Sirona Care & Health C.I.C.

1-290660061

Urgent care services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-1333619241	Yate Westgate Centre Minor Injuries Unit	Minor Injuries Unit	BS37 4AX
1-297412138	Paulton Memorial Hospital Minor Injuries Unit	Minor Injuries/Minor Illnesses Unit	BS39 7SB

This report describes our judgement of the quality of care provided within this core service by Sirona Care & Health C.I.C. 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 Sirona Care & Health C.I.C. and these are brought together to inform our overall judgement of Sirona Care & Health C.I.C.

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We rated urgent care services, overall, as good because:

- Patients had safe care. They were assessed to make sure they had timely care, appropriate pain relief, and their safety was monitored. Good records were kept about patients.
- The units were clean, well maintained, and designed to keep people safe.
- People were protected from abuse and avoidable harm. Staff had good knowledge of safeguarding.
- There were mostly good levels of well-trained, experienced and skilled staff, although the level of nursing staff at the Paulton unit, which was what had been agreed with the commissioners, was stretched at times.
- Care was effective and patients had good outcomes.
- Care was delivered with kindness and compassion. Staff made sure the patient was at the centre of the service, and offered emotional support.
- Vulnerable people were supported to have responsive, safe and effective care.
- Complaints and concerns were listened to and acted upon to improve services.
- The minor injuries services reflected Sirona's values to deliver high quality care, and to be caring and compassionate to people they looked after.
- The Friends and Family Test reported that almost everyone who responded would be likely or extremely likely to recommend the service.

However:

- The high demand for the minor injury service in Yate meant the organisation could not always meet the needs of everyone who came for treatment.
- There was a lack of systematic management of risks at a unit level. The team meetings at Paulton did not have a specific structure and some areas of governance were not routinely discussed at either location.
- Some staff did not have sufficient knowledge of consent to ensure it was always provided in line with legislation and guidance.
- The resuscitation trolley needed to be tamper evident (Yate). The audit routines did not include checking and approval of the resuscitation equipment and stocks.

Summary of findings

Background to the service

Sirona Care & Health CIC provides urgent care services through a minor injuries service for people in South Gloucestershire, and a minor injuries and minor illnesses service in Bath and North East Somerset.

The South Gloucestershire unit is located at Yate Westgate Centre in the heart of the shopping precinct, where there is free parking for visitors. The unit is open Mondays to Fridays from 8:30am until 7:30pm, and on weekends and public holidays from 10am to 1:30pm. There are X-ray facilities provided by a local NHS trust that operate from 8am to 8pm on Mondays to Thursdays and from 8am to 4:30pm on Fridays. There are no X-ray facilities on weekends or public holidays. The services are provided by a team of experienced nurses who treat minor injuries including sprains and strains, cuts and grazes, arm, lower leg and foot injuries. Also treated were bites – human and animal, minor burns and scalds, minor head injuries, broken noses and nose bleeds, eye problems such as scratches, and foreign bodies in the eye.

The Bath and North East Somerset unit is located at Paulton Memorial Hospital, where there is free parking for patients. The unit is open every day of the week from 8am to 9:30pm. There are X-ray facilities provided by a local NHS trust that operate from 9am to 4pm on Mondays to Fridays. There are no X-ray facilities on weekends or public holidays. The services at Paulton are the same as those provided at Yate, but Paulton also provides a service for minor illnesses, which includes coughs, cold, sore throats and aches and pains.

In the 12 months from October 2015 to September 2016, the minor injuries units saw 26,014 patients – 7,843 at Paulton and 18,171 at Yate.

We visited the minor injuries unit at Yate on 19 October 2016 and at Paulton on 20 October 2016. We returned unannounced to the Paulton unit on the evening of 1 November 2016. During our inspection, we spoke with the head of the division for specialist services (of which the minor injuries units were a part), the matron at each unit, three of the reception staff, seven nurses, a healthcare assistant, and one of the members of the housekeeping team. We met the X-ray staff at the Yate unit. We heard from patients, their relatives and carers, both during our visits, in pre-arranged telephone interviews, and through comment cards and emails sent to us.

Our inspection team

Chair: Julie Blumgart, invited independent chair

Team Leader: Amanda Eddington, inspection manager

The team included a CQC inspector and a specialist nurse as professional advisor with experience in urgent care services.

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

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 the services, we reviewed a range of information we hold about the organisation, asked the provider to send us a wide-range of evidence, and asked other stakeholder organisations to share what they knew. We carried out announced visits on 19 and 20 October 2016 and returned for an unannounced visit on 1 November 2016. During the visits we met with a range of staff who worked within the services, such as nurses, healthcare assistants, receptionists, and managerial staff.

We talked with people who use services. Our experts by experience telephoned a group of patients and carers who were receiving, or who had received care and support. During our visits, we took time to observe how patients were being cared for, and we talked with carers and/or family members. We reviewed treatment records and other information about people's care.

Good practice

- All staff in the minor injuries units had been provided with a review of their practice and competence in the last year (annual appraisal). Staff also had monthly meetings with their line manager, clinical supervision, and were supported with training and development. For all staff to have had their annual appraisal was an outstanding contribution to patients receiving the quality, safe and effective care.
- The matron at the minor injuries unit at Yate had been supported over a two-year period to help establish minor injury services within 29 GP practices in South Gloucestershire. This relieved pressure on this already high-demand service and more widely for the healthcare economy in that area.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Ensure level three child safeguarding has been updated by all nursing staff when this was relevant to their role.
- Continue to work on improving the triage times at the Yate service towards the best practice of seeing patients within 15 minutes.
- Ensure the use of CCTV monitoring equipment is advertised with clearly visible and readable signs in the minor injuries units and to comply with legal requirements.
- Review how checks of stock levels are recorded in the controlled drugs register in Yate minor injuries unit.
- Ensure the resuscitation trolley in the minor injuries unit in Yate is able to demonstrate the contents have not been tampered with or removed. The contents should be checked and signed for as required on a weekly basis.
- Ensure the checklists at both units are reviewed to reflect national guidance appropriate to the clinical setting. The medicines management audit should ensure these areas are checked and picked up in future audits.
- Update the Sirona website to accurately reflect the services provided by the minor injuries unit at Paulton, and consider whether the name of the service could be amended to reflect that minor illnesses are also treated. The standard operating procedures at Paulton should be updated to reflect treatment for minor illnesses, as these are not described.
- Make sure patients' privacy, dignity and confidentiality is at the forefront of their care and treatment.
- With exceptions for vulnerable people, review whether there should be a method for checking with patients who attend the minor injuries unit if they are happy for their GP to be told of their visit. This is currently undertaken automatically, and there may be patients who attend the unit who would prefer their GP not to be informed of their visit if they were given the option to decide.

Good

Are services safe?

- Ensure the way in which consent is recorded and obtained in the minor injuries units meets the Department of Health guidance for consent and the law.
- Make sure relatives and carers are not asked to provide consent for another adult, when the circumstances are such that the organisation is able to proceed with care and treatment given in the best interests of the patient. Ensure this is recorded effectively in the patient records.
- Ensure the knowledge of consent is clear as it relates to children and young people.
- Review audit data to determine whether the results of X-ray audits in the minor injuries units are demonstrating good outcomes for patients, or if some patients are having X-rays unnecessarily.
- Consider whether training to deal with rude or aggressive patients would benefit the reception staff, particularly at the Yate minor injuries unit, where early closure of the unit often led to staff being verbally abused by people.
- Revisit the lack of an electronic display in the patient waiting room in the Yate minor injuries unit, which was the area that was most commented upon by patients as being missing.
- Improve the situation resulting from the rising and sometimes unmanageable demand at the Yate minor injuries unit to avoid closures.
- Review the staffing levels and skill mix at the Paulton service to provide appropriate levels of nursing support at all times.
- Review the governance process at local level to introduce a structured approach to team meetings at the minor injuries unit, and ensure standing agenda items are agreed and included, minuted and discussed at all meetings.
- Ensure all low level local-level risks have management and mitigation recorded and tracked.

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the safety of urgent care services as good because:

- Lessons were learned when things went wrong.
- There were reliable systems to keep people safe from abuse.
- The environment and its cleanliness, infection prevention and control were good and well maintained. Staff practiced good infection control routines.
- There was good management of medicines, records were accurate and well maintained, and training was well attended.
- There were mostly good levels of well-trained, experienced and skilled staff, although the commissioned levels of nursing staff at the Paulton unit were stretched at times.
- The majority of patients were assessed quickly to ensure they were safe, although there was an example on our visit to Yate, of when this process could be flawed and not happen as expected.

However:

- Training in level three safeguarding for children had only been undertaken by half of the nursing staff.
- The checking of what was a minimal stock of controlled drugs was not itemised for each medicine. This could lead to confusion if an error was found.

Good

Are services safe?

- The Yate resuscitation trolley was not tamper-evident. The issues with the Paulton resuscitation trolley having excess items and not all the items listed on the checklist had been resolved when we want back to the unit on our unannounced visit.
- There were some items of equipment in the clinical areas showing signs of age and wear and tear. This made it difficult to keep them clean.

