Gloucestershire Health & Care NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Urgent and emergency care service delivery in Gloucestershire

A summary of CQC observations on urgent and emergency care services in Gloucestershire

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. On this occasion we did not inspect any GPs as part of this approach. However, we recognise the pressures faced by general practice during the COVID-19 pandemic and the impact on urgent and emergency care. We have summarised our findings for Gloucestershire below:

Provision of urgent and emergency care in Gloucestershire was supported by health and social care services, stakeholders, commissioners and the local authority. Leaders we spoke with across a range of services told us of their commitment and determination to improve access and care for patients and to reduce pressure on staff. However, Gloucestershire had a significant number of patients unable to leave hospital which meant the hospitals were full and new patients had long delays waiting to be admitted.

The 111 service was generally performing well but performance had been impacted by high call volumes causing longer delays in giving clinical advice than were seen before the pandemic. Health and social care leaders had recently invested in a 24 hour a day, seven day a week Clinical Assessment Service (CAS). This was supported by GPs, advanced nurse practitioners, pharmacists and paramedics to ensure patients were appropriately signposted to the services across Gloucestershire.

At times, patients experienced long delays in a response from 999 services as well as delays in handover from the ambulance crew at hospital due to a lack of beds available and further, prolonged waits in emergency departments.

Our findings

Patients were also remaining in hospital for longer than they required acute medical care due to delays in their discharge home or to community care. These delays exposed people to the risk of harm especially at times of high demand. The reasons for these delays were complex and involved many different sectors and providers of health and social care.

Health and social care services had responded to the challenges across urgent and emergency care by implementing a range of same day emergency care services. While some were alleviating the pressure on the emergency department, the system had become complicated. Staff and patients were not always able to articulate and understand urgent and emergency care pathways.

The local directory of services used by staff in urgent and emergency care to direct patients to appropriate treatment and support was found to have inaccuracies and out of date information. This resulted in some patients being inappropriately referred to services or additional triage processes being implemented which delayed access to services. For example, the local directory of services had not been updated to ensure children were signposted to an emergency department with a paediatric service and an additional triage process had been implemented for patients accessing the minor illness and injury units to avoid inappropriate referrals. Staff from services across Gloucestershire were working to review how the directory of services was updated and continuing to strengthen how this would be used in the future.

We found urgent and emergency care pathways could be simplified to ensure the public and staff could better understand the services available and ensure people access the appropriate care. Health and social care leaders also welcomed this as an opportunity for improvement. We also identified opportunities to improve patient flow through community services in Gloucestershire. These were well run and could be developed further to increase the community provision of urgent care and prevent inappropriate attendance in the emergency departments.

There was also capacity reported in care homes across Gloucestershire which could also be used to support patients to leave hospital in a timely way. The local authority should be closely involved with all decision-making due to its extensive experience in admission avoidance and community-based pathways.

Our Findings

The 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust came together to form Gloucestershire Health & Care NHS Foundation Trust in October 2019.

The Trust continues to provide the mental health services it ran before the two trusts came together. It also provides the community-based physical health services previously run by the acquired trust.

The ratings of services previously acquired by another trust do not carry over to the new trust. This report includes ratings for all the mental health services previously run by 2gether and for the one community health service we inspected this time. The ratings for other community services will be displayed once we have undertaken inspections of these services. Ratings for other community health services from previous inspections are shown on our website page for the former Gloucestershire Care Services NHS Trust (cqc.org.uk/provider/R1J).

Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, our usual inspection work has been curtailed by the COVID-19 pandemic so we inspected only the community urgent care service. We rated the service as good overall.

Our findings

The service comprises six minor injury and illness units (MIIUs) which are available to anyone living or working in the Gloucestershire areas. The units provide treatment and advice on a range of minor injuries and illnesses not serious enough to require attendance at an emergency department.

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents effectively and learned lessons from them.
- Staff provided good care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make their own decisions about their care, and promoted access to suitable information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them to get better. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services.
- The trust had introduced a telephone triage system in July 2020. Records seen and evidence provided by the trust showed that patients identified at risk received a call back within 10 minutes with routine patients receiving a call back within two hours.

However:

- The service at Cirencester MIIU did not carry out consistent checks on equipment to check it was clean and maintained for use. The doors to the sluice and treatment room that contained medicines, were unlocked meaning unauthorised personnel could potentially access these areas.
- Designated Control of Substances Hazardous to Health (COSHH) cupboards were not always locked or managed in line with trust policy. The Control of Substances Hazardous to Health (COSHH) Regulations 2002 is a law that requires employers to control substances that are hazardous to health.
- Daily checks of the resuscitation trolley and bag at North Cotswold MIIU were inconsistently carried out, which was not in line with the service's recommended guidance.
- Medicines were issued via a patient group direction (PGD). During the inspection we found examples of expired PGDs. The trust following the inspection provided us with an up to date risk assessment which outlined the process for the use of out of date PGDs.
- Due to the demand on the service, staff had not had regular supervision or attended team meetings.

Our findings

- While we saw staff asking patients for their consent staff were unaware of the consent process audits to ensure the service was following legal requirements.
- The MIIUs did not have information on display within their waiting room informing patients on how to request a chaperone if they needed one, or how to make a complaint or raise a concern.

None of the MIIU locations have been inspected under Gloucestershire Health and Care Foundation Trust (GHC) but were inspected in April 2018 under Gloucestershire Care Services NHS Trust where urgent care was rated good for all domains.

