## Locations inspected

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<th>Location ID</th>
<th>Name of CQC registered location</th>
<th>Name of service (e.g. ward/unit/team)</th>
<th>Postcode of service (ward/unit/team)</th>
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<td>Lymington New Forest Hospital</td>
<td>Urgent care services</td>
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<td>RW170</td>
<td>Petersfield Hospital</td>
<td>Urgent care services</td>
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This report describes our judgement of the quality of care provided within this core service by Southern Health NHS Foundation Trust. 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 Southern Health NHS Foundation Trust and these are brought together to inform our overall judgement of Southern Health NHS Foundation Trust.
## Summary of findings

### Ratings

#### Overall rating for the service

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<th>Rating</th>
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<td>Are services effective?</td>
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Summary of findings

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Summary of findings

Overall summary
Background to the service

Southern Health NHS Foundation Trust provides two nurse led Minor Injury Units (MIU's), one at Lymington New Forest Hospital and one at Petersfield Hospital. The MIU staff see, assess and treat people presenting with minor injuries, they do not treat people who are unwell or children under the age of two years at Lymington and one year at Petersfield.

Both units provide a 7 day a week service 365 days of the year. Lymington MIU is open from 8am to 9pm and Petersfield MIU is open from 8am to 6pm.

Both units were led by clinical lead, a nurse practitioner. In Lymington on average 1600 patients attended the service per month and in Petersfield this average 820 patients per month.

We visited both Minor Injury Units as part of the inspection of the trust.

Our inspection team

Our inspection team was led by:

**Head of Inspection:** Karen Wilson-Bennett

**Inspection Manager:** Caroline Bishop

The team included an inspection manager, an inspector, an assistant inspector and a specialist advisor, a nurse from a minor injuries unit.

Why we carried out this inspection

We carried out this short notice inspection of Southern Health Foundation NHS Trust to follow up on some areas that we had previously identified as requiring improvement or where we had questions and concerns that we had identified from our ongoing monitoring of the service.

How we carried out this inspection

To get to the heart of patients’ experiences of care, unless stated otherwise, 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?

We used the findings of previous inspection and ongoing monitoring information to decide which services to inspect. Prior to the inspection, we reviewed a range of information we held.

We gave a week’s notice of announced inspection of the two minor injury units, one at Lymington New Forest Hospital (Lymington) and one at Petersfield Hospital. We looked at the two MIUs due to previous non-compliance. During the visit 27-29 March 2017, we interviewed matrons, clinical leads, nursing staff, administrative and clerical staff; we looked at some of the governance systems and processes at the minor injury units and checked how the data was then used by the trust to assess and manage safety and quality.

We talked with patients and their carer and family members and reviewed patients’records and treatment. We undertook seven interviews and reviewed 25 records.
Summary of findings

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment provided by Minor Injury Units (MIU’s) at Lymington New Forest Hospital and at Petersfield Hospital.

What people who use the provider say

Good practice

Areas for improvement

**Action the provider MUST or SHOULD take to improve**

**Action the service SHOULD take to improve**

- Ensure all staff report incidents.
- Implement across both MIUs an audit plan on the use of national guidances locally.
- Develop children’s waiting area at Petersfield MIU to provide visual and audible separation from the adult waiting areas.
- Develop systems to ensure complainants are responded to in a timely manner.

- The trust should ensure staff across the urgent care provision are informed of the trust plans for the service, including those arising from discussions with the CCGs.
- Review the governance reporting framework for the Petersfield MIU.
- Ensure there is clear support structure in place with clear lines of accountability for the MIU in Petersfield.
- Review the staffing levels at the MIU in Petersfield to ensure they are able to offer a safe service at all times.
- Review the ability to ensure there are sufficient numbers of staff trained in the care of a sick child, on duty at all times in MIUs.

**Action the provider COULD take to improve**
By safe, we mean that people are protected from abuse

Summary

- Safety was a priority at all levels. Staff took an active role in delivering and promoting safety, learning and improvement. Safety performance included waiting times for assessment and treatment, adverse incidents, complaints and compliments, which were monitored continuously and were reported to the board.
- Incidents were investigated, learning was communicated to staff.
- Safeguarding vulnerable adults, children and young people was a priority, appropriate systems were embedded. The unit worked with others to safeguard others.
- There were systems and processes to promote safe care, which were reliable and met relevant guidelines. This included the approach to infection prevention and control; layout, cleanliness and maintenance of facilities; use and maintenance of equipment; medicines management; records management; and staff recruitment checks.
- Effective emergency preparedness and incident plans were in place.

However we found;

• There had been improvement in the reporting of incidents, at Petersfield MIU but some staff were unable to record details of all incidents due to lack of time.

There was no dedicated children’s waiting area in Petersfield MIU, to provide them with a safe place to wait separate from adults.

Detailed findings

Safety performance

• Safety performance for the Petersfield and Lymington New Forest (Lymington) minor injury services (MIU) included waiting times for assessment and treatment, adverse incidents, complaints and compliments, which were monitored continuously and were reported to the board. This was also shared with staff at governance, locality and team meetings. We reviewed safety data from April 2016 to December 2016 and found no serious issues. This demonstrated that safety performance over time, based on external and internal information was good.

