Shropshire Community Health NHS Trust

R1D

Urgent care services

Quality Report

Shropshire Community Health NHS Trust
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL
Tel: 01743 277500
Website: www.shropscommunityhealth.nhs.uk

Date of inspection visit: March 2016
Date of publication: 07/09/2016

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)
R1D22	Bridgnorth Community Hospital	**minor injury services**	WV16 4EU
R1D21	Ludlow Community Hospital	**minor injury services**	SY8 1QX
R1D34	Whitchurch Community Hospital	**minor injury services**	SY13 1NT
R1DX5	Oswestry Health Centre	**minor injury services**	SY11 1GA

This report describes our judgement of the quality of care provided within this core service by Shropshire Community Health 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 Shropshire Community Health NHS Trust and these are brought together to inform our overall judgement of Shropshire Community Health NHS Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

We have rated this service as requires improvement. This is because:

- There were not always staff on duty with all the appropriate skills and no formal arrangements for clinical supervision of lead nurses or supervision from paediatric doctors although each MIU saw children and babies.
- Arrangements for feeding back to staff and for learning from incidents were variable.
- There were inconsistencies in safe staffing levels and high numbers of staff absence from work
- Care and treatment was mostly based on evidence based guidance but staff were not trained in dealing with sepsis.
- The service had not compared its performance against other similar services or undertaken any local checks of how well it does.
- The trust's scheme to support patients with dementia through their treatment pathways was not understood by MIU staff
- X-ray services were not always available at the same times an MIU was open which meant patients had to be referred elsewhere.

However, we also saw that:

- The MIU's all consistently met national targets for response times.
- Services were planned and delivered to meet the needs of the local population and there was evidence of the service working with local commissioners to improve access for patients.
- Staff were kind and professional in their approach and attentive to patients' needs.
- Patients felt informed and involved in their care and decisions about their care.

Summary of findings

Background to the service

The trust provided four minor injuries units (a type of walk-in clinic service) in rural locations spread across the county. Three were located within community hospitals at Whitchurch, Ludlow and Bridgnorth and the fourth in a community health centre at Oswestry. Each unit is nurse led, staffed by emergency nurse practitioners (ENPs) who can work autonomously to treat minor injuries such as lacerations and fractures.

The minor injuries units saw in total 27,688 patients between January 2015 and February 2016. This included 7,088 children and babies. Oswestry saw the greatest proportion of patients (40%), followed closely by Bridgnorth (31%). Ludlow saw 5200 (19%), Whitchurch is the smallest unit seeing around 2,900 patients each year.

We visited each unit including one out of hours and spoke with twenty two patients including children and with thirteen staff.

The trust also provided a diagnostics, assessment and access to rehabilitation and treatment (DAART) service. It offers patients an assessment and diagnostic service including assessment by a GP with special interest in older people. Assessment is completed by multidisciplinary teams. The aim of the service is to keep poorly patient out of hospital where appropriate, allowing care to be given closer to their home or in a community setting.

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including: Community matrons; physiotherapists; occupational therapists; senior community nurses; community children's nurses; school nurses; health visitors; consultant clinical psychologist; palliative care consultant; nurse practitioner; head of quality; deputy director of nursing; palliative care nurse; substance misuse consultant, substance misuse nurse, CAMHS practitioner.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

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

How we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

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?

Summary of findings

- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 7 to 11 March 2016.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a very defined period of time, however we did contact Shropshire Healthwatch and Telford Healthwatch to seek the views that they had recently formed on the trust. Additionally, number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held six focus groups with a range of staff across Shropshire who worked within the service. Around 20 staff attended those meetings and shared their views.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

We carried out an unannounced visit of the minor injury services on Thursday 24 March 2016.

What people who use the provider say

We spoke with people using the services in all four MIU's. Patients were very positive about the services and commented on the convenient location and told us services hold a good reputation amongst the local communities and are highly valued. People who had used the service told us staff were very caring and sensitive, answered all their questions and explained things well. They also commented on the short waiting times and quick service. One patient who used a walking aid commented that there was no ramp access to the MIU at Ludlow.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must review the staff sight line and visibility of waiting patients to aid quick identification of a deteriorating patient especially children and that triage and assessment arrangements are consistently in place across all four MIUs.
- The trust must review the inconsistent approach to identifying and managing risk across the MIU's.
- The trust must review the formal arrangements for clinical supervision of emergency nurse practitioners and medical supervision from paediatric doctors.
- The trust must review staffing levels to ensure sufficiently skills number of staff are on duty at all times in order to meet the needs of the service.

Action the provider SHOULD take to improve

- The trust should ensure that lone working arrangements reflect trust policy at all times and protect staff from the risk of harm
- The trust should ensure that incident reporting across all four of the MIU's is consistent and reflects good practice
- The trust should review its participation in national clinical audits and local audit of its services, and improve staff understanding of the benefit of audit including of the outcomes for children
- The trust should ensure that staff are familiar with the significant morbidity and mortality associated with sepsis and possess the knowledge and skills to recognise it early and initiate resuscitation and treatment.

