Gloucestershire Care Services NHS Trust

R1J

Urgent care services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/unit/ team)
R1J11	Lydney and District Hospital		
R1J10	Dilke Memorial Hospital	<Placeholder text>	<Placeholder text>
R1J13	Stroud General Hospital	<Placeholder text>	<Placeholder text>
R1J07	Vale Community Hospital	<Placeholder text>	<Placeholder text>
R1J06	Cirencester Hospital	<Placeholder text>	<Placeholder text>
R1JX2	North Cotswolds Hospital	<Placeholder text>	<Placeholder text>
R1J18	Tewkesbury Community Hospital	<Placeholder text>	<Placeholder text>

This report describes our judgement of the quality of care provided within this core service by Gloucestershire Care Services NHS Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Gloucestershire Care Services NHS Trust and these are brought together to inform our overall judgement of Gloucestershire Care Services NHS Trust

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall rating for this core service Requires Improvement l

Overall, minor injury and illness services required improvement.

We could not be assured that there were always sufficient numbers of appropriately qualified, experienced and skilled staff to ensure that people were protected from avoidable harm. Staffing levels, skill mix and competencies had not been reviewed in response to increased demand and a changing profile of attendance. At times units operated with a skeleton staff and this put people at risk. We were particularly concerned that patients arriving at minor injury and illness units (MIiUS) were not being promptly assessed by a registered nurse to ensure that they were appropriately prioritised and cared for. In some MIiUs, patient assessment was being undertaken by non-registered nurses and we could not be assured of their competence to undertake this role.

Risks associated with staffing had been identified but were not yet fully understood. A lack of reliable information compounded this and meant we could not be assured that steps taken to mitigate risks were adequate. Plans to re-model staffing and assess and address any outstanding areas of staff competence were being developed but were in their infancy. Risks did not appear to have been given sufficient attention or priority by the board.

The service was appreciated by those who used it. Patient feedback was overwhelmingly positive. Patients and their relatives told us that staff were caring and compassionate. They they said that they were treated with courtesy and dignity, were given information about their condition and were supported to make informed decisions about their care and treatment. However, we could not be assured that care was effective. The trust provided little evidence that they audited their practice to show that they followed evidence-based guidance and achieved good outcomes for patients. Where audits did take place, there was little evidence of learning or dissemination of learning. There was little assurance of the competencies of staff because this information was not held centrally. Staff received little formal supervision and no clinical supervision.

Patients did not always receive the right care and treatment in the right place at the right time. The service was consistently meeting or exceeding targets in respect of time spent in MIiU and the time people waited for treatment. However, waiting times had increased as demand for the service had increased and, particularly at weekends, staffing levels did not always match demand or the pattern of attendances. Care pathways for people presenting with minor illness were confusing and cumbersome for patients and often entailed patients having to wait, return at a later time or travel to another hospital. Premises were not all fit for purpose. Some waiting areas were cramped and the triage area at Stroud General Hospital did not allow for private consultations.

The management and governance arrangements in urgent care MIiU services did not assure the delivery of high quality care. We were concerned about the lack of information which was available to demonstrate that the service was fit for purpose and able to respond to changing demands.

The service was going through a period of change, brought about by increased activity and a changing profile of attendance. Support provided by out-of-hours services had decreased, following a change of provider. The impact of this change had been significant and had exposed deficiencies in the governance and leadership of the service. It had also exposed vulnerability in terms of staffing levels, skill mix, staff confidence and competence. Some steps had been taken to mitigate identified risks but improvements plans were in their infancy and there were no timescales or accountability agreed for making necessary improvements. Risks did not appear to have been given sufficient attention or priority by the trust board. Board members were not visible or influential in urgent care.

Summary of findings

Background to the service

Information about the service

Gloucestershire Care Services NHS Trust (the trust) ran seven minor injury and illness units (MIiUs) which served the county of Gloucestershire seven days per week. These were located in Cirencester Hospital and Stroud General Hospital (24 hours a day), Dilke Memorial Hospital, Cinderford, and Lydney and District Hospital (8am to 11pm), North Cotswolds Hospital, Moreton in the Marsh, Tewkesbury Community Hospital and Vale Community Hospital, Dursley (8am to 8pm). The service saw adults and children over one year of age who either self-presented or were referred by their GP, NHS 111 or the ambulance service. Treatment was provided for a range of minor injuries and illnesses, including sprains, minor fractures, minor burns, minor head injuries, skin problems such as rashes, stings and minor eye conditions. X-ray facilities were available at all community hospitals, although opening times varied. Patients who presented with serious injury or illness were stabilised as appropriate and arrangements were made to transfer them to the nearest acute hospital.

Six out of the seven units were nurse-led by Emergency Nurse Practitioners (ENPs). ENPs are specially trained nurses who are able to see, treat and discharge patients. ENPs were supported at times by out-of- hours General Practitioners (GPs), either in person or by telephone. At Cirencester Hospital MIiU nurses were supported by a specialty doctor based in the department from 9am to 5pm Monday to Friday. There was a resident medical officer available 24 hours a day who provided medical support to the whole hospital. There were plans for the department to become nurse-led by the end of September 2015, when medical cover was to be withdrawn.

The out-of-hours (OOH) GP service, previously run by the trust, had recently transferred to another provider. Service provision had reduced and the service was no longer co-located with MIiUs on all hospital sites. The out-of-hours service no longer accepted self-referring patients who were now assessed by MIiU staff and only referred to OOH following a discussion with the OOH doctor. This had resulted in increased activity and a change to the profile of presentations to MIiU, with nurses seeing more patients with minor illness.

The trust saw 68,374 patients in its MIiUs in 2014/15 which was an increase on the previous year. The change in out of hours arrangements, combined with a drive within the county to divert more patients from the county's emergency departments had resulted in a continuing increase in activity. There was a 6.7% increase in activity seen in April and May 2015, compared with the same months in 2014. Significant increases were seen at the Dilke Memorial Hospital (9.4%), North Cotswold Community Hospital (9.2%), Tewkesbury Community Hospital (32%) and the Vale Community Hospital (28%).

We visited the following MIiUs for half a weekday each: Cirencester Hospital, Stroud General Hospital, Dilke Memorial Hospital, Lydney and District Hospital, Vale Community Hospital. We made unannounced visits to the Vale Community Hospital and Stroud General Hospital on a Saturday morning. We spoke with a range of staff and managers. We spoke with 12 patients and relatives and also received feedback via comments cards from patients.

Our inspection team

Our inspection team was led by:

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

Team Leader: Mary Cridge, Head of Hospital Inspections, Care Quality Commission

The team of 34 included CQC inspectors and a variety of specialists: district nurses, a community occupational therapist, a community physiotherapist, a community

Summary of findings

children's nurse, a palliative care nurse, a sexual health consultant and specialist sexual health nurse, a health visitor, a child safeguarding lead, a school nurse, directors of nursing, an ex-chief executive, a governance lead, registered nurses, community nurses and an expert by experience who had used services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

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

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

'Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 24, 25 and 26 June 2015. We also conducted unannounced inspections on 4 July 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how patients were being cared for and talked with patients attending the clinics to seek their views. We reviewed care or treatment records of patients who used the service.

What people who use the provider say

Feedback from patients we spoke with during our visits confirmed they were all happy with the way they were treated by staff. Comments we received via comments card were also entirely positive. Comments included:

- "From the first time I walked in the door everyone and everything was tops, everyone put me at ease" – Stroud General Hospital

- "The staff have been excellent and very caring and have treated me with dignity and respect, my needs were responded to with the right treatment, they listened very carefully." – Tewkesbury Hospital.

- "Staff respected my dignity, fast response and kept me up-to-date and informed me of my care and conditions" – Vale Community Hospital.

- "I was treated with respect and dignity and my needs were met" Lydney and District Hospital.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Review and take prompt action to ensure that MIiUs are consistently staffed by sufficient numbers of suitably qualified, experienced and skilled staff.

Summary of findings

- Ensure that patients arriving at MIiUs receive prompt assessment (triage) by an appropriately trained and experienced registered nurse.
- Monitor and take appropriate action to ensure that staff receive regular mandatory and essential training.
- Monitor and take appropriate action to ensure that equipment, medical devices and medicines are regularly checked.
- Develop and improve systems and processes and governance arrangements to assure high quality, effective and safe care and treatment.

Action the provider SHOULD take to improve

- Investigate incident reporting levels in urgent care. Encourage staff to report incidents, including near misses and ensure these are acted upon and lessons learned and disseminated.
- Ensure that patients seated in MIiU waiting areas can be observed by staff.
- Ensure that in the MIiU at Stroud General Hospital, triage takes place in an enclosed and private area to allow private discussion and examination.
- Improve monitoring systems and take appropriate action to ensure that MIiU premises and equipment are regularly cleaned.
- Improve joint working with the provider of out of hours GP services to ensure that the care pathway is seamless and the service convenient and reliable.
- Work with the local mental healthcare trust and emergency departments to ensure that MIiU staff are supported to assess and select the appropriate care pathway for patients presenting with mental health concerns.