GHC has six minor injury and illness units (MIIUs) which are available to anyone living or working in the Gloucestershire areas. The MIIUs provide treatment and advice on a range of minor injuries and illnesses not serious enough to require attendance at the emergency department.

From April to November 2021 there were 45,186 attendances across the MIIUs.

During the inspection on 7, 8 and 9 December 2021 we visited the following four locations; Stroud, Cirencester, North Cotswold and Lydney and District MIIUs. All the MIIUs are open seven days a week between 8am and 8pm except for Stroud MIIU which is open from 9am to 4:30pm for a booked appointment service only due to ongoing refurbishment works.

The service is staffed by emergency practitioners (EPs), nurses, healthcare assistants and receptionists. EPs are senior nurses with accident and emergency and/or minor injury and illness experience, who have received additional training that enables them to provide treatment for minor injuries and conditions. The EPs can assess, treat and discharge patients within predetermined guidelines.

To manage patients safely during the Covid-19 pandemic and maintaining social distancing in waiting areas, the trust developed a telephone triage system in July 2020 enabling them to allocate time slots for people attending the MIIUs. Guidance from the trust's website was that all patients who need to be seen in one of the MIIUs should contact the service for a telephone triage assessment prior to attending.

CQC registered the provider to carry out the following regulated activities at the services:

- Diagnostic and screening procedures
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

How we carried out the inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Our findings

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- spoke with 14 patients during the inspection.
- spoke with 29 staff members, including the service director for urgent care and specialist services, clinical leads, emergency practitioners, nurses, health care support workers, student nurses and receptionists.
- looked at a range of policies, procedures and other documents related to the running of the hospital and each of the core services.
- we visited four of the six Minor Injuries and Illness units (MIIUs) registered with CQC and looked at the quality of the environment including the clinic and treatment rooms.
- looked at 36 care records of patients and medications records.
- attended a staff handover.
- observed the care and support provided and interactions between people, visitors and staff throughout the inspection.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

- The trust should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system in Gloucestershire.
- The trust should ensure that the sluice at Cirencester MIIU is not left unlocked and that the areas is kept tidy.
- The trust should ensure that Cirencester and North Cotswold MIIUs have locked COSHH cupboards that are managed in line with the trust's policy.
- The trust should ensure that the main door to the drug/treatment room at Cirencester MIIU is kept locked when not in use.
- The trust should ensure that North Cotswold MIIU carries out daily checks on its resuscitation trolley and bag.
- The trust should ensure that staff have regular clinical supervision.
- The trust should consider having information on display informing patients of the use of chaperones if required.
- The trust should ensure that staff have access to consistent team meetings.

Our findings

The following pages show ratings for all the mental health services run by this trust and for the one community health service we inspected this time – the community urgent care service.

Ratings for other community health services from previous inspections are shown on our website page for the former Gloucestershire Care Services NHS Trust (cqc.org.uk/provider/R1J), which is now part of this trust.

For further information please see *Our findings* on page 3 of this report.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Mar 2022	Good ➔➔ Mar 2022	Good ➔➔ Mar 2022	Good ➔➔ Mar 2022	Good ➔➔ Mar 2022	Good ➔➔ Mar 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Outstanding Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016
Community-based mental health services for older people	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Wards for people with a learning disability or autism	Requires improvement Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Community mental health services for people with a learning disability or autism	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Requires improvement Jan 2016	Good Jan 2016
Wards for older people with mental health problems	Good Jun 2018	Good Jun 2018	Outstanding Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Mental health crisis services and health-based places of safety	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Good Jan 2016	Outstanding Jan 2016
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Forensic inpatient or secure wards	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Specialist community mental health services for children and young people	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Community-based mental health services of adults of working age	Requires improvement Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community urgent care service	Good Mar 2022	Good Mar 2022	Good Mar 2022	Good Mar 2022	Good Mar 2022	Good Mar 2022

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community urgent care service

Good

Is the service safe?

Good

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Face to face training had been limited due to Covid-19 restrictions so staff confirmed they had completed most of their training on-line. The overall training compliance figure for MIIUs was 95%. Records showed that all relevant staff had completed level 3 advanced life support training. This gave staff a good level of clinical competency when dealing with life threatening conditions such as cardiac arrests.

The provider had set up a telephone triage system to support and provide advice to patients attending the MIIUs. Staff followed the 'Manchester triage system', a clinical management triage tool used to safely manage patient flow when clinical needs exceed capacity. Staff we spoke with confirmed that they had been trained in its practice which we saw being used during the inspection.

The health and safety report for 2020/21 identified that all staff had completed annual manual handling training.

Staff completed a structured induction and mandatory training programme which included moving and handling, equality and diversity, infection prevention and control, safeguarding children and vulnerable adults which incorporated the Mental Capacity Act and information governance.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The trust had access to a "joining up your information" system. This was a shared records system which included social workers, health visitors and GPs.

Staff had access to the Child Protection - Information Sharing (CP-IS) alert system. The CP-IS shares information for those children who were subject to a child protection plan, looked after children and any pregnant woman whose unborn child had a pre-birth protection plan.

