

Queen Victoria Memorial Hospital (Minor Injuries Unit)

Inspection report

King Edward Avenue
Herne Bay
Kent
CT6 6EB
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good 

Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Good 

Overall summary

This service is rated as Good overall. (This was the first inspection of the service since its registration with CQC on 20 September 2017)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Queen Victoria Memorial Hospital minor injuries unit and improved access service on 05 September 2019. The inspection was carried out as part of our inspection plan.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.

- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The service was meeting or exceeding the targets set by the commissioners.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **should** make improvements are:

- Devise a more formal induction process for permanent and locum staff and retain records of inductions.
- Consider producing a dedicated website for the services.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC second inspector, a GP specialist adviser and a practice manager specialist advisor.

Background to Queen Victoria Memorial Hospital (Minor Injuries Unit)

The Queen Victoria Hospital Minor Injuries Unit and improves access services are run by Herne Bay Integrated Care, an organisation formed from the collaboration of two general practices in Herne Bay.

The services are run from:

The Minor Injuries Unit, Queen Victoria Memorial Hospital, King Edward Avenue, Herne Bay, Kent, CT6 6EB which was visited during the inspection.

The minor injury/illness service provides a service run mainly by paramedic practitioners. The minor injury service is available from 8am to 8pm Monday to Sunday. The minor illness service is available from 6.30pm to 8pm Monday to Friday and 8am to 8pm Saturday, Sunday and bank holidays. The service is only permitted to treat patients whose condition lies within strictly defined criteria.

The service is staffed by a unit manager, paramedic practitioners, health care assistants and reception staff all of whom are employed by Herne Bay Integrated Care.

The improved access service is run by GPs and nurses working for the two practices in Herne Bay for the patients of the these practices only.

The improved access service operates from 6.30pm to 8pm on Monday to Friday and at weekends. At weekends the service is open on Saturday from 10am to 1.30pm and 2.30pm to 6pm for GP appointments and from 8.30am to 10.30am for appointments with the nurse for dressings. On Sunday the GP service is available from 10am to 1.30pm. There is a nurse dressing service available on bank holidays but no GP service. Appointments are pre-booked through the patients' own practices. This is not a walk-in service.

Currently there is no website dedicated to the services but there is a page on the Kent Help Health Now website and also on the Queen Victoria Memorial Hospital website

Are services safe?

The following comments refer to both the minor injuries unit and the improved access service unless otherwise specified.

We rated the service as good for providing safe services.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- A form was filled out for children that presented at the service. Details were entered on to the computer system so that they would be flagged up at their normal GPs practice and highlight potential safeguarding concerns.
- The service worked with other agencies to support patients and protect them from neglect and abuse. If there were safeguarding concerns they would inform the appropriate teams and the patient's GP. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). A decision for all reception staff to be DBS checked was taken by the provider in August 2019. They were waiting for one member of non-clinical staff who did not carry out chaperone duties to supply current photo identification before applying for their DBS check. All other staff had been DBS checked.

- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- With respect to the minor injuries/minor illness service (MIU), there were arrangements for planning and monitoring the number and mix of staff needed. There was a system for dealing with surges in demand. Additional clinical staff were available at busy times such as Mondays and for periods at weekends. The clinician on duty had permission to call in additional staff should they be required and there were systems to aid this. However, on occasions the service could become very busy. This had been recognised by the providers and they were currently advertising for an additional clinician to help mitigate this. There were three minor injury units in the area and an app for a tablet or mobile phone was available to patients which would advise how long the wait was at each unit and the time it would take them to get there from their current location.
- Non-clinical staff covered one another during absences, although the unit had a list of regular bank staff that they could call on should they need to. All staff had access to a secure encrypted social media group (limited to staff if the minor injuries unit only). This was also used successfully by staff to arrange cover at short notice for sickness absence.
- The improved access service was staffed solely by GPs and nurses who worked in the two participating GP practices that formed Herne Bay Integrated Care. Appointments were only available by pre-booking through the patients' own practice and the work load

Are services safe?

was therefore relatively predictable. The improved access service did not use locum staff and there were systems in place to obtain internal cover in the instance of staff illness.