Summary of findings

- The trust should review systems for documenting consent to treatment on record for patients.
- The trust should ensure that staff receive training in awareness for patients with dementia, learning disability and mental ill health.

Care Quality Commission

Shropshire Community Health NHS Trust

Urgent care services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as 'requires improvement' for safe. This is because:

- Criteria for incident reporting varied across the four MIU's and there was no consistent arrangement in place for feeding back to staff and for learning from incidents;
- Waiting areas did not always provide a clear view for staff to quickly identify a deteriorating patient including children;
- Lone working arrangements for staff were not robust in one MIU;
- Triage and assessment arrangements were not consistently in place in each MIU;
- Staffing rosters showed that safe staffing levels were achieved inconsistently, staff absence levels were high;
- The approach to identifying and managing risk at each MIU varied.

However we also found:

- Staff knew how to report incidents;
- Staff understood their role in relation to safeguarding children and there were good systems in place;
- Medicines were safely managed;
- The MIU's were well equipped and maintained;
- The MIU's were clean and uncluttered and cleaning schedules and checks were in place;
- There were good infection control measures in operation consistently.

Incident reporting, learning and improvement

- Staff we spoke with in each of the four minor injuries units (MIU) told us they used the trust's electronic system to report incidents and gave us examples of this.
- Not all health care assistants were confident about completing reports without assistance however; they said they passed information to nurses verbally.
- What was reported through the incident reporting system varied across the four MIU's. For example at the Oswestry MIU local leaders told us they routinely made staffing incident reports (of insufficient/skilled staffing to safely meet the planned safe staffing numbers). At Bridgnorth local leaders told us they did not report staffing incidents "unless it was something that had given us alarm." This meant the trust may not get a robust picture of issues across the service.

Requires improvement

Are services safe?

- We heard mixed accounts as to whether staff received feedback on incidents they had reported. For example Oswestry staff told us they received no feedback from divisional leaders on these reports. At Ludlow we noted a print off of incidents reported by that team on the staff notice board with the follow up action included so staff could see the outcome of the reports they submitted.
- At Bridgnorth staff told us they escalated concerns by reporting staffing incidents to local leaders 'but not filling out a report each time'.
- Local leaders told us were not aware how lessons learned from reported incidents in the minor injury units or from complaints were shared across the units. Staff at one MIU did tell us they were aware incidents were discussed at divisional managers meetings.
- One senior nurse was not familiar with 'root cause analysis' (RCA) and told us hearing about incidents from other parts of the service was considered 'gossiping'. Others did not refer to RCA but understood that learning lessons from incidents was beneficial.
- We asked at each MIU for examples of any improvement action plans as a result of learning from incidents or near misses but we were told there were none.
- Nursing staff we spoke with in most MIU's told us they understood the Duty of Candour and had some experience of exercising it within their role, for example immediately telling a patient if a mistake had been made in their care or treatment and putting it right. However some, although clear about their professional duty to be open and honest about mistakes, were not sure about the Duty of Candour requirement.

Safeguarding

- Nursing staff on duty we spoke with gave us examples of paediatric safeguarding concerns and referrals they had made recently this demonstrated they were aware of and understood their responsibilities. They confirmed a safeguarding tool was part of paediatric assessment and this provided a good platform to initiate questioning. We observed this during our visits.
- High attendance rates by children were flagged on the electronic system and four visits across the MIU's would trigger a review and if considered appropriate, a safeguarding referral.
- We saw staff noted and senior nurses checked and signed off re attendances within a 12 month period of patients under 16.
- Local leaders confirmed a report was generated on the electronic records system for every patient under five years who attended and a copy of the report was sent to the child's health visitor. A similar report for children under 16 year olds was generated and sent to the relevant school nurse.
- We heard of a recent example at Whitchurch MIU of staff referring a query non-accidental child injury to the local acute trust emergency department and contacting the department in advance to expect the patient. This was then followed up by a safeguarding alert to the local safeguarding children authority.
- The trust set a target of 85% for mandatory training including safeguarding. Data provided by the trust showed minor injury unit compliance rates were well above this with 95% for level 1 adults and 92% for level 1 children's safeguarding.
- The Head of Nursing and Quality told us any aged child was seen in the MIU's, all nursing staff had level 2 child protection training, but we were not provided with any data to demonstrate this.
- The trust had put in place a pathway to paediatrics advice for MIU staff. There was 24 hour telephone access to Shrewsbury and Telford Acute Hospitals and then discussion with the safeguarding lead.

Medicines

- Nurses had access to trust pharmacists for advice.
- We saw medicines were safely managed across all four MIU's for example, monitoring information being held in at the nurse's station in a file.
- We specifically focused on practice in one MIU. Records showed fridge temperatures were being monitored against the minimum and maximum safe range and single temperatures recorded for March 2016 were all within range. Staff were able to tell us the procedure in the event of a break in the cold chain.
- The room temperature where medicines were stored was monitored and we noted records for March 2016 as all below 25 degrees as it should be.

Requires improvement

Are services safe?

