Derbyshire Community Health Services NHS Foundation Trust

RY8

Urgent care

Quality Report

Derbyshire Community Health Services NHS
Foundation Trust
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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)
RY8Y9	Buxton Hospital	Urgent Care Services	SK17 6TE
RY846	Ilkeston Hospital	Urgent Care Services	DE7 8LN
RY8Y4	Ripley Hospital	Urgent Care Services	DE5 3HE
RY8Y1	Whitworth Hospital	Urgent Care Services	DE4 2JD

This report describes our judgement of the quality of care provided within this core service by Derbyshire Community Health Service NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Derbyshire Community Health Service NHS Foundation Trust and these are brought together to inform our overall judgement of Derbyshire Community Health Service NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Overall, we rated urgent care services provided by the minor injury units as outstanding.

Feedback from patients was continually positive about the way all staff treated them. There was a strong, visible person-centred culture; patients described being treated as “individuals” rather than a “number”. Patients and relatives told us all staff go the extra mile and the care they received exceeded their expectations. One relative of a child told us they chose to attend the unit with their child as staff “understand" the needs of children and their experiences have always been “positive”. They told us staff went “above and beyond” what was expected of them. Other patients described being treated like “family” describing the service as “absolutely brilliant” and said the care was more “attentive” than at bigger hospitals. Staff across all units were highly motivated to offer care that was kind, compassionate and promoted patient’s dignity. During our inspection we were particularly impressed with the interpersonal skills demonstrated by staff.

The services provided by the minor injury units (MIUs) were tailored to meet the needs of the individual patient and were delivered in a way to ensure flexibility, choice and continuity of care. Patients could access the service in a way and time to suit them. The units had set up nurse led fracture clinics to reduce the numbers of patients having to transfer to acute hospitals for the management of simple fractures. The MIUs also offered clinics for patients requiring follow up treatment or review of conditions such as burns, foreign body removal, eye problems and wounds. There was a proactive approach to understanding the different needs of people and delivering care to meet those needs. Waiting times and delays were minimal and managed appropriately if they did occur. The service exceeded targets in respect of time spent in MIUs and the time people waited for treatment.

Patients attending MIU were protected from avoidable harm and abuse. We saw effective and reliable systems and processes in place for infection control, medicines management, patient records and assessing and responding to patient risk. The systems and processes were sufficient to protect patients from avoidable harm. We saw an effective system in place to ensure patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of arrival to MIU in line with best practice. Staff across all MIUs were up to date with mandatory training. Staffing levels and skill mix were appropriate to keep patients protected from avoidable harm. The safeguarding of vulnerable adults, children and young people was given sufficient priority. Staff were actively engaged in local safeguarding procedures and worked effectively with other relevant organisations.

Patients’ care and treatment was planned and delivered in line with current evidence based guidance and standards. Staff were qualified and had the skills they needed to carry out their roles effectively. Patients had a comprehensive assessment of their needs, which included clinical needs, mental health, physical health and wellbeing needs.

There was a clear statement of vision and values, driven by quality and safety, staff knew and understood the trust vision and values. Unit managers had the experience, capacity and capability to lead the services and prioritised safe, high quality, compassionate care. There was a high level of staff satisfaction. Staff said they were encouraged and supported to develop, were proud of the teamwork within the units and the willingness to help and support each other and said there was a positive regard for their welfare. Over 30% of the compliments received by the trust related to the positive care and experiences of people attending the MIUs.

Summary of findings

Background to the service

Derbyshire Community Health Services (DCHS) NHS Foundation Trust provides urgent care services for adults and children at four minor injury units (MIUs) based at Ripley, Ilkeston, Buxton and Whitworth Hospitals. The units provide care to adults and children of all ages who either self-present, are referred by their GP, NHS 111 or the ambulance service. The units are open between 8am and 10pm seven days per week. Treatment is provided by all MIUs for a range of minor injuries and illnesses, including sprains, broken bones, wounds, minor burns, minor head injury, insect and animal bites, minor eye injuries and conditions. X-ray facilities are available at all of the units, although opening times vary. Patients presenting with serious injury or illness are stabilised as appropriate and arrangements made to transfer them to the nearest acute hospital.

The units operate a nurse led fracture clinic for the management of simple fractures and follow up clinics for review of conditions such as burns, foreign body removal, eye problems and wounds.

Emergency nurse practitioners (ENPs) lead all of the units. Staffing across all units consists of emergency nurse practitioners (ENPs), registered nurses, paramedics who are emergency care practitioners (ECPs), health care assistants and reception staff. ENPs and ECPs are specially trained nurses / practitioners who are able to see, treat and discharge patients.

In the reporting period January 2015 to April 2016 the units treated 77,939 patients, 20,710 (26%) of these were children.

We visited all of the trusts four minor injury units. We spoke with 28 patients, 24 staff, including junior and senior nurses, student nurses, health care assistants, paramedics, allied health professionals, administrative, housekeeping and estates staff. We observed interactions between patients, relatives and staff and considered the environment. We looked at 11 electronic records of care and treatment including medication prescribing and administration information. Before our inspection, we reviewed performance information from and about the hospital.

Our inspection team

Our inspection team was led by: Carolyn Jenkinson, Head of Hospital Inspection

Chair: Elaine Jeffers

Team Leader: Carolyn Jenkinson, Care Quality Commission

The team included CQC inspectors, inspection managers, pharmacy inspectors, an inspection planner and a variety of specialists including:

Clinical Project Manager, Non-Executive Director, Community Children's Nurses, Community Health Visitors, Dentist, Dietitian, Occupational Therapists, Physiotherapists, Paramedic, Nurse Consultants, District Nurses, Palliative Care Director, GP, Learning Disability Nurses, Specialist Nurses and a Mental Health Act Reviewer.

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

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 23 to 25 May 2016.

What people who use the provider say

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

Patients and relatives told us that staff go the extra mile and the care they received exceeded their expectations. One relative of a child said they chose to attend the unit with their child as staff "understand the needs of children" and there experiences have always been "positive". They told us staff went "above and beyond" what was expected of them. Other patients described being treated like "family" describing the service as "absolutely brilliant" and said the care was more "attentive" than at bigger hospitals.

Good practice

- Staff at Ripley MIU were able to call a "pit stop" in the unit. The "pit stop" was a way of gaining an overview of the units and prioritising patient needs in the unit. All staff would attend the "pit stop" and create a plan.
- The units had adopted safeguarding children supervision. Safeguarding children supervision was a formal process of professional support and learning, which aimed to ensure clinical practice promoted the child and young person's welfare. This was achieved by staff thinking and talking about what they had observed, heard or read, doing so supported the development of good quality practice and was a way of ensuring staff were up to date and knowledgeable in safeguarding procedures. We saw records of these sessions.
- A nurse led fracture clinic had been set up across all units; led by the ENPs this aimed to reduce the numbers of patients having to transfer to acute hospitals for the management of simple fractures. This benefited patients from the local community as well as visitors to the area. ENPS saw patients with simple fractures; they assessed, diagnosed, treated and followed-up patients in the same hospital. This had shown to be a positive experience and benefit to patients particularly children, as all hospital experiences have the potential to be frightening.
- Patients had access to ENP clinics, patients could book to attend these clinics for follow up treatment or review of conditions such as burns, fractures requiring x-ray, foreign body removal, eye problems and wounds.
- MIU had access to short stay beds on the wards nearest to the unit. The beds could be used for variety of reasons for example, a simple observation period following treatment, application of plaster of paris, awaiting x- ray opening times or for safety concerns whilst awaiting home support. Access to these beds prevented admissions to the acute NHS Trusts.
- Live waiting times for Ripley and Ilkeston MIU were available on the trust's website, local newspaper's, and clinical commissioning group's website. The times were displayed against the current waiting times at the

local acute emergency department, this encouraged patients to attend MIU where their conditions allowed and reduce the demand on the local emergency department.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should consider reviewing the children's waiting areas to ensure they provide visual and audible separation from the adult waiting areas in line with Intercollegiate standards for Children and Young People in Emergency Care settings.
- The trust should consider if the MIU managers should have protected supervisory time in line with other unit managers within the trust.