Incident reporting, learning and improvement

• Staff recorded any accidents or incidents using an electronic reporting which all staff we asked knew how to use.
Are services safe?

- Staff at the Petersfield MIU told us they did not have the
time to report incidents. However, the clinical lead had
identified this as a key issue to address.
- The line manager completed an assessment of the
potential severity and actual impact of the incident and
may complete further investigation. The report was then
forwarded to the lead person in the trust.
- The electronic system enabled the manager to send an
outcome email to the member of staff submitting the
report. Staff told us they received feedback from the
reporting of incidents. Learning from incident were
shared at team meetings and placed in the staff folder for
future reference.

Duty of Candour

- There was knowledge among staff of when to apply duty
of candour and staff knew they were required to be
open and honest, and apologise to people when things
went wrong. The duty of candour is a regulatory duty
that relates to openness and transparency and requires
providers of health and social care services to notify
patients (or other relevant persons) of certain ‘notifiable
safety incidents’ and provide reasonable support to that
person.
- The electronic reporting system prompted people to
consider the duty of candour. The clinical leads told us
there were no examples to share with us were the duty
of candour has been invoked, as no incidents had met
the criteria.
- Staff had a good level of understanding about duty of
candour.

Safeguarding

- Staff we spoke with had a good understanding of
safeguarding. Staff were able to identify the types of
abuse and how to report. Staff were aware of the
safeguarding policies and knew how to access them on
the organisation intranet.
- Safeguarding supervision was available three times a
year from the trusts safeguarding team.
- Two members from the trusts safeguarding team linked
with each MIU. One for children and one for adults.
- Representatives from the in Petersfield MIU attended
the ‘safeguarding quality work stream multi-disciplinary
meeting’ where safeguarding issues such as taking
photos of children were discussed.
- The staff at both MIUs had access to the child protection
information sharing system enabling them to check if
there were any known concerns about a child.
- In Lymington MIU they used a paediatric safeguarding
pathway to capture information about each child or
young person visiting the department on discharge this
was scanned and merged with the electronic patient
record.
- In Petersfield MIU, with paper records, a yellow children
assessment form was used. They captured the same
information as the pathway used in Lymington and
formed an integral part of the notes.
- There were clear pathways to follow when safeguarding
concerns were identified, with contact numbers for the
relevant departments clearly displayed. We were told
that any concerns would also be reported through the
trust incident reporting system.
- We were told if there were any concerns about domestic
violence the individual practitioner would be
responsible for asking about children and making any
referrals.
- Clinical notes of children attending MIU were either
securely faxed or emailed to child services for
information sharing with the child’s GP, health visitor or
school nurse. In the event of a safeguarding concern for
an out of area child, the organisations safeguarding
protocols were followed.
- Children presenting at MIU were asked about previous
attendances in the last 12 months to other healthcare
settings and findings were recorded on the safeguarding
template. Children frequently attending MIU were
flagged to other child services using the appropriate
form with details of dates and the presenting problems.

Medicines

- Patient Group Directives (PGD’s) facilitate the
administration of named medicines by non-prescribing
health care professionals. The PGDs for administration
of medicines for pain relief, antibiotics and other
emergency medication were regularly reviewed and
available for operational use. These aligned to the stock
held.
- Records demonstrated that staff had received training in
the use of PGDs. Staff also signed a form that indicated
that they had read and agreed abide by the PGD’s.
- PGD’s were reviewed by the medicines and formulary
committee of the trust and these were all in line with the
Department of th guidance, HSC 2000/026
Are services safe?

- The supply of medicines was provided to both MIU by hospital pharmacy. There was a system for the ordering and receipt of medication designed by the clinical pharmacist and they also made regular spot checks so as to confirm the process was followed. We inspected three sets of spot checks and they all confirmed the system was followed.
- Medicines were stored safely and securely in both MIUs. The clinical room and medicine fridge temperature were monitored and recorded. We confirmed all recorded temperatures were within the agreed range. There was a clear guidance for staff to follow if there were any anomalies in the temperatures.

Environment and equipment

- Although the waiting area appeared to be adequate at Lymington, it was cramped at busy times. There was a separate dedicated children’s waiting area.
- The waiting area in Petersfield was small and could be cramped at times. Neither was there any dedicated waiting area for children providing them with audio and visual separation from the adult patients.
- Both MIUs were well equipped and equipment was checked daily to ensure it was ready for use. We saw maintenance records and equipment inventories, which showed a regular programme of maintenance and servicing. For example, the fire extinguishers at Lymington had recently been serviced (February 2017).
- There was a comprehensive range of resuscitation equipment for both children and adults. This was stored in two tamper evident resuscitation trolleys, which were checked daily in accordance with the organisations policy.
- To facilitate the safe disposal of waste we observed all waste was segregated.
- A spot check of stock items in the dirty clinical room at Lymington found them to be in date.