- Oxygen was checked as part of the medicines check.
- Staff carried out monthly check of expiry dates of all stock medication held in the locked clinic room and stock checks to ensure they had the correct amount and right stock for patients.
- A monthly check was made of expiry dates of all stock medication held in the locked clinic room.
- We spoke with one member of the nursing staff team who demonstrated a clear understanding of safe management of medicines

Environment and equipment

- All four MIU's were situated in appropriately set out environments and well equipped. Three MIU were part of community hospitals and the MIU at Oswestry was in a newly refurbished community health centre.
- Each had an equipped and decorated children's cubicle/treatment room and most necessary assessment equipment was available in child sizes.
- We saw equipment trolleys were clean, well-organised and well stocked.
- We saw from records that resuscitation trolleys were regularly checked on a weekly basis and this included the medicines contents and expiry dates.
- Arrangements were in place to secure premises that opened out of hours. For example at Ludlow MIU the access door to minor injury services was switched out of hours to a side door and waiting area with CCTV monitoring and this was clearly signed from the front door of the hospital.

Quality of records

- An electronic system held patient records across all four sites and this facilitated 'flags' for significant triggers. The MIU's used a paper based attendance system. We observed the card for each patient was generated and printed off from the electronic system when the patient booked in. At the end of the episode of care, information carrying codes was transferred from this card back onto the electronic system and a discharge letter was generated.
- We looked at a sample of these records, the last six under two year old patients seen before our visit, at one MIU. They were clearly and fully completed and included details of assessment, treatment and transfer arrangements or discharge.

Cleanliness, infection control and hygiene

- The trust had a policy and set of procedures for hygiene and control of infection.
- Data provided by the trust showed that 93% of MIU staff were up to date with infection control training.
- We observed that each area of each MIU was clean and uncluttered and we noted cleaning schedules and checks in place.
- We saw dispensers with alcohol hand gel on walls around each MIU and wall mounted dispensers of protective clothing such as gloves and aprons in treatment rooms, which staff used.
- We noted there were wash basins at the point of care in each treatment room in each MIU and saw staff cleanse their hands before and after treating patients and were bare below elbows in clinical areas.
- We saw some information to patients and visitors about the importance of hand hygiene but this did not have a high visual impact and we saw no patients using hand dispensers in any of the MIU's during the three days of our visit. Nor did we see staff prompt them to do it.

Mandatory training

- Data sent to us by the trust showed the average training compliance for the MIUs overall was 81%, which was below the target compliance rate for the trust (85%).
- Of note, fire safety had a compliance rate of 39% with a 0% rate recorded for Whitchurch MIU. The only other compliance rate under 80% was conflict resolution (78%).
- Basic adult life support and basic paediatric life support training update compliance was at 82% respectively.
- We noted from records at Ludlow MIU that all staff were up to date with mandatory training and safeguarding training updates were in progress at the time of our visit.

Requires improvement

Are services safe?

- Local leaders assured us all staff at Bridgnorth MIU were up to date and this includedextra mandatory competency of blood transfusion and falls prevention as this team also provided the DAART) service.

Assessing and responding to patient risk

- We noted that none of the units we visited had dedicated reception staff. Health care assistants or temporary (bank or agency) staff rostered as part of the nursing teams, acted as receptionists. The trust told us that Oswestry MIU has a dedicated receptionist on weekdays when activity is greater.
- We saw that staff had a list of conditions including shortness of breath or head injury that they were expected to draw to the attention of nursing staff quickly if a patient presented at reception with them.
- We noted that although during our visits there were few patients for minor injury services, the staff acting as receptionists were constantly diverted away from the patient arriving and booking in to deal with outpatients' clinics running in the same area and receiving blood samples. Where the reception was also the front door of the community hospital such as at Bridgnorth, they also dealt with therapists and visiting professional queries. This meant that patients may not be observed whilst waiting for treatment and if a patient's condition deteriorated whilst they were waiting it may be missed.
- Nursing staff in each MIU told us they were satisfied that they had a clear visual field of waiting patients through the small glazed hatches from their nurse's office. However we noted these offices were not always occupied as nurses were treating patients in cubicles or supporting outpatients, phlebotomy clinics or at Whitchurch MIU, minor operations. At Whitchurch MIU, where there were no reception arrangements we noted the glass partition was opaque and closed over on occasions.
- We noted there was CCTV surveillance of any out of hours waiting areas that were away from the treatment areas when the main doors were locked for security.
- All nursing staff we spoke with were aware of the risk of a deteriorating patient particularly children and babies.
- All MIU's treated minor injuries in children and babies but none were commissioned to treat minor illness. Nursing staff told us they were always made aware by 'reception' staff when a child or baby had been booked in. The approach to minor illness in presenting children varied between the MIU's.
- The receptionist check list for presenting conditions to immediately refer to nursing staff we saw at Bridgnorth MIU did not include babies or children under two years. This could increase the risk of rapid deterioration in an infant's condition.We raised this with the nurse in charge who agreed that it should be included.
- In one MIU we observed practice where the assessing nurse handed over to the emergency nurse practitioner (ENP) and the ENP then referred the child to the local on-site GP and conducted the handover of the patient.
- In another MIU a nurse gave us an example of assessing a toddler's condition as a minor illness and sending the patient and parent home with verbal advice to obtain an over the counter remedy. This nurse told us they felt confident that was a safe discharge because they were themselves, a parent.
- We noted public information leaflets about children that pointed out 'their healthcare can be best provided by a facility with well-trained hospital staff whose only interests and concerns are met with the total health and well-being of children and adolescents'.
- We asked the trust for data on recent emergency transfers to acute ED's but we noted this data did not include data such asresponse times so the trust could establish a full picture of its service.

