Cornwall Partnership NHS Foundation Trust

Community urgent care service

Inspection report

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Ratings

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

Our findings

Community urgent care service

Good 

Cornwall Partnership NHS Foundation Trust provides urgent care at 10 minor injury units located across the county. Minor injury units (MIUs) provide treatment and advice on a range of minor injuries and illnesses not serious enough to require accident and emergency department treatment.

Our inspection was a short notice announced inspection so we could check if all sites were accessible on the day of inspection. We had a focus on the urgent and emergency care pathway for patients across the integrated care system in Cornwall. We carried out a comprehensive inspection of this service so we could provide a rating of the service.

A summary of CQC findings on urgent and emergency care services in Cornwall

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. We have summarised our findings for Cornwall below:

Cornwall

The health and care system in this area is under extreme pressure and struggling to meet people's needs in a safe and timely way. We have identified a high level of risk to people's health when trying to access urgent and emergency care in Cornwall. Provision of urgent and emergency care in Cornwall is supported by services, stakeholders, commissioners and the local authority and stakeholders were aware of the challenges across Cornwall; however, performance has remained poor, and people are unable to access the right urgent and emergency care, in the right place, at the right time.

We found significant delays to people's treatment across primary care, urgent care, 999 and acute services which put people at risk of harm. Staff reported feeling very tired due to the on-going pressures which were exacerbated by high levels of staff sickness and staff leaving health and social care. All sectors were struggling to recruit to vacant posts. We found a particularly high level of staff absence across social care resulting in long delays for people waiting to leave hospital to receive social care either in their own home or in a care setting.

GP practices reported concerns about the availability of urgent and emergency responses, often resulting in significant delays in 999 responses for patients who were seriously unwell and GPs needing to provide emergency treatment or extended care whilst waiting for an ambulance. GPs also reported a lack of capacity in mental health services which resulted in people's needs not being appropriately met, as well as a shortage of District Nurses in Cornwall.

A lack of dental and mental health support also presented significant challenges to the NHS111 service who were actively managing their own performance but needed additional resources available in the community to avoid signposting people to acute services. The NHS111 service in Cornwall worked to deliver timely access to people in this area, whilst performance was below national targets it was better than other areas in England.

Our findings

Urgent care services were available in the community, including urgent treatment centres and minor illness and injury units and these services were promoted across Cornwall. These services adapted where possible to the change in pressures across Cornwall. When services experienced staffing issues, some units would be closed. When a decision was made to close a minor injury unit (MIU) the trust diverted patients to the nearest alternative MIU and updated the systems directory of services to reflect this. However, this carried a potential risk of increased waiting times in other minor injury units and of more people attending emergency departments to access treatment. This had been highlighted on the trust's risk register.

Due to the increased pressures in health and social care across Cornwall, we found some patients presented or were taken to urgent care services who were acutely unwell or who required dental or mental health care which wasn't available elsewhere. Staff working in these services treated those patients to the best of their ability; however, patients were not always receiving the right care in the right place.

Delays in ambulance response times in Cornwall are extremely concerning and pose a high level of risk to patient safety. Ambulance handover delays at hospitals in the region were some of the highest recorded in England. This resulted in people being treated in the ambulances outside of the hospital, it also meant a significant reduction in the number of ambulances available to respond to 999 calls. These delays impacted on the safe care and treatment people received and posed a high risk to people awaiting a 999 response. At the time of our inspection, the ambulance service in Cornwall escalated safety concerns to NHS England and NHS Improvement.

Staff working in the ambulance service reported significant difficulties in accessing alternative pathways to Emergency Departments (ED). When trying to access acute assessment units, staff reported being bounced back and forth between services and resorting to ED as they were unable to get their patient accepted. Many other alternative pathways were only available in specific geographical areas and within specific times, making it challenging for front line ambulance crews to know what services they could access and when. In addition, ambulance staff were not always empowered to make referrals to alternative services. The complexity of these pathways often resulted in patients being conveyed to the ED.

Hospital wards were frequently being adapted to meet changes in demand and due to the impact of COVID-19. There was a significant number of people who were medically fit for discharge but remaining in the hospital impacting on the care delivered to other patients. The hospital had created additional space to accommodate patients who were fit for discharge but were awaiting care packages in the community; however, staff were stretched to care for these patients.

