Cornwall Partnership NHS Foundation Trust

RJ8

Urgent care services

Quality Report

Tel:
Website:

Date of inspection visit: 25 October 2017
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RJ866	Bodmin Hospital	Minor Injury Unit	PL312QU
RJ817	Camborne and Redruth Community Hospital	Minor Injury Unit	TR153ER
RJ842	Falmouth Hospital	Minor Injury Unit	TR112JA
RJ805	Helston Community Hospital	Minor Injury Unit	TR138DR
RJ870	Launceston Community Hospital	Minor Injury Unit	PL159JD
RJ8A3	Liskeard Community Hospital	Minor Injury Unit	PL143XD
RJ807	Newquay Hospital	Minor Injury Unit	TR71RQ
RJ8Y2	St Austell Community Hospital	Minor Injury Unit	PL266AA
RJ8Y4	St Mary's Hospital	Minor Injury Unit	TR210LE

This report describes our judgement of the quality of care provided within this core service by Cornwall Partnership 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 Cornwall Partnership Foundation Trust and these are brought together to inform our overall judgement of Cornwall Partnership Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

We rated this service as requires improvement overall because:

- Out of hours and at weekends patients were not always kept safe because reception staff were not scheduled to work. This meant that patients with serious or life-threatening conditions may not have been identified promptly. There was also no observation of patients in the waiting room.
- Risks associated with out of hours staffing and emergency ambulance transfers had not been highlighted at department level and there was no evidence that safeguards were put in place to mitigate these risks.
- The trust did not record and monitor how quickly patients were assessed by triage or were seen by a nurse practioner. The recording of the time triage started did not include the time patients waited to be booked in and so did not recognise the risk that a serious or life threatening condition may not have been identified promptly.
- The practice of when the time triage started was not clear and so did not inform the trust accurately. It was unclear in some MIUs when the 'clock started' in order to meet the 15 minute triage target. In some MIUs patient records showed that the triage time started and stopped with the receptionist taking the initial booking information. This would indicate that the receptionist triaged the patient when we saw that the nurse or trained health care assistant did the full triage.
- There was no auditing of the reasons patients attended the units to identify any themes or trends. There were no risk assessments and reviews of the units which presented specific geographical challenges and how they should be managed.
- Mandatory training compliance did not meet the trust's target and not all staff received mandatory training in line with trust policy. Due to the amalgamation of two providers, training records were unclear and the trust was still in the process of reviewing them, despite having had 18 months to have completed this. Training attendance was difficult for the staff at St Mary's MIU on the Isles of Scilly. No systems had been considered to enable staff to remain updated.
- Staff did not have consistent knowledge of policies and procedures in place to support them to run the service to within the planned opening hours and so staff were delayed in closing the units. There was no planning consideration for planned public events during the holiday season, other than at St Mary's Hospital. These events meant a substantial influx of visitors to a small town, without consideration of how this impacted on demand for MIU services.
- The trust website did not reflect when primary service GPs were not available at Camborne Redruth MIU. This meant that patients were not correctly informed about the medical services available and who would be available to see and treat them.
- Staffing planning systems did not meet the needs or geographical challenges of the region. The rostering of staff at St Mary's MIU on the Isles of Scilly did not address the locations specific challenges with regard to access to the islands because of the weather.
- There was a corporate vision and strategy in place for staff but there was no specific minor injury unit vision or strategy in place.
- Not all premises were suitable for patient assessment, treatment and maintaining confidentiality. Falmouth, Newquay, Bodmin and Liskeard hospitals stored hazardous substances in unlocked sluices, including bleach tablets, cleaning solutions and nail varnish remover. These substances if ingested would be hazardous to health and should be secured.

However:

- There were systems in place to report, investigate and learn from incidents.
- Cleanliness, infection control and hygiene were well managed in most of the minor injury Units.
- Medicines were managed in a way that kept patients safe. Medicines were stored securely.

Summary of findings

- The management of patients' pain was established as part of triage and treatment.
- Systems were in place to ensure patients' information was kept .safe. Records were stored securely.
- Policies and procedures were in place to support the safeguarding of vulnerable adults and children. Patients' consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.
- The trust's policies and services were developed to reflect best practice and evidence-based guidelines. The trust had in place systems to monitor aspects of the service, which included the minor injury and illness units.
- Staff treated patients with kindness, dignity, and respect. Staff interacted with patients in a positive, professional, and informative manner. The hospital took account of patients' specific needs and had access to support services.
- There was a strong ethos of teamwork and staff felt well supported. There was flexibility and willingness among all the teams and staff. Staff worked well together, and positive working relationships existed to support each other.

Summary of findings

Background to the service

Cornwall Partnership Foundation Trust provided urgent care at ten minor injury units located across the county.

Minor Injuries and Illness Units (MIIUs) provided treatment and advice on a range of minor injuries and illnesses not serious enough to require accident and emergency department treatment.

We visited all ten minor injury units. Nine were on the Cornwall mainland at Newquay, Stratton, Helston, Falmouth, St Austell, Bodmin, Camborne Redruth, Launceston and Liskeard. The other MIU was in St Mary's on the Isles of Scilly.

While minor injury units were nurse-led and provided advice and treatment for minorinjuries , the full range of services on offer varied greatly including the treatment of minor illness depending on the staff available and the setting the service is provided in. At six of the units, nursing staff provided treatment for minor illnesses, such as conjunctivitis, infections, colds and sore throats, and rashes. Minor illness services were provided at Stratton Hospital in Bude, Bodmin Hospital, Camborne Redruth Community Hospital, Liskeard Community Hospital, Newquay Hospital and St Austell Community Hospital.

Primary care medical support was available from a General Practioner at oneminor injury unit: Camborne Redruth but was also available from an GP practice close to St Mary's.

Services were provided without appointment to adults and children for both local residents and visitors to the area. Services were provided in most units seven days a week from 8am to 10pm (Helston 8am to 8pm). At St Mary's Hospital and Stratton Hospital services were available 24 hours a day.

Each unit is staffed by registered nurses and/or paramedic practitioner, a healthcare assistant and a receptionist. Helston MIU employs one band five nurse, whilst the remaining nine units employ band six and seven nurses with band five nurse development posts also being in place. Not all units have access to a health care assistant and a receptionist outside of normal working hours and at weekends.

One unit had a nurse on duty who was a qualified nurse prescriber. The remaining units had nurses who worked from a series of patient group directions, which enabled them to administer identified medicines only.

Of the ten minor injury units, nine locations provided X-ray departments. These were open on weekdays from 9am to 5pm. Liskeard hospital had X-ray facilities open on a Saturday and Launceston Hospital was the only location with X-ray facilities on a Sunday. St Mary's Hospital had access to X-ray in the hospital each Wednesday, weather permitting, as staff were visiting from the mainland to operate the X-Ray equipment.

Attendances at the minor injury and illness units fluctuated, with an increased demand during holiday seasons. The total number of patients seen in August 2017 was 11312. The total seen for April 2016 – March 2017 was 107523. The number of children seen could not be identified. The increase in attendance from previous years is attributed to the commissioning of a Primary Care Centre (PCC) at Camborne and Redruth Community Hospital with an associated increase in the number of medical and nursing staff. In the remaining units there is minimal change from the previous year.

We inspected all ten of the MIUs over two weeks. During our visits we observed care and treatment and spoke with nine patients, three relatives and 42 staff. We looked at 93 patient record cards and observed 20 episodes of assessment and treatment being provided to both adults and children. We also received nine comment cards from patients.

We inspected this core service as part of our ongoing comprehensive inspection programme.

Summary of findings

Our inspection team

The inspection of Cornwall Partnership NHS Foundation trust was led by:

Karen Bennett-Wilson, head of hospitals inspection, supported by Michelle McLeavy, inspection manager, mental health and Mandy Williams inspection manager, community health.

The team who inspected this core service included two Care Quality Commission (CQC) inspectors and one specialist nurse advisor.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive inspection programme.

The trust merged with Peninsula Community Healthcare NHS Trust in April 2016 and as such we always undertake a comprehensive inspection at an appropriate time following a merger.

How we carried out this inspection

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 service and asked other organisations to share what they knew. We carried out an announced visit between 25 and 04 October 2017. Before the visits we held focus groups with a range of staff who worked within the service, such as nurses, therapists. 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.

What people who use the provider say

We observed the care and treatment being provided to patients in each minor injury unit. Staff showed an encouraging, supportive and sensitive attitude to patients and those close to them. Patients said their needs were responded to in time and with good care. When patients experienced physical pain, discomfort or emotional distress, we saw staff responded with kindness and compassion.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service MUST take to improve

- Accurately record the time triage started at all times, including the time patients waited to be clerked in to ensure the risks of patients deteriorating unseen in a waiting room are understood.
- Ensure thetriage start time is correct and so informs the trust accurately. It was unclear in some MIUs

when the 'clock started' in order to meet the 15 minute triage target. In some MIUs patient records showed that the triage time started and stopped with the receptionist taking the initial booking information.

- Ensure appropriate action is taken to address patient transfer delays. Once the patient had been identified as needing a transfer to the acute trust staff in all locations had experienced unacceptable delays in the patient being transferred.
- Ensure that governance at department level is effective to monitor and improve patient safety. There were no risk assessments and reviews of the units which presented specific geographical challenges and how they should be managed.