We saw staff had access to a safeguarding referral folder which included information on the date of a referral, the services referred to and any follow up actions or outcomes.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were cleaned on a regular basis and well-maintained. Staff worked to an agreed cleaning schedule and recorded this on display boards throughout the services. Senior leaders conducted spot checks and cleanliness of the building was checked by team leaders. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, at Cirencester MIIU we did not see evidence of labelled equipment which meant that it was unclear when staff had last cleaned an area or the equipment after use.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was appropriate PPE available for staff such as gloves and disposable aprons which staff used as required. There were adequate supplies of hand gels for staff, patients and visitors to use.

Staff told us they had an allocated room if patients with an infection needed to be isolated to minimise the risk of cross infection, for example, patients with a high temperature or a rash.

We saw both the hand hygiene observation and infection control audits which showed 100% compliance for Lydney and District and North Cotswold and 95% for Cirencester. There were no issues or concerns identified.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. However, COSHH cupboards did not have signage displayed and were not secure at both Cirencester and North Cotswold Minor Injuries and Illness units.

The design of the environment followed national guidance. All waiting rooms had close circuit television (CCTV) displayed so staff could monitor patient safety. At Lydney and District access to the unit was via a secure door which had a keypad entry system. They also had a lockdown policy which showed exit routes and how to access police support if required.

Staff confirmed they had access to silent panic alarms to request security or police assistance should a patient became agitated or display aggressive behaviour.

The service had suitable facilities to meet the needs of patients.

Seating had been reorganised in line with Covid-19 regarding social distancing. There were clear signposts at the front of the hospital and throughout directing patients to the units. All locations except for North Cotswold had a separate entrance which meant the MIIU did not encroach on the main hospital entrance. All patients were asked to enter unattended where possible unless accompanied by a parent or carer.

The service had enough suitable equipment to help them to safely care for patients. All sites had a resuscitation room or area that provided all the required equipment. Staff informed us that following a major injury debrief, the MIIUs had put additional equipment in their resuscitation bag to manage trauma situations.

Staff disposed of clinical waste safely.

The door to the sluice at Cirencester MIIU was left unlocked even though it had a working "Digi lock" in place. We also found the sluice to be cluttered with empty cardboard boxes and a full linen bag on the floor. This was brought to the attention of the manager during the inspection, following this they took action to rectify this issue.

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 is a law that requires employers to control substances that are hazardous to health. At Cirencester and North Cotswold MIIUs COSHH cupboards did not have signage in place to identify the safe storage of such materials. The COSHH cupboards were unlocked during the inspection. We found staff had stored items such as alcohol gel, cleaning solutions and anaesthetic spray in unmarked, unlocked cupboards. This was not in line with the trust's policy which indicates that COSHH cupboards should have signage displayed and be secured. This was brought to the attention of the managers on site who confirmed they would address our concerns.

During the inspection we were not provided with evidence of current ligature risk assessments for the MIIUs. However, following the inspection, the trust provided us with up to date copies of ligature risk assessments for all locations visited. Staff confirmed they were currently sourcing ligature cutters but did not have any onsite on the day of our inspection. However, staff informed us, and we also observed during the inspection that patients were never left unattended when on site. There had been no reported incidents of patients using ligatures in the MIIUs.

Staff told us that when required they aimed to provide patients with a separate room if they needed a quieter waiting and treatment area.

All equipment such as the electrocardiogram (ECG) machine, blood pressure monitors and oxygen cylinders had up to date electrical testing stickers which ensured they were fit for purpose.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

The trust had an action plan for when it went above "OPEL 2' status. OPEL 2 denotes a trust 'starting to show signs of pressure'.

When patient safety was at risk due to demand on the MIIUs, the trust had a procedure which involved closing the smaller MIIUs and relocating staff to strategic named locations.

Staff completed risk assessments for each patient on arrival using a recognised tool, and reviewed this regularly, including after any incident.

Systems were in place to assess all patients in the MIIUs to determine how quickly they should be reviewed. Walk-in patients were seen by the receptionist who carried out an initial verbal assessment and logged the patient's details onto a computerised record system. Any identifiable concerns were prioritised, for example, head injuries, chest pain, shortness of breath or suspected fractures. Most patients attended at a designated time slot determined after their initial telephone triage conversation.

Community urgent care service

Staff confirmed that their main challenge and risk to patients were for those who needed onward transfer by ambulance to the acute hospital. Staff at all locations said they often waited over two hours and on occasions they had waited until the early hours of the morning for arrival. We saw the clinical governance meeting minutes for November 2021 praising and recognising staff for their commitment to staying late to support patients who were waiting to be transferred to acute hospitals.

During the inspection we observed patients waiting no more than 15 minutes to see the triage nurse. We reviewed the telephone triage system and saw this recorded the call waiting time. Records seen and evidence provided by the trust showed that patients identified as being at risk received a call back within 10 minutes with routine patients receiving a call back within two hours.

Staff confirmed they had been made aware of the increase in respiratory illness in babies and children along with high levels of respiratory syncytial (RSV) which is a common respiratory virus that usually causes mild, cold-like symptoms. All staff spoken with could explain the process should a child present with a respiratory condition.

Silver trauma and frailty assessment was considered for patients aged 65 and over. Silver trauma is a term used to define trauma and injuries occurring in older patients. Staff used the Rockwood frailty score to assess a patient's level of vulnerability and the assistance required to improve both long-and short-term health concerns.