- Patients were checked in at the MIU reception desk and the GPs clinical rooms were closed down by the health care assistants attached to the MIU at the end of the day.
- There was a locum pack for MIU clinicians and we were told that the unit manager or business manager inducted the locum staff and we saw emails where inductions were mentioned. However, we did not see a specific induction record for temporary non-clinical staff.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with their contract as a minor injuries and minor illness (during specific hours) unit, patients were seen in the order that they arrived. However, if they presented with signs or symptoms that they were more unwell, they would be prioritised appropriately for assessment and if necessary safe referral onwards, in accordance with their clinical need. Systems were in place to manage people who experienced long waits.
- Staff in the minor injuries/minor illness unit told patients when to seek further help. They advised patients what to do if their condition got worse. If a patient presented with a condition not suitable for treatment within the unit they would always be seen by a clinician before being referred on to another appropriate unit. For example, the hospital x-ray unit was not open after 4pm Monday to Thursday or at all on Friday or at weekends (this was beyond the control of the service). In that situation the service would review the patient and then contact another minor injury unit a short distance away who had a 24-hour x-ray service and refer the patient to the service.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The minor injuries/illness service used the same computer records system used by local GP practices

which allowed direct access to the patients' medical records and allowed notes to be recorded directly in to the records. Patients from outside the local area would have notes made in to the unit's records and copies would be sent to their own GP either the same day or first thing the next day.

- The GPs and nurses providing the improved access service had access to their patients' records via the computer system. Individual records were written and managed in a way that kept patients safe. The records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The services had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Appropriate and safe use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, minimised risks. Neither the minor injuries unit or the improved access service stocked controlled medicines or vaccines.
- The improved access service kept prescription stationery securely and monitored its use.
- GPs running the improved access service issued printed or electronic prescriptions in line with legal requirements and current national guidance.
- Staff at the minor injuries unit dispensed medicines in line with a limited number of patient group directives (PGDs). This meant that they could issue medicines covered by the PGDs under strict guidelines. They administered or supplied the medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- The service had carried out an antibiotics audit to ensure prescribing was in line with best practice guidelines for safe prescribing and that PGDs were being followed appropriately.

Are services safe?

- Processes were in place for checking medicines and staff kept accurate records of medicines.
- Arrangements for dispensing medicines kept patients safe.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts. We saw records that showed that the business manager recorded and examined all alerts coming in to their own practice. They then assessed (in conjunction with a GP if necessary) whether they were relevant to the Minor Injuries Unit and forwarded any alerts that were relevant. The alerts were looked at and actioned by the manager in the minor injuries unit, disseminated and any actions required were delegated to the appropriate staff.
- Joint reviews of incidents were carried out with partner organisations, including during meetings with other local minor injury and minor illness services.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and acted to improve safety in the service. For example, the non-clinical IT system run by the hospital (not under the direct control of the service) had a single password for the unit. A staff member logged on and was able to see other staff members' documents. Staff were advised to ensure they logged out of their emails and delete their browsing history at the end of a session.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team. The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service. This included regular meetings with other MIUs in the area and quarterly meetings with the clinical commissioning group.

Are services effective?

The following comments refer to both the minor injuries unit and the improved access service unless otherwise specified.

We rated the service as good for providing effective services.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- The service did not carry out telephone assessments, patients were only seen face to face.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example, children with conditions that caused them to become distressed in busy environments could wait with their carer in a separate room.
- We saw no evidence of discrimination when making care and treatment decisions.
- There were no specific arrangements in place to deal with repeat patients. However, all records were sent to the patients' GPs and records were kept in the minor injuries computer system. So repeat attenders would be flagged up to the service and the patient's GP. We saw no evidence of discrimination when making care and treatment decisions.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.

- During the hours that the minor illnesses service was open, the clinicians had access to the GPs working in the improved access service for advice, should it be needed.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Clinician's records were audited approximately every two months by the clinical leads. Initially occasional omissions such as antibiotic batch numbers were noted, but recently they had been finding no cause for concern. This was also our finding on examining an anonymised selection of records. Where appropriate clinicians took part in local improvement initiatives. For example, the service was planning to move into a new location that would also house other care services.

The following data was provided by the Canterbury and Coastal Clinical Commissioning Group with respect to the Minor Injuries Unit.

- There were no areas where the service was outside of the target range for an indicator.
- The service was meeting its locally agreed targets as set by its commissioner.
 - To meet the local target to see, treat and discharge or refer on to hospital 50% of patients within two hours. Target 50%
- Performance Apr 96%
- May 95%
- June 88%
- Jul 94%
- Aug 96%
- To meet the local waiting time target for 85% of patients to be assessed within one hour of arrival 91% against the target of 85%.

The following data was provided by the Canterbury and Coastal Clinical Commissioning Group with respect to the improved access service for the 2019/20 Year to date April – August 2019.

- There were no areas where the service was outside of the target range for an indicator.
- The service was meeting its locally agreed targets as set by its commissioner.

Are services effective?