Incident reporting, learning and improvement

- There was a good culture among staff for reporting incidents. Those staff we met said they felt confident about reporting issues, and there were no barriers to open, blame-free reporting. Staff said the organisation encouraged reporting of incidents. The value of knowing how and why things went wrong was clear to staff, who said it enabled them to put things right and make worthwhile changes.
- Staff recognised what events were reportable, including near misses. Staff described a range of incidents they had reported, from no-harm, through to issues that were more serious. Examples of reporting included patients, visitors or staff accidents or injuries while under the care of the service, medicine errors, closing services early due to high demand, and where near misses were recognised.
- There was feedback to staff from incidents, so learning could be shared and implemented. Team meeting minutes at Yate showed discussions of what had been reported each month as a standing agenda item. Issues reported included events also resulting from failures of care in other provider organisations, so there was a written record of local issues. Where incidents required actions, the actions were recorded and these were followed up at subsequent meetings. This was not evident, however, in the Paulton team meeting minutes, although they were discussed in staff supervision sessions.
- The number of incidents was relative to the size of the service. There had been an average of two incidents reported at Paulton per month in the year from October 2015 to September 2016. None of these had met the criteria for a serious incident requiring investigation. There had been an average of 7.5 incidents per month at Yate. A number of these related to the service closing early to new patients due to capacity. None of these incidents met the criteria of serious incidents. Both units reported near misses within these events, which confirmed what staff told us about these being part of their reporting process.

Duty of candour

- There was knowledge among staff of when to apply Duty of Candour and staff knew they were required to be open and honest, and apologise to people when things went wrong. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation that was introduced in November 2014. This Regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm that falls into defined thresholds. Most staff we met understood the duty of candour, although some tended to mix the regulation with Sirona's 'Taking it Personally' ethos. 'Taking it Personally' was formally established within the organisation in 2014. It comprised of a set of values and behaviours for staff. Some staff we met talked about duty of candour and 'Taking it Personally' as meaning the same thing, whereas duty of candour is a legal duty, and relates only to the most serious of events.

Safeguarding

- Staff were clear about their responsibilities for reporting any suspicion of abuse of a vulnerable person. It was recognised that urgent care services would often see people who were vulnerable, or not having regular healthcare or other support in their community. All staff we met had experience of reporting any suspicions of abuse, and clearly described Sirona's process for keeping people safe. Each unit had their own lead for adult and child safeguarding, and staff knew also who, within the wider organisation's executive team, had the overarching responsibility for safeguarding.
- Staff would recognise behaviour and signs in people who may have been abused. Any child under the age of 18 or an adult with care and support needs, and unable to protect themselves, were described by staff as needing to be safeguarded. Typical signs staff would recognise would be unexplained physical injuries (bruising, for example), patients being anxious or scared, or signs of neglect. Staff said they would act

on being told something directly from a patient, or on signs that gave them cause for concern. This extended to considering any vulnerable people in the care of an adult, so, for example, any children in a family where there were concerns about the parents or guardians.

- All staff had been trained by the organisation in both general child and adult safeguarding, but not enough staff had updated their more in-depth training, as required every three years, particularly in level three child safeguarding. All staff were trained on induction, and this training was revisited every year as part of the suite of mandatory training for all staff. There was then an in-depth three yearly course for staff to achieve in different levels, appropriate to their role. With the exception of one administrator yet to attend this training (and relatively new to the organisation), all staff in the MIU were required to be trained to level two in both child and adult safeguarding. All staff who contributed to assessing, planning, intervening and evaluating the needs of a child or young person should be trained to level three. The organisation offered regular (quarterly) training courses in level two and level three safeguarding to all appropriate staff to ensure they were up-to-date. The status for the minor injuries staff, for the three-year course completion (at the end of September), was:
  - 77% of staff had level two adult training
  - 100% of staff had level two child training
  - 58% of staff had level three child training
- There were standard operating procedures in the minor injuries units for children who did not wait to be seen, or were frequent attenders. All staff were required to be familiar with the procedures. The guidance for staff included the identity of the Sirona named staff for safeguarding referrals, so staff knew whom they needed to contact with concerns. The procedures also described when and how the referrals needed to made. Externally to the organisations, this included social services, the child's GP, health visitor, and school health nurse.
- There were audits to check if staff had been accurately completing safeguarding assessments. The most recent was for child safeguarding procedures, and followed NICE guidance, local and national policies. The audit also looked at how the units reported on children attending who did not wait to be seen. Both the Yate and Paulton units performed well in the requirements for accurate record keeping. Where any deficiencies had been noted, action plans had been produced for re-auditing in 2017. We saw evidence in the team meeting minutes for Yate of the audit results being reported to staff, and staff reminded of actions to be taken in future to gain immediate improvements.

Medicines

- The majority of medicines were stored safely and securely. Storage was slightly different in the two locations, but medicines were in locked cabinets either in the treatment rooms, or in a locked clinical room. The keys were held by senior members of staff. The controlled drugs kept at the Yate unit were in appropriate secure storage. The register of these drugs at Yate was accurate and reflected the small stock kept on site. However, the stock-check of the drugs was not recorded on the same page as the stock item. It was being recorded as one single entry on a separate page, which was not a comprehensive system, despite a small range of stock. The Paulton unit did not have stocks of or use controlled drugs at the time of our visit. There were some medicines in two of the Yate cupboards, which had not been dated to show when they had been opened (although they were within their expiry date). There was one medicine that had expired in August 2016, and another opened in May 2015, which had passed its expiry date when accounting for how long it should be stored once opened.
- Medicines were prescribed or given safely. The minor injuries units worked under a system called Patient Group Directions (PGDs). These were approved documents permitting authorised members of staff to supply or use prescription-only medicines with certain groups of patients within approved guidelines. We looked at a number of the PGDs on both units, and they were both current and approved, as required, by appropriate senior Sirona and Clinical Commissioning Group staff. Records showed all staff using PGDs were trained in their use. Both units also employed a number of nursing staff who were qualified to prescribe and administer medicines (called non-medical prescribers). These nurses were able to dispense or administer medicines from stocks held in the units, or write prescriptions for staff to take to a dispensing pharmacy.
- Prescription pads were in use and stored securely. All pads were locked away when not in use, and

accounted for when issued or used. All staff we asked knew about the security arrangements for the prescription pads, and ensured they were not unattended at any time.

- Patients were asked about any allergies to medicines before any were given or prescribed. The patient record system used by Sirona required staff to check if a patient was allergic to or intolerant of any medicine or anything else relevant to any treatment. This was recorded within the patient's record.
- There were medicines available for patients suffering allergic reactions. The units had anaphylaxis kits with the recommended medicines available for immediate use. All the staff we asked knew where the medicines were kept and in what circumstances they would be used. Records showed all appropriate staff were trained in anaphylaxis guidance and administration.
- Medical gases used were stored safely, were checked, and ready for use. The oxygen and nitrous oxide kept in the units for emergency use were held in safety trolleys or containers. This avoided them falling, and enabled them to be moved to a patient if required.
- Where required, medicines were stored in medical refrigerators. Staff were aware of what medicines should be kept at low temperatures, and all those we saw had been stored appropriately in the refrigerators. The temperatures were checked almost every day as required, although we did see a couple of gaps on a few occasions in the previous three months. There was no particular process in operation for staff to report to the nurse in charge when they saw a previous check had not been recorded for one or more days. This meant the member of staff who had missed the check was not being reminded of the daily responsibility in a timely way.

Environment and equipment

- The units and systems used kept people safe when they arrived and were waiting to be seen. At the Paulton unit there was a system for alerting nursing staff to a patient being in the waiting area if the reception was not staffed (as it was not staffed in the evenings and not across all opening hours on a weekend). The Yate reception area was staffed at all times when the unit was open. After booking in with the reception staff, patients and anyone accompanying them were invited to sit in the waiting area. Staff were able to observe patients in the waiting area either from the unit's nurses' office (Paulton), or moving around the unit (Yate). Both units also had CCTV in operation covering the waiting areas. The law required people to be told if they were being or may be recorded on CCTV, but there were no signs informing people visible in either of the minor injuries units.
- Equipment was maintained and serviced as required. Some equipment was maintained, serviced and calibrated under contract with an NHS trust, and others by local arrangements. Equipment had stickers to say when it had been serviced and when it was next due. All the equipment we saw had been serviced as required and was in date.
- Staff were able to get help in an emergency. There were emergency call facilities in each treatment room. This enabled staff to call for help from other colleagues when they needed it. Staff at Paulton carried personal alarms, which were easy to activate if they had an emergency. The alarms sounded at different locations throughout the hospital site and staff were trained to respond urgently in person to the location of the alarm.
- The equipment used was appropriate for a minor injuries unit. Equipment included examination couches, which were in good condition, wipeable chairs (including those in the waiting areas), all of which were in good condition, and disposable curtains which were clean and replaced as required. There were stools to help patients reach the examination couch, and other mobility aids, such as slides, to help patients move or be moved. Units had portable monitors to check a patient's blood pressure, heart rate, and oxygen saturations. Each unit had a defibrillator as part of its resuscitation equipment. There was storage in each treatment room, which limited the amount of consumable clinical items and other equipment that was on surfaces. This helped with security of these items, and improved cleaning.
- Staff were trained in the use of the equipment in the units. Equipment competency was part of induction and staff were monitored in their use and competence during their training period, when they would be supernumerary (not counted in staffing numbers) and able to shadow and be supervised. The equipment lead at Yate carried out spot-checks with staff from time to time, to make sure all equipment was being

used competently. Any bank or agency staff coming to work on the units had an induction, and were required to sign a statement about their competence in the equipment they would be required to use.