The MIIUs had processes to manage x-rays and suspected fractures. Staff advised patients to return or be redirected to another MIIU if the result was either non acute or non-urgent. There was a daily audit to ensure fractures had been managed and referred appropriately.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The services used nationally recognised tools to identify deteriorating patients such as the national early warning score (NEWS2) or the paediatric early warning score (PEWS). Early warning scores are used to help identify patients with sepsis or other serious conditions. The NEWS2 and PEWS are a quick and systematic way of identifying adults or children who may be at risk of deteriorating. We reviewed 36 records and saw these were fully completed for all patients at risk of deteriorating.

Should a patient deteriorate while attending the MIIU, they had processes and facilities to manage the patient's individual need while waiting for an ambulance to arrive. This included for example, the use of an electrocardiogram (ECG) to check the patient's heart's rhythm and electrical activity or the administration of pain relief via a cannula (a tube that can be inserted into the body for the administration of drugs and fluids).

The service had access to mental health liaison and specialist mental health support when required.

Staff shared key information to keep patients safe when handing over their care to others. The MIIUs had procedures in place for informing the community of the reason for attendance. This included for example notifications which were sent to the patient's GP either electronically or by post. We observed staff asking patients for their consent to inform GPs of their visit.

Shift changes and handovers included all necessary key information to keep patients safe.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Community urgent care service

The MIIUs were staffed by a combination of emergency practitioners (EPs), nurses and healthcare assistants who were also trained to carry out MIIU reception duties.

The service had enough nursing and support staff to keep patients safe. Staffing rotas showed that staffing levels were always met.

The service had low vacancy and turnover rates. Staff leaders confirmed that any unallocated shifts were mostly covered by bank staff and that they rarely used agency staff. When it was necessary to use agency staff, managers requested staff that were familiar with the service where possible. Managers made sure all bank and agency staff had a full induction and understood the service.

The service had low sickness rates. All locations reported very low sickness rates. For example; figures seen for Cirencester MIIU showed this to be less than 2%.

During shift changes the nurse in charge completed a handover. We observed a handover and noted the following areas being covered; staffing levels, the number of patients waiting to be seen which included full case details and any planned returns.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. We looked at 36 records and found all were triaged within 15 minutes of arrival in accordance with the national target of the clinical quality indicator metrics.

We observed a good level of documentation including; sepsis screening, risk assessments, consent to share information with the patient's GP, comprehensive pain scores and the analgesia offered. NEWS and PEWS observations were used and recorded where appropriate.

All records seen identified that patients were seen, discharged, referred on or had follow up bookings within two hours.

Records were stored securely.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Staff followed current national practice to check patients had the correct medicines.

Medicines were issued via a patient group direction (PGD). PGDs are written instructions which allow specific healthcare professionals to supply or administer a medicine with an identified clinical condition without the need for a prescription. Both managers and nurses spoken with confirmed they were assessed as competent before being allowed to give medicines via a PGD.

The MIIUs had a total of 64 PGDs in place and the list was last updated in January 2021. Saw that not all PGDs were in date, however, this had been recognised in governance meetings, and were in the process of being updated. Following the inspection, the trust provided us with a copy of an up to date risk assessment for the usage of out of date PGDs.

Standard operating procedures were in place for medicines processes as well as an induction training book for the MIIUs which contained a medicines management section.

Staff stored and managed all medicines and prescribing documents safely. PGDs were stored safely in locked cupboards.

Medicines were in date and stored in locked cupboards and fridges. However, at Cirencester MIIU we found that the main door to the medicines room was open. We brought this to the attention of the manager who addressed this immediately.

The resuscitation trolley had appropriate emergency medicines available including those for anaphylactic shock. Anaphylaxis is an extreme and severe allergic reaction and must be treated quickly.

The trust had processes for the monitoring of fridge temperatures where medicines were stored that included escalation when the temperature went out of range. At the inspection we found daily temperatures were regularly recorded with no issues or concerns identified.

We saw that daily checks for controlled drugs had been fully completed with no issues or concerns identified. Controlled drugs are subject to higher levels of regulation as a result of government decisions about those drugs that are especially addictive and harmful. Twelve items of medicines were checked randomly and found to be in date and fit for purpose.

The resuscitation trolley had the tamper seal in situ. Most locations completed the checks daily except for North Cotswold MIIU. For example, there were nine days missing in October and 10 in November 2021. This was also reflected in the resuscitation bag check which showed eight days missing in October and 10 days for November 2021. We brought this to the attention of the manager during the inspection who provided assurance they would rectify this issue.

During a consultation with a patient, we witnessed a full medicine history taken and allergy status recorded before suggesting any medicinal treatment. Advice was given to the patient on how to take the medicine. The trust had a non-medical prescribing policy. During the inspection we observed staff carrying out safety checks prior to administering pain relief to a patient. This included a review of allergies, their past medical history and their recent medicine history.

Staff we spoke to were knowledgeable about processes relating to medicines and where further information could be found, including out of hours.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. A monthly newsletter containing information around updates and medicines safety alerts was distributed by the pharmacy team. Staff told us they read these each month to help them keep up to date.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Community urgent care service

Staff knew what incidents to report and how to report them. Discussion with staff evidenced they had a good understanding of what an incident was and felt confident reporting them.

We reviewed a sample of incidents reported for November 2021 and found that actions where applicable had been highlighted together with any relevant outcome. All incidents were reported promptly with clear action plans. Recognised themes were discussed at matron meetings. Examples included; inappropriate referrals from GPs and verbal abuse which had escalated over the last few months.

