Rossendale Minor Injury Unit

Inspection report

Bacup Road
Rossendale
BB4 7PL
Tel: 01706253650

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Rossendale Minor Injury Unit (RMIU) on 19 October 2023. This was the first inspection of this urgent treatment centre under this registered provider. Overall, the service is rated good.

At this inspection we found:

- Strong consistent leadership both at Fylde Coast Medical Services (NW) Limited (FCMS) organisational level and locally at RMIU facilitated the organisation's quality improvement strategy. The primary objective of the service was to deliver a safe, effective and accessible service to people living in the local community.
- A comprehensive cycle of continuous quality improvement with supporting business plans was underpinned by the service's strategy and this reflected the FCMS's vision and values.
- All staff were considered a valued resource and the clinical manager, supported by FCMS, invested training, development and support to ensure each team member delivered the best service they could.
- Staff were positive about working at the service and for the organisations. They told us they were clear of their role and responsibilities. Training programmes and supportive performance monitoring was in place to assist staff to deliver safe care to patients.
- There were clearly defined and embedded systems to minimise risks to patient safety. Incidents, complaints and patient feedback were viewed as opportunities to learn and to improve processes.
- Clinical records provided evidence that care and treatment was provided safely and effectively.
- Systems to safeguard patients were robust and included a specific induction training package in safeguarding.
- Quality and performance was routinely monitored for contract monitoring requirements and records indicated that the service was performing well against key performance indicators.

We saw areas of outstanding practice. These included:

- Collaborative working with local primary care networks (PCNs) to implement a protocol of medicine review by a clinical pharmacist for patients identified by RMIU as being at risk of increased falls due in part to the types of medicines they were prescribed.
- A range of standard operating procedures had been agreed with different health care providers which ensured patients attending RMIU whose care and treatment needs could not be met there had an agreed pathway to access the most appropriate care.
- Outreach work had been undertaken with local schools and patient participation groups to raise awareness of the services provided by RMIU.

Overall summary

Dr Sean O’Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team included a CQC lead inspector and a GP specialist adviser.

Background to Rossendale Minor Injury Unit

Rossendale Minor Injury Unit (RMIU) is located on the ground floor of Rossendale Primary Health Care Centre, Bacup Road, Rossendale,BB4 7PL. The health centre shares the premises with other services such as two NHS GP practices, GP extended access services, and services provided by East Lancashire Hospital Trust (ELHT). These include radiology, physiotherapy, treatment room, podiatry and a hospice day unit.

The minor injury unit was previously registered under PDS Medical (Ltd) which was a subsidiary company of Fylde Coast Medical Services (NW) Limited (FCMS). The service is commissioned by Lancashire and South Cumbria Integrated Care Board (ICB) and the service is registered to provide the following regulated activities:

Diagnostic and screening procedures,

Treatment of disease, disorder or injury.

Rossendale Minor Injury Unit is a nurse led walk in centre for people with minor injuries, serving the people of Rossendale and surrounding areas of Pennine Lancashire. The service is open daily from 8am until 8pm including weekends and bank holidays. The unit is accessible by the general public for the treatment of minor injuries, including sprains, strains, fractures, cuts and grazes, bruises and minor head injuries (where no loss of consciousness has occurred), foreign bodies, bites and stings.

This service is a nurse led service that is managed by a clinical manager and staffed with two advanced clinical practitioners, healthcare assistants and a reception team. FCMS provides a comprehensive management structure that provides additional oversight and support to the team at the unit.

There is car parking available with designated disabled car park spaces and the unit is close to main roads with good public transport links.

The registered provider of this service is FCMS (NW) Limited which is a not for profit Social Enterprise Company Limited by Guarantee. FCMS (NW) Limited provide a range of services from several registered locations: They provide:

- 24 hour, 365 day call taking, prioritisation and signposting of patients for unscheduled health or social care needs.
- Primary Care clinical telephone consultations, advice and treatment.
- Face to face primary care clinical consultations, advice and treatment either in a surgery setting or in the home environment.
- Extended access services.