Derbyshire Community Health Services NHS Foundation Trust

Urgent care

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

We rated safety of urgent care services as good because patients were protected from avoidable harm and abuse.

We found;

- Effective and reliable systems and processes in place for infection control, medicines management, patient records and assessing and responding to patient risk. The systems and processes were sufficient to protect patients from avoidable harm.
- We saw an effective system in place to ensure patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of arrival to MIU in line with best practice.
- Staff across all MIUs were up to date with mandatory training.
- Performance showed a good track record in safety. Openness and transparency about safety was encouraged and staff understood and fulfilled their responsibilities to raise concerns and report incidents.
- The safeguarding of vulnerable adults, children and young people was given sufficient priority and staff were actively engaged in local safeguarding procedures and worked effectively with other relevant organisations.
- Staffing levels and skill mix were appropriate to keep patients protected from avoidable harm.

However we found;

- Children's waiting areas did not provide visual and audible separation from the adult waiting areas. This was not compliant with Intercollegiate Children and Young People in Emergency Care settings standards.

Safety performance

- There were 220 incidents relating to MIU reported to the National Reporting and Learning System (NRLS) in the 12-month period to April 2016. The NRLS is a central database of patient safety incident reports that a trust submits to. All of the incidents reported were categorised as minor, low or no harm incidents. The top three incident themes were safeguarding referrals, violence and aggression (patients) and treatment problems.
- During the 12-month period to April 2016, the trust reported no serious incidents through to the Strategic Executive Information System (STEIS) however, we did note that there was one serious incident reported by the trust relating to a visitor who had fallen in the car park of

Good

Are services safe?

Ripley hospital. Whilst not related to MIU, staff from MIU reported the incident as they were first to respond to and treat the visitor. There was a robust system in place for staff to meet and investigate the cause of serious incidents. Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, they warrant using additional resources to mount a comprehensive response (NHS England, March 2015).

Incident reporting, learning and improvement

- Staff were aware of and appeared knowledgeable and confident about reporting incidents. All trust staff had access to the online reporting system. Staff told us they received acknowledgement they had submitted an incident report, but did not always receive individual feedback about the incident.
- Incidents giving cause for concern, or following a specific trend were discussed in the units' meetings; minutes of these meeting we looked at confirmed this. Staff told us of an example of learning from an incident. A staff member had accidentally allowed some adhesive to run into a patient's eye when closing a wound. Following this incident, the units were trialling a gel product rather than the runny adhesive previously used. In the meantime, the units had introduced the use of white soft paraffin ointment as well as damp gauze as an added protection.
- Staff gave us examples of when they might report incidents such as patients presenting with a pressure ulcer or falls in the unit. Staff said there was a non-blame culture in the units and they felt empowered to report incidents without fear of reprisal.
- Staff were aware and able to explain their understanding of the requirements of duty of candour this was supported by an organisational policy and training sessions provided by the trust. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The online incident reporting system incorporated a duty of candour element and prompted staff to offer an open and honest explanation to patients if an incident had affected patient care.

Safeguarding

- Policies outlined the processes for the safeguarding of vulnerable adults and children. Staff followed specific guidelines and care pathways where concerns around safeguarding of children, young people and adults were identified, such as instances of domestic violence. There were processes in place to escalate concerns and staff showed us a list of safeguarding contacts. During our visit to one unit, we observed staff discussing concerns for a patient with unexplained burns. Staff made a safeguarding referral for this patient.
- The electronic patient record system incorporated a safeguarding checklist for adults and children. School nurses or health visitors were sent copies of children's attendances directly from the electronic system. This ensured children had the necessary follow up.
- The units had adopted safeguarding children supervision. Safeguarding children supervision is a formal process of professional support and learning, which aims to ensure clinical practice promotes the chid and young person's welfare. This was achieved by staff thinking and talking about what they had observed, heard or read, doing so supported the development of good quality practice and was a way of ensuring staff were up to date and knowledgeable in safeguarding procedures. We saw records of these sessions.
- Data across all units showed 100% of available staff (registered and non-registered) had completed level three safeguarding training and 100% of available healthcare assistants had received level two safeguarding training.
- Staff were aware of the female genital mutilation (FGM) policy. Female genital mutilation and child sexual exploitation training was included in level three safeguarding training for registered professionals. Staff were aware of their responsibilities in relation to FGM and child sexual exploitation.
- The units had dedicated safeguarding link professionals who were responsible for keeping staff up to date with any changes in policies or procedures.
- We asked the trust if there had been and safeguarding or serious case reviews in relation to MIU over the last 12 months. The trust told us there had been no serious case reviews affecting MIU in the last 12 months. Unit managers told us if there were any serious case reviews

which MIU staff needed to know about, this would be shared with the unit managers at the monthly managers meeting, and then with the teams in the staff meetings and through the monthly bulletin.

Medicines

- Medicines were stored securely on all MIUs we visited and appropriate emergency medicines were available. We found the treatment room at Whitworth MIU was unlocked. The room however was located in a restricted area where staff were always present. Medicines were all stored in locked cupboards or fridges and the nurse in charge took responsibility for the keys.
- Blank prescription pads and computer paper were held securely and tracked to avoid misuse.
- Medicines requiring storage at temperatures below eight degrees celsius were appropriately stored in medicine fridges .Records confirmed fridge temperatures were monitored daily to check medicines were stored at the correct temperatures. Information was clearly visible to all staff on what to do if temperature was out of range
- Staff carried out checks on controlled drugs (CDs) in line with trust policy. Checklists we reviewed confirmed this.
- Stocks of CDs not subject to safe storage or record keeping requirements were checked daily and a log held to record the names of those who had received them. This minimised the risk of inappropriate supply to patients at risk of drug misuse.
- Staff were responsible for maintaining minimum stock levels and checking medication expiry dates. We checked a number of medicines across all units and found them to be in date.
- Medical gases were stored in designated cylinder trollies, this meant the risk of them falling over and causing injury to someone was minimised.
- Qualified staff used patient group direction (PGD) for the prescription of a variety of medications such as pain relief and antibiotics. Patient group directions provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor.
- We reviewed 12 PGDs for adult and children and found they were all correctly completed, authorised and in date. PGDs included a good criteria under which a patient may or may not be eligible for treatment with certain medicines. Staff signatures were present to confirm they had read these. Staff were able to access the PGDs directly from the electronic record system; this meant the most appropriate PGD would be selected to ensure the patient received the most effective medication if required.
- We looked at the electronic prescription and medicine administration records for 11 patients across all units, these included seven adults and four children .We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them. Patients' allergies were recorded on the electronic record.
- An audit of antimicrobials (antibiotics) supplied through a Patient Group Directions (PGDs) was carried out across all units for a four week period during September 2015 to ensure the continued safe and appropriate supply of antimicrobials through PGD. The audit showed excellent compliance with both the PGD inclusion criteria and recording of antibiotic use to demonstrates compliance with the recommendation of Antimicrobial Stewardship.

Environment and equipment

- All of the MIUs we visited were well maintained, free from clutter and provided a secure environment for treating patients.
- Premises were fit for purpose; the design and layout of MIUs meant staff could observe waiting patients. This meant reception and clinical staff could identify if a patient's condition deteriorated or if a patient or visitors' behaviour put other people at risk. There were a suitable number of seats available in all units including if the units were extremely busy.
- Children's waiting areas did not provide visual and audible separation from the adult waiting area. This was not compliant with Intercollegiate Children and Young People in Emergency Care settings standards. During our inspection we did not see any children in the children's waiting areas, and staff told us children would be prioritised for treatment on arrival to the units therefore the children's waiting areas were used rarely.
- There were adequate supplies of available, accessible and suitable equipment, including resuscitation equipment, which was in date and ready for use. There was a schedule for regular checks of this equipment and we saw they were up to date and had been completed daily over the last three months.