Quality of records

- Individual care records were written and managed in a way that keeps people safe. We looked at 25 sets of records and found that most were accurate, complete, legible, up to date and stored securely. Two sets of records had information placed in incorrectly. Both these were immediately rectified.
- Both Lymington and Peterfield MIUs undertake four monthly audits on the quality of records. The audit in September 2016 showed that some records had incomplete information regarding their weights. The last audit in December 2016 showed the continuous improvement in record keeping. Recording of weights met the set standard. There were no recommendations to implement.
- Lymington MIU used a secure electronic patient record system. Petersfield MIU kept paper based records which were securely stored.
- Risk assessments were an integral part of the system. For example, allergies and mental health assessments. We looked at five patient records, found that risk assessments had been completed, and were appropriate. All patient records were clear and comprehensive.
- Discharge letters were sent via the secure NHS electronic system.

Cleanliness, infection control and hygiene

- The waiting rooms at both minor injury units appeared visibly clean, tidy and dust free. Equipment that had been cleaned was identifiable by the use of ‘I am clean stickers’.
- Hand sanitiser gel was available in each reception and before entering clinical areas. They were clearly signposted for use prior to entering the department. Hand washing facilities were readily available and we observed staff washing their hands or using sanitiser gel immediately before and after patient contact, which was in line with the National Institute of Clinical Excellence (NICE) Quality Standard 61 (statement 3).
- Monthly hand hygiene audits consistently showed compliance between 98% and 100%. The “bare below the elbow” policy was adhered to. Staff used personal protective equipment such as aprons and gloves correctly to prevent the spread of infections.
- Cleaning schedules were displayed in clinical and public areas, with cleaning audits compliance above 95% for the last 12 months for both MIUs.

Mandatory training

- There was a wide range of topics included in mandatory training. For example, infection control, basic life support (BLS) frailty, pain awareness, safeguarding and fire awareness. Some topics were covered by e learning and others took place during mandatory training sessions tailored to the specific needs of the service.
- At the time of our inspection, mandatory training compliance was at 94% across both units.
Are services safe?

Assessing and responding to patient risk

- People attending the minor injury service were greeted by a receptionist or a member of staff who had received training in recognising ‘red flag’ conditions such as chest pain. This initial face-to-face observation provided an immediate assessment. If a person presented with a lifethreatening condition or the member of staff greeting them had any concerns then the person was taken immediately to the clinical area for a full assessment by the nurse practitioner (NP).
- The Manchester Triage system was in use at both MIU’s. Triage was undertaken by a registered nurse at Lymington and was used for initial assessment and identification of patients who needed more urgent treatment. Triage at Petersfield was undertaken by a member of the clinical team. The clinical staff could either be a registered nurse, a nurse practitioner, or a band 4 assistant practitioner who had completed competency assessment to undertake this role.
- The aim of the minor injury service was to treat minor injuries but the matrons had recognised that people would sometimes attend with serious clinical conditions. Therefore, staff had received specific training in the recognition of a deteriorating patient. There were clinical protocols for the recognition of a sick adult, sick child, and life threatening conditions such as peri-arrest situations and sepsis.

Staffing levels and caseload

- There was no nationally recognised acuity tool to calculate the required staffing levels for the MIU’s.
- The Petersfield unit was staffed by five nurse practitioners, four full time and one working 32.5 hours, a band 5 registered nurse (23.5 hours), a band 4 assistant practitioner (28.5 hours) and a receptionist (30 hours). The aim was for there to be two nurse practitioners on duty at any one time but the current staffing pool did not facilitate this. This was not tracked through the submission of incident reports. We were told at times of stress on the system staff worked flexibly, including working additional or extra hours.
- Following a review of activity a case had been agreed for a 25% increase in the number of staff at Lymington MIU. There were working towards a new model of three nurse practitioners plus one registered nurse or care assistant, with receptionist cover 7:45am to 9:45pm. Staffing was 1 clinical lead with 4.8 whole time equivalent (wte) band 7; 2.3 wte band 6’s; 2 wte band 5’s and 1.9 wte band 2/3. The new model would be 1 lead, 5.5 wte band 7, 6 wte band 6, 1 wte band 4 and 3 wte band 3.
- At Lymington outstanding shifts were either covered by part time staff working extra hours or NHS Professionals. A review of two weeks off duty confirmed three nurse practitioners on duty supported by either a care assistant or staff nurse.
- It was not possible for there to be a nurse with specific training in the care of a child with an injury to be on duty at all times. This was managed with advice being available from the local acute trusts.
- The level of staff sickness and turnover were minimal and staff covered each other’s shifts at short notice to ensure continuity of care.

Managing anticipated risks

- There were plans in place to deal with possible disruptions to services such as computer failure, power cuts and flood. Both MIUs were part of the organisations response to major incidents and staff was aware of their responsibilities.
- There were emergency call bells throughout both MIUs should staff need to summon assistance. Should there be a risk of violence towards patients or staff the police would be called.
Are 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**
- Patients received care, treatment and support that achieves good outcomes.
- Patients needs were assessed appropriately and care and treatment was planned and delivered in line with recognised evidence based guidance.
- Staff were appropriately qualified and competent at the right level to carry out their duties. There was effective supervision and appraisal of staff.
- The learning needs of staff were identified and training was provided to meet those learning needs. Staff across all MIUs were supported to maintain and develop their professional skills and experience.