Rossendale Minor Injury Unit is 1 of 10 registered locations. The other locations are:

Morecambe Urgent Treatment Centre

Bay Urgent Care (Morecambe)

Urgent Care Centre Blackpool

Urgent Care Centre Doncaster

Doncaster Same Day Health Centre

Fleetwood Urgent Treatment Centre

West Lancs GP out of hours service

PDS Planned Care Diagnostics

Compass Medical Practice

Good

Are services safe?

We rated the service as good for providing safe services.

Safety systems and processes

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

- Safeguarding children and adults was a priority at the service. A comprehensive and separate safeguarding induction training programme was undertaken with all new employees. The safeguarding training programme included reviewing policies, procedures and referral pathways and included discussion with senior managers to demonstrate competency in recognising and responding to suspected abuse and or identifying someone in potential vulnerable circumstances. Staff were also trained to the appropriate levels as required by best practice guidance.
- We saw evidence that documented in detail concerns raised by staff and the communication undertaken with appropriate primary and secondary agencies including safeguarding teams. Clinicians had access to child protection information on the NHS spine. (The NHS spine is the digital platform for key NHS online services and allows the exchange of information across local and national NHS systems).
- A 'Did not attend' standard operating procedure was in place if a child or vulnerable patient did not attend an appointment. The procedure had clear steps for staff to follow in these circumstances and this included referral to the safeguarding team as appropriate.
- The provider, FCMS, sent out a quarterly safeguarding newsletter to all staff to ensure they were kept updated with changes in safeguarding processes and to highlight different types of abuse. The newsletter used actual safeguarding incidents (anonymised) to capture attention, reinforcing the importance of action to safeguard people.
- The designated safeguarding lead at RMIU was supported by an organisational leadership structure that included leads for safeguarding. Internal monthly governance meetings reviewed the safeguarding referrals raised and the action taken in response to the referral, and also identified any learning. Monthly quality reports for commissioners included brief narratives of the safeguarding referrals and the management of these.
- The service worked with other agencies to support patients and protect them from neglect and abuse. We heard of examples where staff from RMIU shared concerns with staff at local emergency department to ensure appropriate review.
- Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider conducted staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Staff who acted as chaperones were trained for the role and had received a DBS check.
- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information as part of their induction and ongoing refresher training. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- There was an effective system to manage infection prevention and control (IPC). Regular IPC audits were undertaken and areas identified for improvement actioned.
- The premises was clinically suitable for the assessment and treatment of patients and the Xray department was close to the RMIU. Facilities and equipment were safe and equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

Good

Are services safe?

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

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand. Senior staff were easily identifiable and available for staff to escalate their concerns. Close working arrangements were in place with other FCMS services including Morecambe Urgent Treatment Centre and West Lancs GP out of hours service. This collaborative working provided an additional layer of resilience if staffing issues occurred.
- The service used advanced clinical practitioners on occasion for unfilled shifts from a couple of health care recruitment agencies. The agency staff had to meet certain criteria set out by FCMS and the clinical manager for the unit. This included being up to date with all mandatory training and additional training and experience of treating minor injuries.
- The clinical manager for the unit had set up a “red tray” where latest information such as changes in practice protocols, updates to best practice guidance from NICE and relevant patient safety alerts were placed. All clinical staff including agency staff were required to read these updates and sign a confirmation sheet whilst working on the unit. This had been evaluated as an effective method to share essential information quickly and was being rolled out to other FCMS urgent care centres.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately.
- The RMIU offered a minor injuries service only, and did not provide a treatment service for minor illness. The unit did not turn people away and took action to ensure the patient with an illness got access to the right care at the right service. We heard of examples where liaison had occurred with emergency departments or other health care services so that patients assessed as requiring emergency treatment were sent to these other services.
- The clinical nurse manager for the RMIU had worked with a range of healthcare professionals across the region to develop and agree a range of standard operating procedures (SOP) to simplify patient treatment pathways with different services. So for example patients attending the unit with a mental health issue could be safely referred to the mental health team. Similarly patients attending the local emergency department could be referred to the RMIU if their injury could appropriately be managed there.
- Staff told patients when to seek further help. They advised patients what to do if their injury deteriorated and additional treatment was needed.
- When there were changes to services or staff, the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment.