Good

Are services safe?

- Resuscitation equipment for children was available on the adult resuscitation trolley and the drawer was highlighted to indicate where this was located, however, at Buxton MIU we found the drawer was not highlighted.
- There was a safe and effective system in place for the repair and maintenance of equipment. We looked at 24 pieces of equipment across all of the units we visited which included vital sign machines, blood glucose monitoring equipment, scales and examination lights, all of these were up to date with routine maintenance. During our visit to Ilkeston MIU, we saw staff had reported a malfunctioning examination light. The estates department were attending to repair the equipment whilst we were in the department. Unit managers said they did not have a problem with the responsiveness of the estates department.
- In 2010 and 2015, the Department of Health issued an alert to NHS trusts requiring action to reduce the risk of strangulation in children and vulnerable adults from loop cords and chains on window blinds. There was a window blind with loop cords in the children's treatment room at Ilkeston MIU; this posed a risk to children. The blinds had not been risk assessed, although the trust had completed a trust wide ligature risk assessment. We escalated our concerns to the unit manager who arranged for the estates department to remove this. The blind was removed within five minutes of our escalation.
- Firefighting equipment was readily available and in date with routine servicing.

Quality of records

- We looked at 11 patient records across all of the units. Records were electronic. Access to electronic records was through computers at various locations around the units including treatment rooms. This allowed for easy access for all staff caring for the patient.
- Only authorised staff had access to patient records. The system was password protected. Staff accessing patient records in the electronic system following a patient's discharge were required to record the reason for their access; this ensured an audit trail was maintained and unauthorised access to records avoided.
- Patient records showed assessments were carried out in a timely manner and documented correctly. Observations were accurately recorded and the observation times were dependent on the level of care needed by the patient.

Cleanliness, infection control and hygiene

- All the units were visibly clean. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place and we saw the completed schedules, which were up to date. There were clearly defined roles and responsibilities for cleaning the environment and for cleaning and decontaminating equipment.
- The trust used the credits for cleaning software package. A credit for cleaning is an NHS approved monitoring package and was used weekly to audit the cleanliness and safety of the environment. Audit results for the 13-week period from the February 2016 to April 2016 showed 100% compliance with environmental safety and cleanliness.
- NHS England and the Department of Health recommend all hospitals providing NHS-funded care undertake an annual assessment of the quality of non-clinical services and the condition of their buildings. These assessments are referred to as Patient-Led Assessments of the Care Environment (PLACE). In the 2015 PLACE assessments, the trust scored above 99% across all of the locations. Where an MIU was located this was above the national average of 97%.
- Cleansing gel was available at the entrances to each unit and in each treatment room; patients and visitors were encouraged to use it by staff. Posters were prominently displayed encouraging staff and visitors to cleanse their hands and the process to follow to do this effectively.
- Staff were 'bare below the elbow' to allow effective hand washing.
- During the reporting period January 2016 to April 2016, hand hygiene compliance was 100% across all of the four units.
- Protective equipment, such as gloves and aprons, were available and we observed staff using these appropriately. We also observed staff washing their hands between patients.
- We observed all patient-care equipment to be clean and ready for use.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste including the disposal of sharps such as needles and environmental waste.

Mandatory training

Good

Are services safe?

- Staff received mandatory training through a variety of face-to-face and e-learning modules. Modules included moving and handling, infection control, fire safety and resuscitation.
- Data for all units showed 100% of available staff were up to date with mandatory training; this was in line with the trust target of 100% of available staff.
- Staff within the units received children's resuscitation training such as paediatric immediate life support. Records showed 100% of available staff were up to date with adult and paediatric immediate life support.

Assessing and responding to patient risk

- There was an effective system in place to ensure patients received appropriate initial assessment by appropriately qualified clinical staff within 15 minutes of presentation to MIU in line with best practice. In the reporting period April 2015 to March 2016, patients attending MIU were seen on average within 11 minutes with no patients waiting longer than 14 minutes.
- Reception staff told us if a patient presented with symptoms suggesting serious illness, such as chest pain, or serious injury, such as heavy bleeding, they would escort the patient immediately to the treatment area and summon the registered nurse. There was an emergency alarm easily accessible for the reception staff to summon immediate help if required.
- Staff completed an electronic assessment record for each patient who attended the unit. This record included the recording of baseline observations. A nationally recognised early warning score tool for adults and children was used to ensure staff were alerted to the need to escalate the management of a seriously injured, unwell or deteriorating patient. There was an assessment tool in place to identify sepsis (a potentially life threatening complication of infection). Staff told us there was further guidance on the trust intranet; and there were embedded links in the electronic record system to the sepsis website.
- The electronic admissions system alerted staff if any patients had attended the hospital or other MIUs previously so they could be referred to other hospitals if needed.
- Patients were allocated a category at triage. The numbers ranged between one and five. One required immediate response and five was a non urgent presentation to the unit. The scores were recorded on the computerised system so all staff could see patient priority. We saw examples of care being escalated promptly when patients presented to the units scoring priority one.
- The nurse in charge kept an overview of patient priority and the number of patients in the units on a regular basis.
- Staff at Ripley MIU were able to call a "pit stop" in the unit. The "pit stop" was a way of gaining an overview of the units and prioritising patient needs in the unit. All staff would attend the "pit stop" and create a plan.
- Staff had direct access to the local acute NHS trusts for further guidance and support if required. All units had direct access to a paediatrician at a local acute NHS trust for support with children. Staff told us there were good links with the local acute NHS trusts and we saw staff referring patients to these trusts when further specialist input was required.
- We saw the units had access to a metal wand; this was used to detect coins a child may have swallowed.
- All units had ample supply of ligature cutters on the resuscitation trollies in the event of an emergency.
- Staff had easy access to and we saw staff using toxbase. The toxbase database provides information about routine diagnosis, treatment and management of patients suffering from exposure to a wide range of pharmaceuticals, chemicals (agricultural, household and industrial), plants and animals.
- There were written protocols in relation to the urgent transfer of seriously ill or injured patients by ambulance to an acute hospital. Staff gave us examples of when they had used them for example when a seriously ill child needed specialist care following a convulsion. A convulsion is a sudden, violent, irregular movement of the body, caused by involuntary contraction of muscles and associated especially with brain disorders such as epilepsy.
- There was a process in place to ensure a health visitor, school nurse or general practitioner followed up all children under the age of one, who attended the units.

Staffing levels and caseload

- We found there were sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure patients were safe and received the right level of care.

Good

Are services safe?

- Staffing levels were based on a regular review of demand throughout the year using the electronic patients recording system and the staffing rosters.
- With the exception of Buxton MIU who had two nurse vacancies due to staff promotion, all of the units were fully staffed.
- MIU staffing was made up of emergency nurse practitioners (ENPs),registered nurses, paramedics who were emergency care practitioners (ECPs) health care assistants and reception staff. Paramedics had been recruited to work in the units, and staff felt this had complimented the workforce.
- In the event of staffing shortfalls the units had access to an internal "responsive workforce" bank. One member of the responsive workforce had been allocated to support MIU on a temporary basis to fill a staffing vacancy.
- Two thirds of the MIU workforce were registered professionals such as nurses the remaining workforces was made up of non-registered professionals such as health care assistants.
- Staff told us and we saw there were escalation processes in place on all units for staff to follow if there were staffing shortages.
- The expected and actual staffing levels were displayed on notice boards in each MIU; these were updated on a daily basis.
- Nursing staff handovers occurred at each shift change over and included discussions about patient needs and any staffing or capacity issues.
- There were no registered children's nurses employed in the units however all staff had received training and completed competencies for the assessment and treatment of children. Staff new to the units also spent time in the local NHS trust children's emergency units. ENPs also completed modules in the care and treatment of children as part of their course. Staff were able to access additional paediatric modules through the local university if they wished. All staff had completed the paediatric assessment illness management (PAIM) course.
- There was an effective system in place for the induction of agency staff. Although there were no agency staff in the units at the time of our inspection, we saw completed agency checklists.