Gloucestershire Care Services NHS Trust

Urgent care services

Detailed findings from this inspection

Inadequate

Are services safe?

By safe, we mean that people are protected from abuse

Summary

People were not adequately protected from the risk of avoidable harm. There were few serious incidents reported in MIiUs but we did not know whether this was because staff were reluctant to report incidents. The majority of staff we spoke with expressed concerns about staffing levels and skill mix but few incidents were reported relating to these concerns. Inadequate staffing levels had become the 'norm' and staff were not confident that any positive action would be taken to resolve their concerns. Some staff reported reluctance to report concerns.

We could not be assured that MIiUs were consistently staffed by sufficient numbers of appropriately qualified, experienced and skilled staff. Staffing levels and skill mix had not been adjusted in response to increased and activity and a changing profile of presentations. Although risk registers highlighted the risks of inadequate staffing levels and inappropriate skill mix and a review of staffing was underway, departments continued to run on a skeleton staff and staff were regularly unable to take their breaks. The trust was unable to provide assurance that staff had received and were up-to-date with mandatory and essential training.

There were systems and processes in place to keep people safe but these were not consistently complied with. We were concerned that some patients waited too long to be assessed by a registered nurse on arrival at MIiU and that unregistered practitioners were undertaking this task without adequate training or supervision. We raised our concerns with the trust about this practice during our inspection. They immediately took steps to reduce the risk to patients. They provided us with an action plan going forward with regular updates on progress.

Premises were mostly fit for purpose, clean and appropriately equipped. However the layout of some MIiUs meant that waiting patients, including children, were not observed. Regular checks to ensure the safety of equipment and medicines were not consistently carried out and cleaning records were not consistently completed.

Staff understood their responsibilities in relation to safeguarding people from abuse but we could not be assured that assessments were consistently taking place or that referral rates were appropriate because there was no oversight of safeguarding.

Detailed findings

Safety performance

Inadequate

Are services safe?

Incident reporting, learning and improvement

- There were 41 incidents reported in the three months prior to our visit. Of these, 38 resulted in no harm and three resulted in minor harm. There were 26 serious incidents reported in urgent care in 2014/15, of which 42% of these incidents resulted in no harm to patients.
- In the 2014 staff survey:
- 63% of respondents said they would feel secure raising concerns about unsafe clinical practice. This was worse than the national average for community trusts (72%),
- respondents rated the fairness and effectiveness of the incident reporting procedure 3.4 out of a possible score of five. This was worse than the national average.
- Staff told us they understood their responsibilities to report concerns and incidents, although several staff told us they did not complete incident reports themselves and were encouraged to escalate concerns to a senior member of staff. Although staff's biggest concern was staffing levels, they told us they rarely reported concerns because they believed that this would not make any difference.
- A staff member at Cirencester Hospital told us that incident reporting was time consuming and although they received feedback, this was not always satisfactory as it did not address their concerns. They said the outcome was disproportionate to the time spent logging concerns. They told us that some staff were reluctant to report concerns for fear of being seen as a "trouble maker". Another staff member told us they were encouraged to report incidents and that incidents and outcomes were discussed at staff meetings.
- At the Vale Community Hospital a staff member told us they had reported concerns about lack of reception cover at weekends and temporary limited cover had now been arranged. A staff member at Stroud General Hospital told us they did not receive feedback when they reported an incident.
- We saw some evidence that lessons were learned when things went wrong. One staff member told us that a recent incident involving a patient who had fallen while being transferred from a wheelchair to a trolley, had resulted in a moving and handling update for staff. We asked the trust to provide us with the details of their investigation of a serious incident which occurred at Cirencester Hospital in July 2014. A root cause analysis had taken place and a number of actions had been identified. However, there was no indication of the timeframe in which these actions should be completed or whether they had been completed so we could not be assured that learning arising form this incident had been acted upon.

Safeguarding

- There were systems and processes in place to protect people from abuse but we could not be fully assured that systems were consistently complied with.
- Staff were required to complete safeguarding awareness training every three years. The trust was unable to provide us with training data and acknowledged that there was a known issue regarding the availability of accurate and consistent data. However, where we were able to obtain local training records, we saw that some staff had not refreshed their training within the required timeframe. At Cirencester Hospital a significant proportion of MIiU staff were not up-to-date with their training. Staff we spoke with were, however, familiar with processes for the identification and management of adults and children at risk of abuse and understood their responsibility to report concerns.
- A trust-wide audit of MIiU clinical records in November 2014 identified that a safeguarding assessment had only been undertaken for 73% of patients and in only 51% of records was it evidenced that the question of domestic abuse had been raised. Where safeguarding issues were present, correct referral procedures were followed by staff on all occasions. We checked a sample of records in each of the departments we visited and found that assessments were recorded in most cases. We were told that some staff had attended training in domestic abuse. However, where we were able to obtain local training records, we saw that only two out of eight staff at the Vale Community Hospital and two out of twenty four staff at Cirencester Hospital had attended the training.
- There was a child safeguarding lead who visited the departments once a month and was a source of advice when required. However, apart from the records audit, there was no oversight of safeguarding to ensure that the safeguarding policy was being complied with and that referral rates were appropriate.

Inadequate

Are services safe?

- The patient record system identified previous attendances so that staff would be alerted to possible safeguarding issues. The emergency assessment record completed for each patient attendance included a safeguarding assessment checklist. Child attendances were notified to GPs, health visitors and school nurses.

Medicines

- There were systems in place to ensure that medicines were managed safely; however medicines were not always appropriately stored.
- Medicines were stored in locked cupboards or fridges. However at the Dilke Memorial Hospital we found the medicines fridge unlocked. There were systems in place to ensure that fridge temperatures were regularly checked. We found all fridge temperatures were within the correct range during our visit. However, at the Dilke Memorial Hospital recording of fridge temperatures was inconsistent and there were no records to demonstrate that checks had taken place during April 2015. At the Vale Community Hospital there was no evidence that fridge temperatures were checked. At Lydney and District Hospital temperature checks had not been recorded on five days during May and five days during June 2015. We could not be assured therefore that medicines stored there were safe to use.
- At Cirencester Hospital and Lydney and District Hospital we found that anaphylactic response kits (used to respond to patients who have had an acute allergic reaction) had broken seals. This meant we could not be assured this equipment and medicines were safe to use.
- Some ENPs were trained as nurse prescribers so that they could supply and administer certain medicines. There were also Patient Group Directions (PGDs) in place. PGDs are agreements which allow some registered nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor. We saw evidence that staff had been appropriately assessed and signed off as competent to use PGDs.
- There were no PGDS for children under two years. Children presenting with, for example, breathing difficulties could not be administered medicine for breathing disorders. Staff told us that they would be given oxygen and an ambulance transfer to an acute hospital would be requested.
- We checked a sample of records and found that patients' allergy status was consistently recorded. We found one patient record at Stroud General Hospital where a medicine had been administered but the nurse who administered it and the time of administration were not recorded.

Environment and equipment

- Premises were mostly fit for purpose; however, the design and layout of some MIiUs meant that waiting patients could not be observed by staff. This meant reception and clinical staff may not be aware if a patient's condition deteriorated or if a patient's or visitor's behaviour put other people at risk. The College of Emergency Medicine (CEM) recommends in its Triage Position Statement 2011 that in the triage environment, consideration should be given to visualisation of the waiting environment. At Stroud General Hospital the adults' waiting area was only partially observed by reception staff and there was no line of sight to the separate children's area. At Cirencester Hospital neither the adults' nor the children's waiting room were directly observed by staff, although a close circuit television allowed a limited view of waiting patients. At the Dilke Memorial Hospital, the main waiting area was visible to the reception staff but the children's waiting room was out of sight. Staff told us they relied on parents to supervise their children and call for assistance if they needed it.
- MIiUs were appropriately equipped but checks on this equipment were not always carried out. Systems in place to ensure that equipment was safe to use were not consistently complied with. Staff told us they had received training to use appropriate equipment; however at Stroud General Hospital they were not trained to use the slit lamp used to examine eyes. At the Dilke Memorial Hospital and the Vale Community Hospital the daily log for checking blood pressure monitors was not consistently completed during April and May 2015. At the Vale Community Hospital D-dimer equipment (used to detect blood clots) had not been checked for electrical safety within the required timeframe. At Lydney and District Hospital the blood glucose monitor had not been consistently checked and there were no temperature checks undertaken for the specimen fridge.

Inadequate

Are services safe?