- To meet the local target to provide a minimum of six appointments per Local Care Hub each day Monday-Friday 6.30-8.pm:
- Target 6.0 Performance 6.0
- To meet the local target to provide a minimum of eight appointments per Local Care Hub on each Saturday:
- Target 8.0 Performance 36.2
- To meet the local target to provide a minimum of seven appointments on every Sunday and Bank Holiday:
- Target 7.0 Performance 19.6
- To meet the local target that a minimum of 75% of available appointments were utilised:
- Target 75% Performance 83%
- To meet the local target that the Did Not Attend rate was no more than 10%.
- Target 10% Performance 8.7%
- To meet the local target that there was a total provision of a minimum of 2.07 appointments per 1,000 population each week:
- Target 2.07 Performance 2.11

The service had carried out an audit to check that all antibiotics were dispensed in accordance with PGDs. There were no items incorrectly dispensed. There was one item incorrectly recorded on the clinical system.

- We also saw some work done by one of the MIU clinicians in which reception staff were presented with different clinical scenarios and asked how they would respond. Their responses were appropriate, but two areas were identified that needed further training. They were given training in the areas and posters were produced to act as a reminder. A new triage tool was also placed behind the reception desk for use by the reception staff and health care assistants. Receptionists were advised to have a low threshold for calling clinicians to assess an unwell patient.
- The service had carried out two infection control audits six months apart and produced, and were acting on, action plans (The most recent was in August 2019). This was shared with their commissioners.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. However, although the provider said they provided induction for all newly appointed staff, this was not recorded in the staff file of the most recently appointed staff member.
- The provider explained that all but one of the staff had started working for the service several days before it opened and were involved in the setting up of the service and therefore were inducted during this period. The more recently employed member of staff who was employed at a senior level, spent a week with the business manager having a thorough induction, but this was not recorded formally. There were however emails referring to induction. They were in the process of developing an induction process for future employees. There was a comprehensive locum pack for the use of locum staff which contained appropriate induction information.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The provider ensured staff had ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making. The provider had initially planned to audit clinicians monthly but found that the audit results were consistently good and so had carried out audits of notes 10 times in 18 months. Clinicians received 1:1 appraisals with the unit manager every six to eight weeks.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. However, there had not been a need as no poor performance had so far been identified.

Coordinating care and treatment

Staff worked together and worked well with other organisations to deliver effective care and treatment.

Are services effective?

- We saw records that showed that all appropriate staff, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services and when they were referred. Staff communicated promptly with patients' registered GPs so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established pathways for staff to follow to ensure patients were referred to other services as required. For example, staff could refer patients to local opticians who were part of the MECS (minor eye conditions service) for assessment and treatment. They also had direct referral pathways to physiotherapy, the eye emergency clinic at a nearby hospital and the orthopaedic team and accident and emergency department at the local acute hospital. Although trained to read radiographs they also had access to immediate x-ray reporting via the digital PACS (Picture Archiving and Communications System) if required. Additionally, they had an online portal to a specialist burns unit and could send photographs of burns directly to the unit for advice.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service accepted referrals via the NHS 111 service where appropriate with specific referral protocols for patients referred to the service. An electronic record of all consultations was sent to patients' own GPs, normally on the same day or occasionally first thing the next day.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services where appropriate.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given. Any advice would be recorded in their notes and sent to their GP.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- In the minor injuries unit, the provider monitored the process for seeking consent appropriately when auditing clinicians' notes.

Are services caring?

The following comments refer to both the minor injuries unit and the improved access service unless otherwise specified.

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Reception staff gave people who phoned into the service clear information. There were arrangements and systems to support staff to respond to people with specific health care needs such as those who had mental health needs. Although the service was not contracted to assess and treat patients with mental health needs, they would arrange onward referrals to A&E and try to arrange for a carer to accompany them.
- Thirty eight of the 41 patient Care Quality Commission comment cards we received were positive about the service experienced. The other three were mixed being positive about the care received, but negative that they had a long wait and felt more staff were needed. This was in line with the results of other feedback received by the service and the feedback we received when talking to patients.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Telephone interpretation services were available for patients who did not have English as a first language and reception staff would inform patients if they thought it would benefit them. Information leaflets were available in easy read formats if required, to help patients be involved in decisions about their care.
- Patients told us through comment cards and in discussion, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

- A survey of 132 patients carried out by the minor injuries unit showed that:
- 100% rated their greeting on arrival in the unit as excellent.
- 100% felt they were treated with dignity and respect.
- 100% were happy with the care and advice they received.
- 100% were very likely or likely to recommend the Herne Bay Minor Injury Unit to others.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, if a patient had impaired hearing staff would communicate by writing down questions.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Are services responsive to people's needs?

The following comments refer to both the minor injuries unit and the improved access service unless otherwise specified.

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

The provider understood the needs of its population and tailored services in response to those needs. The service was set up by local GPs in response to a local need and request for such a service.

The provider engaged with commissioners to secure improvements to services where these were identified. For example, they were involved in plans to co-ordinate patient accessibility across the three coastal minor injury unit and urgent treatment centre providers. This was so that providers, by working together, would reduce further referrals into acute providers.