Delays in discharge from acute medical care impacted on patient flow across urgent and emergency care pathways. This also resulted in delays in handovers from ambulance crews, prolonged waits and overcrowding in the Emergency Department due to the lack of bed capacity. We found that care and treatment was not always provided in the ED in a timely way due to overcrowding, staffing issues and additional pressure on those working in the department. These delays in care and treatment put people at risk of harm.

In response to COVID-19, community assessment and treatment units (CATUs) had been established in Cornwall. These wards were designed to support patient flow, avoid admission into acute hospitals and provide timely diagnostic tests and assessments. However, these wards were full and unable to admit patients and experienced delayed discharges due to a lack of onward care provision in the community.

Community nursing teams had been recently established to support admissions avoidance and improved discharge. This work spanned across health and social care; however, at the time of our inspections it was in its infancy so we could not assess the impact.

Our findings

The reasons for delayed discharge are complex and we found that discharge processes should be improved to prevent delays where possible. However, we recognise that patient flow across the Urgent and Emergency Care pathway in Cornwall is significantly impacted on by a shortage of staffed capacity in social care services. Staff shortages in social care across Cornwall, especially for nursing staff, are some of the highest seen in England. This staffing crisis is resulting in a shortage of domiciliary care packages and care home capacity meaning many people cannot be safely discharged from hospital. A care hotel has been established in Cornwall providing very short-term care for people with very low levels of care needs; this is working well for those who meet the criteria for staying in the hotel, however this is a relatively small number of people.

Without significant improvement in patient flow and better collaborative working between health and social care, it is unlikely that patient safety and performance across urgent and emergency care will improve. Whilst we have seen some pilots and community services adapted to meet changes in demand, additional focus on health promotion and preventative healthcare is needed to support people to manage their own health needs. People trying to access urgent and emergency care in Cornwall experience significant challenges and delays and do not always receive timely, appropriate care to meet their needs and people are at increased risk of harm.

Summary of Cornwall Partnership NHS Foundation Trust urgent care service

Our rating of this service stayed the same. We rated it as good because:

- Staff had training in key skills and had completed the required mandatory training, they 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.
- Staff triaged patients within national target times and the prioritisation system was clear. The clinical need of the patient dictated the priority in which they were seen. The service had access to mental health liaison and specialist mental health support.
- Staff within the service managed medicines well. They managed safety incidents well 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 decisions about their care, and had access to good information. Key services were available seven days a week.
- The service had enough nursing and support staff to keep patients safe.
- The trust had robust arrangements in place if a minor injury unit had to close due to staffing issues. Patients would be redirected to another minor injury unit to be seen quickly. The trust had highlighted this on the risk register and monitored the impact on patients and on whether it impacted on increased pressure on Emergency Department attendances.
- The minor injury units occasionally stayed open past their commissioned hours in order to support an increase of patients within the system.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Our findings

- 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.
- Outcomes for patients were positive, consistent and met expectations, such as national standards.
- Staff met daily with ambulance crews, doctors, GPs, clinical specialists and emergency nurse practitioners to discuss patient care and ensure any issues facing any party could be addressed speedily.
- 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. Managers made sure staff received regular wellbeing checks during the Covid 19 pandemic. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Blood pressure machines at Camborne Redruth minor injury unit required safety checks – we found these had not been recalibrated when required in September 2021.
- Staff did not always label medicines supplied to take home with the hospital address.
- We saw that's some healthcare assistants (HCAs) were not supervised when carrying out certain assessments that required direct supervision by a senior practitioner, for example, when carrying out assessment of head injuries
- Staff working in minor injury units did not have access to the trust's main shared electronic patient record which caused frustration for staff when trying to access information about a patient who had used other services within the trust.
- Staff working at St Austell minor injury unit were following an out of date printed standard operating procedure for minor injury units.
- Not all staff were receiving regular supervision and appraisals, completion of these had been affected by Covid 19 although managers made sure that staff received regular well being checks
- Community assessment and treatment units had been set up specifically to care for older people which MIU teams could request admission to for local, rapid assessments and treatment. However, these units were full and patients experienced delays to their discharge due to a lack of onward care provision in the community.
- Some staff were not always using approved translators to communicate with patients who required this service.
- The trusts patient advice and liaison service (PALS) did not always respond to patients and families who made complaints about the service in a timely manner.