However, we found:
- The units did not audit the use of national guidelines.

**Detailed findings**

**Evidence based care and treatment**
- The service met the minimum requirements set out in "Unscheduled Care Facilities: minimum requirements for units which see the less seriously ill or injured" (Royal College of Emergency Medicine, 2009)
- While Lymington MIU met the Standards for Children and Young People in Emergency Care Settings 2012, Petersfield MIU did not. At Lymington there was a separate children waiting area and a treatment room where children were seen, however we observed this was also used for other things, for example clinics. Consideration had also been given to how to ensure staff had the right skills to care for children.
- Petersfield did not meet this standards as children were sharing waiting areas with adults. The clinical lead at Petersfield MIU was aware of this and had taken steps to provide a separate area for young children. They had also taken this into consideration during the planning of the refurbishment of the Petersfield MIU staff at both MIU’s provided care to people based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines, and were aware of recent changes in guidance. Staff told us procedures and policies reflected current guidelines, were easily accessible through the trust’s intranet. We looked at six policies and procedures on the trust’s intranet and these were up to date and reflected national guidelines; For example, the local head injury guidelines reflected the national guidelines. However we did not see that the units audited the use of guidelines.
- Staff used a range of treatment pathways for both adults and children which they had developed. These were in line with national guidance and included for example paediatric head injury, deep vein thrombosis pathway and upper respiratory tract infections for adults.
- Staff told us that all clinical policies had to be approved by the trust and the time taken to approve these had improved.
- We saw patient group directives (PGDs) were reviewed in advance of their review date.
- Patients were able to self-refer themselves to MIU for care as they choose. If a patient did not have a GP then MIU staff were able to advise them how to access a GP. If the patient was not from the local area they planned to go back to their GP the patient would be given a copy of their discharge letter or copies of their notes as appropriate. In cases where a child was not registered with a GP then the school nurse or social care would be notified.

**Pain relief**
- Patients we spoke with had been asked about their pain and given pain relief where appropriate and at regular intervals.
- Staff used recognised pain assessment tools to assess levels of pain and documented pain scores on the patients’ record. Children’s pain was assessed using an age appropriate tool where children were asked to point at faces to indicate their level of pain. Children were offered pain relief within 20 minutes of arrival.
- PGDs were in place for non-prescribers to administer pain relief; this meant there was no delay to administering pain relief.
- Staff were able to supply patients with pain relief to take home, to avoid any unnecessary pain once discharged from the unit.
Nutrition and hydration
• Water fountains and vending machines were available in all of the units, however we observed there were no healthy options available.

Technology and telemedicine
• The MIUs had access to digital X-Ray system and could see plain X-Rays.
• Radiological reporting was undertaken remotely by acute hospitals.
• There were no telemedicine links to acute or specialist services.

Patient outcomes
• Both MIU’s monitored the length of time patients spent in the MIU’s. The target for the MIU’s to discharge patients within 4 hours was 95%. Both MIU’s had met this target over the previous 12 months.
• In Lymington for the month of February 2017 there were 1,385 attendances and 99.20% were seen with 4 hours with 100% of patients bought by ambulance attended to within 15 minutes.
• At Petersfield, in the last six month from May 2016 to March 2017, between 1.6% and 8.4% patients were referred to the local emergency department.
• At Lymington in the last six month from May 2016 to March 2017, between 1.5% and 2.5% patients were referred to the local emergency department.
• Unplanned follow-up at Petersfield was between 2 and 22
• Unplanned follow-up at Lymington was between 31 and 82

Competent staff
• Staff told us, and records confirmed that staff had annual appraisals and regular supervision. They were also given opportunities to work in other emergency departments to ensure that their practice was kept up to date.
• In Petersfield two of the nurse practitioners were nurse prescribers and one was undertaking the course. There were plans for a fourth member of the team to commence the course next year.
• The trust was supporting the registered nurse based in Petersfield MIU to complete the nurse practitioner course.

• At Lymington the trust was supporting one care assistant to complete the plaster technician course.
• The current nurse practitioner course covered both adult and children previously these had been two separate courses. At both MIUs, there were two nurse practitioners whose training had included children and at Lymington one registered children’s nurse was being supported to complete the nurse practitioner course.
• Both MIUs had developed staff competency frameworks, in managing clinical pathways.

Multi-disciplinary working and coordinated care pathways
• The X-ray department at Lymington Hospital reported on X-rays for adults.
• At Lymington, children’s X-rays were reported on by the children’s department from Southampton; staff would contact the Orthopaedic registrar on call if out of hours.
• The x-ray department at Petersfield operates between 9am and 1pm, Monday to Friday.
• The trust was part of the Wessex emergency care collaborative, a network for non-medical practitioners within the Wessex region. Originally established for the development of emergency nurse practitioner programmes within Wessex, it has now grown to partner alongside Health Education Wessex, College of Paramedics and Royal College of Emergency Medicine. Working to set agreed standards for urgent care in Wessex.
• Staff told us they received most of their referrals from local GP practices and schools and had good working relationships with them

Referral, transfer, discharge and transition
• Patients were given advice following treatment. This was both verbal advice and written guidance on what to expect with their condition, how to care for themselves and when to seek further help. We saw this information was well documented in patients’ records.
• School nurses or health visitors were sent copies of children’s’ attendances directly from the electronic system, this ensured children had necessary follow up.
• We saw posters to the entrances of all units giving clear instructions to patients on how they could access immediate care and treatment when the units were closed. The posters gave contact numbers for emergency services and the address of the nearest emergency department.
Access to information

• Electronic discharge letters were automatically generated when emergency assessment records were completed, and were sent to the patient’s GP. GP’s could arrange aftercare through the electronic system or through the post. In Petersfield the aim was for discharge letters to be sent within two hours of the patients discharge. For children a copy was also sent to their health visitor and school nurse.