Managing anticipated risks

- An escalation policy and action log was in place to manage anticipated risks. Staff were able to demonstrate how they used this. Staff told us they would escalate risks affecting patient safety, such as low staffing and capacity issues within the units. The action log provided clear actions for staff to support timely decision making to reduce the risk to patients.
- Staff had received training in the event of a patient presenting to the unit with suspected ebola.
- There was no security or police based within the unit; however, staff had direct access to the local police station through an emergency button at the reception. Staff said they were trained to manage difficult situations.
- All units had CCTV and staff were able to view this within the units.

Major incident awareness and training

- There was a documented major incident and business continuity plan across all units. This listed key risks which could affect the provision of care and treatment, such as fire, loss of utilities or disruptions to staffing levels. Staff knew how to access this.
- We saw a policy and procedure in place for mass casualty and contamination incidents.
- A list of key contacts was accessible to staff, such as the unit manager.
- We saw Whitworth MIU had a fire action board in place to support staff in the event of a fire.
- The site manager was available for staff to call upon for further advice and support if required.
- Staff told us although they did not routinely rehearse the major incident or business continuity plans,they were aware of an imminent plan to simulate and rehearse for these. Unit managers told us that this would be a regular occurrence.
- Senior staff were aware the units would be used for see and treat patients in the event of a major incident being declared at the local acute NHS trust.

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.

We rated the effectiveness of urgent care services to be good.

We found;

- Patients' care and treatment was planned and delivered in line with current evidence based guidance and standards.
- Staff were qualified and had the skills they needed to carry out their roles effectively.
- The learning needs of staff were identified and training was provided to meet those learning needs. Staff across all MIUs were supported to maintain and develop their professional skills and experience.
- Patients had a comprehensive assessment of their needs, which included clinical needs, mental health, physical health and wellbeing needs.

Evidence based care and treatment

- Staff provided care to people based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines, and were aware of recent changes in guidance. We saw staff use the British Orthopaedic Association guidance when casting a patient with a fracture.
- Staff in MIU used a range of care pathways for adults and children, in line with national guidance, such as paediatric head injury and croup for children, urinary retention, deep vein thrombosis pathway and upper respiratory tract infections for adults.
- Staff told us procedures and policies reflected current guidelines, were easily accessible through the trust's intranet, and were embedded into the electronic records system. We looked at six policies and procedures on the trust's intranet and these were up to date and reflected national guidelines; however we did not see that the units audited the use of policies.
- We saw in the paediatric treatment rooms, protocols for the emergency treatment of children included specific paediatric parameters. We saw there was specific guidance in relation to recognising the sick infant.
- Monthly meetings took place between the unit managers and the clinical leads to ensure current best practice was in the forefront of all the MIU standard operating procedures.
- We saw patient group directives (PGDs) were reviewed in advance of their review date if clinical guidelines had altered.
- Patients were able to self-refer themselves to MIU for care as they choose.If a patient did not have a GP then MIU staff were able to advise them how to access a GP. If the patient was not from the local area they planned to go back to their GP the patient would be given a copy of their discharge letter or copies of their notes as appropriate. In cases where a child was not registered with a GP then the school nurse or social care would be notified.
- There were processes to oversee nurses' practice in relation to the interpretation of X-rays. ENPs were trained to interpret X-rays so there was no need to refer to a doctor, although advice could be sought from orthopaedic surgeons at the local acute trust. X-rays were reported on by a local NHS trust. ENPs were required to reconcile radiologists' results with their initial interpretation and therefore audit their own practice. There were regular audits to ensure accuracy of interpreting X-rays. In addition, missed fractures were investigated so learning could be identified.
- Discharge letters were automatically generated when emergency assessment records were completed and these were sent to patients' GPs so any follow up or after care could be arranged this was done electronically through the electronic system or through the post for those GP practices not using the same electronic system.
- We saw written information given to patients regarding their conditions and treatment for example following application of a plaster cast. Information leaflets was consistent and in-line with national guidance for example British Orthopaedic Association.

Pain relief

Good

Are services effective?

- Patients we spoke with had been asked about their pain and given pain relief where appropriate and at regular intervals.
- Staff used recognised pain assessment tools to assess levels of pain and documented pain scores on the patients' electronic record. Children's pain was assessed using an age appropriate tool where children were asked to point at faces to indicate their level of pain. Pain tools were available to assess pain in patients living with dementia; this ensured patients' pain was assessed effectively.
- PGDs were in place for non-prescribers to administer pain relief; this meant there was no delay to administering pain relief.
- Entonox was available in all units and staff were trained to use this. Entonox is a ready-to-use medical gas which provides rapid, safe and effective short-term pain relief and is used in a diverse range of clinical situations such as painful procedures.
- Staff were able to supply patients with pain relief to take home, to avoid any unnecessary pain once discharged from the unit.
- The units had involved the specialist pain nurse from the local acute NHS trust in expanding pain relief management for patients who had suffered significant trauma.

Nutrition and hydration

- The units had facilities to make drinks and snacks. We observed staff offering drinks to patients.
- Water fountains and vending machines were available in all of the units.

Technology and telemedicine

- Nursing staff had access to a digital x-ray suite. Nursing staff could interpret images on site or send them to the local acute hospital for a second opinion.

Patient outcomes

- The rate of unplanned re-attendance to the units within seven days was considerably lower than the 5% target set by the Department of Health with an average of 0.5% between November 2015 and April 2016.
- In March 2016, the units participated in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) young people's mental health study, the results of which will be available in 2017.
- There were plans in place to audit the pain management of children, which would include the assessment of pain at triage and prior to discharge.
- A local NHS trust had recently developed an audit tool to look at individual practice in relation to x-ray interpretation, the units planned to roll this out across all four units.
- There were 2410 x-rays performed for suspected fractures between January 2016 and March 2016 of these, less than two percent had missed fractures.
- Staff received regular feedback from the local acute NHS trust about any children they had referred from MIU to the local emergency units. Staff welcomed feedback as a way of ensuring the appropriate outcomes for children had been achieved. Staff told us about a change to the bronchitis protocol for children following a referral to the acute trusts emergency units, the protocol had been amended so staff were more easily able to manage and treat children presenting with this condition in the future.

Competent staff

- There were dedicated clinical nurse educators in the units who were responsible for coordinating the education, training and continuing professional development of staff in the unit.
- There was a variety of link professional roles in the units for example, burns and wounds. Link professionals would regularly update staff on changing practice to ensure they remained competent. We saw evidence of teaching sessions from link professionals.
- Newly appointed staff had an induction to their role in the unit and had a supernumerary period. One new member of staff told us they found the induction process informative and it had prepared them for their role.
- Staff orientated bank staff to the unit using the orientation checklists. We saw copies of completed checklists.
- The units had created resources to support new and bank staff such as the MIU nurse pocket guide.
- Health care assistants had completed the fundamentals in care modules. The fundamentals of care modules cover what is needed to be caring - giving workers a good basis from which they can develop their knowledge and skills.
- Staff received an annual appraisal. Data provided by the trust for March 2016 showed 100% of staff at Buxton and

Good

Are services effective?

Whitworth MIU had received an appraisal in the last 12 months, and 90% of staff at Ripley and Ilkeston MIU had received an appraisal in the last 12 months. One staff member told us the appraisal process was the best they had experienced, they described it as meaningful and said their manager supported development needs. As a result they were sent on additional training courses.