- There was appropriate resuscitation equipment for adults and children and we saw evidence that equipment was checked weekly. However equipment was not sealed to make it tamper evident. In light of this and the fact that the equipment was located in areas which were accessible to the public, we did not consider that weekly checks were sufficient.
- At Stroud General Hospital there were separate resuscitation trollies for adults and children. At Cirencester Hospital items were stored in the same trolley but children's equipment was stored in age specific portable drawers so that it could be easily distinguished. However the checklists for equipment did not correlate to the equipment and we were concerned that staff who were unfamiliar with the unit may not be able to easily identify the correct equipment. At The Vale Community Hospital there was a separate children's medicine trolley which was not easily identifiable. At Lydney and District Hospital there were separate resuscitation trollies for adults and children but only one checklist to check both. This meant there was a risk that checks were not accurately recorded.

Quality of records

- We looked at a sample of clinical records at each MIiU we visited. They were mostly legible and complete. Practitioners signed and dated written entries, with some exceptions. At the Dilke Memorial Hospital we found two records where the Emergency Nurse Practitioner had not recorded the time that they saw the patient.

Cleanliness, infection control and hygiene

- PLACE (patient-led assessments of the care environment) scores for cleanliness for all community hospital sites were above (better than) the national average.
- We observed that departments were mostly visibly clean, tidy and odour free. However, at Dilke Community Hospital we noticed a foul smell in the kitchen. Issues with regard to the condition of the kitchen had already been raised through a recent infection control audit and there were plans for these to be rectified.
- There were systems in place to ensure that equipment was regularly cleaned. However at Lydney and District and the Dilke Memorial Hospitals we checked cleaning checklists and found that these were not consistently completed.
- There were appropriately sited hand wash basins and hand gel dispensers. We saw staff washing their hands and observing standard infection control precautions, such as 'bare below the elbow'.
- We were told that monthly infection control audits were carried out in all MIiUs. The most recent results provided to us by the trust were as follows:
- Dilke Memorial Hospital (April 2015): 90% (concerns were raised in relation to the kitchen)
- Lydney and District Hospital (June 2015): 92%
- Tewkesbury Community Hospital (June 2015): 89% (particular concerns were raised in relation to waste management
- North Cotswold Hospital (June 2015): 98%
- Cirencester Hospital (June 2015): 93%
- No recent results were provided for the Vale Community Hospital or Stroud General Hospital so we could not be assured that audits were consistently taking place.

Mandatory training

- The trust was unable to provide reliable training data to demonstrate that all staff were up-to-date with mandatory training in safety systems, processes and practices or essential training such as resuscitation. They told us "The trust recognises that its collection and reporting of training data is not wholly robust, as currently information is held across a number of different systems. This issue is being addressed."
- Staff we spoke with during our visits assured us that they were mostly up-to-date with their training but they were not able to provide evidence of this. We were able to obtain training records at Cirencester and the Vale Community Hospitals which showed there were a number of unexplained gaps. For example, at the Vale Community Hospital six out of eight staff were not up-to-date with training in resuscitation, which was supposed to be refreshed annually, and three staff had not completed or refreshed training within the required timeframe in the recognition and emergency treatment of anaphylactic reactions. At Cirencester Hospital, 14 out of 24 staff had not completed recent fire safety training

or safeguarding training. Twelve staff had not completed recent training in the recognition and emergency treatment of anaphylactic reactions and there were numerous unexplained gaps in training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

Assessing and responding to patient risk

- Patients were not always assessed promptly on arrival at MIiU. The College of Emergency Medicine's (CEM) guidance on assessing patients (Triage Position Statement, April 2011) states that patients should be rapidly assessed on arrival in order identify or rule out life/limb threatening conditions and ensure patient safety. This should be a face-to-face encounter which should occur within 15 minutes of arrival or registration and assessment should be carried out by a trained clinician. This ensures that patients are streamed or directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life threatening conditions are identified or ruled out so that the appropriate care pathway is selected.
- The trust measured and reported on the time to assessment (triage) of patients arriving by ambulance. There is a national standard that requires that 95% of all such patients are triaged within 15 minutes of arrival. In March, April and May 2015 ninety-five per cent of patients were seen in 10, 13 and 11 minutes respectively. The trust did not routinely report on time to triage for all patients (irrespective of their mode of arrival), although their triage policy stated that all patients should be assessed within 15 minutes. We requested performance data which showed that 95% of all patients were triaged in 23, 23 and 25 minutes in March, April and May 2015 respectively. We were concerned that this performance data was not accurate and would be significantly worse if the service was correctly recording the triage time as the time a patient was seen by a registered practitioner.
- Consistent with CEM guidance, the trust's triage policy (April 2015) stated that triage should be undertaken by qualified clinicians within 15 minutes. The policy also stated that "non-registered staff, when assessed and 'signed off' as competent, may undertake a visual survey to support safe care within the MIiU." The visual survey was not defined within the triage policy; however in the Standing Operating Procedure: Minor injury and Illness Units - Management of patient flow (March 2015) it stated "All patients who present to a MIiU reception should be welcomed and visually assessed for immediately life threatening conditions by a receptionist or healthcare assistant. Examples of these (life threatening conditions) include difficulty in breathing, chest pain, altered levels of consciousness, severe haemorrhaging (bleeding)". If patients presented with life threatening conditions, immediate assistance would be requested from a registered nurse. The Standing Operating Procedure stated that patients should receive an initial assessment by a registered practitioner within 15 minutes.
- At Lydney and District Hospital and the Dilke Memorial Hospital healthcare assistants (HCAs) were stationed at reception and booked patients in on arrival. They told us that as part of the booking process they undertook a visual survey, although the HCA at the Dilke Memorial Hospital described this as "triage". We saw that the completion of this survey was recorded on the emergency assessment record (EAR) as the triage time.
- HCAs told us that if a patient presented with symptoms suggesting serious illness, such as chest pain, or serious injury, such as heavy bleeding, they would escort the patient immediately to the treatment area and summon the registered nurse. However, they told us they routinely undertook baseline observations for certain patients, such as patients presenting with a head injury, and recorded these on the EAR. Based on these observations they made a decision as to whether the patient was safe to wait or whether they needed to be assessed by a registered nurse. One staff member told us that if a patient had sustained a small bump to the head then they would probably judge them to be safe to wait. If they judged the patient was safe to wait, this was recorded on the EAR.
- We asked the HCAs what training they had received to undertake the visual survey and neurological observations. The HCA at Lydney and District Hospital told us told us they had received in-house training and assessment by a registered nurse. The HCA at the Dilke Memorial Hospital told us they had received no training in "triage" and felt vulnerable. They were unable to show us that they had been assessed and 'signed off' as being competent. The Clinical Team Leader for the these

two hospitals later confirmed to us that the staff concerned had not been formally assessed and signed off as competent, although this had taken place informally and had not been documented.

- We looked at a random sample of eight emergency assessment records at Lydney District Hospital for patients who attended MIiU on 23 June 2015. Patients waited 14, 22, 22, 29, 61, 64, 96, 106 minutes respectively to be triaged by a registered nurse. One of these patients had sustained a head injury and was subsequently referred to the emergency department in Gloucester. Another patient was a child who had sustained a fracture. Delayed triage by a registered nurse meant that pain relief was also delayed and was not given to this child for over an hour. At the Dilke Memorial Hospital we looked at three records for patients who attended MIiU on 24 June 2015. All three patients' records showed that they were triaged immediately but on further scrutiny we found that the triage was a visual survey undertaken by a healthcare assistant. They were subsequently seen by and ENP but the time of this consultation was not recorded.
- At the Vale Community Hospital on the day of our visit patients were triaged by an Emergency Nurse Practitioner after being booked in by a receptionist. The receptionist was not trained to undertake a visual survey but was aware of 'red flag' conditions which required the urgent attention of a nurse. We were told that an assistant practitioner (band 4) was employed in the MIiU and was sometimes deployed to triage patients. We were not able to speak with the staff member but we obtained their job description which confirmed one of their responsibilities was to "undertake face to face triage". This was not in accordance with the trust's triage policy as this was not a registered nurse. We asked the clinical team leader for the unit to assure us that this staff member had been trained and assessed as competent to triage patients. They did not have documented evidence to demonstrate this.
- At Stroud General Hospital on the day of our visit a band 5 registered nurse was triaging patients, although we saw two patients were assessed by a HCA. The HCA told us they undertook baseline observations for patients who had fallen or sustained a head injury. Observations included pulse, temperature, respiration rate, oxygen saturation, pupils and blood pressure. They showed us their portfolio of competencies which did not provide evidence that they had been assessed as competent to undertake neurological observations. We looked at the records for the two patients seen by the HCA. One patient waited 28 minutes and one waited 79 minutes before they saw a registered nurse. We were not concerned that these patients were put at risk but we were concerned about the practice whereby non-registered nurses made decisions as to whether a patient was safe to wait for an assessment by a registered nurse. This was not in accordance with CEM guidance or the trust's triage policy.
- At Cirencester Hospital a band 5 registered nurse was triaging patients on the day of our visit. We were told that band 5 nurses who were new to the department 'shadowed' another band 5 nurse for a period of four weeks and were then observed undertaking triage for a further four weeks. We saw no evidence of formal assessment or sign off of competency in triage.
- Staff completed an emergency assessment record for each patient who attended MIiU. This record included the recording of baseline observations. A nationally recognised early warning score tool (NEWS) was used to ensure that staff were alerted to the need to escalate the management of a seriously injured, unwell or deteriorating patient. There was no assessment tool in place to identify sepsis (a potentially life threatening complication of infection). One staff member told us there was guidance on the intranet; another told us they were not aware of any guidance.
- In an audit of clinical records carried out in November 2014, only 34% of records had baseline observations recorded. Only 20% of applicable records documented that the management of a patient was escalated if observations met the pre-arrest criteria. Where we were able to locate training records we found that some staff had not received training in NEWS.
- There were no written protocols in relation to the urgent transfer of seriously ill or injured patients by ambulance to an acute hospital. The NEWS recording form stipulated that staff should call 999 as indicated by NEWS scores. Staff told us they used their clinical judgement as to the urgency of transfers for patients who required on-going assessment or treatment at an acute hospital but did not require a 999 response.