The matron meeting minutes identified shared learning from incidents. A new topic was discussed each month from an incident which happened within countrywide MIIUs. For example, in October 2021 this was silver trauma learning.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations where applicable. Managers shared any lessons learned with the whole team. We saw evidence of identified learning which included for example how to manage challenging people attending the services.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Is the service effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. People's physical, and social needs were holistically assessed. Their care, treatment and support were delivered in line with legislation, standards and evidence-based guidance, including the National Institute for Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM). Examples included; adult and paediatric life support and silver trauma.

Staff were supported to follow best practice guidance by using clinical pathways and protocols which were used for a variety of conditions. These included, cardiac chest pain, head injury and diabetes. We found that the guidance and protocols were up to date and current.

Staff managed patients with suspected sepsis in line with NICE guidance ‘Sepsis – recognition, diagnosis and early management’, 2016. Staff within the MIIU would begin the Sepsis Six tool for patients with suspected sepsis before transferring to the nearest hospital.

Patients were assessed using evidence-based tools, such as the National Early Warning Score (NEWS2) and Paediatric Early Warning System (PEWS).

All staff had access to health and safety information which was confirmed in the annual health and safety audit for 2020/21.

Nutrition and hydration

Staff were able to provide patients with a drink while waiting to be seen in the Minor Injuries and Illness units (MIIUs).

The MIIUs did not have any facilities for patients or their families/carers to have anything to eat. Patients could request a drink of cold water from the receptionists. Staff redirected family members to food outlets within the hospital when asked.

Staff made sure patients had enough to drink, including those with specialist hydration needs.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain as needed.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff prescribed, administered and recorded pain relief accurately.

Patients received pain relief soon after it was identified they needed it, or they requested it. We examined 36 sets of patient records which showed staff prescribed, administered and recorded pain relief accurately to measure the efficiency of analgesia.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and used information from the audits to improve care and treatment. Examples included; chest pain, scaphoid and feverish illness audits. We saw the recently completed chest pain audit. This was in the process of being analysed prior to being circulated. Senior staff confirmed that when the report was distributed this would have an associated action plan to address any areas of concern.

The scaphoid re-audit report dated 24 November 2021 ascertained whether the MIIUs were appropriately identifying, documenting and managing scaphoid injures. We saw results were red, amber, green (RAG) rated. The results ranged from 20% (red) at North Cotswold for the examination of the joint above the injured joint to 100% (green) at Cirencester for the completion of the scaphoid examination. We saw an associated action plan in place to address areas of concern.

We saw the MIIU health and safety self-audit for 2020/21. For example, North Cotswold passed its health and safety and fire safety but failed the violence and aggression and lone working element due to not having an associated assessment. We saw this had been addressed and were shown copies of the related risk assessments.

Community urgent care service

The Feverish Illness in Under 5's re-audit for December 2021 based on a review of 42 patient records showed that 88% had completed the child's pulse, temperature and respiratory rate and 100% had completed the "Alert, Confusion, Verbal, Pain, and Unresponsive" (ACVPU) which is used to record observations or vital signs with scoring systems.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance to support in their development. However, supervision meetings were not consistent across the services.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers ensured staff received any specialist training for their role. Staff spoken with said they had participated in the Oliver McGowen training.This training ensures staff working in health and social care receive learning disability and autism training, at the right level for their role. This enabled them to have a better understanding of people's needs, resulting in improved health and wellbeing outcomes.

As part of their ongoing competency staff completed mental health training which included the demonstration of their awareness and the signposting of patients for onward referrals.

All staff completed a training booklet to assess their competency. Areas of competency reviewed included; eye examinations, wound assessment and closure, cannulation and limb immobilisation. The booklet also covered paediatric specific competencies such as the understanding and implementing of PEWS.

Managers supported staff to develop through yearly, constructive appraisals of their work.Staff told us they had received their yearly appraisal which was confirmed in the data seen.

Managers supported nursing staff to develop their work. However, staff told us that due to the high demand across the services supervision had not consistently been completed. Staff however did tell us they felt supported and could speak with their line managers in-between supervisions.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Triage nurses confirmed they had received relevant training for requesting x-rays for limbs, and for patient group directives (PGD's) to ensure they were safe to administer analgesia. Other examples included both paediatric and adult south west emergency x-ray interpretation courses and a medical urgent care course. Further courses due were prescribing for children and young people in mental health and learning disability services and controlled drugs updates.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff worked well with other teams, such as the radiography department and the safeguarding team to support the needs of patients.

Community urgent care service

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Staff had access to guidelines which outlined the process to follow. This included discussion with the mental health liaison team or referral to the crisis team. We saw examples of lifestyle advice and self-help to support good mental health and well-being.

There was no substance misuse or mental health service at the MIIUs. Staff demonstrated their understanding of the escalation process to the crisis team or the mental health liaison team and explained how to refer patients to these services.

Staff worked well with different specialities, the local hospitals and GPs. They could request further advice for example, if they had an asthmatic child that needed further investigation.

Staff confirmed they regularly spoke with the burns' unit at one of the local hospitals.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

The MIIUs were open seven days a week from 8am to 8pm.

The emergency practitioner worked Monday to Friday between 8am and 8pm and provided an on-call service at weekends which they shared with other team managers and matrons. The matron's weekly newsletter provided information to staff of who was on-call.