- There was a formal system of staff supervision, including clinical supervision, for staff. Group supervision took place at monthly staff meetings.
- A comprehensive competency framework was in place. Staff were expected to complete a variety of competencies in order to fulfil their role, these included triaging, suturing and casting. Staff told us they found these useful for their development.
- Staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line manager, some staff told us the training and learning offered by the units were what attracted them to work at the trust.
- The units had recently created and were rolling out minor illness competencies for staff to work toward to further complement their skills.
- A clinical skills course was run internally at Ilkeston for ENPs. This was available to staff from all four MIUs as well as external applicants. The course involved all four unit senior nurses and matron.
- Staff who requested and reviewed x-rays were trained in Ionising Radiation Medical Exposure Regulations 2000 (IRMER).
- There was a process to assess the training needs of all staff and this was conducted on a yearly basis. Staff told us they were due to complete modules at a local university such as the core principles in paediatrics and non-medical prescribing modules.
- The units had developed links with the local acute NHS trusts who offered shadow opportunities in their units for staff to further enhance their skills. We saw a consultant from the local trust was offering to teach and support staff to develop skills in ophthalmology. Ophthalmology is the branch of medicine that deals with diseases or injury of the eye.
- Unit managers and senior leaders were aware of and demonstrated an understanding of how they would manage staff performance. Managers described a supportive process to help staff improve.
- Staff told us about and we saw trust posters supporting nurses to revalidate in line with their professional bodies guidance.

Multi-disciplinary working and coordinated care pathways

- MIU staff reported good working relationships with radiographers with whom they could discuss results,
- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. We saw good teamwork between Whitworth MIU and local acute NHS trust. A patient presented with an eye injury. The ENP contacted the local NHS trust's ophthalmology team who advised they should see the patient. The ENP subsequently arranged a referral.
- Staff across all units, were in close contact with local GPs. GPs were sent discharge summaries of patient attendances at MIU.
- Staff told us and we saw that there were effective working between physiotherapist and MIU, for example patients were referred from the nurse led fracture clinic for physiotherapy if required.

Referral, transfer, discharge and transition

- Patients were given advice following treatment. This was both verbal advice and written guidance on what to expect with their condition, how to care for themselves and when to seek further help. This was referred to as 'safety netting'. We saw this was well documented in patients' records.
- We saw patients were referred appropriately to other health professionals for follow up, for example the fracture clinic.
- School nurses or health visitors were sent copies of children's' attendances directly from the electronic system, this ensured children had necessary follow up.
- We saw posters to the entrances of all units giving clear instructions to patients on how they could access immediate care and treatment when the units were closed. The posters gave contact numbers for emergency services and the address of the nearest emergency department.
- There was a process in place to safeguard patients in vulnerable circumstances who may have difficulties making follow up GP appointments if required. Managers told us that staff would as make an

appointment on the patients behalf. Discharge letters sent to GPs would reference that an appointment had been made, so that if a patient failed to attend the appointment, the GP could follow this up.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results.
- There were ample computers available in the units; these gave staff access to patient and trust information for example policies and procedures. Direct links were embedded in the electronic system for example links to PGDs and NICE guidance if required, this saved staff time and meant they had the most up to date information at all times.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff demonstrated understanding of the issues around consent and capacity for adults and children attending the units. Staff told us if they were unsure in any circumstances, they would seek guidance from senior staff or from the safeguarding lead.
- The electronic record system had embedded guidance to assess Fraser guidelines and Gillick competence in children and staff told us how they would go about doing this. The system also provided information on the assessment of mental capacity. Staff undertook emergency contraception training which covered Fraser and Gillick competence in further detail. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Fraser Competent is a term used to describe a child under 16 who is considered to be of sufficient age and understanding to be competent to receive contraceptive advice without parental knowledge or consent.
- Staff told us if a patient was considered to lack capacity to make decisions they would seek support of appropriate professionals so decisions could be made in the best interests of the patient.
- Staff asked for consent from patients before their treatment and this was recorded in all of the records we reviewed.

Outstanding ☆

Are services caring?

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

The care provided to patients in urgent care services was outstanding. Feedback from patients was continually positive about the way staff treated them.

We found;

- We spoke with 28 patients and or their relatives. Feedback from patients was consistently positive about the care provided. Patients told us they chose to come to the units rather than the local trusts emergency units as they were treated as "individuals" rather than a "number". Patients described being treated like "family" describing the service as "absolutely brilliant" and said the care was more "attentive" than at bigger hospitals.
- Over 30% of compliments received by the trust related to the positive care and experiences of people attending the MIUs and the NHS Friends and Family test (FFT) results for MIU showed that on average over 99 % of patients who responded would recommend the MIUs to their friends and family. This is above the England average and trust target of 95%.
- There was a strong, visible person-centred culture, patients described being treated as "individuals" rather than a "number".
- Staff across all units were highly motivated to offer care that was kind, compassionate and promoted patients' dignity.
- Patients were treated with respect and kindness during all interactions with staff. During our inspection we were particularly impressed with the interpersonal skills of staff in the interactions we observed.
- Patients and relatives told us that all staff go the extra mile and the care they received exceeded their expectations. One relative of a child said they chose to attend the unit with their child as staff "understand the needs of children" and their experiences have always been "positive". They told us staff went "above and beyond" what was expected of them. Other patients described being treated like "family" describing the service as "absolutely brilliant" and said the care was more "attentive" than at bigger hospitals.
- Staff helped patients cope emotionally with their care and treatment. We saw staff adapting their communication to meet the needs of patients, for example, one nurse used a teddy bear to communicate with a child who was very upset, and this immediately relieved the child's distress. The teddy bear had a bandage placed on it by the nurse to allow teddy to be the same as them.
- Patients were encouraged to be partners in their care. Staff offered support when required and spent time with patients, for example, we saw staff sensitively manage a situation when a young patient presented to the unit for contraception advice and support. Further support and guidance was offered to the patient as appropriate.

Compassionate care

- We spoke with 28 patients and or their relatives. Feedback from patients was consistently positive about the care provided. They told us they were cared for in a kind and compassionate manner by staff. Our own observations supported this.
- Staff on MIU had access to the trust's 10 care makers. Care makers are staff signed up with NHS England who act as ambassadors for the six Cs (care, courage, compassion, communication, commitment and competence) and inspire people, students, healthcare assistants, qualified staff and allied health professionals to practice excellent person centred care.
- Many patients told us they chose to come to the units rather than the local trusts emergency units as they were treated as "individuals" rather than a "number". Patients described being treated like "family" describing the service as "absolutely brilliant" and said the care was more "attentive" than at bigger hospitals.
- During our inspection, we were particularly impressed with the interpersonal skills of staff in the interactions we observed.We saw people treated as individuals and staff spoke to patients in a kind and sensitive manner. Staff smiled, used humour and we saw positive patient-staff relationships. All staff we spoke with highlighted the importance of the patient and stated patients were the main reason for doing their job.
- Staff managed conversations regarding a patient's condition, prognosis, care and treatment options sensitively for example we saw staff take patients away from the clinical areas to private rooms to have private conversations.

Outstanding ☆

Are services caring?

- When patients were treated in closed treatment rooms, we observed all staff knocking on doors and waiting for a response from staff, patients and or a relative before entering and referring to patients by their name of choice.
- We observed "in use" signs on treatment room doors were always used to further reduce the risk of compromising a patient's privacy and dignity.
- Staff throughout the units had joined the 'Hello my name is' campaign, aimed at improving communication with patients and each other. This is recognised as a key part of building trust and supports providing compassionate care. During our inspection we heard staff introducing themselves to patients and relatives using 'hello my name is'.
- The trust used the NHS Friends and Family test (FFT) to obtain feedback from patients. The FFT is a single question survey, which asks patients whether they would recommend the NHS service to their friends and family. The test data between January 2016 and March 2016 showed that on average over 99 % of patients who responded would recommend the MIUs to their friends and family. This is above the England average and trust target of 95%.
- Over 30% of compliments received by the trust related to the positive care and experiences of people attending the MIUs.