Action the service SHOULD take to improve

- Ensure mandatory training compliance meets the trust's target and all staff received mandatory training in line with trust policy. Training attendance was difficult for the staff at St Mary's MIU on the Isles of Scilly. The trust should ensure systems are considered to enable staff to remain updated.
- Ensure staff have access to clear instruction to run the service to within the planned opening hours. Staff did not have consistent knowledge of policies and procedures in place to support them to run the service to within the planned opening hours and so staff were delayed in closing the units. There was no planning consideration for planned public events during holiday's season other than at St Mary's hospital.
- Ensure the trust website has a system which would reflect when primary service GP's are not available at Camborne Redruth MIU. This should ensure patients are correctly informed about the medical services available and who would be available to see and treat them.
- Consider remote e-rostering system recognises the geographical challenges of the region. The rostering of staff at St Mary's MIU on the Isles of Scilly should consider that the location had specific challenges with regard to access to the islands and the weather.
- Ensure that each minor injury unit premises areas suitable for use. Some premises were not suitable for assessment treatment and confidentiality. Falmouth, Newquay, Bodmin and Liskeard had hazardous substances stored in unlocked sluices, including bleach tablets, cleaning solutions and nail varnish remover. These substances if ingested would be hazardous to health and should be secured.

Cornwall Partnership NHS Foundation Trust

Urgent care services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because:

- Out of hours and at weekends patients were not always assessed and traiged promptly because there were insufficient staff.
- The trust did not record and monitor how quickly patients were assessed. The recording of the time triage started did not include the time patients waited to be booked in and so did not recognise the risk that a serious or life threatening condition may not have been identified promptly.
- The time triage started was not clear and so did not inform the trust accurately. It was unclear in some MIUs when the 'clock started' in order to meet the 15 minute triage target. In some MIUs patient records showed that the triage time started and stopped with the receptionist taking the initial booking information. This would indicate that the receptionist triaged the patient when we saw that the nurse or trained health care assistant did the full triage.
- Staffing planning systems did not recognise the geographical challenges of the region. The rostering of staff at St Mary's MIU on the Isles of Scilly did not recognise the location had specific challengeswith regard to access to the islands because of the weather. Staff told us that roster system did not address their needs.Mandatory training compliance did not meet the trust's target and not all staff received mandatory training in line with trust policy. Due to the amalgamation of two providers, training records were unclear and the trust was in the process of reviewing them.
- Training attendance was difficult for the staff at St Mary's MIU on the Isles of Scilly. Face-to-face training was provided on the mainland and staff sometimes had to spend several days there in order to complete their training. No technology links had been put in place to enable staff to access training remotely and no systems considered to enable staff to remain updated.
- There were no contingency plans in place for planned public events during the holiday season other than at St Mary's hospital. There was no forward planning for increases of local activity.
- Minor injury units varied in their environment with some being more suitable than others for assessment, treatment and maintaining confidentiality. Falmouth, Newquay, Bodmin and Liskeard hospitals stored

hazardous substances in unlocked sluices, including bleach tablets, cleaning solutions and nail varnish remover. These substances if ingested would be hazardous to health and should be secured.

However:

- There were systems in place to report, investigate and learn from incidents.
- Cleanliness, infection control and hygiene were well managed in most of the minor injury units.
- Medicines were managed in a way that kept patients safe. Medicines were stored securely. The management of patients' pain was established as part of triage and treatment.
- Systems were in place to ensure patients' information was kept safe. Records were stored securely.
- Policies and procedures were in place to support the safeguarding of vulnerable adults and children.

Detailed findings

Safety performance

- Patient safety was supported by the systems in place to report, investigate and learn from incidents. The trust policy for the reporting and management of accidents, incidents and near misses set out procedures for managing incidents. This policy set out a commitment "to embed a strong patient safety culture within all areas of the organisation, with emphasis on the timely and systematic reporting, reviewing and learning from incidents, accidents and near misses". The trust used an electronic recording system for incidents and concerns.
- We spoke with nursing and administrative staff who all felt there was a good incident reporting culture. Staff were actively encouraged to complete electronic incident reports and they were knowledgeable about the kind of incidents they should report. The trust was noted as being within the top 25% of National Reporting and Learning System (NRLS) reporting trusts, because they were a high reporting trust.

Incident reporting, learning and improvement

- Staff understood their responsibility to report incidents and said they received feedback from incidents and saw changes in practice as a result. Staff told us about an improved process for assessing the risk of thromboembolism following a lower leg fracture incident.
- Staff received regular training relating to patient safety. Quarterly learning events involved staff from across the organisation. Learning identified from incidents was shared with individuals and through attendance at events such as 'Listen, Learn, Act' and trust-wide events such as 'Closing the Loop'. In addition, each ward or unit within the locality hospitals was utilising a newly developed quality indicator dashboard to encourage staff to discuss trends within their own clinical area and compare across the trust.
- Incident learning was extended across the trust. Senior staff attended regular senior nurse forums to discuss learning from their own and other teams. One staff member described these forums as 'invaluable' as it allowed them to learn from incidents that had occurred at other locations. A good culture of learning appeared to be embedded within the nursing staff. An example was an individual staff member who organised a learning event for the whole team in response to a near-miss in the department, in order that the learning was shared.
- The trust recognised the importance of incident management as the trust risk register noted "There will be poor learning from incidents and no consequent improvements if the trust does not have in place robust systems to prevent, identify and manage incidents". This was identified as an amber (moderate) risk.
- Serious incidents were reported and managed by the trust management team. Serious incidents in health care are adverse events where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Between 1 June 2016 and 31 May 2017, the trust reported one serious incident within this core service. The incident was regarding a treatment delay. This incident took 36 days to report to the Strategic Executive Information System (STEIS), when an incident form should have been completed within 48 hours. A full investigation was

completed which looked at the root causes of the treatment delay, and a number of recommendations were made to improve the care given to patients visiting the MIUs.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. 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. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong.
- The trust stated that the organisation ensured compliance with the duty of candour regulation through a combination of standard operating procedures, instructions and training for staff. The trust confirmed that duty of candour was included in their incident reporting policy and there was a specific module for recording duty of candour on the trust's incident reporting system. We spoke with staff who appeared to have a good understanding of the duty of candour and the circumstances in which it applied.

Safeguarding

- Policies and procedures were in place to support the safeguarding of vulnerable adults and children. The trust's safeguarding protocols were available to all staff on the intranet and staff were aware of the procedures and policies to follow.
- Staff received training from the adult safeguarding team during their induction and on an ongoing basis through refresher training and mandatory e-learning. Recent training included learning about female genital mutilation, domestic violence and modern slavery to ensure staff remained updated with a wide range of safeguarding risks. All staff we spoke with said they had received recent training. All staff we spoke with that had clinical contact with patients had received safeguarding training. Managers kept good records to indicate who had received up to date training and who required updating. Staff obtained child safeguarding training as both e-learning and face-to-face training.
- Some of the MIUs' premises were not conducive to the disclosure of abuse. In Falmouth MIU the waiting room was very small and conversations with the receptionist could easily be overheard by those waiting for treatment. In a number of the MIUs, multiple patients were treated in a single treatment area with a thin curtain separating the areas. This meant conversations with nursing staff were at risk of being overheard; this may have detered people from disclosing abuse.
- While there were no paediatric waiting rooms in the MIUs, there was a range of equipment available to nursing staff to put children at ease, which was important in order to have sensitive conversations. This was particularly noticed in Newquay where the League of Friends had made donations of equipment.
- Staff demonstrated good awareness of their safeguarding responsibilities and described their adapted techniques for communicating with children.
- Systems were in place at each location to enable staff to make safeguarding alerts. All minor injury units used a shared system with the acute hospital. Staff confirmed they were encouraged to have a conversation using the appropriate safeguarding helpline, in addition to completing the alert form. Staff told us they always completed an incident form as well so that managers and the safeguarding leads were aware of the referral.
- Children's records differed from adults and had a specific safeguarding checklist to complete**.** Multiple admissions of three attendances in three months or six attendances in six months automatically triggered the case to be reviewed by a safeguarding practitioner. The MIUs were in the process of introducing a child protection information system to ensure safeguarding alerts from elsewhere in the country could be seen by staff at the MIUs. We saw this system in use and staff appeared confident in using it. They told us they found it helpful and used it for every child accessing the MIU service
- This core service made eight adult safeguarding referrals between 1 May 2016 and 30 April 2017. A total of 31 child safeguarding alerts were reported by the minor injury units. We saw evidence of learning from occasions when children were found to have been put at risk. Staff demonstrated they were knowledgeable about the risks to vulnerable adults and there were

prompts on the electronic system to encourage professional curiosity during assessment. The trust had also appointed a number of safeguarding leads and posters were displayed informing staff of their local lead. Staff said they found their lead to be very supportive and had improved their safeguarding practice. The lead frequently attended the MIUs, and provided information and advice to staff.

- The trust undertook an external audit of safeguarding children – Safeguarding in Minor Injury Units June 2017. This audit found that safeguarding controls in place were sufficient but staff safeguarding training figures could not be established as accurate. Camborne Redruth and St Austell MIUs both had low compliance records for level three safeguarding children training, with four of the five community hospitals visited falling below the target level.
- Emergency contraception was available in some minor injury units where there were suitably trained staff. Patient group directions were available for appropriately trained clinical staff to administer emergency contraceptives.