- The service had a system that alerted staff to any specific safety or clinical needs of a person using the service. For example, if a child was considered as at-risk this was indicated by an alert on the patient's notes if the patient was a patient of the local GPs. Visitors to the area would not have alerts on the notes, but if any concerns were raised the unit notes would be marked with an alert for future visits, the appropriate referrals would be made and their GP informed. Care pathways were appropriate for patients with specific needs, for example children and young people.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service. The unit had automatic sliding doors and access to disabled toilet facilities.
- The service was responsive to the needs of people in vulnerable circumstances. For example patients with mental health needs when referring them onwards to the local A&E department.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients were able to access care and treatment at a time to suit them. The minor injuries service operated from Monday to Sunday from 8am to 8pm. The minor illness service operated from 18.30 until 20.00 on Monday to Friday and 8am to 8pm at weekends.
- The improved access service operated from 18.30 to 20.00 on Monday to Friday and at weekends. At weekends the service was open on Saturday from 10am to 1.30pm and 2.30pm to 6pm for GP appointments and from 8.30am to 10.30am for appointments with the nurse for dressings. On Sunday the GP service was available from 10am to 1.30pm. There was a nurse dressing service available on bank holidays. This service was only available to patients registered with the Herne Bay GP practices and appointments were pre-booked. Each appointment slot was for 15 minutes.
- Patients wishing to use the minor injuries or minor illness services could access the service either as a walk in-patient, via the NHS 111 service or by referral from a healthcare professional. Patients did not need to book an appointment and did not have to be registered with a GP in the local area.
- Waiting times, delays and cancellations were generally minimal and managed appropriately. Staff would inform patients of the likely waiting time if it was likely to be prolonged. Where people were waiting a long time for an assessment or treatment there were arrangements in place to manage the waiting list and to support people while they waited. For example, if the wait became excessively long there were procedures in place to bring in an additional clinician. There was also an app available for tablets or mobile phones that informed patients of the current live waiting times at similar local services.
- The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services. For example, the waiting area was large and uncluttered allowing reasonable wheelchair access.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- There was no appointment system for the minor injuries unit as it was a walk-in service. Patients were seen and booked in as they arrived.
- The improved access service was booked in advance via the patient's own practice. They were checked in on arrival by the minor injuries unit reception staff.

Are services responsive to people's needs?

- Referrals and transfers to other services were undertaken in a timely way. For example, if a patient presented with a suspected fracture after the x-ray department was closed, they would be assessed and stabilised by a clinician and then referred to a local unit with an

x-ray service that was still open.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Three complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- Issues were investigated and would be reported back to stakeholders such as the commissioners where relevant. There had not been a complaint where this was necessary, but there was a significant event where an ambulance for a patient was delayed beyond the closing time of the service. This had been discussed with the ambulance service and the CCG.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, a patient who was exempt from prescription fees was sent a request for payment in error. They were sent a letter of apology. Dispensing and administrative procedures were reviewed and discussed with staff.

Are services well-led?

The following comments refer to both the minor injuries unit and the improved access service unless otherwise specified.

We rated the service as good for leadership.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management were accessible throughout the operational period, with an effective on-call system that staff were able to use. The directors including the clinical director were always accessible to staff via a mobile phone.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with patients, staff and external partners. Staff members had started employment with the service prior to its opening and had input in to the setting up of the service.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.

Are services well-led?

- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.

The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the local key performance indicators. Performance compared with services in neighbouring areas was discussed with the commissioners and the provider had input into the urgent care steering group which had oversight of outcomes and direction of urgent care services locally. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.

Clinical audits had been carried out to monitor antibiotic use and the quality of clinical notes.

The providers had business continuity plans in place and had trained staff for major incidents.

The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. The service had identified security issues with some (non-clinical) software, which was not in their direct control, but had taken steps to mitigate this and advised staff on the correct procedures to keep data protected.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. The service had carried out a survey of patients. 132 patients returned surveys between October 2018 and March 2019 and for example in that time 66% of patients surveyed said they were seen within 10 mins with 2% waiting for more than one hour and none more than two hours.
- The minor injuries unit had a strong relationship with the hospitals' League of Friends. The business manager attended meetings with them every five weeks and kept them up to date with current and future issues and changes. The group had a voice in decisions that were made about the service and had a significant role in its introduction. They were very positive about the service and quoted some very positive feedback from patients.
- Staff were able to describe to us the systems to give feedback. Staff could either give feedback directly to managers or via staff meetings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

Are services well-led?

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the service. For example, the lead paramedic practitioner was training to be a non-medical prescriber.
- Staff knew about improvement methods and had the skills to use them.
- The service made use of reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There was a strong culture of innovation the provider was looking to move the service to a nearby facility that would allow them to expand the service and to provide a service unhindered by local restrictions. There were systems to support improvement and innovation work.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.