How we carried out this inspection

We visited six out of the 10 minor injury units at Camborne and Redruth, Helston, Liskeard, St Austell, Bodmin and Newquay. The minor injury units were nurse-led and provided advice and treatment for minor injuries. The full range of services on offer varied greatly, including the treatment of minor illness depending on the staff available and the setting

Our findings

the service was provided in. Primary care medical support was available from a General Practitioner at one minor injury unit, Camborne and Redruth. Patients who needed to access the service were advised to contact NHS 111 by phone or online to find out where they should go and when. These patients were then offered appointments at the most suitable unit. However, patients who turned up without an appointment were still seen and prioritised according to clinical need.

Services were provided in most units seven days a week from 8am to 10pm (Helston 8am to 8pm). Each unit was staffed by registered nurses and/or paramedic practitioners, healthcare assistants and a receptionist. The MIUs employed band six and seven nurses, with band five nurse development posts. Not all units had access to a health care assistant and a receptionist outside of normal working hours and at weekends. Of the 10 minor injury units, nine locations provided X-ray departments. Attendances at the minor injury and illness units fluctuated, with an increased demand during holiday seasons.

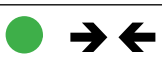
To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

During the inspection visit, the inspection team:

- visited six of the 10 minor injury units and looked at the quality of the environment and observed how staff were caring for patients;
- spoke with 42 members of staff across the units including: registered nurses, health care support workers, paramedics, administrators and a consultant nurse;
- spoke with 25 patients and one carer;
- looked at 45 patient records;
- looked at the medicines storage and medicines administration records at all sites;
- reviewed local policies, procedures and audits at all sites.
- held a staff focus group for those staff unable to contribute during the inspection.

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as good.

Mandatory training

Our findings

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 mandatory training was comprehensive and met the needs of patients and staff. All ward staff received life support training. Healthcare assistants received additional training to be able to triage patients safely. Link workers who worked on the wards provided face to face training when required.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training leads sent out compliance reports for each member of staff to the service manager. Staff accessed their own training records through a shared system which listed all their mandatary 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.

Nursing staff received training specific for their role on how to recognise and report abuse. Staff received level three safeguarding training. Named safeguarding leads carried out specific safeguarding supervision for staff.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff recorded detailed assessments for safeguarding children and adults. Staff posted safeguarding alerts on all relevant patient records.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. At St Austell minor injury unit, the named safeguarding children's lead wore a badge to identify themself and led all the staff training on site. Staff worked tactfully with children to identify possible signs of abuse. However, staff could not access the trust's main shared electronic patient record which held a safeguarding tracker. The children's safeguarding policy signposted staff to contact the MARU direct (available 24/7) for information if children's safeguarding was not available (i.e. out of hours). The adult safeguarding policy signposted staff to contact the police or on call social worker out of hours. There were processes in place to avoid asking sensitive questions which risk retraumatising the patient.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff completed patient specific safeguarding forms with information about how to alert other professionals. The trust had a safeguarding lead who was able to provide support and guidance for any staff requiring it.

Staff followed safe procedures for children visiting the ward. All staff knew how to review children on the child protection register and the process they needed to complete.

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.

Our findings

All areas were clean and had suitable furnishings which were clean and well-maintained. All areas of the minor injury units were cleaned by a dedicated cleaning team, employed by the trust. Some areas in the minor injury units were carpeted, which meant they were difficult to clean.

The service generally performed well for cleanliness. Recent cleanliness audits showed a high percentage of compliance.

Domestic staff completed cleaning records which were displayed on the back of the door of the room they had cleaned. Staff labelled equipment with dated green stickers when they had been cleaned. However, at St Austell minor injury unit, there were no cleaning records on display so staff did not know if an area had been cleaned before they treated a patient.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. There were emergency buttons in all patient areas which sounded in reception rooms. These were tested regularly. When reception staff finished their shift, patients were directed to ring a doorbell which sounded in the treatment area. Staff could monitor the front door with CCTV.

The design of the environment followed national guidance. The minor injury units had isolation areas and decontamination rooms for patients who were symptomatic or had tested positive for Covid. Patients waiting for treatment at Camborne and Redruth and Bodmin minor injury units were not in the line of sight of reception staff. However, nurses frequently passed through the waiting area and were able to check in on patients who might have deteriorated. This risk was highlighted on the service risk register. Staff in other units had sight of CCTV footage from cameras which were located in all patient areas.