Medicines

- Medicines were managed in a way that kept patients safe. Medicines were stored securely. The trust had a medicines policy to support staff to manage all aspects of medicines safely. This policy described the procedures and good practice that should be used when prescribing, supplying or administering a medicine. It included the legal and professional standards that were expected of different staff groups and the personal responsibility involved.
- Controlled drugs were stored securely. The controlled drugs registers were up-to-date and the access to the cupboard keys was only by authorised staff. St Austell minor injury unit dispensed and documented oramorphine as a controlled drug but the medicine was not stored as a controlled drug. This was raised with staff at the time.
- Medicines, including refrigerated medicines, were stored appropriately. Medicines were stored correctly in locked cupboards or refridgerators. Refridgerator temperatures were regularly checked by staff and were within required parameters. Room temperatures were checked to ensure the safe storage of non-refrigerated medicines.
- All FP10 prescriptions available for doctors to use, and the equivalent non medical prescriber prescriptions, were stored and managed securely. Systems were in place to ensure each prescription was accounted for and recorded when the prescription pads had been used and by whom.
- A pharmacy team was available Monday to Friday 8.30am until 5pm to provide clinical pharmacy, medicines management and advice. In addition, the trust had two service level agreements in place with the local acute trusts to provide a pharmacy dispensing service to all minor injury units seven days a week, and an out of hours on-call service.
- Staff confirmed that access to a pharmacist for advice was in place and the systems to order and receive medicines were both safe and reliable. Medicine advice and any queries were directed to the trust pharmacy team to answer. MIU staff also had access to the local trust for additional advice out of hours via an on-call pharmacist.
- Pharmacy teams were involved in the induction training programme for all new staff. In addition to the induction session all registered nursing staff had to complete the medicines management e-learning module every three years. The trust told us drug assessment for PGDs, immunisation & vaccination, intravenous therapy, refresh and personal safety awareness was undertaken. The MIU PGD drug exam was taken once initial training had been successfully completed by all MIU registered nurses. We were not provided with any action plan to identify actions to be taken.
- In addition, the pharmacy team gave a presentation on the correct use of patient group directions (PGDs) in an MIU setting as part of the MIU recognised training course. Patient group directions are written instructions for the administration of authorised medicines to patients and are needed to ensure medicines are only administered to patients by staff with the legal authority to do so. Systems were in place to support the development and review of PGDs for all MIUs every three years.
- All patient records we reviewed included any allergies to any medicines and also recorded any medicines given as prescribed by a doctor or under patient group directions.

Requires improvement

Are services safe?

- There were clear disposal processes in place for wasted or out-of-date medicines. Facilities for the disposal of wasted medicines and destruction could be arranged through the pharmacy.
- There was monthly data collection undertaken on the first five patients seen requiring medicine at each unit on the 10th day of each month. The information collected looked at which medicine was issued under PGD and informed future PGD development.

Environment and equipment

- Each minor injury unit's premises varied, with some being more suitable than others for assessment, treatment and maintaining confidentiality. The premises were a mixture of purpose-built accommodation and older buildings, with some of the hospitals requiring modernisation. The trust board assurance report stated that the care and experience of patients could be compromised if the healthcare estate was not maintained in a fit for purpose condition. The risk register recorded actions and assurance mechanisms to monitor improvement actions being taken.
- Some premises were not suitable to ensure patient confidentiality. We saw that units at St Austell, Newquay, Launceston and Bodmin had treatment areas which did not have sufficient space to ensure one patient could not hear the adjacent patient's discussion.
- Staff at Newquay expressed safety concerns as the reception area was easily accessible to patients who may be confrontational. Training was provided for all staff for managing aggression and violence. Staff told us that some MIUs saw higher numbers of patients who were intoxicated and on occasion the security arrangements at each unit were not sufficient to ensure their safety. We saw the risk assessment for Newquay hospital. While it detailed the need to risk assess patients arriving at 9.45pm, there was no risk identified of the main desk being accessible to challenging patients.
- The trust's risk register noted a lack of piped suction available in all clinical areas. There was no piped suction in some minor injury units, which was noted as required according to Health Technical Memoranda (HTM) guidance. The risk was noted as amber (moderate) and the register did not include any action plan to meet this shortfall. Those units without piped oxygen and suction had portable appliances in place. All cylinders available were secured or on portable trolleys. We saw one unsecured oxygen cylinder at Liskeard Hospital. This would present a risk of injury if it was to fall over. The inspector informed a staff member and was provided with assurance that this would be addressed immediately.
- All equipment we inspected had up-to-date portable appliance checks and service stickers in place. All equipment was serviced in line with manufacturers' recommendations, including calibration or performance testing in accordance with manufacturers' technical guidelines.
- Resuscitation equipment was present in each unit, with the exception of Helston where the resuscitation trolley on an adjacent ward was used. The remaining MIUs had a trolley located for immediate availability and locked with a plastic tag to maintain security. Grab bags were stocked and available for staff to use in the nearby environments if needed. Nursing staff completed daily checks of the resuscitation trolley, ensuring the security tag was in place and the monitoring equipment, suction and defibrillator tested. A full check of the resuscitation equipment and drugs was completed weekly to ensure sterile or shelf life items did not go out of date. Following use of the resuscitation trolley a full check was completed by two nurses, confirming replenished equipment and drugs. We saw the checks were made against a list recorded in a booklet. Nurses did not tick or sign to say they had seen each item, but signed to say they had checked the whole trolley. Any issues were recorded and an audit trail of remedial actions recorded.
- There were clearly identifiable domestic and clinical waste disposal facilities, and we found these were being used appropriately. Falmouth, Newquay, Bodmin and Liskeard MIUs stored hazardous items in unlocked sluices, including bleach tablets, cleaning solutions and nail varnish remover. These substances if ingested would be hazardous to health and should be secured.
- The trust risk register noted that Bodmin Hospital was not compliant with regulatory requirements due to insufficient structural fire resilience. This was a long-standing issue identified in 2014 and remained ongoing.

Requires improvement

Are services safe?

- There was current development work at Launceston Hospital MIU to improve the environment and facilities. Staff moved the unit equipment to another area on a regular basis to accommodate building work. There was good working communication with the building contractors to enable the MIU to remain functional.

Quality of records

- Systems were in place to ensure patients' information was kept safe. We found records were stored securely to ensure confidentiality. Records were kept in a locked cupboard in the MIUs for up to three months, they were then securely stored in the hospital's records department but remained accessible to staff.
- Records we reviewed were in most cases legible, up to date and well completed, with dates and signatures to support records made. Paper and electronic records were maintained.
- Electronic records included all care provided and the system used prompted and stored letters to patients' GPs to inform of their visit and any treatment provided. The electronic system recorded all visits to all the Cornwall MIUs and also the local urgent care centre and acute trust. This meant information was shared to ensured patient safety. When referrals to other health professionals or services were made, photocopied records went with the referral to ensure continuity of care.
- A 'red flag' system operated on the electronic patient records to alert staff to previous records relating to patients with specific needs, including any learning disability or safeguarding risk.
- The trust had available on their website a 'Record keeping standards for Health and Social Care' policy. This was in place to standardise the way in which staff in the health records department and related clinical administrative roles across the community worked when dealing with patient health records.

Cleanliness, infection control and hygiene

- Cleanliness, infection control and hygiene were well managed in most of the minor injury units. There were systems and processes to reduce and control the risk of cross infection. Cleaning was completed by two general service assistants daily, with each member of MIU staff cleaning their own equipment. All departments we visited, with only one exception, appeared visibly clean. Falmouth MIU had some areas which were not clean, including a high level of dust behind a radiator and in the sluice, and the children's toys in the waiting area did not appear clean. We reviewed cleaning details for this department for April 2017 and saw that the cleaning rota did not include the cleaning of the children's toys.
- An infection control policy was available on the trust website. This provided clear guidance on the measures required to prevent the spread of infection. Under the Health and Social Care Act 2008, all trusts are required to have clear arrangements for the effective prevention, detection and control of healthcare associated infection, including the procedures to be taken in the event of an outbreak of infection.
- Staff in all areas we visited wore the correct uniform and used personal protective equipment, such as gloves and aprons as needed. Staff followed the hospital policy of being 'bare below the elbow'.
- We saw that all staff washed their hands or used sanitiser gel immediately before and after patient contact. This was in line with the National Institute for Health and Care Excellence (NICE) Quality Statement 61 (Statement 3).
- Local hand hygiene audits were undertaken by the unit infection control lead and results were displayed, with a percentage score overall. All units had achieved high scores. One infection control lead explained that any issues would be dealt with by them, for example advising staff on hand hygiene practice. The infection control link nurse in each unit attended quarterly infection control meetings and each meeting had a learning theme. The most recent learning was about sepsis and the lead nurse then cascaded the learning to the MIU staff.

Mandatory training

- A programme of mandatory training was provided for all staff. Mandatory training compliance did not meet the trust's target and not all staff received mandatory training in line with trust policy. Due to the amalgamation of two providers training records were unclear and the trust was in the process of reviewing these.

Requires improvement

Are services safe?

- Training was provided for all staff to ensure they were familiar with safe systems and processes. There were systems to monitor and remind staff when training was due; emails were sent to staff to remind them when training was due. Training was provided by either e-learning or face-to-face, dependent on the subject. Staff told us they could not access e-learning from home and so it had to be done in work time, however when they were busy this was not possible.
- There were 36 training courses which the trust classed as mandatory for this core service. The compliance target for most of the courses was 85% but some had 95% target compliance. For the most recent time period (1 April 2017 to 31 May 2017), 32 out of the 36 courses were below target compliance.
- As of 31 May 2017, the training compliance for this core service was 42% against the trust target of 85% (except the following courses where trust target was 95%; E-stat update, Fire safety face-to-face and Information governance).
- The trusts risk register noted that there was no bespoke moving and handling training available to minor injury unit staff. This was being reviewed and discussed at the trusts health and safety meetings. Staff told us that at Camborne Redruth if moving and handling assistance was needed ward staff were happy to help them..
- The trust advised us that it was not confident about the reliability of the training data supplied as there was an ongoing data review process, following the amalgamation of two providers in 2016.
- Out of the ten minor injury units, Falmouth hospital had the lowest mandatory training compliance rate of 24%. Newquay hospital had the highest compliance rate at 66%. Training attendance was difficult for the staff at St Mary's MIU on the Isles of Scilly. The e-learning was possible, but any face-to-face training was provided on the mainland and required staff having to spend several days on the mainland. No screens or technology links had been put in place to enable staff to attend remotely and no systems considered to enable staff to remain updated.
- All staff within the MIUs had been trained to deliver immediate life support (ILS) to both adults and children, and were also up to date with basic adult life support training (BLS). Staff treating children under the age of 18 received paediatric competency modules as part of their training to ensure they could provide safe care to those children.