- There was equipment for use in an emergency. Both units had resuscitation trolleys, although they were different in terms of security and stock carried. The Yate unit had a trolley of open plastic drawers containing the equipment required for emergency intervention or resuscitation. However, this trolley did not have any way of showing if the equipment or medicines had been tampered with through a seal or other mechanism. The medicines were also not secure as they should be at all times. The trolley had also not been checked each week to make sure everything was in order. The Paulton unit had a more traditional red metal trolley, with lockable drawers, which had been secured with a tag. If this tag was found to be broken, it would provide evidence that the contents of the trolley may have been tampered with or removed. However, at the time of our visit to the unit, the Paulton trolley contained a number of items not required by the list of contents, some multiples of stock not required, and some items were missing. The trolley had been regularly checked each week, but these issues had not been identified, addressed or reported. The medicines management audit did not include an area that would have picked this up. The issue with the resuscitation trolley at Paulton had been resolved when we went back to the unit on our unannounced visit. The stock had been checked and reduced so all overstocking had been removed, and any missing items had been replaced. There was also a new checklist with more detail for staff to follow.

Quality of records

- There were good records written and maintained about patients. The computer-based records system used by the units required the nursing staff to record standard information where available. This included names, addresses, and patient contact details, and those of any parents, guardians or carers. Basic information was gathered by the reception staff, further details then recorded by the triage nurse (this stage was more standard in the Yate unit), and full details by the nurse who treated the patient.
- There were mostly good records of a patient's visit and any treatment, care or advice provided. We reviewed four sets of patient notes as they were being completed when we were with the nursing team in Yate. These were comprehensive and clear. We reviewed six sets of patient notes at the Paulton unit and found five sets well completed, with comprehensive and clear notes. The information and history the patient, or their parent, guardian or carer, gave, was recorded, as were the questions and responses asked of the patient or the person who spoke for them. Any treatment, guidance or advice given was documented, as were any leaflets given to the patient, or referrals onwards to other services. In the sixth record (relating to a head injury), no observations had been recorded and there was no clear record of any advice given when the patient was discharged. This was discussed with the matron at the unit, who noted the gaps and told us the record would be used as a training example in a future team meeting.
- Records were maintained and updated for patients who came to the unit more than once. This saved time from needing to continually request standard data from patients. It also enabled staff to recognise if there were vulnerable patients who were frequently attending the unit, and act should there be any concerns around abuse or neglect.
- Patient records were confidential and secure. The units used computer-based records and staff had access to these using a personal smart card and their own confidential login details. This kept the records secure from people not authorised to see them. Staff also only had access to areas of the records they were entitled to see and update.

Cleanliness, infection control and hygiene

- Both the units were visibly clean and tidy and there were good arrangements for maintaining cleanliness. The units were cleaned each day by housekeeping staff, with certain specific areas and equipment cleaned directly by the nursing team. This included damp dusting the surfaces, cleaning and decontamination of equipment, and checking for and cleaning of any spillages (following specific procedures). There was visual evidence of all areas and equipment having been effectively cleaned. Each member of staff we met was clear about their responsibilities. The nursing staff also cleaned the examination couch and any other equipment used

with patients after each consultation. The patients we talked with who had been to the units before our visit said they recalled the units always being clean and tidy. We observed cleaning being thoroughly undertaken at the Paulton unit on our unannounced visit.

- There was some wear and tear making equipment difficult to clean. Most equipment was in good condition, but there was some equipment in the Yate unit showing signs of age. The waste bins were rusted in places at the base, and we saw a set of weighing scales that had the coating missing, and slightly rusting metal exposed in places. This made these items difficult to be effectively cleaned.
- There was a good use of disposable or single-use items. Treatment rooms had disposable curtains to pull around the examination couches. These had all been changed recently and were in good condition and clean. Staff said they were changed every three months or sooner if they were soiled or damaged. There was paper used on couches, which was disposed of after every patient. There was single-use clinical equipment (such as syringes), gloves and aprons. There was eyewear available should staff need to protect their eyes during any procedure.
- We observed good hand-washing techniques and frequency from the nursing staff. Those staff we observed washed their hands at regular and appropriate intervals. This included before and after every episode of direct patient contact or care delivered. The hand washing was thorough and in line with best practice. Patients we met said they remembered seeing staff wash their hands, and a number said they clearly recalled this happening when they had visited the unit before. There were hand-washing facilities and personal protective equipment provided. Each clinic and treatment room had clinical sinks, hand towels, and liquid soap provided.
- The units reviewed their own infection prevention and control measures. The matrons of the service carried out spot checks within the units. This was to examine cleanliness and other areas, such as staff complying with the uniform policy (bare below the elbow), and using effective hand-washing techniques. The audits showed good levels of compliance with the spot checks. Where issues had been identified, these were recorded and discussed at the matrons' hygiene meetings.
- Clinical waste was well managed. Each clinic room had a clinical waste bin and a bin for general waste (which we observed were used appropriately). There were containers to store used sharp instruments, such as used needles or scalpels. These were stored appropriately off the floor on shelves or attached to the wall at a reasonable height for safety, and were not overfull. Those we saw had been dated when they were opened in order that items were disposed of in a timely way, even if the container was not full.
- The units were able to limit the spread of any infection arriving in their unit. There was a protocol for keeping a patient with a possible infectious illness or condition isolated to an extent in one of the clinic rooms. The room was then deep cleaned before it was brought back into use with other patients. Staff said they specifically ensured all infection control and hygiene routines had been followed, such as hand washing and wearing of personal protective equipment. Any staff exhibiting symptoms would be treated and sent home or to their GP.

Mandatory training

- Staff undertook a range of mandatory training each year. The training programme had recently changed and was now being delivered as a course for staff to attend over a full day each year. The courses offered included (but were not limited to) health and safety, fire safety, infection control, basic life support, safeguarding, dementia awareness, lone working, and equality and diversity. New staff undertook this training as part of their induction and then updated it again each year.
- Most staff in the minor injuries units were up-to-date with their annual mandatory training. At the end of September, of the 22 staff employed in the units, 86% had updated their annual training.
- Staff said the mandatory update training was of a good quality, and was relevant to their day-to-day work. Most staff thought the training was now easier to keep up-to-date as it was run over one full day, and they were not trying to fit parts of the training into their working day. The matrons of the minor injuries units and their manager were aware of the status of staff compliance with mandatory update training, and it was discussed at the regular one-to-one meetings.

Good

Are services safe?

Assessing and responding to patient risk

- Patients coming to the minor injuries units were assessed for the risk of their injury or illness, and staff responded quickly when the risk was high. Reception staff on duty, who booked patients in to see a nurse, were trained to recognise higher risk conditions. There was a flowchart for staff to follow to ensure a patient was safe to wait to see a nurse. Staff on reception had a list of symptoms a patient might describe which alerted a member of the reception staff to request urgent assistance from one of the nursing team. This included, for example, chest pains, breathing problems, rashes, allergic reactions, chemicals in the eyes or on the skin, and a possible stroke with body or face weakness. Patients were also referred or transferred to the local accident and emergency department for accidental or suspected drug overdoses, loss of consciousness, open fractures, or serious burns. Staff were also alerted to babies under the age of two years coming onto the unit, and they would be assessed quickly. There was, however, one episode of care at the Yate unit we observed failing to meet these criteria. There was one patient (a child) who had sustained a facial injury following a fall, and a bump to the head. The reception staff told us they believed the child had seen the triage nurse, but the parent said they had not been seen. They were waiting for at least 37 minutes when we last saw them, without any triage, despite a fall and bump to the head being involved. There was no query made of the patient or the parent as to whether they child had suffered any loss of consciousness.
- Staff responded appropriately when a patient was more seriously unwell or deteriorated while waiting or being treated. If a patient was very unwell or at high risk, the nursing staff were trained in resuscitation and emergency care. While care was being given, an ambulance would be called to either attend the patient on site, or take them onwards to an NHS accident and emergency centre. The units also had guidance for when to request an ambulance transfer. The local NHS ambulance trust had provided a guide for healthcare professionals about patients' conditions, response times, and how to contact the service (as not all patients needed a 999 response).
- Triage (used at the Yate service) was not seeing enough patients in good time. The triage service was provided for staff to make an immediate assessment of patients' needs and risks. This service operated as a rule at the Yate unit, but not often at Paulton, where there was less demand on the service. At Paulton, patients were usually seen and treated at the same time. Patients were sometimes seen and treated at Yate, when this was practical, but the triage system was a more embedded process. There was a trained member of the nursing team on triage duty each day. Here, the service used the recognised Manchester Triage Tool to allocate care to patients on a five-point scale according to their clinical need. The scale ranged from immediate – where a patient needed to be seen by an emergency nurse practitioner on arrival, through to non-urgent, where a patient needed to be seen within four hours. Staff were trained to use the tool on induction, and needed to demonstrate their knowledge through an assessment test. Pain relief could be given if necessary and patient observations recorded. The objective was to see patients within 15 minutes of their arrival. In practice, due to demand, this was only achieved for around 30% of patients, although the unit had achieved 52% in August 2016.
- The minor injuries units had a protocol for screening patients for sepsis. The tool had been designed recognising how the condition was life threatening, and needed urgent identification and treatment. Any patient meeting the screening criteria as a positive risk would be urgently transferred to hospital. There was a document for staff to complete with essential information to hand to ambulance or medical personnel when transferring any patient identified, suspected, or at risk from sepsis.
- An observation recording system was being trialled in certain circumstances. Where it was relevant, nursing staff would complete national early warning scores (NEWS) for patients who were being transferred to hospital. This was currently being piloted and would be audited to see if it added any value to the service, or patient transfers. It involved taking and recording some patient clinical observations and indicators to enable clinical staff to determine if the patient's condition had deteriorated or improved. NEWS was otherwise not systematically used in the units, as it would be inappropriate for the majority of patients.