On-site radiology services were available Monday to Friday between 9am and 5pm as well as some ad-hoc weekend cover.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

Due to Covid-19, the service had limited the information available to patients. Staff mostly gave verbal advice but where necessary could print leaflets to give to patients.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe and knew how to access policies and get accurate advice on Mental Capacity Act.

Community urgent care service

From our discussions with staff and our observations we evidenced that staff understood the Mental Capacity Act and how vulnerable patients who were not able to make their own decisions could be protected by following the Royal College of Emergency Medicine guidance.

Staff clearly recorded consent in the patients' records. During interactions between staff and patients we observed staff obtaining consent from patients and parents appropriately in relation to care and treatment. They explained what they were going to do and the reason for it.

During the inspection staff at the MIIUs were unaware of consent recording audits to ensure they met legal requirements and followed national guidance. However, after the inspection the trust informed us that they completed regular clinical audits and provided us with a copy of the report for November to December 2021. This identified the outcome for the recording of consent across the MIIUs together with an associated action plan to manage any concerns.

Staff reported that restraint was not used in the department and that physical violence was uncommon. If physical violence occurred, security and/or the police would be contacted.

Staff had guidelines to follow when carrying out a mental health risk assessment. The assessment reviewed the patient's appearance and behaviour as well as their cognition and thought process. The assessment form also considered the patient's capacity, what was in their best interests and whether they needed the support of an independent mental capacity advocate.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff in the MIIU were aware of and explained how and when they would use Gillick competence. The Gillick competency and Fraser guidelines help to balance children's rights and wishes with the MIIUs responsibility to keep children safe from harm. Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

Is the service caring?

Good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Staff followed policy to keep patient care and treatment confidential.

During the inspection, we observed how people were put at ease and reassured by staff. Staff met patients with smiles and empathy. Patients told us they had received a great service and that staff treated them well.

Community urgent care service

We observed staff speaking to patients in a polite, helpful and respectful manner. Patients were treated with dignity and respect. Patient's privacy was respected. Patients confirmed that staff asked them clear questions and provided details of how to manage their care.

We observed staff knocking on doors before entering and using door signs to display when rooms were in use.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff we spoke with said they understood their role in providing emotional support to patients and their families. Several parents mentioned that staff were very reassuring, and that they felt calmer and more relaxed after speaking to staff.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff being polite with patients and showing concern about their illness and/or injury.

Parents said they "felt safe" when staff dealt with their child and staff were "very helpful."

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback was collected via an electronic text system. The friends and family rating at Lydney and District MIU showed 100% of people satisfied with the service provided. At Cirencester MIIU we saw a notice board displaying September 2021 feedback which showed 93% of people rated the service as very good and 98% said they were treated with respect and privacy. We saw compliment cards on display throughout the MIIUs praising staff for their kindness and attention.

Staff supported patients to make informed decisions about their care.

Is the service responsive?

Good

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Community urgent care service

Managers planned and organised services, so they met the needs of the local population. Patients could access information about the MIIU services on the intranet. This included information on when to access the MIIU regarding urgent medical attention in contrast to a life-threatening situation. The trust's internet page also provided details of how to access their telephone triage system. All patients who attended the MIIU were given a card which outlined telephone contact details and the trust's six MIIU locations.

Facilities and premises were appropriate for the services being delivered. The MIIUs could access emergency department support when required, but generally because most patients were on an appointment basis, they knew what to expect and were able to treat the patient appropriately. Staff told us that they sent very few patients to the emergency department for further investigation.

While the service had systems to help care for patients in need of additional support or specialist intervention the specialist teams were looking at ways to improve these. Areas for review were more cohesive working with the district nursing and physiotherapy teams on how to support deteriorating patients in their home to prevent hospital admission. It had been identified that frail and complex patient's needs had worsened post Covid-19.

To reduce attendance at the MIIUs the end of life (EoL) and palliative patient care was well supported by the EoL pathway with district nursing and rapid response teams working closely with EoL patients at home.

Managers monitored and took action to minimise missed appointments. The number of patients not attending for their appointment was very low. For example, Stroud had only had one in the last two weeks. All "do not attend" patients were escalated to the team leader for referral to the telephone triage system for follow up. However, if a child was believed to be at risk, they took immediate action and phoned the parent. They completed a paediatric liaison health visitor form as part of the safeguarding process as well as ringing the safeguarding team to ensure the child was not on the "at risk" register.

The MIIUs offered emergency department streaming of 15 appointments per day. However, we saw very little collaboration between the MIIUs and the emergency department during the inspection. Staff informed us that when MIIU staff were present within the acute hospital's emergency department, they were able to redirect patients, but this had not been maintained when staff were redeployed to other locations due to the Covid-19 pandemic.

Staff at all locations said that many patients visited the service because they could not be seen by the own GP. This was also confirmed by members of the public spoken with during the inspection. Staff confirmed they received inappropriate referrals from GPs daily. Examples included repeat dressings for wounds. Staff said they would never turn anybody away but if the patient had no identifiable injury, they would refer to the GP for further investigation.

Planning for service delivery was made in conjunction with other external providers, commissioners and local authorities to meet the needs of local people. The trust was part of the Gloucestershire Hospitals NHS Foundation Trust which included the MIIUs. The trust had created an integrated Homeward Assessment Team with the aim of reducing admission to both the emergency department and the MIIUs. The vision of the integrated team is to focus on improving patient experience through admission avoidance by completing early specialist assessment of the frail and non-frail pathway. This was in its infancy and continued to be a work in progress. Other areas under consideration were; a fall pick up service for nursing homes which would divert unwanted falls attending the emergency department. Funding had been obtained and this service is due to be implemented in January 2022.

