had either private rooms they could use or single-use treatment rooms. Staff said they would do their best to keep conversations private, although this was not always possible. One of the reception staff said they would offer patients the opportunity to write down the nature of their visit to the MIU if they preferred to do so rather than explain at the reception desk.
- Nursing staff spoke about care and compassion. Those staff we asked about what they did well told us it was giving a patient some time, understanding and help. All the nursing staff we met demonstrated a caring and compassionate attitude to patients, and patients were put at the centre of their service.

Patient understanding and involvement

- Nursing staff were experienced and trained to ensure patients understood what was happening to them and why. Staff said they made sure the patient and any carer (where appropriate) had been given a diagnosis, told why the staff reached that conclusion, and asked if the patient agreed. Patients were able to ask any questions, including the risks and benefits of any proposed treatment. Patients were also told what they might expect after they left the unit and under what circumstances they should come back or seek further help or advice.
- Staff followed up patients where they were concerned about their understanding of any after-care or making arrangements to see other professionals. Patients and carers were encouraged to come back at any time if they were worried about anything or they could telephone for advice.

Emotional support

- Staff had a good understanding of local support networks. For example, in Stratton Hospital MIU, staff told us about a local school support centre for children needing extra support or someone to talk with. Nursing staff were able to refer people with mental health problems to the local crisis service run by the Cornwall Partnership Trust. The contact details were on the notice boards or the internet.
- Staff would refer patients to their GP if they felt there were, for example, mental health problems that were not being managed well or could benefit from therapy.
- Staff understood the needs of carers and family when a patient in their care was unwell. We witnessed a calm, compassionate and reassuring approach from nursing staff in Launceston MIU when dealing with the parent and grandparent of a distressed child. The staff had requested attendance of an ambulance, which took over 45 minutes to arrive. The staff remained calm, professional and reassuring, despite the delay of the ambulance arrival. Another unwell patient presented in the midst of this situation and staff calmly attended also to this patient without causing distress or anxiety.
- Staff recognised when a patient needed more emotional support. A patient who spoke with one of our experts by experience said they felt “traumatised” as they arrived at the hospital MIU. They said the attitude of staff was “invaluable” and they had “tremendous emotional support.”

Good

Are Urgent care services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

Services were responsive to the needs of patients. They were planned to meet the needs of all patients, including those who were vulnerable or had complex needs. Patients were mostly seen in less than four hours and over 90% were seen within two hours. Services were closed if the service was not able to provide safe staffing levels, but this was infrequent.

Planning and delivering services which meet people's needs

- Services were planned and delivered to meet people's needs. Although the services did not have flexible working to meet the busier times of the year, almost all patients were treated within the target time of four hours and 93% within two hours. Even in the busiest months of the year, the performance for treating patients within four hours did not drop and was around 99% each month. The rationale for providing the same service all year round was patients would always know what times their local MIU was open and did not have to make allowances for different times of the year. Also, the MIUs had limited treatment areas, so were not able to expand their services at busy times. Patients were seen very quickly and efficiently when the service was less busy. When we visited the units, with the exception of Camborne and Redruth, which was busier than that others, patients were being seen within 15 minutes, including seeing the GP in St Austell MIU.
- Very few patients left the service without being seen. In the nine months from April to December 2014 only around 0.1% of patients (against a target of fewer than 5%) left without being seen. Nursing staff said this was usually when a patient came to see how long the wait was and if they had to wait longer than they wanted to, they would leave and often come back at another time. Some patients also found they felt better after a short wait and left without further treatment.
- Services were developing to meet identified local need. The relatively new urgent care services and minor illness services were provided as a pilot programme by funding from the Prime Minister's Challenge Fund project for Minor Illness and Urgent Care Services. Services were being piloted until 31 March 2015 and had been established from October 2014. Provision for minor illness started in October 2014 and funds were being used for administration and clerical support to reduce the time nurses spent on registering and recording patients. Patient feedback collected by the organisation was very positive. Urgent care services were slower to establish as this involved recruiting local GPs to work sessions between 11am and 7pm, seven days a week. The service was developing well and local GPs were coming on board. Patients we met told us this was a service they were pleased to be offered, but many felt it had not been well publicised. The provision at St Austell was not mentioned on the PCH website and no patients in the waiting room knew it was offered. A GP we met at another service said the establishment of the service had not been ideal. They had arrived for a shift and were not expected. There were no prescription forms available and none of the medicines they wanted to use or prescribe were available.
- There were other services to provide efficient and responsive care. Most of the MIUs had X-ray facilities on site. Nursing staff were able to order X-rays for upper and lower limbs and were trained to read non-complex X-rays. MIUs had plastering services and nursing staff were trained to apply plaster to fractured limbs. Patients could also have appointments with visiting plaster technicians.
- There were leaflets, posters and other information for patients. Patients or carers for patients with certain injuries or conditions were given leaflets or information sheets about caring for themselves or their relative. Staff gave advice and written information about after care for illnesses, injuries or infections. This included how long a patient should wait before seeking further treatment if a condition had not cleared up or injury not repaired. Other leaflets and posters included information about prescription charges, abuse and safeguarding, contacting social services, carbon monoxide safety, coping with pain, and anxiety and depression.