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Staff had access to the NHS spine to obtain and share information. In addition the staff used a nationally recognised clinical patient management software programme specifically for urgent and emergency care settings. The clinical lead for the unit had established productive working arrangements and implemented a range of standard operating pathways with other health care services such as the local hospital trusts, the ambulance service and GP services.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

Good

Are services safe?

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

- The systems and arrangements for managing medicines, including medical gases, emergency medicines, equipment, and vaccines, minimised risks.
- The service conducted regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. We saw audits for antibiotic prescribing and the prescribing of other medicines used to support the treatment of minor illnesses. There was evidence of actions taken to support good antimicrobial stewardship.
- One clinical audit undertaken for the treatment of dog bites identified that 95% of clinicians had prescribed a course of antibiotics in accordance with best practice guidance. However, 5% of prescriptions were for a longer course of antibiotics which did not reflect the current best practice guidance. The audit prompted immediate action informing clinicians at the unit (and across FCMS services) by newsletter of the best practice guidance regarding antibiotics following a dog bite. The individual clinicians identified by the audit were also contacted and advised of the best practice guidance.
- Staff prescribed, administered, or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- Processes were in place for checking medicines and staff kept accurate records of medicines.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity, implementing cycles of monitoring and review as part of their quality and improvement strategy. This helped to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts. These were logged and the logs identified if they were relevant to the service and if so, the actions undertaken in response to these. The clinical manager had set up the 'red tray' so that staff had quick and accessible access to safety alerts and changes to guidance.
- Joint reviews of incidents were undertaken with partner organisations, including the local emergency departments, GP and out-of-hours GP services, NHS111 service and urgent care services.

Lessons learned and improvements made.

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. The organisation's culture was one of 'no blame' and 'continual learning' approach. Staff spoken with confirmed they felt comfortable raising concerns. Staff feedback forms returned to us also unanimously confirmed reporting incidents and shared learning from these was part of the support.
- There were comprehensive systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. An incident log was maintained which detailed the incident, the action undertaken, and the learning shared both with individual staff members, with the local team and with the wider organisation. For example, the radiology department was provided by the local hospital trust, a number of the incidents logged by RMIU indicated that patients were unable to have an x-ray on occasion due to failures or breakdowns of the Xray machines. Alternative Xray departments in the local hospitals were used in these instances. The incident log also recorded all safeguarding referrals and last minute staff absences.

Good

Are services safe?

- Governance arrangements underpinned all quality improvement activity and incidents, complaints, patient feedback, and systems of internal monitoring were used to identify gaps and address in service quality and safety.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews and root cause analysis and we saw one example of this which reviewed how a bone fracture was missed. The investigation and review of the serious incident identified areas where improvements may have resulted in a different outcome. The analysis identified learning and this was shared in FCMS's regular clinical newsletter as a 'lessons learnt' which was shared with RMIU and across the organisation's other locations.
- We saw evidence where the clinical manager for the service liaised and reviewed incidents including inappropriate referrals with other community health care services.

Good

Are services effective?

We rated the service as good for providing effective services.