Community urgent care service

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff supported patients living with dementia and learning disabilities. Staff described how they adapted their approach to practice and communication when caring for patients living with dementia or a learning disability.

All providers of NHS care and publicly funded adult social care must follow the Accessible Information Standard as of August 2016. This is in line with section 250 of the Health and Social Care Act 2012. The Accessible Information Standard applies to people using the service (and where appropriate carers and parents) who have information or communication needs. The service did not have information on display to ensure they met people's needs. For example, the MIIUs did not have information on display should a patient require the use of a chaperone. However, staff said they would provide this service when asked.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff accessed telephone translation and the British Sign Language services when required. Face to face interpreters could be arranged by appointment.

Information leaflets on display were available in English. Staff said they requested other languages or formats such as large print to support individual patients when needed.

The MIIUs were accessible for wheelchair users and were all on one level with wide doors. There were designated disabled parking bays on site.

Triage nurses were able to refer or signpost patients to other services. These included; access to dental services, the mental health crisis team, orthopaedic and virtual fracture clinics.

Access and flow

People could access the service when they needed it to receive the right care promptly.

The MIIUs were able to see urgent patients who would walk in or be referred via the NHS 111 service. The trust also operated a telephone triage service whereby they allocated slots for patients to be seen. For example, at Stroud, the maximum number of patients they saw daily was 25. During the inspection figures seen showed 17 and 20 attendances on 5 and 6 December respectively. Patients said they found this helpful as it meant they knew what time to arrive and that they would be seen with very limited wait time.

We saw the MIIU activity report from April to November 2021 which showed 45,186 attendances. The data showed that 41% of patients had self-referred to MIIU, 31% related to telephone triage, 3% presented from the NHS 111 service and 3% from GPs.

From the quality data seen, 82% were first time attendances, 13% were planned follow ups and 5% unplanned attendances.

Community urgent care service

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival to the MIIU. We saw the NHS data relating to the MIIUs for November 2021. There had been a total of 5,555 attendances with 5,529 (99%) attendances being seen within four hours.

There was a risk management process in place to manage demand and capacity. This included a telephone clinical triage and a dental line providing a clinical assessment service (CAS) function to navigate patients into appropriate services.

The telephone triage activity had increased significantly since its launch in July 2020 from 204 to 2,071 for October 2021. All phone calls to the telephone triage system were dealt with by a trained call handler who logged the information electronically. All calls were assessed for their urgency prior to being referred for triage. The electronic ledger was able to red flag any patient deemed at risk who would be given priority.

The MIIUs undertook daily assessment of their service to manage surges in demand. Areas considered were; the number of patients in the unit, the number of telephone triage patients due in two hours and the level of acuity to maintain patient safety. The information was input into a situation report from which staff obtained their red, amber, green (RAG) rating. This triggered if the MIIU needed to close for 30 minutes, one hour or more. While at Cirencester MIIU the system triggered black, which meant they closed for two hours. When closed the MIIUs put a sign-up advising patients of the wait time for re-opening as well as a contact number for NHS 111 and the telephone triage system. Data seen for Cirencester MIIU showed there had been 15 closures in November and four closures as of 7 December 2021. All closures were recorded as "demand closures" based on the volume of patients attending.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. Information on how patients could raise a concern or complaint had been removed due to Covid-19. However, the trust informed us this had been addressed after the inspection.

Patients, relatives and carers we spoke with were unclear as to how to complain or raise concerns. There was no information on display within the MIIUs on how to raise a concern or complaint. When asked, patients and relatives informed us they would either complain to a member of staff at the time or write to the hospital after they had left. Although there were very few complaints, there was evidence of comprehensive investigation and learning from complaints and incidents.

The trust informed us that posters on how to make a complaint were removed due to Covid-19. However, they confirmed this had been addressed and that all MIIUs now have posters on display.

Staff understood the policy on complaints and knew how to handle them. There was a policy for the management of complaints. Senior staff reviewed and managed the complaints and contacted the complainant to apologise as soon as possible.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Community urgent care service

Managers shared feedback from complaints with staff and learning was used to improve the service. The units had investigated complaints and apologised to the patients for their poor experience. Themes from complaints were reviewed during staff meetings to identify areas for improvement.

Is the service well-led?

Good

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders understood and could tell us the challenges within the MIIUs in order to provide high quality, timely and sustainable care. All the staff we spoke with felt senior managers, including board and divisional directors, were approachable and supportive.

The matrons attended weekly meetings from which learning was shared with MIIUs across the county.

While there was a centralised communication and reporting system of what was happening within the Gloucestershire urgent and emergency care system, staff we spoke with had very little knowledge and most believed that this was not relevant to them. They felt that they were being integrated in what was happening within the acute hospital's emergency department which they believed did not involve them. There was no forum to bring teams to review processes and work together. The senior leadership team confirmed this continued to be a work in progress.