Equality and diversity

- Staff in MIUs dealt with all patients as individuals. As a major tourist area of England, staff said they met and

Good

Are Urgent care services responsive to people's needs?

treated people from, for example, many different ethnicities and religions with a range of mental and physical abilities and varied social circumstances and backgrounds. Equality and diversity training was delivered at induction and then every three years. Staff we asked did, however, say they were not aware of the organisation having a lead for equality and diversity. They did not know of specific approved resources on equality and diversity they could access, other than those produced by staff with special interests.

- There were telephone translation services available for staff to use. Most staff said as patients were 'passing through' they usually managed to treat patients with limited English by getting help from family members or other staff who could translate, or using symbols and signs to denote, for example, pain or discomfort.

Meeting the needs of people in vulnerable circumstances

- The service had support and advice from a lead nurse for people with a learning disability. Staff had been trained in caring for patients with a learning disability. There was an information folder for further support. This included a guide for staff to refer to when discussing a person with a learning disability having a regular health check, information about autism and Asperger's syndrome, easy-to-read symbols or 'flash cards' to use with a patient for better communication and Makaton signing techniques. In St Austell, all the staff were trained in using Makaton signing by a member of the nursing team with a special interest. There was access to the learning disability specialist nurse for advice and support. Staff told us they understood how some people with a learning disability were anxious and fearful of hospitals. MIU staff had therefore attended people outside of the premises, perhaps in a car or on a bench, to help reduce their anxiety.
- PCH had a matron leading on care for patients living with dementia. There were link nurses and liaison nurses in each hospital and staff in MIUs could get support if they felt they needed it. All staff were trained to recognise the signs of dementia and PCH was ensuring the dementia liaison nurses had specialist knowledge. Nursing staff said if they had specific concerns about a patient with dementia or a person caring for a patient living with dementia, they would contact the patient's GP or social worker, or, if necessary, the safeguarding adults lead.
- There was information for staff about people in vulnerable circumstances. This included records and guidance for making mental capacity assessments, how to get support from an independent mental capacity advocate (IMCA), the Royal College of Nursing guide to the use of restraint and using hospital passports for people with a learning disability.
- Access for patients was not always optimal. In Bodmin and St Austell MIUs the receptionists were in offices with small windows to open to greet patients. In both these units patients using wheelchairs were not easily visible and had to be looked down upon to be seen. This was detrimental to patient confidentiality and dignity. In other units, such as Launceston, Newquay and Stratton (Bude) there was a low level reception desk without glass or other barriers separating patients.