Good

Are services safe?

Staffing levels and caseload

- The units were mostly safely staffed, and met the staffing expectations of the contract with the commissioners. The service employed a range of senior nurses, including nurse prescribers, emergency care nurse practitioners, triage nurses, healthcare assistants, and support staff. The number of staff met Sirona's established levels, and to do this, posts were supplemented by some bank nursing staff, and occasionally an agency nurse. The use of agency staff had reduced over the last year (October 2015 to September 2016) to almost zero in the units. As with most healthcare organisations, there was some regular use of bank staff, with the majority of shifts in the Paulton unit. There had also been recent recruitment to vacant posts. Although the service at Paulton was relatively small, and might only need two nurses on duty most of the time, there were times when there was only one nurse on duty. This was usually between 8am and 10am. There were inevitable risks from lone working and we identified staff had felt vulnerable at times. On our unannounced inspection at Paulton, we were concerned that a new nurse, who was supernumerary, was being included in the staffing numbers (there was only one other staff member on duty – an experienced band five nurse). We brought this to the attention of the head of the service, and the arrangements to support the new member of staff were to be reviewed.
- The rotas for staff cover were well managed. There was flexibility in the staffing rota, which staff managed among themselves to an extent. The shifts at the Yate unit were planned in advance, as there were more staff and patients to manage. The staffing rota at Paulton was more flexible, which worked well among the nursing team. Our view was the safety of the unit for staffing levels, given the nature of the risks, was acceptable, although there were times when it was stretched and relied upon the goodwill of staff.
- There was a good skill mix among the nursing team. Most of the nurses were band six or seven experienced urgent care nurses. The units also employed band five nurses, who were actively involved with triage or direct patient care appropriate to their level of experience and knowledge. Healthcare assistants provided support to the units and the other nursing staff. The Paulton unit employed one of the Sirona apprenticeship staff, who provided administration support and reception duties. This provided more weekend and evening cover for the reception.
- There was reasonable staffing cover and knowledge of treatment for children. The provision met the contract agreed with the commissioners of the service in relation to the number of staff on duty. There were staff trained in children's emergency treatment, and paediatric immediate life support. The Yate service had three of its nursing team who were trained in both paediatric and adult emergency care. The rotas were scheduled to include a paediatric-trained nurse as often as possible, as the Yate service saw around 500 children and young people (under the age of 18) each month (around a third of patients). The Paulton service saw around 250 children and young people each month (around 40% of patients). One nurse of the team in Paulton was a trained paediatric nurse, although they were currently only working a small number of hours due to a secondment post. Four of the other staff were trained in the accredited qualification 'minor injuries and minor illnesses in children (known as MIMIC). All nursing staff were trained in paediatric immediate life support. Paulton and Yate nursing staff had close links with paediatricians in the local NHS emergency departments, and the local children's hospital. From here, they would get advice on a child or young person. If there were risks to a child at either Yate or Paulton, and the staff on duty at the time felt unable to manage these, the child would be transferred to the acute hospital as per protocol.
- There were handovers to new staff coming on duty. Where nursing staff came on duty later in the day, or finished their shift before the unit was closed, staff handed over any information about the unit or patients waiting to be seen. Any risks or issues were also discussed. This include any safeguarding concerns, or information that was outstanding.
- There were induction checklists for new bank or agency staff, or staff who had not worked at the unit for a while. A checklist was worked through by one of the regular staff, and signed by both the new nurse and the regular nurse, to check everything had been pointed out and understood. Subjects included health and safety, resuscitation equipment, policies and procedures, and equipment competence.

Good

Are services safe?

Managing anticipated risks

- Staff still ensured patients were safe to be redirected to another service when a unit had closed due to high demand. The routine was to ensure all patients were spoken with by one of the nursing team before they were directed elsewhere. This meant any patients needing prompt attention, such as calling an ambulance, or clear redirection to an accident and emergency department, were still assessed and helped. Patients were also given a leaflet with an explanation as to why they had been asked to either come back the following day, or seek alternative treatment when the unit was not taking new patients.
- The units would adapt to various potential and actual risks they had or might face. Staff would assess the risk in the event of adverse weather affecting transport routes. In Paulton, for example, most of the nursing staff lived locally to the hospital and some recalled having walked to work through the snow in winter to provide a service. If it was not safe to open the units, the protocol was to advise senior management within Sirona, NHS 111, local GPs, and the local ambulance service. The same protocol would be applied to any unexpected closures of the Yate service.
- The units had emergency evacuation procedures in the event of the need to clear the building. Emergency exits were clearly marked with the recognisable green signs. Any patients being treated when an alarm sounded would be evacuated from the building as soon as it was safe and they were fit to do so. Staff said they would not complete any non-essential tasks or treatment with people and would act quickly to move people from both the treatment areas and the waiting areas.

Good

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 rated the effectiveness of urgent care services as good because:

- The units used evidence based care and treatment. Best practice was encouraged throughout the service and treatment provided.
- Patients were assessed and treated for any pain.
- Patients had good outcomes after their care and treatment.
- Staff had the skills, knowledge and competence to deliver the service. Staff were enabled and supported to have professional development appropriate to the service.
- There was good multidisciplinary working, and good cooperation and coordination with other local services and providers.
- Patients were discharged, transferred or referred to other services effectively and as appropriate.

However:

- There was limited knowledge about consent, and best interest decisions for people who might not be able to make their own decisions due to their mental capacity.

Evidence based care and treatment

- The care provided was based upon national guidance and best practice for delivering care in minor injuries units. Sirona also had internal experts who were able to provide guidance to the service, such as pharmacists, safeguarding specialists, therapists and children's nurses. Examples of practice in line with national and local guidance was that used in safeguarding adults and children, patients presenting with head injuries, and assessing pain.
- Audit work was based on national guidance. For example, the infection control audits were based upon guidance from, among others, the Department of Health and the World Health Organisation. Safeguarding procedures and audit work was based upon National Institute for Health and Care Excellence (NICE) guidance, and collegiate documents. A NICE-based audit had been completed to look at how insect bites were being effectively treated, and how patients were treated following a head injury.
- Leaflets provided for patients were approved by the organisation. Some were produced with other partner organisations, including charities specialising in supporting certain conditions such as arthritis and dementia, and Public Health England. The leaflets provided were relevant, and written in clear, straightforward language. They included head injury advice (for both adults and children), care of plaster casts, back injuries or pain, nosebleeds, insect bites and burns and scalds, among many others.

Pain relief

- Patients were assessed for pain as soon as possible. Patients who were triaged were assessed for pain as part of that process, and offered analgesia if the pain was significant. Patients said they had been asked early on in their assessment if they were in any pain. A patient at Paulton who had attended the unit previously for a suspected fracture, said they had waited a short time to be seen, but a nurse had come into the waiting room to see if they needed any pain relief. Patients who had been triaged at the Yate unit said they had been asked if they were in any pain. One patient who had been, said they had been offered some simple analgesia.
- There were recognised tools in use to assess pain, although these were not available on the patient record system. Patients were asked to describe their pain on a scale of zero to 10, with zero being no pain, and 10 being the worst pain imaginable. There were certain descriptors of pain as well, such as the patient saying the pain "caused difficulties" and "stopped them doing things", or they had "no control". If the patient could not grade or describe their pain (they might be a very young child or not able to communicate) staff would use a facial recognition scale to help determine if the patient was in pain. Staff would also ask parents, guardians or carers for their opinion, or any signs they might have recognised to indicate a patient, who may not be able to communicate, was in pain.

- There were pain strategies for nurses to use to provide patients with the most appropriate pain relief. Through non-medical prescribers (nurses who were qualified to prescribe medicines) or medicines authorised by the organisation for nurses to give patients (called Patient Group Directions) patients were provided with a range of pain relief. This ranged from simple analgesia, such as paracetamol or ibuprofen tablets, through to strong pain relief such as intranasal or intravenous morphine.