Staffing levels and caseload

- The trust told us they had experienced staffing difficulties in the minor injury units at the time of our inspection. Staff we spoke with at each of the MIU's told us the unit was short staffed and they felt levels were unsafe.
- The trust said there were high levels of sickness leave and many staff were reluctant to travel the distances between units to cover vacant shifts and agency staff were used to cover some shifts.
- We noted the numbers of WTE vacancies for qualified nurses supplied by the trust were very low with 0.30 for Bridgnorth MIU; 0.47 for Ludlow MIU; 0.04 for Whitchurch MIU and 1.00 above establishment rate at Oswestry MIU.

Requires improvement

Are services safe?

- The trust used paper rostering forms for three MIU's and an electronic format for Oswestry MIU. The trust identified the staffing levels for each shift and told us they used the West Midlands Quality Standards (WMQRS) to ensure appropriate staffing levels. The quality standards state that at least one registered health practitioner should be available and have competencies in a range of skills including intermediate life support (ILS) and paediatric life support (PILS).
- We reviewed staffing rosters for the four months December 2015 to March 2016. The rosters showed us that shifts were frequently unfilled or the WMQRS standards were not being met. For example, we noted for February 2016, the staffing roster for Oswestry MIU showed nine triage nurse shifts were not filled and 14 Band 6 (leadership) shifts had been filled by agency staff.
- While Bridgnorth MIU recorded no use of agency or bank staff during that period, rosters and supporting records demonstrated the trusts staffing levels were not met on 50 shifts as worked in January and February 2016.
- Thirteen separate days for January 2016 showed staffing without the full quota of competencies for all or part of the shift. Six of these days fell at a weekend (3 per weekend day) and four fell on a Monday. This pattern continued through February and March 2016.
- For Ludlow MIU, rosters showed one day in February 2016 where there were three hours with no cover for ILS and PILS. For two days in March 2016 there was one full shift (8am -8pm) with no cover for ILS or PILS and 1.5 shifts with no cover for the same (2pm-8pm).
- Staff at Bridgnorth, Whitchurch and Ludlow also supported outpatients and minor operations or phlebotomy services on site. This took them from their role in the MIU's to a greater or lesser extent. For example when we visited Bridgnorth unannounced on Thursday 24 March 2016 we found the unit staffed by one nurse, who was covering minor injuries, phlebotomy appointments and the DAART service because of staff sickness absences.
- When there were staffing shortages patients did not always get the full attention of clinical staff. For example we observed one nurse working on duty single handed for a number of hours before an agency nurse arrived to fill one of two sickness vacancies. The telephone was constantly ringing in the treatment room where the nurse was seeing patients and then the agency nurse interrupted consultations with enquiries because they were not familiar with the service.
- Patients could not be guaranteed the same standard of care and access depending on which day they attended including within the same unit.
- Staff shortages and lone working had been identified as red risks on the risk register for Ludlow MIU in September 2015. There was no date to indicate that these risks had been formally reviewed since that time.

Managing anticipated risks

- We were concerned about the vulnerability of lone working staff at the Bridgnorth MIU out of hours. Measures were in place but appeared less than adequate. We raised this with the trust during our visit and it agreed to review these arrangements.
- The Bridgnorth MIU risk register had a number of clinical risks relating to serious presenting conditions addressed on its risk register.
- The Ludlow MIU had no clinical risks relating to serious presenting conditions addressed on its risk register.
- The Oswestry risk register had no clinical risks relating to serious presenting conditions addressed on its risk register except ligature points.

Major incident awareness and training

- We asked staff at one MIU about major incidents awareness and they showed us the trust 'incident response plan dated November 2015 on the intranet. We noted however that it did not include any specific role for any of the MIU's. We raised this with local leaders and they had no information about the specific role their MIU would be expected to perform or contribute to in the event of a major incident. The trust confirmed there is no defined role for MIUs in the event of a major incident, but decisions would be made on what their contribution might be as part of the wider process.

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

We have rated this service as 'requires improvement' for effective. This is because:

- The service had not participated in national clinical audits or undertaken any local audit of its services for two years, staff had little understanding of the benefit of audit including of the outcomes for children;
- There were not always staff on duty with the appropriate competencies that had been identified by the trust as necessary;
- Nurses had no specific training in awareness or pathways for patients with dementia, learning disability or mental ill health;
- There were no formal arrangements for clinical supervision of emergency nurse practitioners or medical supervision from paediatric doctors although each MIU saw children and babies;
- There was no sepsis pathway and staff were not trained in dealing with sepsis;
- Consent to treatment was not recorded for patients.

However we also found:

- Extensive evidence based clinical guidelines and pathways were in place in each MIU;
- The trust set out staffing competencies for each MIU based on regionally agreed standards;
- Nurses had developed good working relationships with GP's, local acute hospital emergency departments and paramedics.