Inadequate

Are services safe?

- During our unannounced visit to Stroud General Hospital we saw a patient, who presented with a head injury, was quickly brought to the attention of nursing staff by the receptionist. The patient was prioritised and assessed promptly. It was quickly decided that the patient needed to be seen at an emergency department and observations were being carried out to assess the urgency of this transfer. We also saw two children under one year present to the MIiU. Again they were prioritised and seen quickly and it was then arranged for the out-of-hours doctor to review them. Staff told us that had these children presented in the afternoon, when there was no doctor present, they would have been referred at an emergency department.

Staffing levels and caseload

- The trust's risk register highlighted that nurse recruitment and retention was a cause for concern; however the trust was unable to provide information about staffing levels at each MIiU. A detailed piece of work was underway to look at the number and profile of presentations so that staffing and skill mix could be re-modelled accordingly.
- The unscheduled care risk register dated June 2015 highlighted that the staffing establishment in the two MIiUs in Lydney and District Hospital and the Dilke Memorial Hospital was insufficient to cover the full opening hours. It was reported that in order to ensure safe staffing levels it had been necessary to close one or other of the units, often at short notice. There was also reliance on bank and agency staff to ensure safe staffing. These two units were routinely staffed by two staff; an Emergency Nurse Practitioner and a healthcare assistant. This meant there was no allowance for staff to take breaks. Staff told us they did not take breaks. This was accepted as normal practice.
- During our visit to Lydney and District Hospital the HCA, who also undertook reception duties, left the reception desk on a number of occasions to undertake patient assessment and observations, leaving the reception desk unmanned. Although these absences were only for few minutes, during one absence a patient with a laceration to the head and an anxious relative arrived and could not get staff's attention. The department had an additional staff member working that day so we judged when the department was staffed to the usual level, staffing would be significantly stretched at busy times. At the Dilke Memorial Hospital the healthcare assistant told us they "struggled" to monitor patients in reception and assist with patient care, for example, undertaking patient observations, when there were only two staff on duty.
- At the Vale Community Hospital the Clinical Team Leader and the matron told us that the number of MIiU attendances had risen significantly but staffing levels had not been adjusted to manage this increase in workload. Staffing was described as "tight" and concerns were recorded on the hospital risk register. They confirmed that they had concerns for staff's wellbeing as they were not able to take breaks. The Clinical Team Leader regularly undertook clinical shifts to ease the pressure and did so on the day of our unannounced visit. They were working alongside an Emergency Nurse Practitioner who was working a twelve hour shift. We asked the ENP when they would be able to take a break. They told us they would "grab a drink or something to eat" if activity allowed but with only two staff working, they would not be able to leave the department and there was no overlap built in to allow a proper rest break. This put staff at risk of fatigue which could compromise patient safety.
- The Clinical Team Leader at Vale Community Hospital told us that they had observed changes in the pattern of presentations, with more patients presenting shortly before the department was due to close at 8pm. This meant that staff regularly worked late. It was well known that the number of MIiU attendances was significantly higher at weekends; yet staffing levels did not reflect this. During our unannounced visit, there were two staff on duty, with one (the Clinical Team Leader) also being in charge of the rest of the hospital, potentially meaning that they would have to leave one nurse working single handed for periods of time.
- In the minutes of the MIiU staff meeting held in March 2015 it was recorded that staff had expressed concerns about difficulty in getting a break on the late shift, particularly if they were the only ENP on duty. It was reported that this was "leading to fatigue and decreased clinical ability". Staff were reminded by the Clinical Team Leader that this was their responsibility to ensure that they took a break, even if this meant that patients had to wait an extra 20 to 30 minutes.

Inadequate

Are services safe?

- Staff at all of the sites we visited told us that temporary staff were regularly deployed to cover gaps in the rota, although existing staff tried to cover shifts between them. Rotas were issued four weeks in advance to facilitate peer to peer cover. Information provided by the trust showed there was significant use of temporary staff at some MIiUs. In May 2015:
- 32% of band 2 (HCA) shifts were filled by temporary staff at Cirencester Hospital.
- At Lydney and District Hospital 100% of band 2 shifts and 55.5% of band 6 (ENP) shifts were filled by temporary staff.
- At the Dilke Memorial Hospital 29.7% of band 5 (registered nurse) shifts were covered by temporary staff.
- At Stroud General Hospital 42.7% of band 2 shifts were filled by temporary staff.
- At the Vale Community Hospital 21.3% of band 5 shifts and 20.9% of band 6 shifts were filled by temporary staff.
- We asked the trust to explain this high rate of temporary staff usage. They told us it was mainly due to difficulties in recruiting to staff vacancies. Although staff told us that regular bank staff were used, they expressed concerns about the use of agency staff who were not familiar with the units.
- MIiUS at Cirencester Hospital and Stroud General Hospital were open 24 hours a day. At night they were staffed by one registered nurse. At Stroud General Hospital this nurse was always an ENP; at Cirencester Hospital it was sometimes a registered nurse who was not qualified as an ENP. If this was the case, they had to call the resident doctor on call to attend the department because they were not appropriately qualified to 'see and treat'. Some staff expressed concerns about working single-handed at night. At Stroud General Hospital a staff member told us they had recently experienced a situation when two patients attended at night, both of whom required urgent attention. One patient needed to be transferred to Gloucester Royal Hospital and the ambulance transfer had been delayed, which put them under pressure.
- The trust was unable to provide assurance to us that nursing staff had received training to ensure they were competent to assess and treat children. They told us that this information was held in staff's personal files and was not available centrally. We were told that all MIiU staff attended level 4 resuscitation training which included paediatric life support training. The trust was unable to provide evidence that all MIiU staff had undertaken and were up-to-date with this training.
- The Standing Operating Procedure (SOP) for MIiUs stated that children under one year old would not be treated in a MIiU. However there was a lack of clarity regarding this. At Stroud General Hospital a nurse told us that they would only treat children over two years for injury and over five years for minor illness. A senior staff member told us that they wanted the age restriction to be amended to two years because some staff were not comfortable seeing babies and toddlers. At Cirencester Hospital we were told that a number of staff had received training to treat minor injury and illness in children but no evidence was provided to support this.
- The risk register for Cirencester Hospital identified that there was an ongoing shortage of reception staff, which meant that clinical staff and bank staff were having to cover gaps in the rota. Staff told us that only temporary contracts were being offered to new reception staff, pending the outcome of a review of MIiU staffing. Reception cover was also a problem at the Vale Community Hospital. Until recently there were no reception staff employed at weekends; however increased activity meant that nursing staff needed assistance. Existing administrative staff were working additional shifts temporarily to provide cover from 10 am to 6pm on Saturday and Sunday.

Managing anticipated risks

- There was no allowance to adjust staffing to meet spikes in activity at weekends or during busy holiday periods. The staffing establishment was felt to be inadequate at times, especially at weekends. We were told that when safe staffing levels could not be maintained, MIiUs would close temporarily.
- We were told that all MIiU staff were trained in resuscitation, in the event of cardiopulmonary arrest. We were told that registered nurses were trained to level 4 (advanced), although training records did not support this. We asked how a resuscitation scenario was managed, particularly when there were few staff or only one staff member on duty. At the Dilke Memorial Hospital and Lydney and District Hospital staff told us that ward staff would be called to assist. We were told

that an emergency call test was undertaken every Tuesday but there was no documentation available on either hospital site to support this. Similarly, we were told that fire alarm testing took pace every month but we were given no evidence to support this.