Staff felt they had achieved a good working relationship with local GPs. However, they felt there had been an increase in the number of inappropriate referrals to the MIIUs in recent months. Senior staff confirmed they were in conversation with local commissioners to see how they could support GPs further to ensure they did not send patients to MIIUS when inappropriate to do so.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

We saw the trust's vision and values on display throughout the MIIUs which all staff spoken with knew of. Staff could demonstrate where to find the information on the trust's intranet.

The MIIU leads were clear on how well the units had developed during the Covid-19 pandemic and all said that while access and flow was on occasions challenging, they felt this had improved.

We saw that the MIIUs vision was incorporated in their induction booklet, which was to be an "effective and skilled team, well respected within the local community, who can be relied upon to deliver excellent person-centred care."

Community urgent care service

Staff felt that the role of the MIIUs was to contribute to reducing waiting times in the emergency departments by providing the local community with easy access to a high-quality service for patients who had suffered a minor injury.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff told us they were well supported by their immediate managers and were able to raise issues.

Senior managers recognised the dedication of staff staying late into the evening while waiting for ambulance responses.

Managers encouraged learning and a culture of openness and transparency. Staff said they were encouraged to speak up and felt comfortable about raising any concerns.

Staff said morale within the teams was good and they had adapted to working well when one of the units was closed. Staff said the service had changed and evolved to meet public demand. Staff informed us they had continued with daily huddles to provide guidance and support to staff.

Staff felt supported by the executive team. Staff at Cirencester MIIU said the chief executive officer had visited which had boosted morale.

There was a strong culture of patient focussed care in the MIIUs and staff felt valued for the work they contributed.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were governance frameworks in place to provide oversight of quality and safety performance. The unit managers said there was a clear performance management reporting structure which looked at operational performance which included a review of incidents, complaints, staffing, infection control and education and training. We saw the quality board display for November 2021. This identified training figures, the average triage waits time and the number of patients seen within four hours.

Clinical governance minutes for November 2021 looked at what was working well, action updates and matters arising including staffing vacancies. The minutes identified learning from incidents such as a review of all automated external defibrillator (AEDs) across the MIIUs.

Staff told us that team meetings were inconsistent with poor attendance. However, this was counterbalanced by providing staff with up to date information in the form of a weekly report summary based on the matrons three times weekly meetings. We saw the meeting minutes for October and December 2021 and noted the following areas discussed; learning from incidents, Covid-19 updates, medicine management, staffing, recruitment and safeguarding. .

Community urgent care service

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were processes in place to monitor and review aspects of performance to identify areas of good practice. During the inspection we saw that most patients were seen within the 15-minute triage time. This corresponded with the quality board results for November 2021 which showed the average triage wait time of six minutes. Patients identified as being "at risk" via the telephone triage system were prioritised and received a call back within 10 minutes while those requiring routine triaging could wait up to two hours for a return call. This service was proving to be very successful with staff receiving between 60 and 100 calls daily. For example; we saw the service received 73 calls on 2 December 2021 of which 56 (77%) were referred to MIIU, four (6%) to the emergency department, five (7%) to the GP, seven (9%) for self-care and one (1%) whom they were unable to contact. However, there was no defined outcome measure to monitor the length of time patients waited to be called back to establish how effective the system was.

There was a corporate risk register which was discussed at governance meetings. Managers recognised staffing was the major risk to the service. There were recruitment and retention initiatives in place to mitigate the risk.

Senior staff had oversite of all issues relating to the urgent care and speciality services directorate. We saw the data from April to November 2021 which had identified key areas which included; MIIUs seeing patients who could be seen appropriately in primary care, staff being subject to aggressive and abusive behaviour from patients and staff working extended hours while waiting for ambulances to transfer patients.

The units had risk assessments to maintain staff's welfare while working in the MIIUs. We saw copies for the management of Covid-19 and the risk to staff of violence and aggression from those attending the MIIUs. Both risk assessments were in date and had been updated in line with government guidance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to patient's health records and the results of investigations and tests in a timely manner. The MIIUs used the picture archiving and communications system (PACS) for the storing of images, reports and managing patient x-ray information appropriately.

Staff were able to tell us how they made referrals to the safeguarding team and worked with the local authority and other specialists.

The provider shared data securely with the Care Quality Commission and other agencies in accordance with legislation. Serious reportable incidents were reported when they occurred in line with the National Reporting and Learning System (NRLS) requirements.

Staff confirmed that while the information technology (IT) support teams were very busy they always fixed problems quickly. The introduction of the telephone triage system had increased demand and there was ongoing communication with commissioners and GP practices about the implications this may have. However, it was noted that patients ringing into the telephone triage system were likely to receive a same-day appointment.

Community urgent care service

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Due to the nature of the MIIUs, it was not always easy for staff to obtain feedback from patients and their relatives. In line with guidance from NHS England, the Friends and Family Test (FFT) was suspended during the COVID-19 pandemic.

Cirencester MIIU had a notice board displaying recent feedback collected from patients in which showed most people rated the service as very good and felt they were treated with respect.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff we spoke to were committed to making improvements. The service leaders as a team recognised the need to drive improvement across the service. They understood the issues within the service and were committed to improving the quality and safety of the service.

The trust had recognised the staff who manned the telephone triage system. They had recently won the trust's quality improvement and innovation award.

Stroud MIIU were aiming to introduce "the 15 steps challenge" guide once the refurbishment had finished. The 15 steps challenge is a suite of toolkits that explore different healthcare settings through the eyes of patients and relatives. The toolkits were under review for consideration by all team leads.