Evidence based care and treatment

- We specifically focussed on the care and treatment of eight patients including children through their experience across three of the four MIU's. We observed assessments to be appropriate, thorough and in line with evidence based guidelines.
- Where staff required advice with treatment plans we heard them seek it from colleagues.
- We noted the "Red Dot" system for interpretation of X ray images was in place in some MIU's but not others. The aim of the red dot system is to reduce the number of missed fracture diagnoses by emergency medicine staff when specialist radiologists are not immediately reporting on the image. It is good practice to have a system in place consistently across the trust to allow for audit of its effectiveness. The trust told us that all radiographs are reported on by a specialist radiographer.
- There was no sepsis pathway at any MIU. Staff who provide emergency care have a key role in identifying patients with sepsis. They should be familiar with the significant morbidity and mortality associated with sepsis and possess the knowledge and skills to recognise it early and initiate resuscitation and treatment.
- The Royal College of Emergency Medicine and the UK Sepsis Trust have developed a clinical toolkit for emergency medicine. Sepsis Without quick treatment, sepsis can lead to multiple organ failure and death. Appropriate and skilled response within the first hour (the golden hour) can be crucial to saving the life of an infant or child

Patient outcomes

- The trust told us it had taken part in no minor injury service audits activity during 2015.
- In keeping with the Urgent and Emergency Care draft Quality Standards of the West Midland Quality Review Service (WMQRS) the trust had undertaken a record keeping audit in 2012.
- No local audit of its minor injury services had been undertaken for two years and we noted from the trust audit plan that minor injury services were not included for 2016. One local leader told us the Minor Injuries Unit Forum was the basis for agreeing and planning audit activity and four audits had been 'pencilled in' for 2016. These were NICE management of fracture, head injury,

emergency care transfer to the acute ED and bench marking against other MIU's. No dates had been agreed for these at the time of the inspection. There seemed to be no focus on children's outcomes.

- Staff we spoke with in all MIU's and a divisional clinical manager confirmed no governance system was applied to monitoring outcomes for patients transferred to local acute emergency departments (ED) for example.
- We asked the trust for data relating to recent transfers to acute ED from each MIU and noted that the information collected was minimal. This meant there was no structured opportunity to assess clinical practice and check the quality of 'safety net' arrangements in place for, for example a deteriorating child as recommended by the RCPCH standards 2012.
- The trust had a protocol for the referral for x-ray examination of patients, including children attending the MIU's by registered nursing staff and we noted this had been last amended in 2014. The trust had not audited this process to evaluate the outcomes.

Competent staff

- We noted the trust set out safe staffing competencies for each MIU and these reflected the Urgent and Emergency Care Quality draft Standards of the WMQRS
- The trust told us MIU staff were encouraged to undertake the university specialist emergency medicine modules and this was confirmed by staff we spoke with. On the day of our unannounced visit to Bridgnorth MIU we were told both Band 6 sisters were absent because it was their graduation day at Wolverhampton University.
- We noted the skills and experience level varied among nurse leaders of the units. Many were highly skilled and qualified and some carried ENP status, all were very experienced. The Head of Nursing and Quality told us the trust had prioritised MIU training with a view to uplift all nursing staff to ENP competence.
- At the time of our inspection three senior nurses in Oswestry MIU were nurse prescriber trained, two at Ludlow, one at Whitchurch was in training and none at Bridgnorth.
- Nurses in Oswestry MIU were all IRMA trained and so could order and interpret x ray images.
- One bank nurse who told us they worked across two MIU's said they had no minor injuries training. This meant they were carrying out work they were not qualified for or experienced in.
- Some nurses held emergency medicine of the child qualifications. Two nurses, one at Whitchurch and one at Oswestry held paediatric nursing qualifications.
- Local leaders told us there were no formal arrangements in place for their clinical supervision and no protected time for team meetings meant they had to be conducted before or after a shift when the service was not open.
- Nurses in all MIU's told us they had no specific training in awareness or pathways for patients with dementia, learning disability or mental ill health.
- Nurses in all MIU's told us they had no training in sepsis.
- The overall staff appraisal rate for the trust was 67%, based on 1,202 non-medical staff. Trust data sent to us before our visit showed the appraisal rate for minor injury services was 78% as the end of September 2015. We were not aware of a trust-wide target for appraisals. Nurses we spoke with confirmed they had their annual appraisal for 2015/16.

Multi-disciplinary working and coordinated care pathways

- At three of the four MIUs, the duty GP for the day could be contacted for advice on patients attending each MIU that could not be managed by the nursing staff. Oswestry had arrangements via an service level agreement to link directly with a local emergency department for advice.
- Also nursing staff could contact the on call doctor for telephone advice, further assessment, and interpretation of x-rays during normal contracted hours.
- We saw this process in practice in Oswestry MIU when we focussed on the care and treatment of a child.
- We noted at Ludlow MIU the out of hours GP service was on site.
- Out of normal contracted hours when the MIU was open there was an arrangement for the out of hours GP service to respond to MIU staff requests for support and advice.