Nutrition and hydration

- The units were able to offer advice to people who had nutrition and hydration problems. Patients were given advice about safe nutrition and hydration where this was recognised as an issue or a symptom of their illness or injury. Patients would be referred to their GP if there were a longer-term problem recognised. If these concerns related to a vulnerable person, and there were suspicions of neglect or other problems, the matter would be referred to the safeguarding team, social services, or school nurses, as appropriate.

Patient outcomes

- There were low numbers of unplanned re-attendance at the minor injuries units. One measure of patients getting good outcomes was them not having to come back within seven days to be seen again for the same problem. The key performance indicator for the units was for fewer than 5% of patients to re-attend the unit within seven days. Data was as follows:
  - In the period from April to September 2016, the average number of patients re-attending at Yate was 1.8% of the total of 9,669 patients. In September of the previous year (2015), the average was 1.3%.
  - In the period from April to September 2016, the average number of patients re-attending at Paulton was 2.2% of the total of 4,387 patients. In September of the previous year (2015), the average was 2.6%
- There was audit work carried out within patient records to determine if the right clinical care had been given, to help determine if the patient had the right outcome. One of the newest audits undertaken, for example, was in accordance with National Institute for Health and Care Excellence (NICE) guidance around insect bites. The audit found the Yate unit (where the audit was undertaken) provided care within the strict NICE guidance in 85% of cases. For the remaining 15%, the audit reported how the nursing staff could have taken a slightly better route to meet the guidance. The audit was to be repeated in 2017. An audit of X-rays was undertaken at the Paulton unit. This audit reported that 40% of patients X-rayed had positive results (fractures were identified) but the audit did not say if this was an acceptable result. The audit determined there was timely reporting of X-rays to patients, although this was not set against any objectives.
- Patients we met said they felt they had good outcomes from their treatment or advice provided. A number of the patients we met had visited the minor injuries units before. All of these patients said they felt they had good treatment. None of them had to return to the unit, unless required to do so for further treatment or an X-ray. One patient had visited previously on a weekend. The patient needed an X-ray and had been advised that it was safe for them to wait until the X-ray unit opened the following Monday. They said they had been given advice about what to do if they were concerned they needed assessment that was more urgent. The X-ray was provided on the Monday and the patient said the care and treatment had delivered a good outcome. Patients told us:
  - "I've been here a couple of times now and had excellent treatment. Did not have to come back. Sorted first time."
  - "I've been here a couple of times with both my kids and they have been excellent. Great outcome and good service."
- Audit work demonstrated patients presenting with head injuries were given appropriate treatment. An audit of patients presenting at Paulton minor injuries unit, for example, showed from 10 sets of records that all patients were assessed using the recognised Glasgow Coma Scale. This is a scale to measure the patient's level of consciousness. The audit followed the questions expected to be asked and recorded under the National Institute of Health and Care Excellence (NICE) head injury guidance. All 16 questions within the NICE guidance had been asked and the responses duly recorded.

Competent staff

- Staff in the minor injuries units were assessed for their competency and skills. Each member of the nursing teams had received an annual appraisal with their line manager within the last year. Staff were enabled to have

monthly meetings with their manager as well, and clinical supervision from time to time. Staff told us they had appraisals and supervision that covered their training, development, performance, areas where they could improve, and things they were proud of. They told us they could ask for clinical supervision or support at any time, and this would be undertaken if there were any incidents or areas of concern.

- There was regular service-appropriate training for staff beyond annual mandatory or statutory training. This included immediate life support for both adults and children updated annually. There was also one-off training for staff in relevant subjects. These included dealing with cases of domestic abuse, use of Patient Group Directions (for medicine management), anaphylaxis, and immunisations and vaccinations.
- Staff could apply for professional development, and a number of staff had been or were taking various external courses. Staff were given both funding for professional courses, and time to complete these. A number of the staff had completed or were booked to attend the following courses:
  - Minor injuries and minor illnesses in children (known as MIMIC – professionally delivered, accredited course).
  - Physical assessment and clinical reasoning for both adults and children (known as PCR – professionally delivered, accredited course).
  - Recognition and protocol for female genital mutilation (available as an online course for nursing staff).
  - Mentorship courses to provide support to new staff.
- New staff were given an appropriate period to settle in and gain experience. The time taken to shadow and receive supervision depended upon the new member of staff's experience. The expectation for qualified nurses without emergency care experience was they would spend six weeks as a supernumerary member of staff (not counted in the numbers) or longer if needed. Nurses with training or experience in emergency care would usually be integrated within a couple of weeks. A new member of staff at the Paulton unit was about to join the team. They had been booked already to attend PCR training in 2017, life support courses, safeguarding, medicine courses, and mandatory training.
- Staff had been trained to recognise conditions requiring urgent care. This included courses on sepsis management. There were protocols and flowcharts for recognising and responding to adults and children showing signs of sepsis. Staff also said they would look for signs of serious illnesses such as meningitis, or infectious illnesses, such as chicken pox.
- There was some training not yet included in the regular sessions. For example, there had not been any training for reception staff to deal with rude or aggressive patients. The reception staff at the Yate minor injuries unit had to deal with people who were upset, angry or anxious, for example, about the service being closed early, as was becoming more often the case. The staff here were, nonetheless, provided with panic buttons at the reception desks that were connected directly to the local police. There was also a porter on duty for any support. The Paulton reception staff did not often have to deal with difficult or angry patients, but they equally had no knowledge in advance of who was going to come through the front door, and they were often on their own in this area.

Multi-disciplinary working and coordinated care pathways

- There was good access and referrals to other health and social care services for patients attending the minor injuries units. There were many services based on the same site. Staff could get advice from other services and refer patients to them. For example, there were physiotherapy and podiatry services at both Yate and Paulton, and staff would provide patients with support and advice if time permitted. Paulton hospital had maternity/midwifery services on site and staff could access their support. There was also an urgent care centre and Paulton and patients could be referred to see a doctor if this was required. Paulton had a fracture clinic, outpatients' clinics for the local district general hospitals, and an orthopaedic service on certain days. Other services located in the Yate centre included social services, health visitors, school health nurses, and district nurses.
- There was access to an X-ray service in both units, provided by a local NHS trust. We observed and heard from patients about a coordinated approach from the minor injuries staff who referred patients for an X-ray. There was a good relationship between the teams and a helpful and cooperative relationship to the benefit of patients.
- There were good links with local GPs and staff were able to request urgent appointments for patients when

deemed appropriate. The units had good working relationships with the GP practices, who recognised and respected the skills of the nurses at the units, and endeavoured to act upon requests to see their patients urgently.

Referral, transfer, discharge and transition

- There were appropriate arrangements to transfer patients in both emergency and non-emergency situations. Staff were clear about emergency transfers (see below) but there were also circumstances where a patient would be transferred to an NHS hospital, but not as an emergency. This could be a patient who needed to be admitted to a surgical assessment or medical assessment unit, possibly due to diagnosis of a fracture. Patients could remain at the unit while transport to take them to the hospital was arranged.
- Patients who attended with conditions the units were not commissioned to treat were supported to get the right help. The units were not commissioned by the clinical commissioning groups to treat serious conditions such as chest pain and possible strokes. However, patients would not be turned away, unless they chose to leave, and would be assessed and helped by staff. Patients would then be cared for until an ambulance arrived or they would be signposted to the service they needed.
- There were protocols for transferring children to the local NHS children's hospital or accident and emergency department in certain circumstances. Staff were aware, for example, of where to transfer a child with a burn, dependent upon the age of the child. In this case, staff were required to contact the plastic surgery team at the NHS hospital to ask for advice and handover transfer information.
- People were given information to take with them if they were referred to another service. Sirona had an information booklet for patients attending the minor injuries units. These were designed for the individual unit, and contained specific local information. The booklet would be completed by staff to show which alternative service the patient had been directed to (such as their GP, accident and emergency department, a burns clinic, dentist, or pharmacy, for example). Patients were also told why they were being referred. This might include the condition not being treatable, or needing a different specialist service, such as suture removal.
- Patients discharged home from the service were given appropriate advice. Patients we spoke with said they had been given leaflets, but also advice and guidance about self-care. A patient with a suspected fracture said they had been told about lifting and weight bearing, driving and walking. Another patient said they had been advised about maintaining pain relief, and what to do if any other symptoms, such as headaches or problems with vision occurred.

Access to information

- The service had access to the information needed to deliver effective care. Patient records were available electronically, and results from tests, particularly X-rays were provided to the nursing staff electronically. The record system captured all the information the service needed about the patient, and prompted staff to ask the right questions.
- Staff had access to approved pathways of care. There were standard operating procedures for treating patients, and flowcharts showing how to respond to unexpected events. Some of the standard operating procedures, such as for requesting and reading X-rays and calling an ambulance, had been produced with support from the NHS trusts involved.
- Staff had access to information through Sirona's intranet. Policies, procedures, guidance, and pathways for example, were all available online. There was access to training materials, booking sessions, and professional development. Those staff we asked said they found the intranet useful, and were able to generally find things they needed. Staff said they were able to talk with the in-house team and make suggestions about improving the site and adding areas that were useful or important.