Staff did not always carry out daily safety checks of specialist equipment. Blood pressure machines in Camborne and Redruth Community Hospital were labelled 'do not use after September 2021'. However, staff completed fridge temperature checks and oxygen cylinder checks daily. Clinical waste and sharps bins were in all sites and not overflowing.

The service had suitable facilities to meet the needs of patients' families. Children areas were appropriately decorated and had mobiles, toys and posters. In the larger minor injury units, there were separate areas for children to wait and separate children's treatment rooms.

Not all minor injury units had x ray facilities. This meant some patients had to travel much further distances for treatment and could experience longer waits as they were re-booked back into the system at a different minor injury unit.

Staff disposed of clinical waste safely. General service assistants ensured all clinical waste was stored and disposed of correctly.

Our findings

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff triaged patients within national target times and the prioritisation system was clear. The clinical need of the patient dictated the priority in which they were seen.

Staff did not routinely record patient national early warning scores (NEWS) at Cambourne and Redruth Community Hospital. This was because all seriously ill patients were seen by the GP who do not normally use early warning scores to assess deteriorating patients.

In some locations patients were sometimes asked to wait in their cars following triage. This was a measure taken to prevent the spread of Covid in the waiting area if patients could not socially distance. Staff took their phone numbers, their registration plate and asked them to call the receptionist if they started to deteriorate. Staff had grab bags that were used if a patient required medical attention in the car park. These contained equipment to assist in resuscitation if needed.

Staff followed a standard operating procedure for patients who attended when the unit was closed.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. In all but one of the minor injury units, band three health care assistants (HCAs) carried out the initial assessment of a patient. The minor injury lead had composed a list of competencies the HCAs were required to possess before carrying out this assessment and all HCAs were assessed against them by a senior practitioner. However, there were instances when HCAs were not supervised to carry out some assessments when they should have had direct supervision from a senior practitioner, for example, when carrying out assessment of head injuries. At Camborne and Redruth, which also served as an urgent and primary care centre, HCAs did not carry out patient triage, due to the complexity of the patients they saw.

Staff knew about and dealt with any specific risk issues. If a patient's clinical observations were outside of normal criteria, the trust's system automatically printed out sepsis assessment and treatment pro-forma. Staff were trained in sepsis recognition based on evidence based clinical guidelines.

The service had 24-hour access to mental health liaison and specialist mental health support.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff routinely asked if patients were safe at home and how their mental health was. Staff worked well with other agencies such as the police and mental health services to provide appropriate support for a patient who needed additional support. Managers ensured staff supporting these patients had an opportunity for debrief and time to reflect following treatment.

Staff shared key information to keep patients safe when handing over their care to others.

Our findings

Shift changes and handovers included all necessary key information to keep patients safe. Handovers between staff were professional and informative. Handovers were completed face to face with the patients to explain the background of the injury and what decisions on treatment had been made. Further information was saved on the trust's shared electronic patient record. Patient records were completed comprehensively.

Staffing

Nurse staffing

The service had enough nursing staff and support 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 staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

The trust had robust arrangement in place if a minor unit had to close due to staffing issues. Patients would be redirected to another minor injury unit to be seen quickly. The trust had highlighted this on the risk register and monitored the impact on patients and on whether it impacted on increased pressure on Emergency Department attendances.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Most teams had reviewed and increased staffing levels following feedback from staff that they were not safely staffed. The team at Camborne and Redruth Hospital had not yet been reviewed.

An additional member of staff was rostered on in the afternoon to help catch up with any delays in patient treatment. Staff followed a standard operating procedure which instructed certain minor injury units to close and their staff to relocate to another unit if they were unable to staff the busier unit safely. In the busy summer months, staff could block book agency staff to support the surge in demand. The service had low vacancy rates. Service managers were able to view the vacancies across all locations so they could make informed decisions about when or where to request staff from. Managers struggled to recruit to vacant posts.

The service had low turnover rates.

The service had low and/or reducing sickness rates. Most of the minor injury units had been affected by Covid related staff sickness. However, sickness rates over a 12 month rolling period remained low, averaging 4.9%.

The service had low rates of bank and agency nurses.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

The minor injury units which were also urgent care centres employed doctors to work within the service. Staff working on other minor injury units could access the support of doctors working on the inpatient wards if needed but otherwise called for emergency services if they needed additional medical support.

Our findings

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. All patient notes were stored on a shared electronic patient record, which trust employed GPs could also access. All records were completed thoroughly, including pain relief and medication.