Major incident awareness and training

- Staff were familiar with and had practised 'lock down' arrangements which were designed to keep people safe by restricting access to and/or exit from the hospital.
- Staff at Cirencester Hospital were familiar with arrangements and their responsibilities in the event of a major incident. Staff told us that 'table top' exercises were practised quarterly. At the other hospitals we visited staff said they would refer to their major incident folder but they were not familiar with their responsibilities and had not practised their response.
- MIiUs were locked at night and visitors could only access the departments by ringing the bell. This would alert the hospital porter who would attend the department because nursing staff worked on their own.
- At Cirencester Hospital there were panic alarms which could be used to summon assistance from staff, including a porter. There was also an alarm which could be activated to summon police assistance if required.

Requires improvement

Are services effective?

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

Summary

Staff working in Minor Injury and illness Units (MIiUs) had a range of evidence-based guidance available for the management of a range of conditions but provided little evidence that guidelines were consistently followed. There was limited evidence of audit or learning and improvement in response to audit.

Although there was evidence that staff were given opportunities for training and professional development, the trust was unable to provide evidence that all staff employed in MIiUs were appropriately qualified and competent to carry out their roles effectively. Plans to address identified areas of weakness or lack of confidence were not yet properly formulated. There was no regular supervision, including clinical supervision, of nursing staff.

We saw evidence of effective multi-disciplinary working so that patients received seamless care. There were however some difficulties experienced associated with the change in out of hours provision by GPs which meant that advice and support was not always available promptly.

The trust was not able to fully assure us that people's needs were assessed and care and treatment delivered in accordance with current legislation because not all staff had received training in the Mental Capacity Act 2005.

Detailed findings

Evidence based care and treatment

- There was a comprehensive set of treatment guidelines available on line for all MIiU nurses for a range of minor injuries and illnesses and we saw some evidence that staff were familiar with these. However the trust had limited evidence to show that guidelines were consistently complied with because this was not subject to audit.

Pain relief

- Staff used a pain assessment tool to assess levels of pain and this was recorded on the emergency assessment record. Children's pain was assessed using an age appropriate tool where children were asked to point at faces to indicate their level of pain.
- In an audit of clinical records undertaken in November 2014, 88% of records documented that where a patient was in pain, a pain assessment had been carried out using a validated rating scale. Only 54% of records evidenced that pain relief was administered during the period of care/treatment. We checked a sample of records at each MIiU we visited and found that pain scores were not always completed.
- At Cirencester Hospital we observed a patient being assessed by a nurse. Their pain was assessed using a pain assessment tool and they were given appropriate pain relief promptly.

Technology and telemedicine

- Nursing staff had access to a digital X-rays suite. Imaging could either be interpreted by nursing staff on site or could be sent to the local acute hospital for a second opinion.

Patient outcomes

- Although the trust received overwhelmingly positive feedback from people who used MIiUs, they provided little evidence to demonstrate that care and treatment provided in MIiUs achieved positive outcomes for people.
- There were three complaints received in the three months prior to our inspection which related to the standard of clinical care. One complainant alleged that their relative, who was experiencing chest pain, was turned away from the MIU at Tewkesbury Hospital and later sought treatment at a hospital in another area, where they were admitted. This complaint was under investigation at the time of our inspection. Two complaints related to failure to properly assess and treat

injuries, leading to further complication and prolonged recovery time. One of these complaints was upheld. The other was under investigation at the time of our inspection and had been reported as a serious incident.

- The trust participated in a limited number of local audits so they could benchmark their practice and performance against best practice. Audit reports provided to us contained incomplete action plans and there was limited evidence that areas for improvement had been widely shared with staff and acted upon.
- In 2014 the trust audited the management of children and young people who presented at a MIU having self-harmed, against a quality standard (QS34) published by the National Institute for Health and Care Excellence (NICE). The audit showed some shortcomings in the assessment and documentation of people's mental health needs. There was an action plan which included a commitment to provide training for practitioners in the assessment, treatment and referral of people who had self-harmed. However no evidence was provided to show that this had been undertaken. There were plans to re-audit in October 2015.
- An audit of the management of feverish illness in under 5's was undertaken in 2015. This was a repeat audit to ensure that NICE guidelines were being complied with and that improvements had been made since the previous audit. Areas of good practice included:
- Children's temperature was recorded in 100% of attendances
- Recording of pulse rate increased from 70% to 83%
- Recording of respiratory rate increased from 60% to 79%
- Recording of blood glucose improved to 17%
- Areas for improvement included:
- The recording of capillary refill times, colour, and hydration were inconsistently recorded.
- The recording of AVPU (alert, voice, pain, unresponsive – a tool used to measure a patient's responsiveness) and patients' activity level had reduced from the previous 2014 audit.

Staff we spoke with during our visits were aware of the audit. At Cirencester Hospital it was recorded in the minutes of the MIiU staff meeting in March 2015 that all staff had been sent the audit results and they were asked to familiarise themselves with the relevant NICE guidelines. A nurse at the Vale Community Hospital was aware that an audit had been undertaken but was not aware of the results. At Lydney and District and Dilke Memorial Hospitals staff were aware of the audit but they were not familiar with the results or how the results were acted upon.

- An audit of the management of head injuries was undertaken annually to assess whether NICE guidelines were complied with. The most recent audit, published in June 2015, showed partial compliance. Areas of good or improved practice were as follows:
- The recording of Glasgow Coma Scale (neurological scale to measure a patient's level of consciousness) had improved to 89% compliance and recording of pulse and activity of the patient had also improved.
- Blood pressure and respiratory observations had improved but were not consistently recorded.
- Advice to relatives and carers had significantly improved from 67% to 82%.
- A record of a responsible adult had improved and a record of whether the patient was knocked out had also improved.
- PEARL (pupils equal and reactive to light) was recorded in 88% of head injuries.
- Areas for improvement included:
- recording of the colour of the patient (13%),
- no patients had their capillary refill assessed;
- safety netting had reduced from 98% to 89%.

An action plan had been developed to address areas for improvement, although it was too early to see any progress.

- The trust was consistently failing to meet the standard which requires the number of patients re-attending (unplanned) the department within seven days to be less than 5%. Year-to-date performance was reported in May 2015 to be 5.4%. It was suggested to us that the high re-attendance rate may be attributable to a lack of access to GPs in some areas of the county. However we saw no evidence that this had been audited so that the cause was understood and could be acted upon.
- There were inadequate processes to oversee nurses' practice in relation to the interpretation of X-rays. ENPs were trained to interpret X-rays so there was no need to refer to a doctor, although advice could be sought from the trust's MIiU consultant (medical lead) or from

orthopaedic surgeons at the local acute trust. X-rays were reported on by radiologists employed by Gloucestershire Hospital NHS Foundation Trust. ENPs were required to reconcile radiologists' results with their initial interpretation and therefore audit their own practice. There was a three yearly audit to ensure accuracy of interpreting X-rays. In addition, the medical lead investigated missed fractures so that learning could be identified.

- Staff reported variable X-ray reporting response rates. At Stroud Hospital, reports were usually received within 24 hours and there was an identified senior nurse responsible for matching reports with requests and for chasing outstanding reports. However, we were told about two recent incidents where X-ray reports had been delayed by two weeks, thereby delaying treatment. The X-ray results revealed missed fractures and the patients had to be re-called. As a result, there was now a system in place where individual nurses were responsible for following up X-ray results if they had not been returned within 48 hours.

Competent staff

- The trust could not provide assurance that staff were appropriately qualified and competent to carry out their roles effectively. A process to assess the training needs of all staff had recently been developed but this had not been formally launched or consistently rolled out.
- Some staff reported a lack of confidence to assess and treat patients who presented with minor illness and some staff reported a lack of confidence in assessing and treating children. Some of this lack of confidence was due to the fact that they had previously relied on support from out-of-hours GPs. The trust was unable to confirm the competencies held by MIiU staff. A comprehensive competency framework had been developed and all nurses had been provided with this. Nurses at Cirencester Hospital confirmed they had been issued with competency folders in March 2015. They were required to self-assess themselves against these competencies in order to determine their training needs. The competency framework had not been formally launched and there was no structure or defined timeframe attached to the roll out of this process.
- A clinical education lead was working with MIiU nurses to support them address their training needs and it was reported that some minor illness training was being provided. This was a county-wide resource and it was unclear what level of support they were able to provide. There were vague plans described to appoint practice educators but no clarity as to the level of input they would provide to support clinical development and consolidation of skills.
- A number of practitioners had been identified as leads in specific clinical procedures, for example, an ENP had been identified as a lead in wound closure and suturing and was providing training for colleagues. Another ENP had recently obtained a certificate in plaster casting issued by the British Orthopaedic Association and was providing training to colleagues.
- There was no formal system of staff supervision, including clinical supervision, for nurses. Group supervision took place at monthly staff meetings, although these did not always take place consistently. Minutes were circulated to all staff to ensure they were kept informed. Discussions took place with regard to training, audits, incidents and complaints. Staff told us they had an annual performance appraisal; however, compliance was variable across sites. As at 15 June 2015 appraisal compliance rates by MIiU location were as follows:

- Cirencester Hospital 95.4%
- North Cotswolds Hospital 100%
- Dilke Memorial Hospital and Lydney and District Hospital (staff rotate between the two sites) 100%
- Stroud General Hospital 84.6%
- Vale Community Hospital 100%
- Tewkesbury Hospital 55.56%

Multi-disciplinary working and coordinated care pathways

- X-rays were performed on site by radiographers employed by the local acute trust. MIiU staff reported good working relationships with radiographers with whom they could discuss results. X-rays were sent digitally to the acute trust for reporting but ENPs were trained to interpret results. They could also seek telephone advice from the MIU consultant (trust medical lead for MIiUs) Monday to Friday or from colleagues employed in the local emergency departments (Gloucester and Cheltenham).