Consent and the Mental Capacity act

- Staff knew about the importance of obtaining valid consent from patients or an appropriate adult, but both staff and the organisation were not always clear about consent for people who could not make their own decisions. The patient record system required staff to document that they had asked for, and been given permission to, carry out examinations or provide treatment to patients. Staff knew how the nature of care and treatment provided by the minor injuries units meant verbal or implied consent was satisfactory, and written consent was not required. However, some staff were not entirely familiar with the way in which consent

was handled for people who could not make their own decisions. Some staff talked about other adults providing consent for a patient living with, for example, dementia, and not able to decide for themselves. Equally, the audit examining consent in patients' records included the question: "has the service user (or carer/family member if more appropriate) continued to consent over time." There are very limited circumstances (legal arrangements) in which one adult might give consent for another adult, and staff admitted these were not the circumstances they were relying upon. If a patient cannot give their own valid consent, staff are able to act in their best interests, providing they consult with a carer or an advocate for the patient. These people would be able to speak for the patient, but this would not amount to giving consent. This decision process should be carefully documented. The units' patient record system was not quite sophisticated enough to direct staff to look at an assessment of a patient's capacity, and acting in their best interests. The consent decisions it recorded were too limited to include this alternative process.

- There was a good understanding of consent as it related to children and young people, although some staff were not entirely clear about the implications of the age of a child. Most staff, although not all, were aware of how young people aged above 16 were presumed to be able to give their own consent, unless staff felt they did not have the maturity to do so. For children under the age of 16, most staff knew they could decide if the child demonstrated sufficient maturity to give their own consent (termed as Gillick competent). Some staff thought there was a lower age limit, which is not the case. When a child was deemed not sufficiently mature to provide their own consent, staff would seek consent from the child's parent or legal guardian.
- Staff understood how consent was only valid if the patient or parent/guardian had been given an appropriate amount of information to be able to decide. Staff said, and we observed, how they would tell a patient how they had come to a decision about what course of treatment was recommended. Patients were given the opportunity to say they understood, ask any questions they might have had, and then give their consent. Staff knew patients had the right to change their mind and withdraw their consent at any time.

Good

Are services caring?

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

Summary

We rated the caring of urgent care services as good because:

- People were treated with kindness and compassion.
- There were positive results from views sought of people who used the service, and almost everyone would be likely or extremely likely to recommend the service to their family and friends.
- Patients who used the service, and those close to them, were able to understand and be included in their care and treatment decisions.
- Patients were given emotional support and signposted to other services to support their wellbeing or any other general health issues.

However:

- There was some lack of attention to privacy and dignity.

Compassionate care

- Patients and people who came with the patient were treated with kindness and compassion. We spoke with a number of patients at the inspection, and through pre-arranged telephone calls, and were provided with some comments in writing. Some of those comments included:
  - "The staff were helpful and very caring."
  - "They welcomed me, and put me at east straightaway."
  - "They were with us pretty quick, and very reassuring."
  - "These people are always being knocked in the press…but the job they do is second to none. I trusted these people with my son and they did not let me down."
  - "Excellent treatment, compassionate care to nervous patient."
- On almost all occasions, patients were treated with respect and dignity. Staff respected people's confidentiality, by, for example, not asking them personal questions when other people could overhear. Patients were not required to share their confidential or private information with the reception staff if they did not feel comfortable to do so. We observed curtains drawn around patients to preserve their dignity. There was one example of where a window blind was open when a patient in the Yate unit was about to be examined. The window faced a public area. The nurse rectified this when it was noticed – although not at the outset with the patient undressing. We also observed two occasions when the door to a treatment room was open when a patient was being assessed. The patient toilets were close to the treatment rooms, as was the access to the X-ray department, so conversations that were not behind closed doors could be overheard.
- Chaperones could be provided if a patient or a relative/carer requested it. Patients were told they could have a chaperone with them, and a member of staff would be able to accompany the patient should this be required.
- The nursing staff made sure patients were comfortable with being treated by members of the opposite gender. We observed one of the male nurses check respectfully with a female patient if they were happy to be examined by them – and they were completely comfortable with the arrangement. Staff told us they would make sure all patients were comfortable with the nurse who was looking after them.
- There were positive results from people who used the services at the minor injuries units. Patients and their relatives or carers were asked to complete the standard NHS Friends and Family Test. In the six months from April to September 2016, 99% of people who attended the Yate unit said they would recommend the service. The response was from 915 patients. Paulton reported slightly differently, so in the period from July to September 2016, 98.3% of people said they would recommend the unit. The response was from just under 250 people.

Understanding and involvement of patients and those close to them

- Patients and their relatives were able to ask questions and get the information they needed. They told us:
  - "Yes, they were very supportive and explained to me exactly what was happening."
  - "I cannot speak too highly of the way I was treated. They explained things in detail."
  - "Professional and given appropriate treatment. Kept both myself and the patient informed of what was happening and why it was taking place."

Good

Are services caring?

- Staff recognised when a patient or their relative needed more support to understand and be involved in their treatment. Staff recognised a person who had hearing problems, and spoke with them more slowly and clearly. Staff also said they would recognise if a person needed help to get into the unit safely, or had any disabilities or impairments. They would generally support these people to safely move from the waiting room, and had been out to a patient's car to help support them to get safely into the unit.
- Staff made sure they knew the identity of any person attending with the patient and ensured any private information was only shared with them if the patient was happy with that. We observed one of the nurses check with a patient if the person accompanying them was their spouse and they were happy to talk in front of them. They also checked with the spouse if they were happy to remain with the patient.

Emotional support

- There was support available for people to manage their own health and maximise their independence. Staff had a number of services to which they could signpost people to provide either emotional support, or more appropriate specialist support. For example, smoking-cessation services, drug and alcohol support groups, domestic violence helplines, charities and other support organisations.
- Staff took people's wellbeing into account when looking after them. They tried to see and treat at the same time any patients who were mentally or physically frail, so reducing the confusion, stress or anxiety that more than one session with a nurse might cause (most patients, particularly at Yate were otherwise triaged before seeing the treating nurse). We met a parent with a child with a developmental disability. They told us how staff made sure the family were able to wait in an area away from the main waiting room, so the child "felt safe and secure."

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 rated the responsiveness of urgent care services as good because:

- Services had been planned to take account of local clinical needs. They were designed and provided to help people to avoid accident and emergency departments for minor injuries or illnesses.
- The units were open to anyone who came for treatment.
- There were no barriers to patients or their families in relation to equality and diversity.
- The service responded to support people who might live in vulnerable circumstances.
- The units were open at times to suit local people.
- The services responded well to and learned from complaints.

However:

- The demand for the service at Yate was unable to be met at times. The service was being provided as commissioned, but the demand meant the service had to close too often to new patients in order to safely treat those patients already booked in.
- The waiting times at the Yate service were not displayed to people in the waiting area.
- The services provided by the Paulton minor injuries unit were not made entirely clear to patients.

Planning and delivering services which meet people's needs

- The services met the clinical needs of patients and what they had been established to deliver. The service was commissioned to provide an alternative for local people rather than seeing their GP, and for local people and visitors to the area attending an accident and emergency department for minor injuries. The hours of the service at the Paulton unit were longer in the week and more extensive on the weekends than Yate. This reflected the unit being in a more rural location and 30-45 minutes from the nearest accident and emergency department. The accident and emergency unit closest to the Yate unit could be reached in 20 minutes due to a less rural road system, and if the traffic was reasonable. A patient said of the service:
  - "It's great just having somewhere I can go locally. I know it's on the doorstep and I will get things checked out which I otherwise might not do with my GP, as I would have to wait days."
- Staff were managing people's privacy and confidentiality in the units. The layout of the units meant there was not a great deal of privacy for patients who were booking in to be seen, but there were protocols to manage this as much as possible. In the Yate unit, a cone had been placed in the reception area slightly away from the bank of reception desks. There was a sign asking people to wait near to the cone, in order to give the person being booked in some chance to talk to the reception staff with some degree of privacy. Staff at Paulton were looking at placing a line on the floor of the reception area to provide an indication to people to stand back. Alternatively, patients or their carers booking in a patient to be seen were not required to tell the receptionist why they were there. Patients could complete a form if they did not want to openly talk to the receptionist. The main reason for asking people why they were there was in order to assess if someone needed urgent attention, and be able to alert staff immediately to attend the patient.
- The services were open to all patients whether they were local, visitors to the area from the UK or overseas, or members of travelling or transient communities. Patients did not need to be registered with a GP or make payment for services. Patients were treated free at the point of need. Nevertheless, the majority of patients were local people, and many had used the services before to avoid a possible long wait to see a GP, or the need to attend accident and emergency departments. A patient who had come to the Yate service who was not local had commented to us:
  - "I am not registered here, but was seen very quickly and had excellent care."
- The services the Paulton unit provided were not made entirely clear to patients on the organisation's website. The services at Yate were for people with minor injuries, and this was clear. However, the services at Paulton were also for people with minor illnesses. This was not mentioned on the Sirona website and two of three

people we asked at the service were not all aware of the minor illnesses service. The standard operating procedures for the Paulton unit were also not clear in relation to what minor illnesses would be treated.