However, staff working at the minor injury units did not have access to the shared electronic patient record that the rest of the trust used, which caused frustration for staff when trying to access information about a patient who had used other services within the trust.

When patients transferred to a new team, there were no delays in staff accessing their records.

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. Prescribers and nurses used electronic prescribing and medicines administration (ePMA) to prescribe and administer medicines. Staff could order medicines needed for patients through the pharmacy order portal for quick delivery. Nurses administered medicines safely under patient group directions (PGDs). These were all up to date and suitable for a minor injury unit. Not all nurses had undertaken the required three yearly update.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

However, staff could not always describe how they would provide medicines advice to people who needed adjustments to how information was provided. For example, using larger print for people with a visual impairment or easy read information.

Staff completed medicines records accurately and kept them up to date. Healthcare assistants triaged patients as they arrived in the unit. Records made included medical history, prescribed medicines and known allergies.

Staff stored all medicines and prescribing documents safely. Room and fridge temperatures were monitored daily. Action had been taken to move medicines out of areas that were not air conditioned and likely to become too hot during the summer months. Controlled drugs were stored and recorded in accordance with trust policy. Daily checks were undertaken, with additional pharmacy team audits completed. However, medicines were supplied to people to take home were not always labelled with the hospital address.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Cornwall had one integrated electronic prescribing and medicines administration (ePMA) system across the community hospitals and acute trust. This provided a shared view of what medicines have been prescribed to people in parts of the county that faced Truro.

Staff asked for people's consent to view their summary care records. This allowed them to check what medicines were prescribed by the GP or other organisations.

Our findings

Staff learned from safety alerts and incidents to improve practice. Each minor injury unit had a named pharmacist as a point of contact for advice and support.

Regular medicines audits were completed by staff to make sure the medicines policy was followed. Staff were making improvements to the safe storage of controlled drugs following an investigation into an incident last year where medication had gone missing.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. No medicines were prescribed or available to restrain or control people's behaviour.

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.

Staff knew what incidents to report and how to report them. Staff were familiar with the incident reporting system and when to report an incident. Staff used the 'situation background assessment recommendation' (SBARD) template to report incidents so they could more easily identify themes.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff attended monthly learning forums specific to minor injury units. Senior staff attended a matrons' forum for sharing learning and concerns. Service leads produced a monthly letter to all staff which shared the learning from recent incidents.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Staff reported several incidents relating to a lack of crutches available for patients. As a result, the ordering process for these changed and meant adequate numbers of crutches were available for use.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers reviewed incidents frequently and identified the patient involvement and when families had been contacted.

Managers debriefed and supported staff after any serious incident.

Our findings

Is the service effective?

Good  

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice at most sites we visited. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

There was a standard operating procedure for minor injury units that all staff followed which was regularly updated and accessible on the staff database. However, staff at St Austell followed a paper copy which was out of date.

Clinical effectiveness was an agenda item during quality assurance meetings where there was discussion around referencing practice to the NICE guidelines. Staff followed up to date evidence based clinical guidelines for the recognition and treatment of illnesses. This guidance included videos which demonstrated the correct examination techniques. GPs and practitioners carried out and recorded treatment using standard recognised pathway documents.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had access to food and drink, including those with specialist nutrition and hydration needs. All sites had removed their water coolers due to Covid. However, patients had access to vending machines which supplied snacks and drinks.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

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.

Our findings

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff recorded pain relief and documented pain scores on patient records.

Patients received pain relief soon after it was identified they needed it or they requested it. All patients spoken with in the waiting room said they had been offered pain relief.

Staff prescribed, administered and recorded pain relief accurately. Staff weighed children during triage to determine the correct medication dosage.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Staff completed audits such as hand hygiene and infection control. Staff audited patient x-ray results. Staff recalled any patients if there was a discrepancy. Staff audited patient records each month. There had also been a full audit into non-medical referrals in the form of a presentation to the team and a list of actions to improve.

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

Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Staff completed monthly self assurance checks which could be reviewed as the months progressed.

Managers shared and made sure staff understood information from the audits.

Competent staff

The service made sure staff were competent for their roles. However, appraisal and supervision rates were not consistent across the services.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The trust held a list of mandatory training that was required for each band of staff.

Managers gave all new staff a full induction tailored to their role before they started work. The trust ran a centralised induction programme for all new staff which included a local minor injury unit induction. All records were kept within staff personal files.