Requires improvement

Are services effective?

- Local leaders told us they had good working relationships with acute ED staff that they could contact either through a service level agreement or informally and with the NHS ambulance trust.
- GP's supporting the MIU staff could speak with appropriate on call consultants within the local acute trust, for example paediatricians.
- There were no formal arrangements for medical supervision from paediatric doctors although each MIU saw children and babies.

Referral, transfer, discharge and transition

- We asked the trust for data about the six transfers to acute ED's for each MIU immediately before our visits.
- Divisional leaders told us the trust collected no data on transfers to local acute trust ED's and could not therefore audit the appropriateness and effectiveness of decisions to transfer.
- We observed an example of good practice at the Oswestry MIU when the nurse assessed the condition of a child and made an effective handover referral to the on-site GP.
- There had been six transfers to acute emergency departments in the period prior to our inspection. We reviewed the records of these patients and found there were arrangements in place to safely follow through referral and transfer to local acute ED services where appropriate and GP's and health visitors.

Access to information

- We noted extensive evidence based clinical guidelines easily accessible to staff in folders and on wall charts within each MIU.
- The Head of Nursing Quality told us very little information could be currently downloaded quickly from the system and the trust was investing in a new one. This would link into other services like the school nurse and health visitor records.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We heard staff ask for parental consent to physical examinations of children.
- To assess whether a child was mature enough to make their own decisions and give consent staff used 'Gillick competencies'.
- However local leaders confirmed, although it was the trust policy and good practice to seek patients consent verbally, it was not established practice to record consent for any patient.

Good

Are services caring?

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

Summary

We have rated caring as good because:

- Staff were consistently kind, friendly and supportive to patients and their families;
- Staff spoke with patients about what they were doing, what assessment they had made and discussed treatment plans with them;
- Parents of young children and babies were reassured and supported to understand the treatment options and follow up requirements;
- Patients', including children, privacy and dignity were maintained.

Compassionate care

- Every patient and relative/friend we spoke with commented on how caring staff were.
- We observed the care and treatment of eight patients across all four MIU's and found staff were consistently kind, friendly and supportive.
- We observed that patients, including children's, privacy and dignity was maintained and patients commented on this when we spoke with them.
- Two of these patients were children, and we noted that one nurse referred to the young patient in the third person and used terms the child was unlikely to recognise, the other child was spoken to in an age appropriate way.

Understanding and involvement of patients and those close to them

- We observed that staff spoke with patients about what they were doing, what assessment they had made and discussed treatment plans with them.
- Parents of young children and babies were reassured and supported to understand the treatment options and follow up requirements.

Emotional support

- A worried parent of a young teenager with a suspected fracture commented to us on the relaxed atmosphere of the MIU compared with a busy ED in a large hospital.
- Patients attending the MIU's could access all support services available within the hospital.

Good

Are services responsive to people's needs?

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

Summary

We have rated responsiveness as good and this is because:

- The minor injury services had generally good relationships with local primary health care providers;
- The MIU's all consistently met national targets for response times;
- Patients were well informed about how to raise concerns and complaints and the trust responded to and learned from complaints.

However we also found:

- The trust's scheme to support patients with dementia through their treatment pathways was not understood by MIU staff;
- X-ray imaging services were not coordinated with MIU operating times which meant patients had to be referred elsewhere.

Planning and delivering services which meet people's needs

- According to trust figures between January 2015 and February 2016 the MIU at Oswestry Community Health Centre saw the most number of patients at 11,042 including 2,871 under 16 year olds. The Whitchurch MIU at Whitchurch Community Hospital saw the least in that period at 2,921 patients, including 750 under 16 year olds. However this was the highest percentage of under 16 year olds seen by any of the MIU's. Patients under 16 years represented by far the largest age group to attend each of the MIU's during that period. The MIU's saw 810 under two year old patients between April 2015 and the beginning of March 2016**.**Bridgnorth MIU at Bridgnorth Community Hospital saw almost as many patients in the age range 61 to 75 years as it did under 16's. Ludlow MIU at Ludlow Community Hospital saw the highest percentage of over 75 year old patients at around 10% of its total. The other three MIU's had seen approximately eight to nine percent of their total patients aged over 75 years.
- The premises and facilities of the MIU's were adapted to support the needs of children patients and 24 hour telephone access to paediatricians in local acute trusts was in place to support MIU staff.
- However we saw no strategic recognition of the high number of child patients that used the MIU's. For example there had been no recent audit activity of how responsive the services were to children and none was in the 2016 plan.
- The trust told us urgent care services was a 'big issue' with local partners as it was a very pressured system and the trust spent a lot of time supporting it. It had set up the diagnostics, assessment and access to rehabilitation and treatment (DAART) to support the needs of elderly patients and divert them from unnecessary visits to the local acute ED's. However we did not see heavy uptake of this service during our visits.
- We found during our visits the MIU's were under used by the public. Perhaps with the exception of Oswestry where local leaders told us they saw on average 50 patients each day (opening hours 8.30 to 6pm Monday to Friday and 8.30am to 1pm at weekends). For example Bridgnorth opening hours were 8am to 9.30pm seven days a week but when we visited on a Wednesday evening there were no MIU patients. When we visited on a Thursday morning there had been 15 MIU patients before 10.30 and no further patients between 10.30 and 13.15.
- We observed that all MIU's were assessing minor illness in babies, children and adults as well as injury. Local leaders confirmed the service was not commissioned to treat minor illness and no staff were nurse prescribers.
- Trust leaders told us the trust was in the process of 'developing what offer it could make' to local commissioners of services to meet community needs beyond just providing rural urgent care centres.
- We observed and staff confirmed they had generally good relationships with local primary health care providers.