Understanding and involvement of patients and those close to them

- Patients and relatives told us they were involved and kept up to date with their care and treatment. They said the staff took time to make sure the patients and relatives understood the care and treatment and the options available.
- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- We saw good interaction between a nurse and a patient and relative when explaining how to use crutches following a foot injury.
- We saw staff adapting their communication to meet the needs of patients, for example, one nurse used a teddy bear to communicate with a child who had become upset and this immediately relieved the child's distress. The child was able to take the teddy bear away with them, a bandage had been placed on the teddy bear to reassure the child "teddy" was the same as them.
- One relative of a child attending Whitworth MIU, told us the child had a previous bad experience at a local acute NHS trust, and they chose to attend the unit with their child as staff "understand the needs of children" and their experiences have always been "positive". They told us staff went "above and beyond" what was expected of them.
- We saw staff sensitively manage a situation when a young patient presented to the unit for contraception advice and support. The staff member communicated in a sensitive manner and the patient appeared at ease. Further support and guidance was offered to the patient as appropriate.
- Observations of staffs behaviour and attitudes confirmed that staff recognised patients personal, cultural, social and religious needs. Staff told us that this was as important part of the triage process.

Emotional support

- We observed staff providing reassurance and comfort to patients. Patients told us they were supported with their emotional needs.
- Our observations and discussions with patients confirmed staff were understanding, calm, reassuring and supportive. One patient told us this helped them to be relaxed and is why they chose to attend MIU.
- We saw staff providing reassurance to patients' relatives who were anxious. This included a nurse spending time with the relative, explaining what the patient should experience and how staff would help.
- A staff nurse at Ripley MIU had created a leaflet for young children attending the unit. The leaflet known as "Poorly Sam visits the minor injuries unit" was in pictorial form and used a teddy bear to describe the patient journey. This was used to ease patient anxiety. We saw a staff member explaining this leaflet to a child attending the unit; it appeared to ease their distress. The leaflet was available across all units.
- We saw staff explaining information leaflets providing information about counselling services.

Outstanding ☆

Are services responsive to people's needs?

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

We rated responsiveness of urgent care services as outstanding because services were tailored to meet the needs of the individual patient and were delivered in a way to ensure flexibility, choice and continuity of care.

We found;

- Patients could access the service in a way and time to suit them. The units had set up nurse led fracture clinics to reduce the numbers of patients having to transfer to acute hospitals for the management of simple fractures. MIUs also provided clinics for follow up treatment or review of conditions such as burns, fractures requiring x-ray, foreign body removal, eye problems and wounds.
- Involvement of other organisations and the local community was integral to how services were planned to meet patients' needs. In partnership with a local ambulance trust, the trust had launched a new Paramedic Pathfinder Triage tool, which supported paramedics in making decisions around transporting patient to emergency department (ED) alternatives such as MIU, where clinically appropriate.
- There was a proactive approach to understanding the different needs of people and delivering care to meet those needs. Records provided factual accounts of care and treatment and were not judgemental about people's individual preferences, culture, habits or faith. There were arrangements in place to access support for people living with dementia, learning disabilities and mental health concerns.
- Care and treatment was coordinated with other services and providers.
- Waiting times and delays were minimal and managed appropriately if they did occur. The service was consistently exceeding targets in respect of time spent in MIU and the time people waited for treatment.Ninety Nine percent of patients were admitted, transferred or discharged within four hours of arrival with 56% of patients spending less than one hour in MIU, 32% and less than 1.5% three to four hours.
- Complaints and concerns were always taken seriously. It was easy for patients to complain or raise a concern and patients would be treated compassionately doing so in line with the trust's "Caring Always" promise.

Planning and delivering services which meet people's needs

- Patients told us they appreciated the short waiting times in comparison to local emergency departments.
- In partnership with a local ambulance trust, the trust had launched a new Paramedic Pathfinder Triage tool, which supported paramedics in making decisions around conveyancing patient to emergency departments (ED) alternatives such as MIU, where clinically appropriate.
- A nurse led fracture clinic had been set up across all units; led by the ENPs this aimed to reduce the numbers of patients having to transfer to acute hospitals for the management of simple fractures. This benefited patients from the local community as well as visitors to the area. ENPS saw patients with simple fractures; they assessed, diagnosed, treated and followed-up patients in the same hospital. This had shown to be a positive experience and benefit to patients particularly children, as all hospital experiences have the potential to be frightening.
- A recent review of the fracture clinics had taken place by an orthopaedic consultant from a local acute NHS trust, the results were positive, and it was planned to further extend the variety of fractures seen in the fracture clinic.
- Patients had access to ENP clinics, which could be booked for follow up treatment or review of conditions such as burns, fractures requiring x-ray, foreign body removal, eye problems and wounds.
- MIU had access to short stay beds on the inpatient wards nearest to the unit. The beds could be used for a variety of reasons for example, simple observation periods following treatment, application of plaster of paris, awaiting x- ray opening times or for safety concerns whilst awaiting home support. Access to these beds prevented admissions to the acute NHS trusts. The short stay beds were for adult patients only.
- Staff within MIU worked closely with local authority in support of the "C card" scheme. A "C card" provides a structured (or monitored) supply ofcondoms to 13 to 24 year olds. Young people could present to the unit who displayed the "c card" logo, show their "c card" and be provided with "c card" services by staff who had been specifically trained by the local authority.

Outstanding ☆

Are services responsive to people's needs?

- MIU had taken part in the "You're Welcome" project. This is a national quality accreditation scheme from the Department of Health which shows health services have been assessed as young people-friendly, and are of a high standard. All of the units had been accredited. As part of the accreditation process, the units had invited teenagers to review the service to provide information on how they may improve the service.
- Senior staff were part of the emergency care network and were involved in discussing service planning across the region.
- Whitworth MIU was part of a pilot project with 111, who were directly booking appointments for patients with minor injuries to attend Whitworth MIU. This avoided unnecessary attendances at the local emergency departments. Staff told us although the trial was new, it was positive and it was hoped this would be rolled out across all MIUs.
- Staff told us they attended local events in the area to raise the profile of MIU and so potential patients knew of the services offered by their local MIU.
- Seasonal fluctuations in activity for example local festivals and an increase in tourist activity over the summer were discussed and planned for at managers meeting, in conjunction with unit staff.
- MIUs were mostly easily accessible and well signposted. Parking was available on all hospital sites. We noted a sign on the main road to Ripley MIU read 2Minor A&E". This could be confusing to patients. The unit manager was aware of the signage and there were plans to address this.

Equality and diversity

- Access to language services was easily available to staff. Interpreters could be requested and patients used translators over the phone.
- Staff told us and we saw guidance on how to access interpreting services on the trust intranet and on posters within the unit. Staff had access to a multi-lingual phrase book.
- Patient information leaflets were available for a wide range of injuries and illness most of these were only available in English, however we did see some leaflets in polish at Whitworth MIU. Staff told us and we saw a range of contact information such as an email address on the front of the leaflets on how the publication could be requested in different languages or other formats, such as braille, if required.
- All of the units we visited had hearing loop facilities for patients who had difficulty with hearing.
- All units were wheelchair accessible and reception desks were of a suitable height to accommodate patients using a wheelchair. Disabled toilet facilities were available in all units. We saw space within the fixed seated waiting area to accommodate a wheelchair. Wheelchairs were available for patients to use at the hospitals.
- Due to a previous incident at Ilkeston MIU, patients presenting on mobility scooters were asked to leave the scooters outside. There was sufficient signage to alert patients to this. A call bell was located at the front of the MIU so support from staff could be summoned. We saw reception staff respond promptly to the call bell and appropriate support was provided to the patient.
- Staff told us for those patients presenting to the units who may require additional support with their mental health needs they had access to the mental health crisis team employed by the local mental health trust. The trust had carried out a ligature risk assessment of the environment in order to minimise the risk to patients who were a suicide risk, all units had suitable areas where staff could observe patients. Staff told us if they had concerns about a patient's safety in relation to their mental health needs they would arrange for them to be transferred to an emergency department.
- Records we reviewed provided factual accounts of care and treatment and were not judgemental about patients' individual preferences, culture, habits or faith.