- The services were accessible to people in terms of physical access. Both units were in relatively modern buildings. They met the requirements of the Disability Discrimination Act in accommodating people with disabilities on an equal basis to others. Both the units were on the ground floor and located close to a car park with disabled parking bays. The buildings were well lit, clearly signposted, and there was usually a member of staff available to provide support to help people with access.
- The amount of space provided for the minor injuries service in Paulton was not always ideal. On a weekday, the service shared the area with a number of other services, including local NHS outpatient clinics, physiotherapy clinics, the fracture clinic and a doctors' urgent care service. The unit had only one dedicated clinic room, and its other room was shared with the other services when required. This was being managed by the staff as much as possible, but it limited the amount of patients that could be seen at times, although staff managed patient priority at all times.
- There were X-ray facilities at both minor injuries units. These were provided by staff from local NHS trusts. Radiographers saw patients referred to by the nursing staff, along with patients referred by their GP or another referring service. This service meant patients with suspected fractures or other injuries, such as possible foreign bodies in cuts, could be X-rayed on site. The X-ray facilities were not open across the same hours as the minor injuries units, but patients were able to come back to the unit at the next opportunity, or were referred to another service if the situation was more urgent. There were protocols as to what X-rays could be requested by nursing staff, and how the results were to be interpreted. This included obtaining an opinion from a radiologist within the NHS trust.
- There was some provision of food and drinks for patients, but only in one of the units. There was a vending machine with snacks and hot and cold drinks in the Paulton unit, and a water dispenser in the treatment area of the unit. There were, however, no facilities in the Yate unit, although it was located in the centre of a large shopping precinct and there were places to purchase food and drink within a short walk from the unit. Staff said they would give any patients who asked a glass of water at any time and a hot drink where this was the right thing to do. A comment from a patient about Yate was:
  - "Disappointed they could not provide drinking water in the waiting room. I was there for ages and did not want to pop out to get some in case I missed my slot."
- There were telephone-based services for staff to provide translation for people who had no or limited English. Staff were aware of the translation service and how to access it. Staff told us they would not rely on a child to translate for an adult patient unless the situation was critical, and would contact the translation service. The service had been responsive in the past and had been quick to provide a translator to the units. There was also a system within the Sirona intranet to produce their leaflets in another language for patients.

Equality and diversity

- There were no barriers to any patients attending the units in relation to equality and diversity. Staff understood where people might have different needs, and adjustments may be needed to the care and treatment they were given, to make sure the outcomes were equal to those for others. There were no barriers to or discrimination of people in relation to their age, gender, race, sexuality, pregnancy status or any of the other protected characteristics. The only circumstances giving rise to a patient not being treated were if the patient came with a condition, injury or illness the service was not commissioned to treat. Patients would be supported to seek help at the right service. This included mental health problems and sexual health concerns.

Meeting the needs of people in vulnerable circumstances

- The units saw where patients might be in vulnerable circumstances, and recognised where these patients would benefit from being seen more quickly. A patient recognised or described as living with dementia, a patient with a learning disability or difficulty, a patient under the influence of drugs and alcohol, and challenging, angry or aggressive patients, were among

those who may be seen more quickly. This was for the safety of the patient, to reduce anxiety for the patient, and possibly to reduce anxiety for other patients and relatives who were waiting to be seen.

- Staff had been trained to support people with complex needs. There was training in dementia awareness on induction and updated each year. However, the units were not designed with any particular signage to aid orientation for people living with dementia. The matron at the Paulton unit was looking into how that could be improved upon. Otherwise, the patient record system used did not have a particular template to help staff assess people with dementia.
- Staff were trained to work with the provisions of the Mental Capacity Act 2005 to ensure people who did not have capacity to make their own decisions were properly supported. Staff said how they would look to carers or care workers to provide helpful information about patients who might be anxious, confused, or not able to make decisions themselves. The units had been in touch with local care homes, on occasion, to enable them to provide the right response to patients coming to see them. The reception staff said patients (or their carers) who said they could become anxious if asked to wait in a busy waiting room, could sit in areas just outside of the unit, but within their sight or hearing. The reception staff would reassure patients they would not be missed, and staff would be informed that the patient was waiting in a different place.
- Staff had been trained to recognise and support patients who said or displayed symptoms of domestic violence or abuse. There were procedures to follow to help people who would agree to guidance or support being offered. There were also procedures to safeguard any children that might be part of the family group.
- The rooms and waiting areas were child-friendly. There were some toys and books for children to play with in the waiting areas, and these were visibly clean and in good condition. Staff said they made sure children were safe at all times when treating their parent or guardian. Staff would make sure young or anxious children were not left in the waiting room, and not looked after by anyone else while the parent or guardian was assessed.

Access to the right care at the right time

- The services in Yate were not able to see all the patients that attended at times, although the unit was providing the service it had been commissioned to deliver. The service was also not systematically reporting the data for service closures through its performance report in order to gauge the extent of the issues. Closures were reported as part of the organisation's 'Safer Services' measure, but this tended to mask the issue among the other stronger areas of service provision. However, staff told us the unit had to close early "several times a week" and "most weekends". The service was providing the staff and the facilities it was commissioned to provide, but it was not able to meet the demand from patients. We were told that sometimes there were as many patients as could be seen safely and effectively on a weekend waiting outside the door of the unit when it opened at 10am. The unit would often then have to redirect patients elsewhere from around midday so they could treat the patients that were waiting, before the unit closed at 1:30pm. The Paulton unit had not closed to new patients for as long as the staff could remember.
- The organisation had recognised the risk of the increased demand on their Yate service. The issues on a weekday had been placed on the Sirona corporate risk register just over two years ago. The weekend issues had been raised in October 2016. There had been some changes internally to endeavour to deal with the demand and waiting times (more dedicated triage time), but the unit was also a victim of its own success. We know from local people and comment cards given to us how people would come from what would be usually outside of what Sirona would see as its catchment area to use the service. Patients knew they could park for free, and that the service was good. The problems had been discussed on a number of occasions with the local commissioners, but without any increase to service provision due to financial pressures.
- People were told how long they might have to wait, but this was not displayed in the waiting room in the Yate unit – only Paulton. The Yate service had sought, but been denied permission by their property owner, to place a television screen in the unit waiting room which displayed waiting times and other useful information. This was not a problem for the Paulton service, which had a different estates' contract. Yate staff endeavoured to indicate on a board in the reception area how long the waiting time was. Staff admitted this was not always as accurate as it could be due to time pressures and a lack of automation of waiting times.

Good

Are services responsive to people's needs?

- The majority of patients were seen at the minor injuries units without having to wait too long. The key performance indicator was for 95% of patients to be seen within four hours.
  - In the six months from April to September 2016, 99.6% of patients coming to the Yate unit were seen within four hours. Of these, 33.9% were seen within the hour. The median waiting time was 1 hour 20 minutes. In September of the previous year (2015), the numbers were 99.8% seen within four hours, and 41.1% within the hour. The median waiting time was 1 hour 11 minutes. However, in the feedback to the service from the Friends and Family Test, the only area where patients made negative comments was about the waiting times.
  - In the six months from April to September 2016, almost 100% of patients coming to the Paulton unit were seen within four hours. Two patients fell outside of this target in July 2016, although this was just 0.3% of patients in that month. Of these patients, 70.4% were seen within the hour and almost all patients within two hours. The median waiting time was 43 minutes. In September of the previous year (2015), the numbers were 100% seen within four hours, and 69.9% within the hour. The median waiting time was 44 minutes.
- There were low numbers of patients who left the Paulton unit, after being booked in, without being seen. Staff told us the data provided for Yate (which showed zero patients each month) was not accurate, although they said the numbers were also very low. In Paulton, in the period April to September 2016, just 0.4% of patients (17 patients) left before being seen.
- There was a protocol for the 111 service and the ambulance service to send or bring relevant patients to the minor injuries units. The 111 call centre staff signposted patients to the minor injuries units and worked to an agreed and approved schedule of services provided in Yate and Paulton (which were slightly different). The ambulance crew had a process, which required them to telephone the unit and discuss a patient with the nurse in charge. The patient could be brought to the unit if the clinical criteria was appropriate. If the nurse in charge was uncertain, the ambulance personnel could bring the patient to the unit. The patient would then be assessed on board the ambulance by the nurse to avoid moving the patient unnecessarily. If the patient needed a different service, the ambulance crew would take the most appropriate other course of action, such as admission through accident and emergency.
- GPs were informed about one of their patients being treated at one of the units within two days of the visit. This included children who did not wait to be seen (or they were removed by their parent or guardian before being seen). The notification to the patient's GP (presuming the patient was registered with a GP) was made by default and staff admitted patients were not asked if they consented to their GP being notified of their visit.