Access to the right care at the right time

- Patients had timely access to treatment. Almost all patients were seen within two hours of being registered. In the less busy times of the year, patients were often seen without waiting more than 15-30 minutes. Patients were generally triaged on arrival and patients were seen in accordance with clinical priority. Patients we met said this was something they understood. Reception staff said they would make patients aware if the wait had extended due to staff dealing with a higher priority.
- Services were rarely closed. In December 2014 there were four days when services were closed early due to staff shortages but none were closed for a full day. In January 2015 the services in St Barnabas Hospital MIU, Saltash, were fully closed due to staffing issues. This was one of the smaller services and patients were redirected to services at Liskeard or Launceston. This was publicised on the NHS Choices website, through local media, and the PCH website. Staff said the local GPs and the ambulance service had also been informed.
- There was access to other associated services, although not at all times. X-ray services were provided in most MIUs at different times of the weekday and weekends. Fowey, Helston and St Barnabas (currently closed to minor injuries) did not have X-ray facilities and there was a limited service at St Mary's Hospital on the Isles of Scilly. To expedite treatment, nursing staff were able to order and read non-complex X-rays for upper and lower limbs and had back-up support from trained radiographers.

Good

Are Urgent care services responsive to people's needs?

- Services ran in accordance with published times. The PCH website was the main resource for patients to check on opening times. These were the same in the units for each day of the week (although times and services were varied) and minor injuries services were provided every day of the year. Some units did not, however, clearly display their opening times, waiting times or services provided in entrances to the units. The services were nevertheless open to anyone and there was no appointment system. Patients were able to walk in and be seen by either a registered nurse or health care assistant, or at certain times of the day in the urgent care centres, by a GP.
- Access to the MIU service in Newquay did not meet people's needs. Three relatives bringing patients wrote to us about visiting Newquay. One remarked how when they arrived at 10am on a Saturday they found the reception closed (it was not staffed as a rule at weekends) and were unsure what to do. The option to use the intercom to get attention was not clear. When the patient was being seen the nurse had to excuse themselves three times to make sure other patients arriving were checked and spoken with. Another relative commented about the poorly displayed signs to enable to them to gain entry when reception was closed, and this was repeated to them by other patients arriving. The third person said they were confused by the shutters being down at the reception desk at 8am and waited outside until they opened at 8:30am as they thought the unit was closed (staff were on duty from 8am).
- There was a varied understanding in the local community about the services offered by urgent care and minor illnesses. The advertisement of the new urgent care services did not appear to have been effective enough. Most of the patients we met did not know of the GP-led service and were mostly unaware of the minor illnesses services and when they were available.

Complaints handling (for this service) and learning from feedback

- Complaints and concerns were listened to and used to improve services. There had been few complaints or concerns made to the service, but those made had been recorded in the provider's complaints log. Most related to the attitude of staff, and most were partially upheld. The matron or one of the senior staff had contacted the complainant in a number of cases to apologise.
- There was information available on notice boards in MIUs and leaflets available in waiting areas about making complaints and how they should be handled. Staff said they would record any concerns or complaints made verbally to them and pass them to the nurse in charge.

Requires Improvement

Are Urgent care services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

There was strong leadership of the units at local level and from senior management. Staff felt well supported and there was a positive, cohesive culture overall. The governance arrangements, including systems to monitor and manage quality and performance required improvement. There was no representation from the clinical lead nurse for urgent care and minor injury services in any clinical governance forum. There was some quality and statistical data collected, but there was no evidence to demonstrate how it was used. Apart from data on attendances and waiting times, there was little evidence produced for the board to be assured the service was delivering safe and effective care. There was no supervision in place for MIU staff. This was a gap in ensuring frontline practitioners are well equipped and supported to discharge their safeguarding responsibilities.

Service vision and strategy

- There was a vision for urgent care services in PCH. This was based around a five-year strategy to develop a model for urgent care across the county. This sat within the wider community drive to divert patients away from accident and emergency departments and GPs to reduce pressure on those services.