Meeting the needs of people in vulnerable circumstances

- There were arrangements in place to access support for people living with dementia and those with learning disabilities. There was a flagging system embedded in the electronic record system to identify patients with a learning disability.This meant staff could provide additional support if required. Staff told us they had access to a learning disability team in the trust for further support and guidance.
- A former patient with a learning disability had been supported by the units to create a pictorial guidebook for patients attending the units. The guidebook gave an insight into what the patient journey through MIU would look like. Staff said they would offer this to patients when required.

Are services responsive to people's needs?

- Staff told us and our observations confirmed that frail elderly patients and children were prioritised for care in the unit. Staff also told us this would also be the case for patients living with dementia and patients with learning disabilities.
- We were told the environment at Whitworth had recently been audited in relation to being dementia friendly. As a result, additional signage had been placed in the area, and black carpets by the entrance had been removed to avoid any distress to patients presenting to the unit living with dementia.
- We saw staff had access to resources to support them in recognition of delirium, depression and dementia. Staff told us they had received dementia awareness training. On average 73% of staff had completed dementia awareness training across the four units, and there were detailed plans in place for the remaining staff to complete this, for example access to an e-learning module.
- Staff across all units had access to communication cards to support care delivery to patients who may have communication difficulties.
- At Ripley MIU there was a use of a "teenage" room, for teenagers presenting to the unit. The room provided a relaxed environment and included a resource folder specifically designed for teenagers. The file included information about pertinent issues to young people, such as cyber bullying, substance misuse and sexual health. The folder included a list of contacts should a young person wish to seek further support. At Whitworth MIU we saw a teenage resource board, this provided similar information to the resource folder used at Ripley.
- There were suitable arrangements for the treatment of children in all units there were dedicated treatment rooms with a sufficient amount of toys and games for all ages. All of the units had access to iPads and we saw these used for children in the units when they became distressed.
- Staff had access to resources to sign post patients to additional services such as alcohol and smoking cessation support services.
- We saw posters advocating that the units had a chaperone policy in place. We saw staff chaperone patients when sensitive examinations were taking place. A chaperone is a person who accompanies a patient during an examination for example a female would be accompanied by a female member of staff when being examined by a male member of staff. Staff did not receive specific training in chaperoning; however, there was detailed guidance and policies in place that were easily accessible to support staff in chaperoning procedures should they be required.

Access to the right care at the right time

- Access to MIU services was the same across the four MIUs. Opening times were from 8am to 10pm seven days per week. Staff told us if a patient presented to the unit prior to closing time, they would always see the patient rather than turning them away.
- Live waiting times for Ripley and Ilkeston MIU were available on the trust's, local newspaper's, and clinical commissioning group's website. The times were displayed against the current waiting times at the local acute emergency department This encouraged patients to attend MIU where their conditions allowed, and reduce the demand on the local emergency departments. There was a plan to roll this out to Buxton and Whitworth MIU.
- We saw a patient flow escalation plan in place and staff were aware of when they would need to use this. An escalation plan is a set of procedures in place to deal with potential problems with a surge in demand for services.
- The Department of Health (DH) target is to admit, transfer or discharge 95% of patients within four hours of arrival. The trust constantly achieved above 99% across all MIUs between April 2015 and March 2016. In the same reporting period 56% of patients spent less than one hour in MIU, 32% between one and two hours, 9% two to three hours and less than 1.5% three to four hours.
- While waiting no more than four hours from arrival to departure is a key measure of MIU performance, there are other important indicators, such as how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a median wait of below 60 minutes. The trust consistently achieved this target. The median wait in the period April 2015 to March 2016 was 53 minutes.
- The trust consistently achieved above the national target, which requires the number of patients who leave the units before being seen (by a clinical decision-maker) to be less than 5% (recognised by the Department of Health as being an indicator that

patients are dissatisfied with the length of time they have to wait). The proportion of patients who left before being seen in the period April 2015 to March 2016 was less than 0.4%.

- The DH states handovers between ambulance and MIU must take place within 15 minutes of arrival with no patients waiting more than 30 minutes. The trust exceeded this target. In the period April 2015 to March 2016, the 168 patients arriving by ambulance were seen and assessed within two minutes of arrival.
- In the period April 2015 to March 2016, zero patients had been turned away from MIU due to high demand in services.
- Access to x-ray facilities varied across hospital sites. X-Ray facilities were not provided at the weekend. This meant patient were referred to another hospitals x-ray department or asked to return when the x-ray units were open. The units were auditing x-ray provision; as a result the x-ray facilities at Whitworth MIU were now open all day each Monday rather than just Monday morning sessions.
- There was an effective system in place to ensure that people who did not have a registered GP could access diagnostics and referrals, all patients were treated on a clinical need and could access all services available regardless of GP status. In cases where patients did not have a registered GP they were given a copy of their discharge summary letter so they could take the copy to whoever they choose to register with.

Learning from complaints and concerns

- The Patient Experience Team oversaw the complaints procedure. The trust had established systems and procedures in place to ensure the handling of complaints and the investigation process was managed through the trust's complaints/concerns policy.
- Staff reported receiving very few formal or verbal complaints. Where possible staff dealt with complaints on an informal basis at the time they were raised. All staff demonstrated an awareness of their responsibilities in relation to complaints.
- Staff at regular team meetings discussed complaints, when they did occur and received feedback about them.
- In the period January 2015 – January 2016 four complaints were made relating MIUs; these related to staff attitude and access to x-ray facilities. As a result of the x-ray complaints a standard operating procedure in relation to the x-ray pathway was being trialled at Whitworth MIU. Patients were able to attend a local acute NHS trust for x-ray at weekends. The x- ray could be reviewed with patient choice and consent back at Whitworth. If the radiographer noted a clinical finding that required immediate, attention the patient was referred directly from the x-ray department at the local acute NHS trust to the emergency department for review. The trust was in discussions with other local NHS trusts to create a similar agreement for the other MIUs staff had created and were trialling and standard
- We saw leaflets described how patients could provide the hospital with feedback and make a complaint.
- We saw the units displayed the trust's eight "Caring Always" promises; these were promises of how anyone raising a complaint would feel. The trust told us these were used as the basis of every response to a complaint and included, feeling welcome and valued, having the opportunity to discuss what is going to happen at every stage and feeling comfortable and safe.

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.

The leadership of urgent care services was good because leaders prioritised safe, high quality person-centred care.

We found;

- There was a clear statement of vision and values, driven by quality and safety, staff knew and understood the vision and values. We saw specific unit mission statements. The units had adopted the 'DIGNITY' acronym to underpin their mission.
- The leadership team was knowledgeable about quality issues and priorities. There was an effective governance framework in place. Quality, risks and performance issues for urgent care were monitored through the integrated community based services framework
- Unit managers had the experience and capability to lead the services and prioritised safe, high quality, compassionate care.
- The service proactively engaged and involved staff and ensured the voices of all staff were heard and acted on.
- There was a high level of staff satisfaction. Staff said they were encouraged and supported to develop. Staff were proud of the teamwork within the units and the willingness to help and support each other. Staff said there was a positive regard for their welfare.