Learning from complaints and concerns

- The minor injuries services learned from complaints and concerns, although these were uncommon. There had been no complaints to the Paulton service in the last year, and two that were upheld at the Yate service. These two complaints were related to reception staff not giving patients accurate information. It led to the procedures for the receptionists being updated and training provided.
- Staff learned from complaints even when they were not upheld or not directly about their service. In Yate, for example, this had led to better communication. The 'Your Further Care' cards had been produced for patients who were being referred to other services. There was training in how to manage burns, work with GP teams locally, and further training about stewardship of antibiotics.
- There was information available for people to make complaints, raise concerns or pay compliments. People could write to the organisation, send an email, telephone the customer care service, or talk to someone in person. There were leaflets available, which had all the contact details in order to do this. The leaflets provided people with advocacy services for people who wanted support to make a complaint. The information was also on the Sirona website.

Good

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 judged the leadership of urgent care services as good because:

- The vision was to deliver high quality and safe care.
- There were strong values among the staff, underpinned by the organisation.
- The governance and management structures understood the risks, performance, and quality of the service.
- The leadership of the services and the directorate reflected the values, and encouraged openness and transparency.
- People who used the service, and the staff employed there, were engaged in giving feedback about the service. People and staff were listened to, and their suggestions for improvements or changes were taken into account whenever possible.
- Staff felt supported by the senior management, their own direct management, and one another. There was high morale and staff satisfaction with the care and treatment they were able to provide.

However:

- Some of the risks recognised by the staff themselves were not being systematically recorded to demonstrate they were known about and being managed.
- The team meetings at Paulton did not have a specific structure and some areas of governance were not routinely discussed at either location.

Service vision and strategy

- The objectives of the unit were to deliver high quality care. The objectives described by both the minor injuries units at Yate and Paulton included care being patient centred; services being delivered safely, effectively and through a learning environment; services being accessible and convenient; services being appropriate and responsive; and services delivered in a clean and pleasant environment.
- Staff talked about 'Taking it Personally' and the values and behaviours that underpinned their care for patients. Taking it Personally involved patients being treated with courtesy and respect – so people felt welcome; there being effective communication – so people felt valued; staff being caring and supportive – so people felt supported; and care being effective and professional – so people felt safe. Those staff we asked about this initiative were all able to describe it well, and what it meant to them. One member of Sirona staff commented upon how close it was to the things the Care Quality Commission would rate their services upon. They said, "We must have all got right the things that matter then."

Governance, risk management and quality measurement

- There was management of the recognised more significant risks to the service, although lower-level risks were not captured in a review system. The more significant risks for the service were held on the divisional risk register. This included the issues with high demand at Yate, weekend closure and the lack of reception cover at Paulton at evenings and weekends. These were held by the head of the division and would be discussed at the monthly board meeting. However, there was no specific review system for local risks. There were no local risk registers in use. There were a number of areas that did not have systemised review. These included, for example:
  - The limited availability of rooms at times at the Paulton service.
  - The occasions of lone working at the Paulton service.
  - The lack of the waiting time being displayed in the waiting room at the Yate service.
- The minor injuries services were discussed at divisional meetings and significant issues would be presented to the board. The issues with demand at the Yate service, for example, had been escalated to the board through the corporate risk register. At divisional level, the services were discussed with the head of their service, and there were monthly meetings with the heads of the services and the lead for specialist services.

Good

Are services well-led?

- Staff were informed about the governance of the service, announcements, new information, and updates to the organisation. Data was shared through the monthly team meetings, and on the well-used staff noticeboards in the departments.
- The team meetings did not cover a structured agenda and agreed standing agenda items, specifically at the Paulton unit. At Yate, there were regular standing agenda items including discussions about incidents and complaints at team meetings, but there were no regular or routine audit results or outcome measures discussed. There were a number of audits completed by the services on a regular basis, but this was not a standing agenda item to be discussed and reported. All the audits we saw had action plans attached, but there was no progress of these actions being discussed and reported upon to ensure they were on track. At Paulton, there were lists of those things discussed at team meetings, but no minutes of the discussions. The records we saw did not include incidents, complaints, concerns, audits or other standing agenda items. We understood these were discussed at individual one to one meetings, but they were not being captured within a governance framework.

Leadership of this service

- The services had stable and respected leadership both within the unit and within the wider organisation. All the staff we met spoke highly of their immediate manager or leadership team. Many of them had met or had contact with or from the executive team in the organisation. The managers were described variously as “although they don’t really have a door some of the time, their door is, metaphorically, always open” and “there would be nothing I would not approach them with for help or support.”
- The leadership had the experience and skills to lead the services. Each of the minor injuries units had an experienced matron, supported by either band seven or band six nurses with much experience in emergency care. The units sat within the specialist services division, and were supported by an experienced head of service, who reported directly to the director of nursing and operations.

Culture within this service

- The culture within the service encouraged openness, candour and honesty. Staff told us they knew the organisation gave them a number of options they could use to speak up if they were concerned. Most staff said they would talk directly with their line manager, which demonstrated good local relationships within teams. Others said they knew of the organisation’s whistle-blowing policy, and said they were confident to use it. None of the staff we met said they felt they would be in any way penalised by Sirona if they spoke up. A number of staff said they were confident about writing to or calling the chief executive, Janet Rowse, directly, and this had never been discouraged.
- Staff felt problems were resolved quickly. We were told there was usually a teamwork approach to problems. This meant solutions were looked for across the service between the experienced team. Issues were discussed at team meetings (although only documented in any detail at Yate), and they would remain open in the minutes until a solution had been found and seen to work. Staff said they felt they had enough experience in the service to be able to offer solutions to problems they encountered, rather than just handing problems on to others. Senior staff told us their teams were proactive and often looking for ways to improve.
- There was team working between the two services. They were geographically too far away for staff to support the other service on a regular basis. The units were around 23 miles apart and this could take up to an hour by car. The matrons therefore met at divisional meetings, but talked on the phone and sent emails on a regular basis. They shared good and best practice with one another, and designed leaflets, standard operating procedures, and other mutual documents and protocols together. This avoided duplication of work, and encouraged sharing of new and good practice.
- There was a good culture of teamwork and inclusion in the units. The staff we spoke with all said they felt one of the best things about the service was the support and high staff morale. One of the very regular bank staff at the Yate service told us they were treated as one of the team at all times, and were supported and encouraged in their nurse training. They said they wanted to work for the service fulltime when they were qualified, as they “love working here.”

Public engagement

- The views of the public were sought on a regular basis. Patients and their relatives or carers were asked to complete the standard NHS Friends and Family Test.

Good

Are services well-led?

Comments made by people were also captured and distributed to the staff each month so they were able to see what people thought of the service. There were very few negative comments, among a long list of 99% patients who said they would be 'extremely likely' or 'likely' to recommend the service. The negative comments related only to the waiting times in the Yate service, and there was one among several hundred about the lack of drinking water in Yate.

- The organisation took notice of people who complained but also who took the time to compliment the service. The Paulton service had nine compliments in the three months of July to September 2016, one concern, but no complaints. The Yate service had 20 compliments in the six months from April to September 2016, two complaints, and nine concerns. Sirona had reported on its risk register how the demand on the Yate service since the closure of the NHS accident and emergency department at Frenchay Hospital (local patients now had to travel further to Southmead hospital) had been commented upon. The risk register showed how complaints about waiting times and crowding in the service had increased.
- People who raised concerns or made suggestions were listened to. There was good evidence of 'You Said: We Did' on noticeboards in the units. This had led, for example, to the electronic display in the Paulton unit with useful information for patients, including the waiting times.

Staff engagement

- The organisation engaged with its staff. There were a number of ways for staff to both be engaged with the service, one another, and senior executives to communicate with their staff. There were team meetings each month at a local level. One of the matrons told us how they had gone through the minutes of several of the most recent team meeting minutes with a member of staff who had not been able to attend. This was to ensure the member of staff still felt included and had not missed any key messages. There were also newsletters for staff and regular email updates and information. Sirona had an email inbox designed for staff to ask questions of the organisation. The Chief Executive recorded a video response to staff each month without rehearsal or knowing the questions in advance.
- There were services provided or signposted by Sirona for staff wellbeing. These included occupational health reviews and guidance, employee counselling services, and in-house physiotherapy services.
- Staff were recognised for their contribution. There was a staff excellence award scheme, and a number of staff in the minor injuries units had been awarded these over the years. This had included recognition for work with local GPs in the area local to the Yate service to establish minor injury services at these practices. The award certificates were displayed on the staff notice boards, and staff were keen to point these out for their colleagues who had been awarded them in the past. This showed good teamwork, and staff being proud of each other's achievements.

Innovation, improvement and sustainability

- Innovation and improvement was encouraged and supported. The minor injuries service in Yate had been supported, recognised and commended for its work to establish services with local GPs. The matron of the service had been recognised for working with these GPs over a period of two years, and delivering four days of training to practice nurses, nurse practitioners and GPs. The commissioners had supported the matron of the Yate service in this project, which was now established with 29 GP services in South Gloucestershire. The GP services had lower clinical criteria than the Yate service, but the practices had created slots for patients to attend. The services were now used by around 5,000 patients a year.
- Staff told us they did not believe internal financial pressures had compromised care. They said they had been required to make savings in the service, along with the rest of the organisation, and staff had been proactive and successful with ideas for reducing waste. However, the care and treatment of the patient had not been compromised. Staff said the only issue was with the demand at the Yate service being so high, and not slowing down, was now not being able to provide the service that met public demand, particularly on the weekends.