There was a range of compliance for completion of annual appraisals throughout the minor injury units. Three out of nine minor injury units had full compliance whilst the rest had under 50%, with three units under 10%. Formal appraisals were stood down during the pandemic, and instead a focus was placed on personalised health and wellbeing

conversations and plans. The trust re-introduced appraisals in September 2021 and took a range of actions to support appraisal completion, including training for appraisers, appraisal briefings for appraisee's and the development of refreshed appraisal documentation. The system has been in critical incident since October 2021 which has led to low availability of staff to complete appraisals.

Supervision rates in all but two of the minor injury units were very low. This was due to Covid restrictions preventing face to face meetings, staff being too busy with patients on the unit and also due to staff being responsible for uploading their own supervision records for them to be recognised on the trust system. This issue had been identified through quality assurance group meetings. It was also highlighted on the service risk register. This meant there was a risk of unsafe practice, compromising patient safety, failing to comply with regulatory and clinical standards and impacting negatively on the trust's reputation. There was a reluctance in some areas to engage with the recording of supervision utilising the recently introduced electronic system. Managers made sure staff received regular wellbeing checks during this time.

The clinical educators supported the learning and development needs of staff. Training was staff group specific and staff received their own online alerts as well as reminders that went out in newsletters.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff supported the learning needs of student nurses who worked alongside them on shift. Staff empowered students to support patients whilst under their supervision. Morale and support was strong between the students and their supervisors.

Managers made sure staff received any specialist training for their role.

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

Multidisciplinary working

Doctors, 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 met daily with ambulance crews, doctors, GPs, clinical specialists and emergency nurse practitioners to discuss patient care. Quality improvement meetings were attended by different disciplines and discussed various issues relating to the minor injury units.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff working in the minor injury units utilised the specialisms of the other services such as mental health and medical staff. Medical staff assisted in some treatments and mentored minor injury staff. Paediatric consultants from the acute hospital were available to assist with paediatric based concerns from any of the minor injury units. Managers met with each other across different wards and sites where this was possible to share concerns and ideas. Staff were able to hold video conferences with the acute hospital to speak to consultants.

Our findings

Staff working in the minor injury units worked closely with the acute hospital to manage the transfer of patients. Communication from the acute hospital was not always sufficient to inform staff about patients who were being diverted to the minor injury unit. This meant that staff working in the minor injury units could not anticipate what resource might be needed to include these additional patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Seven-day services

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

Minor injury units were open seven days a week from 08:00am to 20:00pm or 22:00pm.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, whenever they needed to.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. Smoking cessation advisors and groups were listed on information boards.

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

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff had a direct link into trust resources for mental capacity documents and guidance.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Our findings

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as 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.

Patients said staff treated them well and with kindness. Patients said staff were friendly, helpful, polite and considerate.

Staff followed policy to keep patient care and treatment confidential. Staff had access to assessment bays and a private room where they could draw the curtain for confidential assessments.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

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 supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff valued patients' emotional and social needs. They demonstrated empathy and understanding when patients were distressed.

Our findings

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff worked with local bereavement services to support patients and families who had experienced a death.

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. Staff worked beyond their rostered hours in order to support a patient emotionally. They told us they would prefer to stay with their patient until the patient was transferred to the main site or discharged from the service.

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.

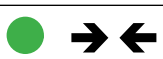
Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with said they understood what was happening to them and knew what the next steps in their treatment would be. Every patient knew how long they might have to wait for and understood that staff had to prioritise patients according to their degree of injury or illness.

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. Recent patient experience surveys showed very positive results in all locations.

Staff supported patients to make informed decisions about their care.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as 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.

Managers planned and organised services so they met the needs of the local population. Staff had a good understanding of their local population and adapted services to meet their needs.

The trust had opened community assessment and treatment units (CATUs) at Bodmin and Camborne and Redruth. These wards were designed to be a 48 hour turn around service for those patients who required diagnostic tests and assessments following treatment at the minor injury unit. These wards were full and patients experienced delays to their discharge due to a lack of onward care provision in the community.

Our findings

The minor injury units occasionally stayed open past their commissioned hours in order to support an increase of patients within the system. The trust monitored this.