Assessing and responding to patient risk

- Patients in the minor injury units were kept safe during normal daily opening hours because they received prompt assessment and treatment. However, out of hours and at weekends, when reception staff were not employed, there was a risk that patients' initial assessment may be delayed, because nursing staff were seeing other patients. This posed the risk that patients with a serious or life threatening condition may not be identified quickly. For example, 673 patients arrived at the St Austell MIU at 7pm over the 12 month period September 2016 to August 2017. This was an average of 56 patients a month. The reception staff finished their working day at 5pm. It was noted from data received that Mondays after 5pm were consistently the busiest out of hours time for seven of the MIUs. Staff at most MIUs told us this was a concern for them.
- Patients who arrived at the department having made their own way presented to a reception desk in a waiting room to give their initial details. Where the MIU had a main hospital front door receptionist, the initial booking in was usually completed by them. However, this depended on the receptionist and the time of day which varied in each hospital. For those hospitals without a main receptionist the patients were booked in by the MIU receptionist during working hours and by a nurse out of hours and at weekends.
- Patients were initially booked in by recording their name and presenting condition. At this time a series of questions were asked which were recorded on the computer system. Once the mandatory fields, including presenting complaint and demographic details, were completed the attendance would appear on the screen ready for clinical team to triage the patient.
- Where the initial booking was completed by a health care assistant, training was providedto ensure they were competent for this role. Where the initial booking was done by the receptionist, training was provided to

ensure they could recognise 'red flag' concerns, for example chest pain or shortness of breath. We were assured staff without that extra training did not undertake the initial booking.

- The initial electronic booking in screen required only the patient's pain score and analgesia requirements to be entered. This was suitable for lower acuity standard minor injury attendances. Alternatively, the full triage screen could be used for any unwell patient. This included the pain questions plus a full set of observations, completion of which wwould give an early warning score.
- The computer system calculated an early warning risk score and if sepsis was identified as a risk, a sepsis tool was produced for staff to follow. This system could be overridden if staff felt the score did not match their concerns. All staff understood that should a patient present with a visible sepsis risk they would have immediate escalation to a registered nurse. Out of hours and weekends this booking in was done by the trained nurse on duty.
- The trust aimed for all patients to be seen and triaged by a suitably trained staff member within 15 minutes in line with their own policy. This member of staff was not always a trained nurse and may have been a health care assistant with some extended training, who in turn was supervised at the end of the assessment by a trained nurse. The trust monitored performance against this 15 minutetimescale. We observed this timescale was mostly met, but in some cases the triage by the trained nurse or health care assistant with extended training was delayed due to staff being busy. In
- Time to triage recording did not include the time patients had waited to be booked in and so did not highlight the risks of patients deteriorating unseen in a waiting room. At Stratton and Helston MIUs out of hours and at weekends patients would have to press a buzzer to access the MIU and the nurse from the MIU or ward would leave their department to let the patient in. Systems were not always in place to manage this risk and potentially patients could have arrived and be deteriorating in the waiting area, unknown to staff. This risk was not recorded on the trust risk register and the data was not collected.
- The time triage started was not clear and so did not inform the trust accurately. It was unclear in some MIUs from ten patient records seen when the 'clock started' in order to meet the 15 minute triage target. In some MIUs, patient records showed the triage time started and stopped with the receptionist taking the initial booking information. This was not in line with the Royal College of Emergency Medicine (RCEM) guidance, which states triage should be undertaken by a registered healthcare clinician. This was also not in line with the trust's triage policy, which stated the initial booking undertaken by the receptionist "Once the mandatory fields, including presenting complaint and demographic details, have been completed the attendance will appear on the screen ready for clinical team to triage the patient". We were assured the healthcare assistants undertaking triage had received further training to enable them to undertake this role. The receptionists had not undertaken this training and so to start the clock at initial booking was not accurate recording.
- We saw there was an increase in the time patients waited to receive assessment and treatment at all of the MIUs between February and August 2017. The trust told us that in the summer months some extra daytime administrative staff were employed but this additional staffing did not include out of hours and weekends. The three hospitals that had the highest length of times to treatment, and were consistently above the average for all of the providers hospitals, were CamborneRedruth, St Austell and Falmouth.
- The trust had a policy and guidance on caring for a deteriorating patient. This included identifying and treating a patient with sepsis, following national guidance. The trust used the 'sepsis six' tool, which is a care bundle that should be implemented within one hour. Currently the trust was not in a position to fully implement the sepsis six due to the nature of community services. The trust told us that issues were in relation to the community MIUs' ability to obtain the appropriate blood results and the limitations of the specimen courier service. A delay could also arise in relation to the administration of intravenous antibiotics, specifically due to the availability of medical staff. Clinicians were taught the importance of the 'golden hour' and how to start the sepsis six with oxygen, blood cultures, cannulation and fluid challenge, in line with the trust's patient group direction.

Requires improvement

Are services safe?

- The trust used an early warning score system to indicate if sepsis was a risk. If the scoring system was triggered a sepsis tool was automatically produced. The tool was not the National Early Warning Score (NEWS) but followed the sepsis six guidelines for treatment and made reference to the NEWS recording tool. For children, the Paediatric Early Warning Score (PEWS) was used.
- Staff were aware of the actions to take when sepsis was indicated and told us their priority was to transfer the patient to the local acute trust by either emergency ambulance or air ambulance if needed. This was because most MIUs didn't have access to a doctor to start fluid and antibiotic therapy. This was with the exception of Camborne Redruth, when a doctor was available, and St Mary's MIU which had immediate access to a GP. There was no PGD in place to support staff to start fluid therapy. The minor injury nurse consultant for the service reassured us the PGDs were being reviewed and there were plans to include PGD for fluid access.
- The infection control and prevention team had delivered sepsis awareness training sessions at the community hospitals (including MIUs) to staff groups which included nurses, healthcare assistants, therapists and doctors. Within these sessions the trust aimed to ensure that all staff understood the importance of the sepsis escalation chart and when it was appropriate to escalate their concerns to either a doctor or dial 999.
- Infection prevention leads were in the process of updating the sepsis policy in line with NICE guidelines and were working with the governance leads to produce an audit on sepsis incidents within the trust. This audit was not yet available.
- Patients who required emergency transfer by ambulance to an acute hospital were placed at risk due to delays in ambulance response. While this impacted on the Minor Injury Units, it was not caused by Cornwall Partnership Foundation Trust. Staff in all locations told us they had experienced unacceptable delays. Staff had, on occasions, to remain in the department after it had closed to wait for emergency ambulances to arrive. This risk was not on the trust risk register. Data was being collected to provide evidence of the times and delays placing patients at risk. We saw from this data that while no harm had occurred, there was potential for harm. The risks were described as difficulty in delivery of care to other patients due to the increased care required while waiting for the ambulance transfer. Delays month by month varied, with six delays in May 2017, five delays in June 2017 and 12 delays in July 2017.
- The trust told us that reporters of the incidents had raised concerns in regards to the risks and potential harm and not actual harm to patients, with staff stating that they are unable to provide the definitive/diagnostic level of care required within the advised timeframes for certain conditions. The harm level in the majority of the incidents reflect report concerns increased patient anxiety or distress. There is evidence within the incidents that appropriate care has been delivered to the individual patient whilst awaiting the arrival of the ambulance. However staff reported difficulty in delivery of care to other patients due to the increased care required for the individual patient.
- The trust said several reports stated that ambulance services as part of their triage consider NHS services as a place of safety.
- The trust told us that Initial conversations held by the Interim Deputy Director of Nursing on identification of the increasing trend had resulted in the commencement of joint working between CPFT and the ambulance service to identify areas for improvement and to promote safety of patients and to support staff appropriately.They also advised that all reported incidents were reviewed on a daily basis and escalated appropriately to the ambulance trust in regards to the delay of emergency ambulances.
- Should a patient in the MIU have a cardiac arrest, staff would commence resuscitation and request an emergency ambulance. Emergency treatment was also available for anaphylactic shock, allergic reactions and asthma attacks. Helicopter access was available for the air ambulance at some of the MIUs, including Launceston and Stratton. There was local airport access at St Mary's.

Staffing levels and caseload

- Staffing levels were consistently maintained at planned levels with the appropriate skill level, which varied dependent on location. Agency staff were employed to cover shifts when required. Staff told us they considered staffing levels to be safe. We were told required staffing

levels and skill mix were assessed using a staffing tool but the tool described was not a nationally recognised tool. Another staff member told us that if a MIU saw over 10,000 patients per year the team of two trained nurses was increased to include a health care assistant.

- We saw an example of how the remote e-rostering system did not meet the needs of the geographical challenges of the region. The rostering of staff at St Mary's MIU on the Isles of Scilly had specific challenges with regard to access to the islands because of the weather. The trust told us that the e-Roster team have visited the Isles of Scilly (IOS) to work with the services on an individualised operational approach to e-roster, recruitment and deployment of staff to the IoS. However staff told us that roster system did not address their needs. Agency staff booked to work were not sent out in a timely way and were sometimes delayed. This meant permanent staff sometimes had to work very long hours to cover shortfalls. This did not ensure patient safety. The shortage of permanent staff at St. Mary's meant this was an ongoing problem and impacted on staff leave, training and senior nurse on call cover.There were four vacancies at St Mary's; three were full time and one was part time. Two of the registered nurse vacancies had been unfilled for two years. Recruitment was ongoing but there were difficulties recruiting due to the location. Incentives had recently been added to the adverts, but the detail of the incentives was not available to ward staff who responded to interested parties. This meant they were unable to discuss the full details with potential applicants.
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- The trust's risk register noted that failure to recruit, develop and retain an appropriately skilled and engaged workforce would result in the trust's inability to deliver high quality services within a positive working culture. This was rated red, the highest level of risk.
- Staff had different skills to meet the demand of each location. All registered nurses had completed minor injury training. Some staff had completed minor illness training, enabling them to see and treat a range of minor illnesses. One location provided primary care with a GP attending. All registered nurses had completed PGD training to administer specific and identified medicines. Some staff had qualified as nurse prescribers and so could prescribe the required medicines for some illnesses and injuries.
- All registered nurses were band six or seven, with the exception of Helston MIU where a band five nurse worked alone. Ban five development posts were also in place. Those MIUs which stayed open overnight would have a band sixnurse on duty overnight to ensure staff who worked alone had the skills and experience needed. At Stratton MIU the registered nurse at night was included in the ward staffing number but did not

work on the ward. One of the day time registered nurses at Stratton Hospital also covered the day theatre but remained on the MIU staffing numbers. At St Mary's the MIU nurse was also the ward nurse on duty.