• The MIU at Lymington used a computerised record system. Staff told us that the system linked with the emergency department at Southampton General Hospital. They also had the ability to check patients previous attendances. If the MIU’s needed further information this was requested from the Southampton emergency department.

• Petersfield MIU kept paper based records and was not able to link with other emergency departments to determine if the patient had attended recently or the details of the attendance. Staff advised us that they would contact Queen Alexandra Hospital in Portsmouth on occasions if they had any concerns.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

• Staff told us if a patient was considered to lack capacity to make decisions they would seek support from appropriate professionals. Decisions would be made in the best interests of the patient.

• Training on the Mental Capacity Act and Deprivation of Liberty Safeguards was included as part of the Safeguarding Adults Level 2 staff training. As of March 2017, 100% of staff at Petersfield MIU had completed their Level 2 training, as had 87.5% of staff at Lymington MIU. The trust target for mandatory training completion was 95%.

• Staff asked for consent from patients before their treatment and this was recorded in all of the records we reviewed.

• Staff demonstrated an understanding of the issues around consent and capacity for adults and children attending the units. For example, there was a ‘consent to assessment examination and / or treatment policy that included a section for Fraser guidelines (A child under 16 years may consent to medical treatment if he/she is judged to be competent to give that consent) with Gillick competency guidelines incorporated.

• Staff understood and were able to explain the use of Gillick competency guidelines in relation to consent. Gillick competency guidelines refer to a legal case which looked at whether doctors should be able to give advice and treatment to under 16 year olds without parental consent. They are now used more widely to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

• Staff told us if they were unsure in any circumstances, they would seek guidance from senior staff or from the safeguarding lead.
Are services caring?

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

**Summary**

- Staff treated patients and those close to them with dignity and respect. Patients felt supported and provided positive feedback.
- Staff responded compassionately to pain, discomfort and emotional distress in a timely and appropriate way.
- Patients understood and were involved in decisions about their care and treatment.
- Verbal and written information that enables people who use the service to understand their care is available to meet people's communication needs.

**Detailed findings**

**Compassionate care**

- Staff treated patients with dignity and respect. Staff kept treatment room doors closed and curtains drawn during consultations to protect the privacy and dignity of patients. Staff knocked and sought permission before entering such areas.
- Staff established and honoured patient preferences for sharing information with family members and carers.
- At both Petersfield and Lymington MIU, the reception area was located within the main waiting room. Reception staff were mindful of patient confidentiality and spoke discreetly during patient conversations.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. At Lymington, the 2016 PLACE score for privacy, dignity and well-being was 90.8%, significantly better than England average of 84.2%. At Petersfield, the privacy, dignity and well-being PLACE score was similar to the England average at 83.2%.
- We observed all staff to be courteous, compassionate and kind when interacting with patients. We observed staff greet patients appropriately and introduce themselves by name.
- Patient and relative feedback was consistently positive. The patients and relatives we spoke with said that staff were ‘all friendly’, ‘very helpful’ and ‘fantastic’.
- The results of the Friends and Family Test (FFT) for both MIU in February 2017 showed 95% of community patients would be ‘likely’ or ‘extremely likely’ to recommend the service to their friends and family.
- Staff offered patients a chaperone service during intimate personal care. Chaperone service information signs were displayed in both waiting areas.

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

- Staff communicated with patients about their care and treatment in a way they could understand. Staff provided patients with relevant information, both verbal and written, so they could make informed decisions about their care and treatment.
- Patients had sufficient time during both their triage and assessment to ask further questions.
- The Petersfield MIU did not treat children under the age of one and for Lymington this was under the age of two. At both units we observed staff support parents of babies and explain the local treatment options available to them.

**Emotional support**

- Staff showed a clear understanding of the importance of providing emotional support to patients. We observed staff support an anxious mother when they showed signs of distress.
- Staff encouraged patients to manage their own health and care (when possible) to maintain independence.
- Staff gave patients and their carers appropriate information to cope emotionally with their care or treatment.
Are services responsive to people’s needs?

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

**Summary**

- The local population received care which met and was responsive to their needs. Patients had timely access to diagnosis and treatment, although X-ray services were limited. Staff prioritised care and treatment to meet the most urgent needs first.
- The department planned and delivered services to meet the needs of most patients.
- Patients were able and supported to access the right care at the right time. Patients had the information they need whilst they waited and risks were managed in the meantime.
- The MIU departments had clear processes to report, investigate and learn from complaints.