Service vision and strategy

- Most staff were able to articulate the trust's vision and the values, which was to be the best provider of local healthcare and to be a great place to work. Values included to get the basics right, to act with compassion and respect, to make a difference, to value and develop teamwork and to value everyone's contribution because everyone matters.
- We saw specific unit mission statements. The units had adopted the 'DIGNITY' acronym to underpin their mission. The values were based on what staff aspired to.
- The mission statement included how the units would deliver care to patients in line with the "DCHS Way". The "DCHS Way" had three elements which reflected the organisation's objectives. These elements were "quality service", "quality people" and "quality business", for example the unit's statement for "quality service" was to respond to patients' care needs quickly and safely to reduce anxiety, pain and suffering.
- We observed staff delivering care and demonstrating behaviours in line with the hospital vision and values, the unit's mission statement and in line with the "DCHS Way".
- Senior leaders and unit managers told us the vision for urgent care services were for the MIUs to become urgent care centres. The units were working to align themselves with the national framework for urgent care centres. They had, for example started to increase the skills of the workforce by developing minor illness competencies.

Governance, risk management and quality measurement

- Staff received monthly bulletins. Monthly bulletins were sent electronically through email and we saw paper copies on staff notice boards. The bulletins were used to keep staff up to date with quality indicators such as the number of unplanned re attendances within seven days, incident and complaint themes, medical device information and any risks within the units.
- None of the units had a specific risk register; however, senior leaders told us risks affecting the units would be placed on one trust risk register should they occur. Senior leaders told us risk would be assessed, actions put in place to mitigate the risk and then removed from the register to become a "resolute risk". Incidents were investigated to identify patterns and trends and if it became apparent actions put in place had not been sufficient to mitigate the risk, risks would be re added to the corporate risk register.
- We did not identify any specific risks within the units, which would require adding to the trust risk register.
- There was an effective governance framework in place. Quality, risks and performance issues for urgent care were monitored through the integrated community based services framework. Unit managers did not regularly attend clinical governance meetings; the

senior leaders attended these. Senior leaders told us any staff member was welcome to attend governance meetings if they chose too, however we were not assured that staff were made aware of this.

- There was a good feedback loop from governance meetings, which included monthly bulletins highlighting learning from incidents. These were displayed in staff areas and staff told us they also received them electronically.
- We saw minutes of meetings and unit leaders told us they met with the matron monthly who would share information from clinical governance with unit leaders. Following an agreement in 2014/15, the group provided a quarterly update to the clinical effectiveness group (CEG) to ensure transparency and governance links were appropriate.
- Records confirmed routine audit and monitoring of key processes took place across the units to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored by the trust. These were cascaded to staff through performance dashboards displayed in the clinical areas and through bulletins.
- There were good working arrangements with commissioners and third party external providers for example we saw that work was ongoing with the local ambulance trust in relation to the paramedic path finder.
- Unit managers and senior leaders met regularly with the local acute NHS trusts' emergency departments and ambulance provider, to ensure effective working relationships and to discuss any issues and challenges encountered in a bid to improve services for patients.
- The trust had created a quality always programme. This was a trust wide initiative focused on improving quality of care. The process involved an assessment, review and accreditation of the service linked to the Care Quality Commission standards. All four MIUs had been accredited as green, which was the highest accreditation possible.

Leadership of this service

- MIUs formed part of the integrated community based services division.
- The senior leadership team consisted of a general manager, professional clinical lead and matron.
- Unit managers had the experience and capability to lead the services and prioritised safe, high quality compassionate care.
- Unit managers were available in all units and were visible to staff. Staff told us who they would approach if they had any concerns and would not hesitate to do so.
- We saw senior nurse leaders and unit managers were committed to providing a safe service for their patients.
- Staff in the units we visited told us they felt well supported by their direct managers who were visible and accessible. Staff told us and minutes confirmed staff meetings took place monthly so they were up to date.
- A senior staff member was the shift coordinator; their role was to manage the day-to-day running of the unit.
- All unit managers had completed the trust leadership development scheme; this ensured the managers had the skills to lead teams to be the best they can.
- Unit managers were not solely supervisory like other ward managers, they said at times this posed a challenge to juggling the demands of the service, especially at peak times, and often meant less time dealing with the human resource elements of the role. We asked the chief nurse why unit managers were not supervisory. They told us the workload of managers in MIU fluctuated which meant there were times when managers had opportunities to carry out their management responsibilities. We were not assured this was the case.

Culture within this service

- Many staff had been in post for 10 years or longer and described the trust as a good place to work.
- We saw effective team working across all units and an obvious mutual respect amongst staff. All the staff told us they felt proud of working for the trust and enjoyed working within the unit. We observed staff working well together and could see staff supporting each other.
- Staff told us there was a friendly and open culture and they were most proud of the teamwork within the unit and the willingness to help and support each other.
- A staff member gave an example of when they had required additional support and assistance in their personal lives due to a medical condition in order to remain at work and carry out their job. The extent of the support provided to the staff member showed a positive regard for their welfare.

Good

Are services well-led?

- Staff said they were encouraged and supported to develop. One member of staff told us how they had been encouraged to progress in their career, another member said the trust was considering them for a nurse training secondment.
- A student nurse told us they felt part of the team, were given as much support as they required and provided with good learning opportunities to support their development.

Public engagement

- Information boards in the waiting areas displayed the numbers of complaints and compliments received by the units in addition to thank you cards.
- Comment cards were available across all units. As a result of the comments made by patients the units displayed "You said, we did" posters on the information boards within the units. "You said, we did" posters are a simple visual demonstration of the units commitment to improve services by listening to the people who use and visit the service. The posters showed comments made by patients alongside the changes made by the services in response to the comments. On one unit we saw the response in relation to poor car parking, the manager had reported escalating this within the trust.
- The trust had developed an MIU YouTube video, which was a bid to help educate the public and key stakeholders such as the ambulance service as to the services, which could be accessed more locally and in a more timely way.

Staff engagement

- Staff told us of weekly emails from the chief executive. These were information-giving emails updating staff on changes and developments within the trust, staff told us they found the email very useful and informative.
- Staff across all four units attended team “away” days three times per year. The away days brought professionals from all four units together to share best practice and further develop. Staff told us they found it useful to meet with other units.
- Staffs at Whitworth MIU were nominated for team of the year as part of the DCHS 2015 extra mile awards scheme. The unit made it to the final.
- The trust used their own independent staff satisfaction survey (Pulse). The pulse results the MIUs in the period January 2016 to March 2016 showed high levels of staff engagement across all four MIUs with an average score of 86%.

Innovation, improvement and sustainability

- Engagement in the future of urgent care services was being undertaken on a national and local scale. DCHS were a key stakeholder in the Derbyshire 21st Century/ Joined up Care work streams, which were currently reviewing the models of urgent care provision within the localities and vanguard sites. Vanguard sites are care models developed to support local health and care services keep people well, and bring home care, mental health and community nursing, GP services and hospitals together.
- Paramedics in the unit had worked with the matron to look a developing crash bags which could be easily transported outside of the immediate clinical area in the event of a cardiac arrest outside of the units, this included suggestions on what to include in the bags**.**
- The units had been awarded silver standard dignity awards by Derbyshire County Council for a number of projects they had been involved in for example at Ilkeston MIU the award was for excellence in the care of children and young people.
- A nurse led fracture clinic had been set up across all units; led by the ENPs this aimed to reduce the numbers of patients having to transfer to acute hospitals for the management of simple fractures. This benefited patients from the local community as well as visitors to the area. ENPS saw patients with simple fractures; they assessed, diagnosed, treated and followed-up patients in the same hospital. This had shown to be a positive experience and benefit to patients particularly children, as all hospital experiences have the potential to be frightening.
- Patients had access to ENP clinics, which could be booked for follow up treatment or review of conditions such as burns, fractures requiring x-ray, foreign body removal, eye problems and wounds.
- Live waiting times for Ripley and Ilkeston MIU were available on the trust’s, local newspaper’s, and clinical commissioning group’s website. The times were

Good

Are services well-led?

displayed again the current waiting times at the local acute emergency units, this encouraged patient to attend MIU where their conditions allowed, and reduce the strain on the local emergency units.