Facilities and premises were not always appropriate for the services being delivered. The facilities and premises were not adequate to meet the demand in resources during the busy summer months.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff followed a mental health referral guidance document for minor injury units which suggested the appropriate service to contact dependent on the patients' presentation. Contact numbers for all available services were listed on this document. Staff followed a checklist which prompted questions around mental health and safety of a patient.

The service relieved pressure on other departments when they could treat patients in a day. The minor injury unit website showed live wait times and the number of patients in attendance so patients could inform themselves of the potential wait time before deciding where to go. Staff working in the minor injury units were able to alert other services in the system when they became overwhelmed. They could change their location status from green to amber to indicate that they were busy so other services could divert patients to another green location.

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 made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff followed clear policies around supporting patients with additional needs and encouraged these patients to bring their support person in with them when required. Staff could access support and advice from the dementia and older people's mental health team when required.

Staff understood but did not always apply the policy on meeting the information and communication needs of patients. Staff understood the communication needs of travelling families around the county and seasonal foreign workers. Staff signposted these patients to dedicated community services that were available locally. Staff had access to interpreters but instead tended to rely on an internet translation function. This system did not always translate accurately and had led to communication errors between staff and patients.

The service had information leaflets available in languages spoken by the patients and local community. Each service displayed leaflets on booking interpreters, how to identify abuse, sexual health referrals and chronic health conditions.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access urgent care services when needed and received treatment within agreed timeframes and national targets. Most patients were triaged within the required time of 15 minutes. Most patients did not have to wait longer than four hours for treatment. Wait times were either displayed for patients at the entrance to the minor injury unit or available online.

Our findings

Managers and staff worked to make sure patients did not stay longer than they needed to.

The number of patients leaving the service before being seen for treatment was low.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff followed standard operating procedures for transferring patients to community services using a single electronic referral form.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff sent patients' discharge summaries to their GPs when they were discharged. When required, staff contacted district nurses to see patients at home after discharge. Staff could access support from outpatient clinics, especially with dressings. There was a separate dressings clinic on some sites, separate to the minor injury unit which avoided patients coming back in to have their dressing changed. Staff liaised with the relevant community service before discharging a patient if they needed additional support.

Staff supported patients when they were referred or transferred between services. Staff went over and above expectations to make sure patients were cared for as they waited to be transferred to another service. Patients experienced long delays waiting for an ambulance response.

Managers monitored patient transfers and followed national standards. Staff remained in contact with the emergency department to monitor when redirected patients had arrived. Reception staff contacted patients who had been booked into the minor injury unit via 111 or their GP but did not turn up.

Managers monitored that patient moves between services were kept to a minimum. Some minor injury units did not have an x-ray machine on site which meant that patients had to make additional journeys to access this facility at another location and go through the admission and wait time process from the beginning at another hospital. This had a negative impact on the patient experience and meant delays in their treatment.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. Patient advice and liaison services (PALS) information was displayed in the minor injury units.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to access complaints policies and gave examples of instances raised to the speak up guardian.

Managers investigated complaints and identified themes. At a local level, complaints were well documented and contained appropriate escalation, response and action as a result in a timely manner. Where learning was identified, this was passed on to staff from the service leads. However, where a formal investigation was required, at times long delays for a response have been experienced due, in part, to the impact of sustained operational pressures. This had resulted in leaders not always being able to complete the complaint process in a timely way and respond to patients.

Our findings

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

Managers shared feedback from complaints with staff and learning was used to improve the service. Quality improvement meeting minutes contained examples of lessons learned from complaints.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. Team leaders were dedicated trained practitioners with a variety of relevant skills and abilities which enabled them to run the services well. Minor injury unit leaders met every day to discuss any issues. Leaders said they experienced a very supportive senior leadership team.

Leaders understood and managed the priorities and issues the service faced. Leaders met with the senior executive team at the trust to discuss their ideas about creating a more robust urgent care service across the county.

Leaders were visible and approachable in the service for patients and staff. Team leaders worked on shift with their colleagues, supporting the team when they experienced pressure. Staff spoke highly of their team leaders and confirmed they were approachable and available for support when needed.

They supported staff to develop their skills and take on more senior roles. Team leaders supported their teams well, including student nurses.

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. Staff felt that they were being listened to following the recent changes in trust leadership and were positive that they had already started to see positive change occur.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders had plans in place to increase the capacity of minor injury units across the county. The desired outcome meant there would be less people admitted to the local acute hospital as there would be an urgent care centre closer to where patients lived. These developments boosted staff morale as it meant a more defined career pathway with further development opportunities.