Good

Are services responsive to people's needs?

Equality and diversity

- Each MIU was situated on the ground floor of premises with good access including automatic doors and car parking close to the entrance.
- Staff at Whitchurch MIU told us a significant national minority in the local population was Polish. However, although there were a comprehensive range of information leaflets about common conditions and injuries available, there was no notice in Polish to identify this information and inform patients how it could be obtained in Polish or other languages.

Meeting the needs of people in vulnerable circumstances

- Each MIU had one child friendly treatment cubicle and two had a play space for children in the waiting area.
- We asked staff in all MIU's about dementia friendly pathways. They told us there was a 'butterfly' scheme in place. None could describe to us exactly what this meant however. They struggled to demonstrate a clear understanding of providing proactive support to improve the experience of minor injury services for patients with complex needs.

Access to the right care at the right time

- Staff we spoke with confirmed the trust website information and a leaflet we saw at Ludlow MIU that each MIU 'is open to anyone of any age'.
- Each MIU operated different opening hours. Bridgnorth opened between 8am to 9.30pm seven days each week; Ludlow opened between 8am and 8pm seven days a week; Whitchurch opened between 9am and 5pm on Monday to Friday and Oswestry opened between 8.30 am to 6pm on Monday to Friday and 8.30 to 1pm at weekends. These were clearly and prominently shown on the trust's website.
- Each MIU had met the national response targets for urgent and emergency care during 2015/16. These included treatment times (arrival to seen time); assessment times (arrival to triage time) for arrivals by ambulance; percentage of people who leave MIU without being seen; total time in department (arrival to discharge) and unplanned re-attendances (within 7 days of discharge).
- With the exception of one patient, all the patients we spoke with and specifically focussed on during our visits in March 2016 were seen within a few minutes of arrival. However the services were not very busy at those times.
- Notices were prominently displayed in each MIU external area about the opening hours and included advice and details for patients to access other services such as the nearest acute hospital ED out of these hours.
- X-ray imaging services were not coordinated with MIU operating times. For example at Whitchurch MIU the x ray service was available only between 9am and 1pm weekdays and not available at all on the day we visited. When we asked why this was staff told us 'because it's Thursday'. This seemed to a local long-standing commissioning arrangement that everyone just continued to accept. The Easter two bank holiday weekend was serviced by X ray imaging being made available on only one of the bank holidays. This meant patients had to be referred elsewhere out of those times or return the following day.

Learning from complaints and concerns

- We saw notices and leaflets about how to raise concerns and how to access the PALs service in each MIU.
- Data provided by the trust showed between October 2014 and October 2015 minor injury services had received one complaint. This was about detection of a hair line fracture through x ray imaging.
- Minor injury services received a total of eight compliments for that period.
- Staff we spoke with across all four MIU's were able to give us examples of how the local team had made changes or improvements in response to comments made by patients.
- We saw 'you said, we did' displays on the notice boards at two MIU's. For example the waiting area seating was reconfigured at Whitchurch MIU as part of a trust 'improvement day' project.

Requires improvement

Are services well-led?

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

Summary

We have rated this service as 'requires improvement' for well-led. This is because:

- There was not a clear, shared vision for the minor injury services at the trust.
- Systems in place to identify and monitor risk were not robust and significant clinical risks were overlooked.
- Some leaders beyond the MIU did not have the necessary experience to lead effectively.
- Governance systems did not support robust review and assessment of key clinical processes and service performance. This meant that leaders working in MIU were not always sighted on governance issues.
- There was limited evidence of public engagement.
- Staff did not feel fully engaged with the trust.

However, we also saw that:

- There was strong local nurse leadership within each MIU.
- There was an open, positive culture and staff were committed to providing good quality care.

Service vision and strategy

- Currently there is not a clear, shared vision for the urgent care services at the trust. The trust is working on this with other key stakeholders within the health and social care economy on a strategy called Future Fit and also Community Fit which the trust is developing.
- The trust told us a strategic initiative for 2016/17 was a 'solution for sustainable local enhanced community services focussing on [including] urgent care.' For example the Head of Nursing and Quality told us that the trust's strategy for the MIU's was to review the ENP status and bring them all up to a common competency level that included prescribing. In this way the trust was 'wanting to make nurses more confident in a move away from reliance on GP support and towards acute ED support'.
- However staff we spoke with across all four MIU's told us they did not know of any local plan for the service they worked in.