Requires improvement

Are services effective?

- Staff reported good relationships with colleagues in the local emergency departments and the paediatric assessment unit in Gloucester.
- We saw a good example of multi-disciplinary working at Stroud MIiU. A patient presented with a swollen leg. The ENP contacted the trust's single point of clinical access team who advised that the patient should be seen by the intravenous therapy team. A home visit was subsequently arranged.
- Changes to the provision of the out-of-hours GP service had caused some difficulties at some hospitals. At Lydney and District and the Dilke Hospitals staff reported that there was a good relationship with the OOH provider but when GPs were not co-located with MIius they were not able to provide a seamless service. They also told us that because that referral was via a central telephone hub, there were frequent delays in obtaining appointments. At Stroud Hospital however, where the OOH service was co-located we saw good partnership working between the two services during our unannounced visit.

Referral, transfer, discharge and transition

- Patients were given advice following treatment. This was both verbal advice and written guidance on what to expect with their condition, how to care for themselves and when to seek further help. This was referred to as 'safety netting'. We saw that this was well documented in patients' records.
- We saw that patients were referred appropriately to other health professionals for follow up, for example, the falls clinic and the fracture clinic. Discharge letters were automatically generated when emergency assessment records were completed and these were sent to patients' GPs so that any follow up or after care could be arranged.

Access to information

- Staff had access to relevant patient information. There was an electronic patient information system which held patients' personal information, details, such as their next of kin and their family doctor, and details of previous attendances at MIiUs. For new patients this information was entered at the time of arrival. For returning patients, the information was checked and amended as necessary by the receptionist. Emergency assessment records generated for each MIiU attendance would be pre-populated with this information so that nursing staff were aware of these details when they assessed patients.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- An audit of clinical records in November 2014 highlighted poor documentation of consent. For example, only 70% of records had evidence of informed consent to treatment. Where consent had been documented only 69% of cases contained a record of the discussion of risks and complications and only 65% evidenced that there was a discussion about alternative treatment. Only 33% of applicable records showed that actual or potential lack of mental capacity was identified an only 50% had care and treatment plans which evidenced mechanisms to manage capacity issues. An action plan had been developed but had not been updated to show that actions had been taken to improve performance.
- We saw evidence in patients' records that they were asked for their verbal consent before examinations, interventions and treatments were carried out. However we saw that some staff used a stamp to confirm "consent options discussed" but it was not documented what options or alternatives had been discussed.
- Staff we spoke with demonstrated knowledge and understanding of the Mental Capacity Act 2005 and their responsibilities in respect of patients who may not have the capacity to consent. They told us that they involved and consulted relatives and sometimes GPs, in decision making.
- Staff told us they received training in the Mental Capacity Act 2005, although we did not see evidence on all sites to support this. We obtained training data at two hospital sites. At the Vale Community Hospital four out of eight staff had not completed recent training. At Cirencester Hospital 17 out of 24 staff had not received recent training. We could not be assured therefore that all staff understood and complied with their responsibilities with regard to obtaining consent from patients who lacked decision-making ability.

Good

Are services caring?

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

Summary

Staff treated people with compassion, kindness, dignity and respect. Feedback we received from patients and relatives was entirely positive and this was consistent with the feedback captured by the trust in friends and family test surveys. All of the staff: patient interactions we observed were positive, from the receptionists who greeted people in a friendly and helpful manner, through to the nursing staff who exhibited sensitivity, care and a sense of humour, where appropriate.

People were kept informed and given information about their condition and their care and treatment. Patients and relatives were given appropriate emotional support when they were distressed or anxious.

Detailed findings

Compassionate care

- We saw staff taking care to maintain people's privacy and dignity, using curtained cubicles or private treatment rooms for consultations. Reception staff confirmed that if a patient's' complaint was personal or they were visibly distressed they would take them to a cubicle to take their details.
- The trust launched the "Hello my name is…" campaign in February 2015. This is a national campaign which encourages staff to introduce themselves to patients by name on their initial contact. Staff wore "my name is.." badges and we heard them introduce themselves to patients. All of the staff interactions we observed with patients and visitors were positive. Staff were polite, friendly and respectful.
- The MIiUs received few complaints and many more compliments. Two complaints had been received in the three months prior to our inspection which related to poor communication with patients. One complaint was under investigation at the time of our inspection; the other was not upheld and was believed to be a misunderstanding.
- Feedback from patients we spoke with during our visits confirmed they were all happy with the way they were treated by staff. Comments we received via comments card were also entirely positive. Comments included:
- "From the first time I walked in the door everyone and everything was tops, everyone put me at ease" – Stroud General Hospital
- "The staff have been excellent and very caring and have treated me with dignity and respect, my needs were responded to with the right treatment, they listened very carefully." – Tewkesbury Hospital.
- "Staff respected my dignity, fast response and kept me up-to-date and informed me of my care and conditions" – Vale Community Hospital.
- "I was treated with respect and dignity and my needs were met" Lydney and District Hospital.
- The trust used the friends and family test to capture patient feedback. From March to May 2015 between 96.9% and 97.9% of respondents said they were likely or extremely likely to recommend the service to friends or family. Response rates ranged from 18.3% in March to 29.7% in May 2015.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved as partners in their care.
- In a trust-wide audit of MIiU clinical records undertaken in November 2014 93% of records contained evidence of information given to the patient and 92% contained evidence of information given to relatives/carers. The records we looked at provided good evidence that patients had received clear explanations of their condition and given advice about after care, including what do if their condition worsened or they had concerns. We witnessed staff showing patients and their relatives their x-rays and explaining their injuries to them.
- Patients were kept informed of delays. At Cirencester, Lydney and District and the Vale Hospitals we heard staff explaining and apologising to patients about waiting times.

Good

Are services caring?

Emotional support

- Staff were sensitive to people's anxiety and distress. We saw several examples of staff taking patients and relatives to a private room and providing reassurance and comfort.

Requires improvement

Are services responsive to people's needs?

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

Summary

Services were not always organised and delivered so that patients received the right treatment at the right time. The service was consistently exceeding targets in respect of time spent in MIiU and the time people waited for treatment. However, waiting times had increased as demand for the service had increased and particularly at weekends, staffing levels did not always match the activity and pattern of attendances.

Recent changes to out-of-hours provision meant that service provision was not always seamless. The new provider of the out of hours service was not always able to fully staff the service and this caused longer waiting times, inconvenience and disruption for patients. Referral processes to out-of-hours services were cumbersome and often entailed lengthy waits or travel to another hospital. Joint working between these two services needed to improve to ensure care pathways were convenient and reliable.

Premises were mostly fit for purpose and were appropriately accessible and laid out; however waiting areas at the Dilke Memorial Hospital and at the Vale Community Hospital out of hours were cramped. The triage area at Stroud General Hospital was not enclosed and was not conducive to a confidential consultation and did not protect people's privacy and dignity.