- Staff did not undertake a handover of information between shifts. Any patients requiring a return visit would do so and the staff would check back for the patient's notes to inform the patient's care.
- The trust submitted their turnover data for the period 1 June 2016 to 31 May 2017. This core service had an average annual turnover rate of 11% against the trust average of 12.5%. had the highest percentage turnover of substantive staff leavers during the period, with 24.8%. Staff at Liskeard told us that they sometimes used agency staff to cover shifts.
- The trust submitted their sickness data for the period 1 June 2016 to 31 May 2017. This core service had an average sickness rate of 3.6%, against the trust average of 5 %.
- < >he average monthly vacancy rate for this core service over the 12 months up to May 2017 was 5.4% against the trust average of 5.1%. Falmouth Hospital MIU had the highest average staff vacancy rate over this period.For May 2017 the vacancy rate was 2.6% against the trust average of 4.8%.
  Student nurses from local trusts had placements at some minor injury units. We saw student orientation guides which supported student nurses at each location. These included specific local information, learning objectives and suggested reading.

Medical staffing

- Medical staff worked at Camborne Redruth minor injury unit and St Mary's MIU on the Isles of Scilly. Historically, urgent care had been provided at Camborne Redruth MIU only as part of a funded pilot scheme. When this pilot was completed, access to an appropriate urgent care doctor was not available. To develop the service to meet local patient needs one or two GPs were employed daily when available, to provide primary care to the local community.
- The doctors who currently staffed the primary care centre in Camborne Redruth Hospital were provided by other health organisations.All doctors were given a local induction. All appraisals, general training and continuous personal development were monitored by one of the other health providers.
- The doctors who work at St Mary's MIU were supplied through a contractual arrangement with a general practice on the mainland. Three GPs worked on the Isles of Scilly and provided a service to the health centre, hospital and to the MIU.
- One of the issues staff had identified about the primary care service was about patient expectation of the service. Because the GP availability varied, this meant there were times when the doctor was not available. There was no means to include this on the trust MIU website and so patients would arrive expecting to see a doctor and on occasions were unhappy at having instead to see a nurse.
- Staff at nurse-led MIUs told us that whilst they did not have access to a doctor, they could access an on-call consultant for advice and support. The consultant was on-call to answer staff questions and staff confirmed the service was useful. Staff also told us that at units where an out of hours GP service shared the location they would sometimes refer patients to that doctor or request prescriptions if needed.

Managing anticipated risks

- The trust had a major incident and business continuity plan. This plan detailed the organisational structure and specific responses and responsibilities that were necessary when responding to a critical or major incident. The purpose of this policy was to define an emergency response to a range of incidents internal and external to the trust. It defined roles, responsibilities and actions to be taken and included actions for staff in the event of a critical or major incident.
- The trust undertook a continuous process of training and exercising of this plan. A programme of awareness raising sessions, training and exercising was in place. Induction training and update training contained emergency planning training.
- There was no contingency planning or consideration of planned public events during the holiday season, other than at St Mary's Hospital. There were several events in Cornwall which meant a large influx of people to an

event in one local area. We asked locality directors and MIU staff about any plans to increase staffing or any contingency plan for these events. We were informed there was no forward planning for increases of local activity and the impact on the demand for urgent care services.

Major incident awareness and training (only include at service level if variation or specific conerns)

- Staff confirmed that, with the exception of St Mary's MIU, training for incidents took place either as a table top exercise. Staff told us they had practiced lock-down situations and had used the debrief afterwards to ensure learning. A lock down situation took place when the unit needed to be closed to the public to deal with an emergency situation.
- Hazardous materials (HAZMAT) training had not taken place as a practical exercise, but theory training had been provided to all staff.
- The minor injury units had panic buttons which when used alerted other hospital units. The minor injury units, with the exception of Stratton, did not have access to security or support portering staff if staff felt threatened or unsafe. In those instances the police would be called. Staff told us that working in isolation and late at night had caused concerns. Cameras were used in some units to enable staff to see outside of their unit to waiting rooms and hospital entrances, and key pad access was in place for most areas. A lone working policy was in place which risk assessed the lone working environment but did not include risk assessments for waiting areas not visible to staff.

Good

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

We rated effective as good because:

- The trust's policies and services were developed to reflect best practice and evidence-based guidelines.
- Each patient's level of pain was established as part of triage and treatment provided promptly.
- Food and drinks were provided when needed and as were appropriate for the patient.
- Staff had the right qualifications, skills and knowledge to do their jobs.
- Staff had access to patient information to deliver effective care and treatment.
- Patients' consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.

However:

- Staff at St Mary's MIU did not have the appropriate support to participate in face-to- face training and be part of learning across the trust.

Detailed findings

Evidence based care and treatment

- The trust's policies and services were developed to reflect best practice and evidence-based guidelines. The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve outcomes for people using the NHS and other public health and social care services. A trust policy was available to staff to see how NICE guidance was reviewed and disseminated to all areas of the trust.
- Trust protocols were available to staff via the intranet and in a paper format to support their practice. Standard protocols for MIU staff were reviewed annually by the lead nurse consultant for MIUs and the trust MIU consultant lead. The standard protocols referenced information from the British National Formulary, The Royal Pharmaceutical Society, the Nursing and Midwifery Council (NMC) code – Professional Standards Practice 2015 and NICE guidance.
- We observed NICE guidance being followed, for example:
  - We reviewed patient records, which all showed evidence of regular observations to monitor the patient's health. For example, blood pressure, pulse and respirations. This was in line with NICE guideline CG50: Acutely ill patients in hospital - recognising and responding to deterioration.
  - NICE QS61 statement three recommends people receive healthcare from health care workers who decontaminate their hands immediately before and after every episode of direct contact or care. We saw staff consistently followed hand hygiene policies and used personal protective equipment appropriately. We saw clinical staff also followed the 'bare below the elbow' guidance in line with best practice.
- Learning from a recent incident had prompted the clarification of risk assessment for venous thromboembolism (VTE). All patients who attended the minor injury units with a leg injury which required a below-knee immobilisation, such as a cast, had a VTE risk assessment. The risk assessments were audited each month to ensure they were being consistently completed. We noted the risks related to VTE would only be reviewed at the end of the month and so any action missed would not be mitigated for up to four weeks. There was no fail safe electronic mechanism in place that would prompt staff to not be able to continue with the electronic process until the risk assessment had been completed.
- Some protocols were in place for treatment pathways, for example, orthopaedic pathways. This was an overarching policy used for whichever trust was being admitted to.

Good

Are services effective?

Pain relief (always include for EoLC and inpatients, include for others if applicable)

- Pain management was well organised and established as part of triage and treatment. The staff had a policy for pain management. The policy had been inherited from the previous provider and had not been updated.
- Pain scores were calculated and recorded, and appropriate pain relief was administered, for all patients we observed and in all records we reviewed.
- We observed the nurses on reception and triage asking about pain levels on a scale of zero to 10. We observed pain relief being provided in a timely way and the nurse going back in a short while to check the patient was more comfortable.
- There were pictures available for children to point to indicate pain levels. We observed that for children the medicine calculations were available to ensure staff provided the right level of pain relief.

Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others is applicable)

- Food and drinks were provided when needed and as were appropriate for the patient. We observed nurses and healthcare assistants providing water and hot drinks for patients. Before offering any food to patients, staff checked with the nurse or doctor that the patient was able to eat and drink.
- Staff told us that for patients who had an identified need to eat, for example patients with diabetes, a snack box could be requested from the hospital kitchen.
- Patients we spoke with told us they had been offered drinks and snacks where appropriate.
- Intravenous fluids were not available in the MIUs; however, we were advised this was being reviewed to consider its inclusion as part of a patient group direction.

Patient outcomes

- The trust had limited participation in national audits for minor injury units. The trust provided us with details of national and local clinical audits undertaken by urgent care services over the previous 12 months and information as to how it had changed practice.
- VTE risk assessment audits raised awareness of the need to complete VTE risk assessments in appropriate MIU patients. Learning had been provided for staff. Two minor injury units consistently achieved 100% compliance and all units were encouraged and supported to achive full compliance.
- Other audits were undertaken, including audits of patient group directions, controlled drug audits and hand hygiene audits. All audits were reviewed as part of the trust governance process and areas for improvement discussed at governance meetings with a plan for improvement.
- Re-attendance rates were between 1% and 2% for the timescale April to August 2017. Less than 1% of patients left without being treated in the same time period. The average total time patients were in the departments was two hours.

Competent staff

- Staff had the right qualifications, skills and knowledge to do their jobs. Staff told us they had access to e-learning and face-to-face training. They told us that in addition to mandatory training they had specialist training in minor injuries. The sister at Bodmin MIU had developed monthly team supervision, which included learning on a subject identified as part of supervision; however, this wasnot seen in the other MIUs.
- Staff told us about learning opportunities made available by the local acute trust. The week prior to our inspection there had been a learning opportunity in relation to a hand injury, which staff had been able to attend. Staff could also develop their practice with extra learning, which included plastering skills, undertaking observations and echocardiographs.
- Training was regularly reported and discussed at the performance information monitoring meeting held with senior managers and executives. Each of the service's progress throughout the quarter was monitored with targets to achieve full compliance by the end of the quarter.
- An appraisal was used to identify learning needs, and a plan put in place to support staff to develop their

practice. The trust submitted appraisals data for this core service for the time period 1 Aprilto 31 May 2017. For that timescale the overall appraisal rate for this core service was 85%, meeting the trust target of 85%.