Leaders and staff understood and knew how to apply their strategy and monitor progress.

Culture

Our findings

Staff felt respected, supported and valued. Staff morale was high and staff showed great dedication and enthusiasm for their work. There were health and wellbeing champions working on the units. Staff celebrated achievements; for example, sponsored walks and raffles. Staff could access occupational health services for counselling.

However, staff who were required to work at other locations when their minor injury unit closed felt pressured. Being asked to work at another unit meant they had increased travel time, they experienced a negative impact on their work life balance and meant they had to work additional hours in a team they did not know well.

Staff were focused on the needs of patients receiving care. There was continuous communication between staff whilst on shift and they were friendly, courteous and professional. However, staff did not always get a lunch break when they were busy. Staff stayed on past their contracted hours to provide support for patients, even if this meant overnight.

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.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Senior staff met monthly at clinical quality assurance groups to discuss key operational functions within the minor injury units.

Senior staff reviewed incidents including the categorisation of incidents and quantity.

Senior staff regularly reviewed infection prevention and control and included presentations given in this area with staff and patient feedback. There were discussions around safeguarding and duty of candour. Senior staff discussed learning from experience and there was evidence that there had been implementation of new and reviewed processes, with a named person responsible to action those.

Senior staff reviewed patient and staff experience and friends and family tests. They discussed complaints with any items outstanding, complaints with PALS and complaints awaiting feedback. The trust's complaints team were experiencing delays in responding to patients due to the backlog which accumulated during the pandemic.

Senior staff reviewed clinical effectiveness including reference to NICE guidance with suggestions around guidelines which were appropriate for minor injury units. Other quality priorities reviewed were policies, complaints and safeguarding.

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.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. Daily reports were generated to monitor how quickly patients were triaged and treated at each minor injury unit. All staff could contribute to the service risk register.

Our findings

Leaders recognised that supervision and appraisal rates were low and so incorporated additional wellbeing sessions that managers held with staff on a more informal basis, to ensure staff were being adequately supported. They identified and escalated relevant risks and issues and identified actions to reduce their impact. There was a specific minor injury unit forum for staff to come together and discuss relevant risks and issues.

They had plans to cope with unexpected events. Senior leaders developed the 'urgent care engine house' to discuss risk across the system. This involved collaboration from local GPs and surgeries and involved discussions around the impact of patient demand on each service and how they affected the minor injury unit.

However, patients were redirected to minor injury units that needed to be seen at the acute hospital. Staff working in the minor injury units treated those patients to the best of their ability and resource but did not always receive communication about their arrival and their acuity from the acute hospital. These patients' recovery was put at risk due to appropriate treatment not commencing at the acute hospital.

Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. Senior leaders reviewed how staff with joint roles could work across locations. They reviewed how teams could integrate better with 111, who were all on different terms and conditions especially those who did not work towards agenda for change. In order to avoid staff competing for pay scales, senior leaders promoted pay ranges. The trust organised a careers fair to try and address staffing crisis in Cornwall.

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.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. Staff took part in annual staff surveys and leaders conducted regular wellbeing checks on their team. The freedom to speak up guardian and champions were accessible in all locations. All locations displayed the results from their friends and family test results. Feedback was consistently positive for all locations. There were multiple ways for patients to feed information back to the service, such as an app, using a tablet at the minor injury unit, a text service or a feedback card.

They collaborated with partner organisations to help improve services for patients.

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 ran quality improvement projects which included hospital transfer forms, improving compliance with medication processes, improving quantity and quality or patient feedback in the community, community fall and personalisation.

Leaders encouraged innovation and participation in research.

Our findings

Areas for improvement

SHOULDS

- The trust should ensure blood pressure machines at Camborne and Redruth minor injury unit are calibrated regularly
- The trust should ensure practitioners are directly supervising health care assistants during the triage process as per trust policy.
- The trust should ensure staff label medicines supplied to take home with the hospital address.
- The trust should consider how staff might access its electronic patient record so they can access relevant patient information.
- The trust should ensure managers provide staff with regular clinical supervision and appraisal.
- The trust should work with partners to review how patients' discharge from community assessment and treatment units can be expedited when they are medically fit to be discharged.
- The trust should encourage staff to use its available translators when needed.
- The trust should review the response time when responding to patients and families who have made complaints about the service.