However, we found:

- Complainants were not responded to in a timely manner.
- Staff at Petersfield MIU were unaware of what the local Clinical Commissioning Groups plans were for the service.
- There was no evidence of an urgent care delivery or review group to support the development of urgent and emergency care at the trust.

**Detailed findings**

**Planning and delivering services which meet people’s needs**

- The Minor Injury Units delivered services around the needs and demands of local people. The trust worked with the local Clinical Commissioning Groups (CCG) and GP practices to try and improve patient access to services. For example, the trust had approached their local CCGs to discuss developing urgent care services at Lymington hospital. The MIU staff at Petersfield were not clear about the future plans for the unit. Staff at Lymington were working with the in site GP service to expand their role to support the GP’s by running clinics for people with minor illnesses.

- Staff at Petersfield were developing a service specification which they believed reflected the service they delivered.
- Both MIUs were located in community hospitals and were clearly signposted. Staff informed us that they had appropriate facilities to care for patients attending the MIU.
- Both MIUs treated and cared for children aged two years and above in Lymington and one year old above in Petersfield. Staff referred children under too young for them to treat, to other services following an initial assessment. Staff obtained paediatric advice from the local acute trusts if required. The trust was in the process of agreeing more formal arrangements for young children, with two local acute trusts under a service level agreement (SLA). The SLA would provide MIU staff with clinical supervision, paediatric support and advice.
- In Petersfield, the MIU was hoping to incorporate the same patient records system as the local GPs when the unit transferred over to electronic record keeping.
- There was no evidence of an urgent care delivery or review group to support the development of urgency and emergency care at the trust.

**Equality and diversity**

- The trust planned and delivered services to meet the needs of different people. The MIUs delivered personalised patient care in line with patient preferences, individual and cultural needs, following a person centred care approach.
- Staff received Respect and Values training which incorporated the Equality Act 2010, recognition of discriminatory behaviour and staff responsibilities within equality and diversity. All staff at both MIU sites had completed their respect and values training, as of March 2017.
- Patient-led Assessments of the Care Environment (PLACE) are a collection of assessments, used to measure the quality of the patient environment for NHS patients. In the 2016 assessment, Petersfield hospital
Are services responsive to people’s needs?

scored 90.1% and Lymington hospital scored 87% for the suitability of the environment for a disability. Both hospitals performed better than the England average of 78.8% for community trust.

- Both MIU departments were located on the ground floor and were accessible for patients with impaired mobility. Waiting areas and consultation rooms were all wheelchair accessible. Waiting area chairs were a mix of heights to help patients with mobility issues. Both hospitals also had accessible toilets and a lift if patients required access to another floor.

- Staff provided patients with written information to compliment the verbal advice given during triage and assessment. Patient leaflets were displayed in both MIU waiting areas. The patient information leaflets were written in English, but were available on request in other formats and languages including large print, braille and audio. The trust also had a language line and interpretation service.

Meeting the needs of people in vulnerable circumstances

- The approach to meeting the needs of vulnerable people varied at each MIU site. At Lymington MIU, there was a dedicated children’s waiting area, with toys, small chairs and child décor. Staff assessed and treated children in a separate treatment room, which was also decorated for children. There was no dedicated children’s waiting area or treatment room at Petersfield. This was not compliant with Intercollegiate Children and Young People in Emergency Care setting standard.

- Staff told us that vulnerable patients normally attended the MIU with a relative, spouse or carer and explained how they would adjust their approach in order to meet their individual needs. Staff described how they involved both the patient and their carer during the assessment, planning and the delivery of treatment.

- For all staff who may have contact with a person living with dementia, dementia awareness training was also available. All staff at Petersfield MIU had completed this training and 90% of MIU in Lymington had completed this.

- At Lymington, the hospital’s PLACE score for the suitability of the environment for a patient living with dementia was 81.47%. This is better than the England average of 75.3%. Data for the dementia assessment at Petersfield was unavailable.

- At Petersfield, we saw a dementia information board which included details of local support groups and various information leaflets for patients to take away. The site also had an easy-read hospital communications book and easy-read complaints leaflets for patients with a learning disability.

- The MIU department at Lymington had a dementia link nurse who attended trust-wide meetings and provided support and advice to colleagues. The site also used pictorial signage to support patients living with dementia.

- Patient information met communication needs and was available in different accessible formats.

Access to the right care at the right time

- Patients could access care and treatment at a time that suited them. Both MIUs were open seven days a week. Petersfield MIU operated from 8am to 5.45pm and Lymington MIU was open 8am to 9pm.

- Access to X-ray facilities was limited. At Lymington MIU, X-ray services on-site operated Monday to Friday, 8.45am to 4pm. X-ray services at Petersfield were provided by a local acute trust, Monday to Friday, 9am to 1pm only. When X-ray services were not available, MIU staff referred patients to the nearest acute hospital or, if non-urgent, the patient would be asked to return the following day. When X-ray services were available, a diagnosis could be given promptly and treatment commence without delay.

- At Lymington, all paediatric X-rays were sent to the local acute NHS trust to be reported on. Radiographers at Lymington were able to discharge patients, reducing patient waiting times.