Detailed findings

Planning and delivering services which meet people's needs

- MIiUs were mostly easily accessible and well signposted. Parking was available on all hospital sites, although this was not always close to the MIiUs. There were no drop off areas.
- At the Vale Community Hospital, although the hospital was well signposted on the approach, it was difficult to locate the MIiU on site as it was not signposted. Once inside the hospital, internal signposting was also confusing. There was a window just inside the entrance which was labelled 'Minor Injury Unit Reception'; however the window's blinds were closed, leading us to believe the department was closed. A sign directed visitors to ring a bell to gain access. In fact, visitors were expected to continue to the hospital's main reception desk to be booked in. During our visit we witnessed several patients appear at the MIiU entrance and ring the bell, which meant that the receptionist had to shout to them to come through the next set of doors to the main reception desk.
- Patients attending the Vale Community Hospital were booked in by the reception staff and asked to wait in the main waiting room, which was shared with the outpatients department. Staff told us that out of hours, when the reception desk was not staffed, nursing staff would greet visitors at the window or door and they would be booked in and wait in the department itself. We were told that at busy times the waiting area in the corridor/circulation space became cramped. There was a sign displayed explaining to patients and visitors that the triage system in use meant that patients would be seen in order of priority and not in order of arrival. Patients were advised to contact a member of staff if they waited more than 30 minutes.
- MIiU accommodation was mostly appropriately designed and configured. The MIiU at the Vale Community Hospital was purpose built and the department at Cirencester Hospital had been upgraded and reconfigured approximately three years ago. At Stroud General Hospital the accommodation was not fit for purpose. Patients were triaged in an open area with no screens or curtains to protect their privacy and dignity. The College of Emergency Medicine's guidance, Triage Position Statement (2011) recommends that "the triage environment should be conducive to the exchange of confidential information." Staff told us that if necessary and where possible, they would assess a distressed patient or a patient who required clothing to be removed, in the resuscitation room to allow more privacy. The environment at the MIiU at the Dilke Memorial Hospital was dated and cramped. Staff told us there were sometimes not enough chairs in the waiting room, although this was not the case during our visit. There was no separate waiting area for children.

Requires improvement

Are services responsive to people's needs?

- Patients and visitors could obtain hot and cold drinks and snacks from vending machines and there was a television and reading material available in waiting areas. Toys were provided in children's waiting rooms.
- Out of hours (OOH) GP services in Gloucestershire, previously provided by the trust, had been taken over by another provider on 1 April 2015. Since 1 April 2015 OOH GPs were not based on all hospital sites and were not always co-located with MIiUs. All self-presenting patients presenting with minor illness were now required to be assessed by an ENP, rather than go directly to the OOH service, as was previously the case. Staff were concerned that this increased their workload and waiting times for patients. Many staff expressed concerns about the new arrangements and what they perceived to be a cumbersome and confusing patient pathway. On some hospital sites, in order to refer a patient to see an out of hours doctor, nursing staff firstly had to speak with a doctor. This was arranged via a receptionist if there was one on duty or via a central telephone hub if not. Staff reported that delays often ensued before they could speak with a doctor and even after the doctor had accepted the referral, further delays may be encountered, depending on the availability of appointments. Staff told us that patients referred by NHS 111 were often confused as to whether they had been referred to MIiU or to the OOH service but they all presented MIiU and thus became the responsibility of the MIiU to assess. Some patients were unable to see a doctor at the hospital they attended and were referred to the nearest available hospital with medical cover.

Equality and diversity

- Staff dealt with people as individuals and this was evident in their behaviour and attitudes. Records provided factual accounts of care and treatment and were not judgemental about people's individual preferences, culture, habits or faith.
- Staff told us that they had access to printed information in different languages.

Meeting the needs of people in vulnerable circumstances

- The service took account of individual needs of different patient groups.
- All MIiUs were accessible and had appropriate facilities for people who used a wheelchair. Wheelchairs were available for patients to use in the hospital. At Cirencester Hospital a cubicle was available which could accommodate bariatric (obese) patients. Hearing loops had been installed at the Vale Community Hospital and Cirencester Hospital MIiUs.
- There were nappy changing facilities available at all sites and staff told us that private spaces could be made available for breastfeeding mothers.
- Patients who attended MIiU with mental health problems were treated sympathetically but staff told us they had no specific training or guidance to assess people's mental health needs or provide appropriate care. They told us they sought support from the mental health crisis teams employed by the local mental health trust. The response from this service was variable and there was limited availability of private spaces where vulnerable patients could be observed or available staff to observe them. Staff told us if they had concerns about a patient's safety they would arrange for them to be transferred to an emergency department.

Access to the right care at the right time

- The trust consistently exceeded the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at MIiU. Annual performance for 2014/15 was 99.8%, with 95% spending less than two hours in the department. In April and May 2015 the time spent in the department had increased slightly, with 95% of patients spending two hours and ten minutes and two hours and 15 minutes in MIiU respectively.
- While waiting no more than four hours from arrival to departure is a key measure of MIiU performance, there are other important indicators, such as how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a median wait of below 60 minutes. The trust consistently achieved this target. The median wait in 2014/15 was 21 minutes.
- The trust consistently achieved the national target which requires the number of patients who leave the department before being seen (by a clinical decision-maker) should be less than 5% (recognised by the

Department of Health as being an indicator that patients are dissatisfied with the length of time they have to wait). The proportion of patients who left before being seen in 2014/15 was 0.7%.

- Access to MIiU services varied across the county, with variable opening hours. We were told by staff that on occasions, lack of staff or appropriate staff skill mix meant that units had to close. Patients were directed by a sign on the door to other MIiUs or emergency departments. At the Dilke Memorial Hospital staff told us the last time the department was closed was December 2014 or January 2015. At Lydney and District Hospital staff estimated that the department was closed approximately three times a year, the last time being December 2014. The trust confirmed that only one closure had taken place in the last six months; this was at the Dilke Hospital.
- Access to X-ray facilities varied across hospital sites, with only Cirencester and Stroud Hospitals providing facilities seven days a week. This meant that patients were either referred to another hospital or asked to return when the x-ray department was open.

Learning from complaints and concerns

- Staff were familiar with the trust's complaints procedure and knew how to handle complaints. Reception staff told us they may refer patients/visitors to the nurse in charge or direct people to the trust's Service Experience Team.
- There were leaflets available in reception areas; however we found or were given three different leaflets at different units. One leaflet entitled Tell us about your experience with us invited people to share their experience by recording these within a space provided within the leaflet. This could then be placed in a comments box in the department or posted to the service experience team. A second leaflet entitled How do I give feedback or make a complaint? outlined the complaints process and invited people to contact the service experience team. The leaflet also contained details of external organisations which could support people with their complaint. A third leaflet entitled We value your feedback (dated November 2013), which was available at Lydney and District Hospital directed people to the Patient Advice and Liaison Service (PALS). We judged this to be confusing for both staff and patients.
- Staff told us that waiting time was the most common cause for complaint. They said that in such circumstances, they apologised for long waiting times and explained to patients why they had to wait and gave them an indication of how much longer they may have to wait. Staff told us that formal complaints were quite rare but when they were received they would be discussed at team meetings so that learning could be taken from them.

Requires improvement

Are services well-led?

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

Summary

The leadership, management and governance in urgent care were not sufficiently robust to assure the delivery of high quality care.

MIiU services were going through a period of change, brought about by increased activity and a changing profile of attendance. Support provided by out of hours GP services had decreased, following a change of provider. The impact of this change had been under-estimated and had been significant. It had exposed deficiencies in governance and leadership of the service, which were both under review. It had also exposed vulnerability in terms of staffing levels, skill mix, staff confidence and competence. Some steps had been taken to address this area of risk but this was not being managed in a timely and structured way. There was an improvement review of MIiU services underway but there was no timeframe attached to this piece of work and risks did not appear to have been given sufficient attention or priority by the trust board. Board members were not visible or influential in urgent care.

We were concerned about the paucity of information which was available to demonstrate that the service was fit for purpose and able to respond to changing demands. Information about the workforce was particularly poor and we could not be assured that that short term steps taken to mitigate risks in relation to staffing were adequate.

Staff were committed and highly motivated. They worked well as team and were well supported by their immediate managers. They felt disengaged however, from the programme of change which was underway and this had affected staff morale.

Clinical team leaders were well respected and capable leaders but they were not a cohesive team and in the existing management structure, driven by a hospital agenda, they, and urgent care, did not appear to have a voice.

Detailed findings

Service vision and strategy

- The trust had developed a vision statement and a set of values, which we saw displayed in the departments we visited. Staff were well versed in these and, through their behaviour and in discussion with them, demonstrated that they were motivated to deliver safe and effective patient-centred care.
- There was a service improvement review of MIiU services underway at the time of our visit. A business case entitled Implementation of new resource model in Gloucestershire Care Services (GCS) Minor Injury and Illness Centres (MIiU) had been produced and was to be presented to the trust board on 9 July 2015. The business case followed a review of activity, staffing levels and skill mix and recommended a re-modelling of services to meet increasing demand and a changing profile of presentations. The business case did not set out a time scale for implementation of recommendations, if agreed, although the Capacity and Service Improvement Manager told us that a period of staff consultation would precede implementation.
- The vision for the MIiU service was less clear to staff and they had received limited information about the ongoing service improvement project.