Governance, risk management and quality measurement

- There was a lack of governance for the urgent care and minor injuries services. There was no identified named lead for governance of urgent care. Urgent care and minor injuries services did not fit into or report into any clinical governance structure.
- There were identified risks in some of the minor injuries units, but there were none escalated to the corporate risk register and there was no local risk register. For example, staff had recognised the risks of the ongoing provision of service in Fowey MIU and the small number of patients leading to deskilling of staff and a loss of confidence. There were issues with the environment in a number of units, particularly as they related to confidentiality of patients and their records. There were recognised issues with visibility of patients in some units, specifically out of hours in Newquay MIU. These issues were recognised but not escalated to the risk register for consideration by the risk committee or the equivalent.
- There was some audit of data, but this information was not being used to identify service improvements in safety and quality. There was an annual audit of patient records to check for completeness. However, the annual nature of this audit led possibly to a long gap in time between errors being made and them being picked up. There were no audits of patient triage quality and time to triage. There was a report produced outlining the reasons for children presenting in MIUs. There was, however, no analysis of this data to look for trends to inform the wider health community. There was no information collected about adult patients and reasons for their attendance. There was some anecdotal evidence about the MIUs preventing patients from inappropriate visits to A&E, but no formal collection of information. Although there was no evidence to show the service was providing anything other than a high quality and well appreciated service, there was no quality report or evidence provided to the board to demonstrate this. There was no evidence of the board being informed of changes to practise or services from analysis of complaints or incident reporting.
- There was some risk assessment taking place in the units but no standardisation. In Newquay we saw risk assessments undertaken in December 2014 for lone working, confidentiality of patient records, patient health and safety in the waiting room, and reception cover. However there was no standard set of risk assessments for the units, and no bespoke assessments where units had certain environmental challenges. Staff were also unsure of what action, if any, was taken to manage and mitigate risks identified by these assessments.
- There was no audit of complaints or incidents at service level. There was no analysis of trends or action plans at MIU service level to address any emerging patterns or serious concerns highlighted by complaints or incidents.

Requires Improvement

Are Urgent care services well-led?

Leadership of the service

- There was good leadership at local and service level. Each unit had a senior sister in post (or the post was being recruited to) and oversight at an operational level from a matron. The service had clinical leadership from an experienced nurse consultant who was connected with staff, visible and supportive. There was some cross-over between the matrons' responsibilities and that of the clinical nurse lead. We saw this had led to an issue with staffing on one occasion, and one of the units operated for one shift without the established staff skills mix. However, these examples were infrequent and the relationships were mostly complimentary.
- There were many competing priorities for the clinical lead for the service and no back-up for the role if the clinical lead was absent. The clinical lead had recently taken on the role of lead for child safeguarding along with MIU leadership, and they had a heavy workload of high priorities with little room for dealing with unplanned or unexpected issues. There was also no designated deputy clinical lead who could accept delegation or take over the role if the event of an unplanned or planned absence of the clinical lead.
- CQC had reviewed services for looked after children in Cornwall immediately prior to our inspection in January 2015. The review had included review of children's services for Peninsula Community Health CIC. The findings highlighted the lack of capacity for the named nurse to drive forward an agenda of continuous improvement in safeguarding practice within the MIUs as the post holder was also lead nurse consultant for the 12 MIUs across the county.
- There was no operational oversight or comprehensive review of all emergency department and MIU attendances of children, young people and adults, including adults with concerning behaviours to ensure that all opportunities to support vulnerable families were identified and responded to prior to or soon after discharge. As a result, the PCH board cannot be assured of good and effective safeguarding practice within their acute services.
- The CCG Kernow designated nurse for safeguarding was providing supervision to the Peninsula safeguarding named nurse on a monthly basis; however no supervision was in place for MIU staff. This was a gap in ensuring frontline practitioners are well equipped and supported to discharge their safeguarding responsibilities.
- The board of Peninsula had taken account of the findings and plans were being put in place to set up a safeguarding team to ensure the service was provided and able to respond in supporting patients and staff.
- There was a good range of staff meetings. Senior staff met with matrons and the clinical lead on a regular basis. There were unit team meetings where the nurse in charge endeavoured to bring the whole staff team together as often as possible, although not all staff said this happened as planned. This appeared to be a unit-specific problem with staff on some units saying they were often too busy for meetings.
- There was some team building and appreciation of success. Staff in Bodmin Hospital MIU told us about a team 'away day' they had in November 2014, organised by the matron of the hospital. This included a session on learning from complaints, discussion on how to have difficult conversations, and a local GP presented a session on minor illnesses. The away day had led to a pilot being discussed and introduced to change staff shift patterns, and this was progressing.
- Staff said they found the senior management to be involved and visible, although there was a varied view of whom staff had met or seen on their unit. None of the staff were aware of visits by non-executive directors or executive walk-arounds. There was no member of the board with executive oversight for urgent care or minor injury services. Most staff had seen or met the chief executive officer and most staff agreed they could contact him directly if they wanted to. Most staff said they had seen or met the interim director of operations, who had worked at PCH and its predecessor for a number of years. They were also said to be approachable and involved.