- Patients had timely access to diagnosis and treatment. From May 2016 to April 2017, Petersfield MIU had 6,840 patient attendances. All patients were seen, treated and discharged within the four hour national target. During the same time period, Lymington had 19,462 attendances, of which 99.1% were assessed, treated and discharged within four hours.

- At Lymington, all patients were tracked electronically at each stage of their pathway in order to monitor waiting times. At Petersfield this was completed manually by the receptionist on duty however, at the time of our inspection there were no staff cover on reception after
2.30pm. Subsequently, response times were not monitored accurately. The MIU lead nurse was proactively trying to manage this shortfall and recruitment was underway.

• The waiting times at the MIUs were short. Between May 2016 and April 2017, patients waited on average 49 minutes to be treated at Lymington and eight minutes at Petersfield. At Lymington waiting times were displayed in the waiting room and updated by the receptionist. Less than 2% of patients left the MIU before being seen by a clinician, surpassing the Department of Health target of 5%.

• The minor injury unit service prioritised care and treatment for people with the most urgent needs. At Lymington, a ‘see and treat’ model was used; all patients were seen by a nurse practitioner who was able to assess, treat and discharge the patient, thus reducing triage and waiting times. At Petersfield, patients were initially assessed by an associate practitioner, specifically trained in the triage of patients. Patients would then be treated by a nurse practitioner.

• At Lymington, we observed the receptionist support the emergency nurse practitioners by following criteria and alerting clinical staff to any concerns identified when recording attendees on the electronic system, for example chest pains.

• The MIU nurses made direct referrals to some acute services to avoid delays. For example, patients were referred to the fracture clinic for treatment rather than them having to go through the emergency department at the local acute hospital.

Learning from complaints and concerns

• The trust had a complaints, concerns and compliments policy which had been extensively reviewed over the last year. It provided staff with a clear process to investigate, report and learn from complaints. Staff were aware of the complaints processes and had all completed customer care training to assist staff when dealing with concerns from patients. Staff logged complaints onto the hospital’s electronic reporting system for tracking.

• The chief executive had overall accountability for the effective implementation of the complaints policy and signed off all response letters to formal complaints. The quality and safety committee had responsibility for the management of complaints and assigned a relevant internal investigation lead according to the type of complaint.

• Across both MIU’s there had been four complaints between January 2016 and January 2017. One complaint was withdrawn by the complainant, the other three complaints were closed but had not been responded to within the trust’s policy target of 42 days. Within the same time period, the MIU departments received 68 compliments.

• There were procedures for the sharing and learning from complaints. We saw evidence that complaints were discussed at MIU team meetings and at senior management meetings. For example, the department received multiple complaints concerning missed fractures. Following a complaint regarding a missed knee fracture at Lymington MIU, MIU staff received a physiotherapy teaching session on knee assessment and management.

• Complaints leaflets, describing the trust complaints procedure and how to contact the patient advice liaison service (PALS) were available in both MIU waiting areas. Patients told us they would be confident to raise a concern if necessary.

• Patient comments were listened to and acted upon. ‘You said, we did’ posters were on display at both units and highlighted actions that had occurred as a result of patient feedback. For example, following feedback, the trust was developing community nurse clinics in Lymington to offer services that were not already available at the MIU, such as catheters insertions.
Are 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

• Information on patient experience was reported and reviewed alongside other performance data. The trust board had determined and kept under review the information it required to monitor performance, set priorities and make decisions through a local reporting system.
• Staff felt respected, valued and supported. There was a positive culture and a very good supportive team working amongst staff as they felt empowered to make changes locally to the services they provided. Staff at both MIU spoke enthusiastically about their department and the support they received.

However, we found:

• A vision and strategy of the trust’s urgent care provision had not yet completely crystallised at a senior level and as such, staff were unaware how they would need to respond to this.

Leadership of this service

• They had received training in the Duty of Candour and knew that if a patient was harmed they were required to be open and honest about the event.
• Each MIU was led by a nurse practitioner. In Lymington the lead nurse practitioner reported to a matron, in Petersfield this was being reviewed following a change in the Matrons role. We were told consideration was being given to the lead for the MIU reporting to the associate director of nursing and allied healthcare professional for the area. Since January 2017 there had been no clear reporting framework for the Petersfield unit.
• At Petersfield MIU the lead nurse practitioner or clinical lead had worked hard to ensure people understood the challenges faced by the department. One improvement as a result of this was the changes to the staffing for the reception area. This was greatly valued by staff as they felt that their voice was being heard
• This was greatly valued by staff as they felt that their voice was now being heard.

• Staff at both MIUs told us they felt supported by the clinical lead. They felt they could access them and share their concerns and as a result “something positive would happen.”