Governance, risk management and quality measurement

- Governance arrangements had recently changed and were described by senior nurses as “transitional” and “muddled”. Day-to-day clinical and operational management was provided by senior nurses (Clinical Team Leaders) who reported to hospital matrons. The previous county-wide urgent care clinical governance forum had been disbanded. Clinical team leaders therefore had no county-wide forum which focussed specifically on MIiU governance. Hospital matrons met monthly and discussed MIiU issues but clinical team leaders did not routinely attend these meetings.
- It was acknowledged in the business case to implement a new service model that this management structure, consisting of six matrons, led to inconsistency and a lack

of clear accountability for strategic oversight and management of MIiUs. There was a recommendation to appoint an operational and clinical lead to lead the delivery of MIiU services trust-wide.

- There was a capacity, urgent care and clinical quality and patient safety group which met monthly. Issues relating to performance, patient feedback and incidents were discussed in the forum, as well as oversight of the unscheduled care risk register. The group reported to the trust-wide quality and performance committee, and ultimately the board.
- There was a lack of reliable information available with which the service could assure itself that it was operating effectively. For example, workforce information, such as headcount, sickness levels and training performance could not be provided to us. We received an incomplete action plan in relation to a clinical audit. The explanation for its incompleteness was that this was "due to a re-structuring of the governance within urgent care".
- A risk register for unscheduled care was maintained. It was unclear how this risk register interfaced with hospital-wide risk registers. Risks were rated, according to likelihood and consequence and scored accordingly. Although a number of risks scored 12 (significant risk) using this rating tool, they did not appear on the trust's corporate risk register. Controls put in place to mitigate risks were recorded, as well as plans to reduce or eradicate risks; however timescales for addressing risks were not identified and in some cases, progress appeared slow.
- The risks relating to MIiUs were recorded as:
- Staffing establishment in MIiUs in the forest locality (Lydney and District and the Dilke Memorial Hospitals) was insufficient to ensure safe staffing levels were maintained, resulting in some closure. The risk was being mitigated by the use of bank and agency staff, pending a review of staffing models, linked with activity and demand and opening hours. This risk had been identified in July 2014 and was currently scored 6.
- Inadequate available reception cover within the MIiU/ administration budget at Cirencester Hospital. This meant there was a risk that patients may not receive emergency attention and nursing staff may be called away from clinical duties to greet patients or answer the phone. The risk had been mitigated by the employment of a part time receptionist and the deployment of bank and clinical staff. A bell was available for patients to ring if the reception desk was not staffed. It was not clear what the plan was to resolve this concern. The risk was identified in August 2014 and was currently scored 6.
- Hospital reception was not staffed out of hours and no reception staff were provided by the out of hours (OOH) GP provider. There was a risk that patients attending OOH would not be observed. It was recorded that discussions were ongoing with the OOH provider and it was noted that a meeting date had been arranged in July 2015. This risk had been identified on 1 April 2015 and was currently scored 12.
- Safe staffing levels in MIiUs. Staff who are not confident and competent in some areas of service delivery. Actions to mitigate this risk were identified as recruiting additional bank staff, developing a competency framework and identifying training needs. It was noted that minor illness training was underway. This risk was identified on 22 April 2015 and was currently scored 12.
- Migration of out of hours (GP) work to MIiUs, thereby increasing activity in MIiUs. The risk had been mitigated by the development of a standing operating procedure which outlined the interface and joint working arrangements between MIiUs and OOH. The action plan included work underway to review resource allocation to MIiUs and review of leadership and governance arrangements for MIiUs. This risk had been identified in April 2015 and was currently scored 12.
- MIiUs' ability to deliver services consistently across the county. It was identified that MIiU staff required mentorship and training to support the increase in referrals for illness management. Controls included the appointment of the Capacity and Improvement Manager to support MIiUs. The action plan included the development of a competency based training framework, training needs analysis and a review of the MIIU handbook. There was no timescale indicated for this. This risk was identified in April 2015 and was currently scored 12.
- The MIiUs were going through a period of change. Demand for services had increased in 2014/15 compared with the previous year. A continuing increase had been seen since 1 April 2015 when out of hours GP

services were transferred to a new provider. This had resulted in increased activity and MIiU nurses were expected to see and treat more patients presenting with minor illness. The Head of Urgent Care and Capacity told us that the impact of transition to new arrangements for out of hours had been under-estimated. There was confusion about patient pathways, an increase in MIU activity and MIiU nurses were expected to see and treat more patients with minor illness. This had presented challenges both in terms of staffing levels, and staff competencies.

Leadership of this service

- In the 2014 staff survey only 25% of respondents reported good communication between senior management and staff. This was worse than the national average.
- Staff in the departments we visited told us that they felt well supported by their direct managers (clinical team leaders and hospital matrons), who were visible and accessible. Each MIiU held a monthly staff meeting (although these did not always take place consistently) and minutes were emailed to staff so that they were kept informed. Staff told us that senior managers, including the Director of Nursing the Chief Executive and non-executive directors were not regular visitors to the MIiUs and some staff could not name them.
- There was a minor injury consultant who was the designated clinical lead for MIiUs. A large proportion of their time was clinical, running weekly fracture clinics at hospitals county-wide. Their job description stated that they were the clinical governance lead for MIiUs and chaired the county-wide clinical governance group, although we saw no evidence of this. They were also responsible for ongoing training and development of nurses and ENPs and for reviewing MIU protocols, PGDs and guidelines, and overseeing the interface with MIiU and OOH GP services.

Culture within this service

- Staff told us they felt well supported and valued by their immediate managers. Clinical team leaders and matrons were proud of their staff teams and exhibited care and concern for their wellbeing. The Clinical Team Leader at the Vale Community Hospital had cancelled their planned leave during the week of our inspection so that they could be present to support their staff. The matron for Stroud General Hospital and the Vale Community Hospital acknowledged the work pressures that staff were under and the impact on their wellbeing. They told us they visited the MIiUs regularly, telling us "the staff are my patients too".
- Although morale had been affected by uncertainty about the future and staffing levels, the majority of staff we spoke with told us they enjoyed their jobs and felt that their place of work was a happy one. It was evident that hospitals were close knit communities where team work functioned well.

Public engagement

- The trust used the friends and family test (FFT) to capture feedback for patients. The response rate had previously been poor but had recently improved. At the Vale Hospital we saw the receptionist giving patients a feedback form when they arrived. They were asked to complete it when their treatment had finished.

Staff engagement

- Staff were regularly asked to complete FTT surveys to capture their view on the standard of care provided.
- Staff had a vague understanding of the review of urgent care in the trust and the service improvement review being led by the Capacity and Improvement Manager but felt disengaged from the process. There was some information disseminated by Clinical Team Leaders but staff did not feel they had been involved or asked for their views about the way forward. The Capacity and Improvement Manager told us they had visited MIiUs and had involved Clinical Team Leaders in the review but acknowledged that staff had not been involved in the review process.

Innovation, improvement and sustainability

- There was a service development and improvement plan for MIiU services, although this was yet to be approved by the board. A newly appointed a Capacity and Service Improvement Manager had been tasked with reviewing clinical and operational management arrangements, staffing levels and skill mix. A business plan to be presented to the board in July 2015 set out recommendations to re-model the service to ensure that they were appropriately configured and staffed to provide effective staff care within budgetary constraints.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3): Safe care and treatment. 12 (1) The provider did not provide care and treatment in a safe way: - Patients arriving at MIiUs did not always receive prompt assessment (triage) by an appropriately trained and experienced registered nurse.12 (2) (a),(c) - The layout of some MIiUs did not ensure that patients seated in waiting areas could be observed by staff. 12 (2) (d) - There were inadequate systems in place to ensure that resuscitation equipment was safe to use. Safety checks of other items of equipment were not consistently completed.12 (2) (e) - We could not be assured that medicines were always stored at the correct temperatures 12 (2) (g) - Cleaning checklists were not consistently completed to show that cleaning tasks had been undertaken. 12 (2) (h)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (Part 3); Good governance

This section is primarily information for the provider

Requirement notices

17 (1) Systems and processes were not established and operating effectively to ensure compliance with the requirement in this part of the Act.

- The provider conducted limited clinical audit and failed to act on identified areas for improvement. 17 (2) (a)

- The provider had insufficient information to properely assesses whether the service was operating effectively and safely and was able to respond to changing demand.17 (2) (a)

- The provider's systems to identify risks were not oeparing effectively. Staff were not consistently reporting concerns. 17 (2) (b)

- The provider failed to mitigate risks associated with staffing levels in an appropriate timescale. 17 (2) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3):Staffing 18 (1) The provider failed to deploy sufficient numbers of suitably qualified, competent and skilled staff to meet the requirements of the fundamental standards. - Staffing levels had not been adapted to respond to increased demand and changing needs. 18 (1) - Training needs and competence levels were not regularly assessed to ensure that staff were competent to carry out the duties they were employed to perform 18 (2) (a).