Governance, risk management and quality measurement

- The community health service division maintained risk registers. We noted although minor injury services were treating children, including under two years old, the specific risks associated with children and babies attending for care in a setting with no quick physical access to paediatric clinicians was not identified on a risk register. It is nationally recognised that parents are inclined to take very sick children to the closest NHS facility even if this is not an ED.
- There was one risk entered on the divisional risk register for minor injury services and this was rated as 'high amber' at November 2015 and continued to be rated at the same level in February 2016, 'reception at Oswestry MIU hours have changed. In the absence of a receptionist - qualified nursing staff have to be taken away from direct patient care to undertake an administration role at the reception desk. Patient assessment, flow and care are compromised in the absence of receptionist'. We observed this was an issue at each MIU we visited, not just at Oswestry. We noted each MIU had a risk register and we saw copies of each. However these registers did not appear to be actively managed working tools. For example, Whitchurch MIU risk register last entry was dated March 2015, other entries were risks 'opened' in November 2012 and none had any indication of review. The Bridgnorth MIU risk register had a number of clinical risks relating to serious presenting conditions addressed on its risk register but there was not one date anywhere on the document. The Oswestry MIU risk register had no clinical risks relating to serious presenting conditions addressed on its risk register except ligature points. This risk was opened in November 2012 and there was no date to indicate any review.

Requires improvement

Are services well-led?

- The Ludlow MIU had no clinical risks relating to serious presenting conditions addressed on its risk register. 50% of the risks had been opened in September 2012 including the three identified 'red' risks and the others in February 2016. None had any date indicating a review.
- We asked local leaders how risks were monitored and escalated to the Board and they told us they did not know. However staff told us about a trust wide MIU forum. This was chaired by the head of nursing quality, met bi-monthly and was open to all MIU staff. We saw some minutes of meetings and these were displayed on staff notice boards.
- Local leaders told us they attended the forum when they could 'get away' and while they valued it they were clear that it had no operational influence.
- The system for identifying, capturing and managing issues and risks at a team and directorate level was not effectively embedded for the minor injury service.
- We raised this with a clinical services manager. They told us they responded when an incident or national waiting time outlier flagged on the electronic system by producing a report. This was a reactive not proactive approach to risk in four dispersed services that were operating different styles of minor injury service provision.
- The role of clinical manager did not seem to clearly set out their responsibility for quality assessment and improvement. Each of two posts had been recently appointed to by staff inexperienced in the role.
- This meant staff were unable to describe the process of governance influence exercised by this forum and we remained unsure of its status and impact on assuring the Board.
- We noted there were some service level agreements in place for quality control, such as for interpretation of X ray imaging and acute ED consultant opinion.

Leadership of this service

- The MIU were geographically disparate within the county. Three were situated within community hospitals and the head of nursing quality acknowledged they had various models of working.
- Local leadership in the MIU's were Band 6 nurses or Band 5 nurses acting up. We noted their leadership was strong at unit level. They told us they experienced a lack of senior clinical leadership and support. We observed a lack of audit activity of the services. We raised this with a divisional leader. They confirmed that a post for clinical lead of the MIU's trust wide had been vacant for 6 months and the trust was having difficulty filling it.

Culture within this service

- From conversations we had with staff across all four MIU's we found the culture was an open one. Staff told us they could raise concerns with local leaders.
- On the whole staff were interested in learning and developing services and all staff were very committed to providing a good quality service for their patients.
- The MIU forum was recognised as a means for bringing staff across the county together and discussing good practice with a view to achieving consistency.
- However we noted that MIU's were geographically isolated and staff did not really see beyond their place of work and their team. There was minimal movement of staff between MIU's or placements at local acute ED's to gain insight and experience a share skills and knowledge.
- Staff told us they felt frustrated and over worked. While the uptake of the service was unpredictable from one day to the next and some units were open and therefore needed to be staffed 12 hours a day seven days a week, we noted little demand for most of the MIU's during our visits.
- The trust's NHS staff survey results data were not specific to minor injury services.

Public engagement

- During the inspection we saw limited evidence of the services offered by the MIU's being promoted locally. However, the trust told us that they had carried out campaigns to promote the MIUs in the past, using traditional and social media.
- Staff expressed pride that patients that did use the services told them they valued having them locally. One parent accompanying a child patient remarked to us how pleased they were to be informed by a neighbour that a local service existed when they were leaving home to go to the local acute trust ED.

Requires improvement

Are services well-led?

Staff engagement

- The trust told us a culture working group had been established to support change and transformation and this was 'starting to pay off' and staff felt engaged.
- We found across the MIU's staff did not feel engaged. Many for example were working above their salaried grade, Band 5 nurses told us they were acting up to a Band 6 position without the enhanced remuneration.
- Trust data showed between October 2014 and September 2015, minor injury services experienced the second highest staff turnover within the trust at 17.27%. The staff sickness rate for that period was 3.6% and this was the second lowest within the trust.
- Although staff commented positively about university training opportunities being encouraged by the trust, staff absence and vacancies were high within the minor injury services and nursing staff told us they felt their skills were under used.

Innovation, improvement and sustainability

- There were no improvement action plans in place for minor injury services at the time of our inspection.
- The trust told us it was discussing within the wider healthcare economy possible plans for the development of urgent care centres.