Service vision and strategy

• Staff at both MIUs were aware of the overall trust vision. However, the MIU clinical lead at Petersfield had not been able to obtain a copy of either a service specification for the MIU or a copy of the commissioning contract inspite of repeated requests to senior managers. However, a vision and strategy of the trust’s urgent care provision had not yet completely crystallised at a senior level and as such, staff were not aware of it.
• In Lymington the MIU mission statement was displayed on the wall. ‘We are highly experienced dedicated team providing a professional and compassionate service. The staff are patient centred; motivated and committed we continually strive to improve the service for the local community.’
• The vision for Lymington MIU was for further integration with the community. Work had started with ‘The Practise’ a GP surgery on the community hospital site supported by seven local GP practices. Nurse practitioners from the MIU had received additional minor’s injury training and were to provide a service long side the GP for some sessions each week which enable them to provide an enhanced service.
• Staff at the Petersfield MIU, felt with the absence of senior leadership, their understanding of the overall vision and how they fit within this was unclear. Despite this, the local clinical lead/ ensured through their networking their voice was “heard” at the strategic level. For example, the clinical lead had not been able to obtain a copy of either a service specification for the MIU or a copy of the commissioning contract. Therefore they were developing an internal draft specification for the Petersfield MIU. This document would become a discussion document with commissioners.

Governance, risk management and quality measurement
Are services well-led?

- The trust board reviewed on a monthly basis safety performance information on patient experience alongside other performance data such as waiting times for assessment and treatment, adverse incidents, complaints and compliments. The board had identified the information it required to monitor safety and performance and make decisions.
- The clinical lead of the Lymington MIU reported into the New Forest locality governance meeting and the matron of the Petersfield MIU reported into the South East, Fareham and Gosport locality governance meeting. Safety performance information for both MIUs was shared at these meetings. Both of these meetings reported into the integrated service division governance meeting.
- There was an incident reporting and risk management structure in the trust. Staff at both MIUs understood the importance of this. However, as previously reported, staff at Petersfield MIU told us they did not have the time to input information. Both MIUs had a risk register and we found items placed on the risk register that had been addressed. For example, the clinical lead at Petersfield MIU had placed the lack of a full-time receptionist on the risk register. As a result, there had been a staffing review and an appointment of a receptionist was underway.
- All MIU staff we spoke with felt that timely action would be taken if they raised concerns.
- Both MIU’s undertook a variety of audits which included the monitoring of treatment and discharge times and annual audits of patient records and documentation.
- Both MIU’s had regular team meetings within their own departments. Since the last inspection, links with other departments had improved considerably. For example, the MIU at Lymington had made links with the radiographers from Lymington Hospital who attended their team meetings and shared learning. The MIU at Petersfield had made links with local physiotherapy department. Staff had attended learning sessions on advice to give patients upon discharge. The clinical leads of both MIUs regularly met to share good practice and learn from each other.
- Both MIUs had their own quality improvement plans. Staff from the respective MIUs knew the content of these plans. For example, staff at the MIU at Petersfield had highlighted the lack of supervision. As a result, a programme had been set up for all staff to attend clinical supervision three times per year.

Culture within this service

- At both MIUs, there was a positive culture and a very good supportive team working amongst staff.
- The local management structure for both MIUs empowered staff to make changes. For example, significant changes had been made as a result of a very enthusiastic and positive clinical lead at the Petersfield MIU. Staff told us of the changes to the ways of working at Petersfield had been brought about.
- Staff at both MIU spoke enthusiastically about their department and the support they received individually and collectively.
- Information on the trusts whistle blowing service was available for all staff to use.
- Senior trust staff held listening events for all staff. These were an open question and answer session. Staff told us this made them feel valued.
- The CEO also sent out a newsletter keeping staff informed and included staff recognition and thanks.

Public engagement

- The engagement with the public had been through providing information locally of the services the local MIU’s provided. For example, leaflets outlining the services that Lymington MIU provided were sent to the local community.
- Patient experience surveys, including a survey designed specifically for children and young adults, were available in the MIU waiting rooms, allowing patients the opportunity to provide additional feedback.
- The 2017 patient survey results of the Lymington MIU and Petersfield MIU were more favourable than the 2016 survey across all dimensions such as information given to patients, staff understanding patients’ needs and treating patients with dignity and respect.
- The plans to re-modernise the Petersfield MIU had also taken place with the public.

Staff engagement

- The 2016 staff survey highlighted that the overall staff engagement score remained high at 3.78 which was a small improvement on 2015. The results were positive with improvements in some areas such as appraisals, training, health and well being, staff collecting patient feedback and reporting errors and incidents. However, there were a number of areas where the trust needed to
improve. These were areas such as improving the communications between senior managers and frontline staff, getting staff to be involved in decision making and ensuring staff were taken seriously in they raised any concerns.

- Staff received regular updates from the chief executive. These were information giving emails updating staff on changes and developments within the trust.
- The clinical lead for the MIU in Petersfield had been involved in the designs for the refurbishment of the new MIU.

**Innovation, improvement and sustainability**

- The trust was developing community nurse clinics in Lymington to offer services that were not already available at the MIU, such as catheters insertions.
- The Petersfield MIU had made links with a local trust to design pictures for use by patients with learning disability. Patient experience data was from children 16+. The MIU had introduced patient experience questionnaire for children between the ages of 10 to 16.
- In recognition of there being a delay with information being sent to health care professionals after a visit to the MIU in Petersfield, where paper records are used, and an electronic discharge letter, completed by the professional seeing the patients was introduced. This was sent by email significantly reducing the delay.
Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.
This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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