- The expansion of the trust in April 2016 had brought with it challenges in relation to standardisation of the appraisal process. The trust had reviewed and updated the appraisal paperwork and implemented a new appraisal process as a result of staff feedback. Due to inconsistencies with the data available, we were unable to see an overall clinical supervision rate for the core service as a whole. The trust could not provide a breakdown by staff group.

Multi-disciplinary working and coordinated care pathways

- We reviewed patients' notes and saw evidence of multidisciplinary team working. The MIUs liaised with GPs, district nurses, school nurses, social workers and any carers, where appropriate, to arrange ongoing care for patients post-discharge. We saw two records which reflected when a multi-agency approach had been taken to ensure patients had the follow-up and medical support needed. This included letters to GPs and referrals to specialist services.
- Staff described working with the local acute trust to make referrals quickly and efficiently. Depending on the location, different MIUs referred to different local acute trusts. This meant different processes were used. Staff understood the geographical differences in working and ensured referrals were met correctly.
- When MIU staff referred patients to the local trusts they went through that trust's emergency department for access to services. There were no direct pathways to avoid delays. This is at the request of the acute trusts as they operate a single point of entry system.
- Staff at Camborne Redruth MIU described how they had been supported by ward staff to use moving and handling equipment not familiar to them. MIU staff had helped the ward by supporting staff during a cardiac arrest.
- Each MIU had access to a tissue viability specialist nurse to provide support and advice as needed.
- The MIUs did not have direct access to psychiatric, substance misuse or specific health services. Staff told us they could 'signpost' patients to the appropriate services, or would inform the patient's GP to enable community services to be accessed.

Referral, transfer, discharge and transition

- Patients had access to services in accordance with published times and websites were updated if closures were required. The trust website listed all of the minor injury units that were open, and included the waiting times for the units and the local emergency department. This enabled patients to decide the best option for them. The minor injury units were open seven days a week and all were open at varying times between 8am and 10pm. Two units, St Mary's and Stratton, were open 24 hours a day. Patients could attend during open times without an appointment or any prior booking.
- X-ray facilities were available at nine out of the ten minor injury units with varying opening times. The X-ray facilities were available at variable times of the day. Nursing staff could read non-complex X-rays for upper and lower limbs and obtained a secondary review from the local trust for all X-rays. Some delays were observed by staff in the reporting of X-rays in Launceston. Staff kept a record to enable them to follow up reports not sent back to them and would then prompt the X-ray service to finalise their reports. Should the report differ from the MIU staff X-ray interpretation, staff would then telephone the patient and appropriate action would be taken.
- Nine of the minor injury units provided a nurse-led minor illness service when appropriately trained staff were available. The treatment available was limited to certain conditions and included, colds, sore throats, infections, rashes and some eye treatments.

Access to information

- Staff had access to patient information to deliver effective care and treatment. Information needed to deliver effective care and treatment was available via the electronic record system and included all of the other trust MIUs, the local acute trust and the local urgent care centre. Staff kept written records in the department for two months after the patient had been seen to enable staff to access records for follow up visits.

Good

Are services effective?

- The electronic systems in place for local patients worked efficiently; however, the system in place to find the details of patients from out of area was slow and complex. Staff explained the delays caused by the system in place. These delays were particularly challenging during holiday seasons when many patients were from out of the area.
- When patients were transferred to the local trust for urgent treatment a copy of their MIU attendance card accompanied the patient to inform the receiving emergency department of the MIU assessment and treatment. A verbal handover was also provided by telephone.
- Treatment protocols and guidelines were accessible in written formats in each department.
- Discharge letters were sent to GPs daily and included relevant and pertinent information for their attention.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- Patients' consent to care and treatment was sought in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and patient consent.
- Ensuring consent to treatment was the responsibility of the healthcare professional directly responsible for the person's treatment. Staff followed trust policies to ensure a consistent and monitored approach.
- The trust had a consent policy in place and accessible via the internet for all staff. The policy was based on guidance from the Department of Health and referred to physical examination, treatment and care. The policy described the circumstances in which consent should be sought.
- There was a consent policy for children and young people accessible to staff. The policy informed staff that the trust had systems in place to gain and review consent from children and young people who used the services.
- The trust provided training to all clinical staff on the Mental Capacity Act to ensure they were able to undertake their duties in relation to capacity and consent. At 31 May 2017, the overall compliance rate was 98%.
- Two teams within this core service did not achieve the trust target of 95%. This was the compliance, and the

Good

Are services caring?

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

Summary

We rated caring as good because:

- Staff treated patients with kindness, dignity, and respect. Staff interacted with patients in a positive, professional, and informative manner.
- Staff showed an encouraging, supportive and sensitive attitude to patients and those close to them.

We saw staff being observant and supportive of patients and their relatives when anxious and in need of emotional support.

Detailed findings

Compassionate care

- Staff treated patients with kindness, dignity and respect. Staff interacted with patients in a positive, professional and informative manner. This was in line with National Institute for Health and Care Excellence (NICE) guidance.
- The trust used the NHS Friends and Family Test, and bespoke surveys were developed using a patient survey tool, to learn about patient experience. The NHS Friends and Family Test is a satisfaction survey that measures patient satisfaction with the care they have received. Key findings for the trust were largely positive, describing how the trust meets the needs of patients with compassion and professionalism, with phrases used such as "staff are kind, caring, professional and friendly".

Understanding and involvement of patients and those close to them

- Staff showed an encouraging, supportive and sensitive attitude to patients and those close to them. We observed doctors and nurses introducing themselves when they met patients and their families for the first time. All patients were addressed by their preferred name. When patients experienced physical pain, discomfort or emotional distress, we saw staff responded with kindness and compassion in a timely way. Patients said their needs were responded to in time and with good care.
- Staff used curtains around the trolley spaces to provide privacy when assessing and treating patients, and ensured patients' dignity. Voices were lowered when confidential or personal information was being discussed.
- We saw that at St Mary's on the Isles of Scilly the minor injury unit was a fundamental part of the local community. Staff in the MIU had multiple roles, which included the care of patients and relatives in the community and as part of end of life care. This extended role meant staff knew patients and their relatives. The minor injury unit was included in all aspects of care and was inclusive of patients and their relatives.

Emotional support

- We saw staff were observant and supportive of patients and their relatives when they were anxious and in need of emotional support. We observed in Liskeard MIU staff interaction to support an anxious patient. The staff member took time to talk with the patient, to listen to their concerns and to provide reassurance. No treatment was required but staff recognised the patient needed time and comfort. Staff told us some patients visited the MIUs regularly for support and staff understood the importance of this emotional support.
- The spiritual and pastoral care service operated an on-call arrangement for advice to the local teams to ensure the management of the situation appropriately by respecting an individual's beliefs. They could also facilitate support from the appropriate community faith leader as required.
- There was no direct referral facility for staff to counselling services. Advice and patient information was on display and staff were able to talk to patients about these services and how to access them.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Services provided reflected the needs of the local population, ensured choice and continuity of care.
- The service took account of patients' specific needs and had access to support services.
- The service delivered was flexible and creative to ensure flow was maintained
- Complaints were handled in accordance with trust policy.
- Patients had access to services in accordance with published times and the trust website was updated if closures were required.

However :

- The trust website did not reflect when primary care service GPs were not available at Camborne Redruth MIU. This meant that patients were not correctly informed about the medical services available and who would be available to see and treat them.

Detailed findings

Planning and delivering services which meet people's needs

- Services provided when possible reflected the needs of the local population, ensured choice and continuity of care. The commissioning of services in Camborne Redruth had recognised the need to support the local GP services and so had implemented the primary care service, when medical staff were available, at the MIU. This service was available Monday to Friday between 8am and 8pm. This service was staffed by local GPs and locum doctors and had the intention of supporting the local community and preventing admissions when possible to the acute trust emergency department.
- The MIUs at Stratton and St. Mary's were open 24 hours a day; this service was there to support the more isolated areas of the county.
- All the MIUs provided minor injury care; however, when suitably trained staff were available in nine of the units, minor illness care and treatment was provided. This was only undertaken out of hours and at weekends when the patient's own GP was not available. If patients attended the MIU with a minor illness they were triaged for safety, then if suitable, referred to their own GP.
- When the MIU's experienced staffing issues a temporary closure procedure was in place. Those MIUs which saw in excess of 10,000 patients a year were prioritised and other smaller units would be considered too close to provide staff to support the busier units. There was no closure possible at St Mary's due to the location and the community dependence on this resource.
- When staff were not available the units were closed. There had been 18 closures in August 2017. The data showed that the greatest number of closures was at Helston where there were ten closures. These were caused by lack of staff. There were eight occasions when a GP was not available at Camborne Redruth MIU. There was a protocol in place when a reduced operation was needed, this advised staff of the actions to take to ensure other local services were aware of the closures.
- The waiting rooms were adequately sized to accommodate the numbers of patients and their relatives or friends most of the time. However, when units were very busy people would sometimes have to stand. In the waiting room there was information displayed about current waiting times.

Equality and diversity

- The trust worked collaboratively with Public Health, Commissioners, Cornwall Council and other local stakeholder agencies to both understand the health inequalities specific to the largest ethnic minorities and to respond appropriately within service provision.
- The hospital took account of patients' specific language needs. Translation services were available with the use of a language telephone service. Each unit had a language book which could be used be used by the patient to identify which language was needed and had the basic translation of phrases to enable an initial consultation.

Good

Are services responsive to people's needs?

- All of the units had information leaflets for patients to access regarding a variety of medical conditions; staff could not confirm if these were available in different languages. We saw signage in different languages and large print to ensure patients could access the information they needed.
- Most areas of the hospital were accessible for patients with limited mobility or who used mobility aids. Accessible toilets were available for disabled patients and visitors. Equipment was available for patients with bariatric needs.