Culture within the service

- The culture in the service was positive overall. Staff demonstrated support for the service and one another. All the staff we met enjoyed their work and spoke of the service as a "family" or a "strong team." Staff said they felt well supported. There was a low sickness rate and most unplanned vacant shifts were filled by existing staff

or local bank staff who worked regularly at the units. However, several of the nursing staff said their primary concern, if they had one, was not always feeling valued or recognised by the organisation.

- There was a lone-working policy. The PCH policy was staff in MIU did not work alone. Staff said they made sure they were safe and secure if staff had breaks and the organisation had their safety as a priority. If staff were faced with working alone outside of normal breaks, the policy was for the unit to close. Staff we met said this had almost always happened, but one member of senior staff said this "has slipped through on occasion."
- Staff were recognised when they performed above and beyond their role. The matron in Bodmin hospital shared with us how a member of the nursing staff had successfully treated a child with an airway obstruction, as the nurse was specialist trained in this area. This was celebrated at the team away day. Staff were described by their clinical lead as having a "can-do" attitude to their work and patients.

Public and staff engagement

- Public opinion of the urgent care services had provided positive results. The friends and family test questions for the units had been asked of patients since October 2013 and was ongoing. The response rate for the 12 registered MIUs had, however, not always met the provider's target for 15% of all patients to have completed the survey. In the 13 months from October 2013 to October 2014, responses had been received from an average of 13.9% of patients across all MIUs. The rate had, however, improved in October 2014 to 16.6%. Bodmin MIU had recently been congratulated for showing great improvement in the return of questionnaires. In the results, almost all of those patients questioned said they would be extremely likely to use the service again.
- Staff said they felt included in the way the service was delivered and their views were sought at local level. Not all staff felt their views were heard beyond the clinical lead. Some felt they had raised incidents and risks but these had not been responded to. Staff also said they were enabled and encouraged to think for themselves and make appropriate decisions. All staff told us they felt one of the best aspects of the service was the access to training and development.

Innovation, improvement and sustainability

- The vision for the service was to raise the level of service provision to urgent care. The service employed highly trained senior nurses to run the services, and this provided sustainability and the ability to raise the level of services in the future.
- The barriers to improvement and sustainability were mostly from the working environments. There was funding being provided by the League of Friends to improve and increase the size of the MIU in Launceston and a tender for the work was out to offer. Otherwise, most of the services were small and therefore limited in what they could do.

Compliance actions

Action we have told the provider to take

The table below shows the regulations that were not being met. The provider must send CQC a report that says what action they are going to take to meet these regulations.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe care and treatment by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activities: The urgent care and minor injuries services did not have effective governance arrangements to monitor, manage and report on performance, safety and quality. The service had not elevated its risks to a corporate risk register; there was a lack of a routine programme of quality and safety audit or risk assessment that was analysed and reported upon; there was no analysis of incidents or complaints to ensure changes and improvements to services were made; Regulation 10 (1) (a).