Meeting the needs of people in vulnerable circumstances

- The clinical alert system was used for patients with a learning disability, dementia, visual and sensory impairment. This was only in place if the patient had attended previously and the detail had been added to the system. Staff told us they had recently undertaken dementia training.
- Further work being undertaken by the trust included targeted services to support travellers and refugees and homeless services. Staff told us that when this vulnerable group attended the MIUs they were able to provide information or contact local refuges.
- Minor injury units had communal waiting areas and staff remained mindful of this when speaking with patients. There were separate areas within each of the units where personal information could be discussed as required. Some units had a lack of privacy for patients booking in with the waiting room being able to overhear the details being provided. The children's areas in the waiting rooms of Newquay and Falmouth MIUs were not of good quality and there was limited activity provision to keep children busy and distracted.

Access to the right care at the right time

- The service delivered was flexible and creative to ensure flow was maintained. If the MIUs were not busy, patients were triaged and treated immediately. If there were multiple patients in the waiting room, each patient was booked in and triaged as soon as possible and the order of treatment prioritised to ensure the patients with the highest risk were seen first. This level of flexibility was constantly being reassessed to ensure patients were safe but also seen in a timely way. If delays occurred, staff explained to the waiting patients the reasons for the delay.
- We observed patients being treated promptly and there was team work between staff to ensure patients were booked in, triaged, treated and discharged quickly and safely.
- Camborne Redruth had the greatest MIU attendance, followed by St. Austell, then Liskeard and Newquay. Liskeard, Newquay and St Austell had the greatest variance in attendance across the year. St Mary's Hospital had the greatest percentage of patients who left without being treated, with an average across the year (September 2016 to August 2017) of 1.2%, as opposed to the next highest being Camborne Redruth at 0.13%.
- Patients who arrived by ambulance were triaged in the ambulance to reduce the possibility of them being brought into the MIU and then having to return to the ambulance to go to the local acute hospital. All ambulance patients were prioritised to be triaged within 15 minutes. The trust did not gather data to assure themselves that ambulance handover and turnaround times were prompt.
- Patients returning the next day for a wound check or call back were seen between other patients.
- The trust told us that because staff mostly commenced treatment at the same time as the initial assessment, they were unable to break the data down into the required sections (time to assessment then time to treatment). However, we saw time to triage was being recorded, with the majority of units having short timescales. Helston had some of the longest times to triage starting as this was a lone working unit. As noted in the safe section, there was a lack of clarity as to when the clock started recording the time to triage.
- The trust had a target of 65% of all MIU patients being seen within two hours. This data was from 1 June 2016 to 31 May 2017. This was consistently exceeded with scores between 84% and 86%. The trust record of patients seen within four hours consistently exceeded the national 95% target, with a regular score of 99%.

Good

Are services responsive to people's needs?

- The waiting times of four hours from arrival to treatment was met in 95% of cases for the previous year up to May 2017. We reviewed data that said in April 2017 13 patients waited over four hours for treatment. In May 2017 this increased to 41 patients and in June 2017 it was 39 patients. In July 2017 it was 27 patients and in August it was 18 patients.
- Data provided from April to August 2017 showed that there was a consistent increase in patients attending the MIUs and that increase included a consistent increase in patients from out of area. The total had increased from 9,460 patients in April 2017 to 11,312 in August 2017. Out of area attending patients had increased from 15% of the total in April 2017 to 31% in August 2017.
- The data showed that a consistent 5% of patients attending the MIU were transferred to the local acute hospital emergency department. There were issues around delays of the urgent transfer of patients by ambulance to the local trust. This issue is reported under the well led section of this report.
- If staff were not available the unit would be closed and patients directed to the nearest service available. Any closures would be publicised on the NHS Choices website and the trust website. The website did not reflect when primary service GPs were not available at Camborne Redruth MIU. This meant that patients were not correctly informed about the medical services available and who would be available to see and treat them. Staff told us that patient expectations to see a doctor sometimes created problems for the nurses.

Learning from complaints and concerns

- Complaints were handled in accordance with trust policy. The trust had a complaints policy to deal with complaints quickly and appropriately. We saw information in waiting rooms to inform patients of how to complain and leaflets for patients to take with them which explained the process.
- The trust looked for trends in complaints to see if there are any recurring or growing issues that may need special attention. The trust received 109 complaints between 1 June 2016 and 31 May 2017. This core service accounted for 11 (10%) of these. The complaints received by the core service were 'all of aspects of clinical treatment' with nine complaints identified. The complaints did not identify any one specific trend or theme.
- The trust was not completing complaints investigations in a consistently timely way. The trust target to address complaints was 25 to 60 days. The average time it took to close complaints within this core service was 66 days, ranging from zero to 169 days. Within this core service, one complaint was fully upheld, four were partially upheld, three were not upheld and three are still under investigation.
- Learning from complaints was shared by outcomes being cascaded from the matrons to unit sisters to staff. Staff told us that they received learning from MIU complaints and the wider trust.
- There were 126 compliments for this core service in the last 12 months (June 2016 – May 2017). Some MIUs such as Liskeard had high levels of compliments; we saw that they in turn had the highest level of Friends and Family responses.

Requires improvement

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

We rated well-led as requires improvement because:

- We saw some areas where governance had not highlighted issues at department level and so there was no evidence that monitoring the service had been effective to support changes to improve patient safety.
- We saw that whilst concerns were raised with us at each location about delays in emergency ambulance transfers to acute hospitals, this was not recorded on the trust risk register and therefore it was not evident through governance systems that this risk had been escalated for action.
- Staff in seven MIUs told us about risks out of hours and at weekends because nursing staff were required to book, triage and treat patients. Nursing staff did not have reception or healthcare assistant staff support out of hours and at weekends and were constantly pulled away from treatment to answer the door, clerk and triage patients. This was not on the trust risk register.Staff did not have consistent knowledge of policies and procedures in place to support them to run the service to within the planned opening hours and so staff were delayed in closing the units. For units were an incident has occurred due to large volumes of walk-in patients, the trust had put in place a specific process to support staff. All other MIUs were covered under the operational policy which did not detail the actions and timescales staff should follow.
- Staff did not have procedures to follow to support a decision to close to new patients and how this would be reflected accordingly on the trust website.
- Some areas of monitoring did not take place, this included the time triage started to ensure that patients did not wait too long. There was no auditing of reasons patients attended the units to identify any themes or trends and there were no risk assessments and reviews of the units which presented specific geographical challenges and how they should be managed.
- A corporate vision and strategy were in place in the trust; however here was currently no specific minor injury unit vision or strategy in place.
- Visibility of senior management and inclusion in staff events had not been managed to ensure the inclusion of the staff at St Mary's. No resources had been provided for remote inclusion.

However:

- Staff felt leadership was mostly good and unit, hospital and divisional lead staff were accessible. Staff told us they felt supported and heard, and there was a collective culture of openness to drive quality and improvement.
- There was a strong ethos of teamwork and staff felt well supported. There was a flexibility and willingness among all the teams and staff we met. Staff worked well together, and positive working relationships existed to support each other.
- The trust had in place an information governance management framework which included the minor injury units.

Detailed findings

Leadership of this service

- Staff felt leadership was good and unit, hospital and divisional lead staff were accessible. Staff told us they felt supported and heard, and there was a collective culture of openness to drive quality and improvement. This was with the exception of St Mary's MIU which had not had a recent visit from the locality division lead for the previous 18 months and had few visits from senior management.
- At a local level the units were managed by the unit's sister. Staff in each location spoke in the highest terms about the positive support they had from the sisters. Staff told us that they felt well led and sisters were accessible and supportive to ensure patients' safety.
- The minor injury unit staff and sister were led locally by the community matron for each hospital location. The

matron covered the entire location and so relied on the sister to run the unit. All matrons confirmed they worked well with the sisters in charge. Matrons had a forum where they met regularly to support each other and in turn cascade learning and support to the MIU sisters and staff.

- Collectively, units were led by locality divisional directors. They had an area responsibility for the east, mid and west of the county. This divisional role had links to the trust board and was a means to cascade information from unit to board and back.
- Staff told us they trusted the leadership team and found them supportive and approachable. Matrons and ward managers spoke positively about leadership of the trust and felt supported and listened to. They told us divisional managers were visible and approachable.
- Chief executive visits were recorded up to May 2017. The visits were to the community hospitals. Staff told us that since the merger of the trust with the previous community organisation they were aware of the board and knew that they visited the community hospitals.

Service vision and strategy

- Following the transfer of adult community services to the trust on 1 April 2016 the trust consulted with all staff regarding a refresh of the values. This was to ensure the existing values were inclusive of the views of the enlarged organisation. The consultation was completed as part of informal team discussions and engagement days. The response findings were that all staff were willing to embrace the existing values. The vision statement was 'Delivering High Quality Care'. The values agreed were compassionate services, achieving high standards, respecting individuals and empowering people. We saw trust values on waiting room notice boards.
- The trust told us that a leaflet detailing the values, together with the related standards and behaviours (also developed by staff) was distributed to existing and new staff, patients and their carers.
- The organisational development strategy was developed as part of a full business case produced in the support of the transfer of adult community services to the trust. The transfer of the services in April 2016 resulted in the trust doubling in size. As part of its overall approach, the trust focused on developing its staff to deliver a "well led, high performing, continuous improving, high quality, safe and compassionate care organisation".
- Staff did not know of a clear specific vision and strategy for the minor injury units. We asked a division lead for MIUs who confirmed that there was currently no minor injury unit vision or strategy in place and plans for a future vision were in their infancy.

Governance, risk management and quality measurement

- The trust had in place an information governance management framework which included the minor injury units. This provided a management framework to ensure internal information governance was delivered in accordance with national standards and the trust's operating frameworks. To support this process there was an information governance steering group as the responsible group for developing, implementing, reviewing and monitoring compliance governance documents.
- Governance arrangements demonstrated the systems, processes and behaviours through which unit to board reporting and continuous learning was achieved. The arrangements included the processes for collating, analysing and responding to patient, public and staff experience feedback, incidents and risks, key performance indicators and quality metrics and audit results. We saw minutes of clinical assurance audit groups and senior nurse forums which reflected the review of information and implementation of actions as a result.
- Staff understood and felt involved in governance processes. The matrons took a governance lead role for the minor injury units. Staff said they generally received information regarding incidents and audits and were involved in making changes as a result of incident investigations. Staff were encouraged to report incidents and risks and these were discussed at operational and at corporate level to facilitate the identification of issues and trends and resultant learning.
- Within the organisational governance structure were groups which concentrated on particular issues, such as

falls prevention, least restrictive practice and resuscitation. These groups comprised of multidisciplinary staff groups and focused on the quality and safety of care provided.

These operational assurance groups, within services, received and reviewed a comprehensive range of data including incidents, audits and patient experience from across the organisation

- We saw risks were recorded on a trust register and included investigations of serious incidents and root cause investigations. A local risk register was not in place. This meant any risks of concern could be flagged to the divisional and trust board and learning shared across the hospital. The risk registers for the hospital were extensive and it was clear to follow how risks were being reviewed and managed. Staff demonstrated awareness of the risk registers and felt able to raise issues to be included.
- We saw some areas where governance had not ensured that issues at department level had been escalated and action taken. Local risk registers for the MIUs were not evident.
- We saw that whilst concerns were raised with us at each location about delays in patients being transferred by ambulance to the acute trust, this was not recorded on the risk register and was not evident through governance systems that this risk had been escalated for action. Data was being gathered but there was no evidence of feedback to staff.
- Staff in seven MIUs told us about risks out of hours and weekends because nursing staff were required to clerk, triage and treat patients. This was not on the trust risk register. Reception staff and health care assistants were available at different times during the day and increased cover for holiday periods would end as the winter approached. This meant nursing staff did not have reception /HCA staff support out of hours and at weekends and were constantly pulled away from treatment to answer the door, clerk and triage patients. Staff considered this to be a double risk to patients as there was a risk to patients having to wait and a risk to patients being left mid treatment. This area had been reviewed to increase reception/HCA staff during the day but we could not see any assessment, discussion or monitoring to identify how this could be managed safely out of hours and at weekends.
- The practice of when the triage time started was not clear and so did not inform the trust accurately. It was unclear in some MIUs when the 'clock started' in order to meet the 15 minute triage target. In some MIUs patient records showed that the triage time started and stopped with the receptionist taking the initial booking information.
- Staff were not consistently aware of policies and procedures in place to support them to run the service to within the planned opening hours and so staff were delayed in closing the units. For units were an incident has occurred due to large volumes of walk-in patients, the trust had put in place a specific process to support staff. All other MIUs were covered under the operational policy which did not detail the actions and timescales staff should follow.
- There was no auditing of reasons patients attended the units to identify any themes or trends or identify if the visits prevented attendance at local emergency departments. The trust was working with a local acute hospital and had a committee in common. The data relating to four hour waits was shared with the local acute trust to be included in their target data.
- There were no risk assessments and reviews of the units which presented specific geographical challenges and how they should be managed. Some units, for example St Mary's and Helston, had specific challenges of both the location and the working environment which needed to be reviewed and risk management in place to ensure that patients and staff were safe.
- Mortality reviews were not undertaken by the MIU staff and staff did not get learning from the trust mortality reviews. No deaths in any MIU had been recorded.
- The Trust has a robust Whistle Blowing Policy which described the whistle blowing process. The Audit Committee was tasked on an annual basis to review the whistle blowing process throughout the organisation. For the period 1April 2016 to 20 June 2017 the trust recorded four whistle blowing cases. It is difficult to draw out themes from such a small number of cases and none were related to the minor injury units.

Requires improvement

Are services well-led?

Culture within this service

- There was a strong ethos of teamwork and staff felt very well supported. Staff were very complimentary about the leadership within the divisions. Staff told us they enjoyed their jobs, were proud of the minor injury units and of the treatment and care they provided to patients. There was a culture of openness and honesty. Staff told us they felt able to raise concerns and believed they would be listened to and supported.
- There was a flexibility and willingness among all the teams and staff we met. Staff worked well together, and positive working relationships existed to support each other. Staff sometimes moved between the units when one unit closed and staff felt this was manged well. The island culture was evident at St Mary's, with staff working between departments to support each other. For example, we were told that the kitchen dishwasher was broken and had not been replaced. In response all staff, including the matron, the administrative staff and ward/MIU staff all washed the dishes each day. This was done to support the kitchen staff until a new machine was delivered.
- Staff told us that merger with CPFT had provided clearer processes to work by; some felt CPFT was more corporate in its management of staff.

Public engagement

- The trust used two feedback mechanisms to identify themes and learning which were then shared with staff. These were two local surveys; the Friends and Family test and bespoke surveys developed using the Patient Survey tool Meridian. We did not see any results from the Meridian survey. In the last 12 months the trust had not held any formal public consultations.
- The Friends and Family test was used to assess patients' overall experience and was routinely reported to the board. Key findings were largely positive, describing how the trust meets the needs of patients with compassion and professionalism, with phrases used such as "staff are kind, caring, professional and friendly".
- A total of 20,377 surveys were collected during 2016/17. CPFT's ambition of delivering a positive patient experience every time on every interaction was measured by achieving a target of 95% of patients who would recommend the trust. At the end of April 2017 the community scored 97.76%. The minor injury target was 30% of all patients attending completing a form, this target was not achieved. Only Liskeard and Newquay exceeded the 30% target. The target achievement was discussed at the MIU nurses forum with staff reminded to encourage patients to complete the form.
- Areas for development from the Friends and Family test related to:
- The length of time some patients wait to be seen by specialist services and a requirement to easily identify the wait times at the minor injury units. The above areas had been addressed and to demonstrate the actions taken the trust had developed 'You Said – We Did' posters.
- The trust patient experience team had oversight of the implementation of the trust's patient experience strategy and patient and carer involvement strategy. The trust had a monthly carers' forum which provided insight regarding services from the perspective of carers.
- The trust had a Patient Experience Annual Report 2016/17. The patient experience team provided a telephone service on weekdays between 9am and 4.30pm. The team received contacts (telephone, letter, email or web site enquiries) from patients, their families, carers and friends and from trust staff.
- The work of the patient experience team encompassed the Patient Advice Liaison Service (PALS) and triangulated feedback from a variety of sources and identified areas for improvement which were followed up with individual service managers.
- When the patient experience team identified a theme, in the first instance it was raised with the appropriate operational line manager who would talk through some of the solutions with the unit, and if applicable might help in delivering this.

Staff engagement

- The organisation had developed and implemented two trust-wide local staff surveys, a local 'cultural barometer' survey which was used and implemented within team and a 'Health and Well-being' survey that was implemented trust-wide annually
- Top concerns from the local staff survey included :

Requires improvement

Are services well-led?

Visibility of senior managers - to address this issue, the trust has in place a rolling programme of executive director front line informal visits, staff engagement leads team visits, monthly staff experience meetings, chaired by the deputy Chief Executive and quarterly staff engagement day events hosted by the chief executive.

- The top two concerns of the health and wellbeing survey were stress and building resilience at work - a rolling programme of 'building resilience workshops' open to all staff and 'workshops' for managers to raise awareness of spotting the signs of stress in teams and taking supportive action. A programme of mindfulness workshops and other resources and activities were in place for staff to access, including a health and wellbeing fund for teams to access.
- The second top issue was flexible working - an agreed procedure in place for staff to apply for flexible working with an 'appeal' process for a second review.
- Local staff engagement was encouraged. Staff told us they could raise issues and ideas with the sister or matron. Staff were supported to identify what they felt they were good at and areas for improvement. We saw that at CamborneRedruth small awards had been given to the sister in support of her team working practice.
- Visibility of senior management and inclusion in staff events had not been managed to ensure the inclusion of the staff at St Mary's. No resources had been provided for remote inclusion.

Innovation, improvement and sustainability

- An example of improvement and development was the sepsis working group (which included representation from the acute trust and the commissioners). This focussed on a consistent approach to monitoring sepsis, for example, the development of a single National Early Warning Score (NEWS) chart based upon NICE guidance for all providers. Further aspects of work were under discussion to include the adoption of a national screening tool for sepsis and the introduction of sepsis grab bags.
- Cornwall Partnership Foundation trust had been part of a multi-agency accessible communication group for a number of years. This group was established to improve all forms of communication between public sector organisations and patients, clients and the wider population of Cornwall and the Isles of Scilly. National funding to make a promotional video had been received and the group run a conference to raise awareness of the standards prior to implementation. They were currently developing a self-accreditation framework to support organisations with their implementation.

This section is primarily information for the provider

Requirement notices

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **12(1) Care and treatment must be provided in a safe way for service users.** **12(2) without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include** **(a) assessing the risks to the health and safety of service users of receiving the care or treatment** **(b) doing all that is reasonably practicable to mitigate any such risks** • **The records did not accurately record the time triage started to include the time patients waited to be booked in, to ensure the risks of patients deteriorating unseen in a waiting room were understood and managed safely.** • It was unclear in some MIUs when the 'clock started' in order to meet the 15 minute triage target. In some MIUs patient records showed that the triage time started and stopped with the receptionist taking the initial booking information, despite the triage being undertaken by the appropriate staff.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **17(2)(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.**

This section is primarily information for the provider

Requirement notices

- Patients were placed at risk due to delays in emergency ambulance transfer. Once the patient had been identified as needing a transfer to the acute trust staff in all locations had experienced unacceptable delays in the patient being emergency transferred.
- There were no risk assessments and reviews of the units which presented specific geographical challenges and how they should be managed.