Effective needs assessment, care and treatment

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

- There were clear parameters set out by commissioners for the service that governed the types of minor injury treatment the service could provide.
- The clinical manager for the service ensured that all staff had easy access to updated clinical and best practice guidance. Access to guidelines from the National Institute for Health and Care Excellence (NICE) was available on the FCMS's information platform and the clinical manager ensured paper copies were available on the unit.
- The governance systems established by FCMS monitored that these guidelines were followed and where deviations from guidance were observed this was explored with the clinician to understand the reasons for this.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs. Pathways were established for children with injuries and patients requiring an ambulance to the emergency department. In addition, the clinical manager had worked with partner health care organisations to ensure clear and accessible referral pathways were established and these included mutual referral pathways to and from the local hospital trust, mutually agreed pathways between the local Out of Hours GP service; a referral pathway with the North West Ambulance Service and more recently a pathway to mental health services for people requiring mental health support.
- The clinical manager for RMIU had undertaken a patient improvement strategy for people over the age of 65 years. This involved networking and building relationships with local primary care networks (PCN) to reduce the risk of falls by patients who are also prescribed a medicine that is known to have an effect known as an anticholinergic burden (ACB). Patients attending RMIU over the age of 65 years with a history of falls were assessed in accordance with a standard operating protocol that includes the prescribed medicines of the patient and a frailty score. Those assessed as having a high ACB score are given information to take to their GP to request a medicine review. The information and request is also sent electronically to the patient's NHS GP. The clinical pharmacists employed by each PCN in the surrounding community had all agreed that when such a request is received they will review the patients prescribed medicines with a view to reducing the overall ACB impact on the patient. This initiative complies with the NHS long term plan and NICE quality statements. The impact and outcomes of this patient improvement strategy were not yet available as this was in the very early stages of delivery.
- The clinical manager had also undertaken some local teaching with her team on 'Silver Trauma' highlighting the risks of older people attending the unit with one injury but potentially suffering additional injuries that were not obvious and that staff should be extra vigilant to assess the patient fully. The quality and content of the teaching with the power point presentation was assessed by FCMS as being important and disseminated the power point to all of FCMS health care locations and settings.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The ethos of the minor injury service was to look at the whole person and if staff were concerned about a patient's vulnerability, strategies were in place to ensure other health care or support agencies were made aware of this.
- Staff assessed and managed patients' pain where appropriate.

Good

Are services effective?

- Patients attending with needs that could not be met by RMIU, for example with a minor illness, were not turned away from the service. The staff triaged the patient and endeavoured to arrange ongoing care and treatment with another service. Clear explanations were provided to patients and their representatives about the reasons for this. Data supplied by the local out of hours GP service showed that RMIU had booked an appointment for 1 person in May and August and 3 people in September 2023.
- Arrangements were in place to deal with repeat patients. Staff were encouraged to review these patients to identify possible additional health needs or vulnerabilities. FCMS governance systems monitored the number of patients who attended the unit more than once during a calendar month.
- We saw no evidence of discrimination when making care and treatment decisions.
- Technology and equipment were used to improve treatment and to support patients' independence.

Monitoring care and treatment

- FCMS used key performance indicators (KPIs) that had been agreed with Lancashire and South Cumbria Integrated Care Board (ICB) to monitor their performance and improve outcomes for people.
- Data supplied by FCMS from 2021 to 2023 showed the RMIU consistently met the agreed KPIs for the service.
- One of the key performance indicators for RMIU and all health services was to see and treat patients within a maximum time of 4 hours. Supplied data showed the average patient waiting time from arrival at the unit to consultation was 50.3 minutes for the year to August 2023.
- Data for September 2023 showed that 1042 patients attended the unit which was an increase of almost 27% on the planned activity. Despite this increase in attendance all patients were triaged within an average of 18 minutes, with 99.7% of patients being seen and treated within the 4 hour KPI.
- We heard it was rare for patients to wait for more than four hours to be treated. However there had been 3 instances in September 2023 but these were due to reasons outside the control of the service. For example one patient did not attend an agreed return appointment, other patients were waiting on advice from other departments such as orthopaedics.
- The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. Medicine audits for the use of antibiotics and pain relief were available, wound audits and the audit of dog bite wounds and treatment were used to inform and improve safe practices.
- FCMS implemented a comprehensive system of clinical audit to review clinical care and notes on a risk assessed basis for all clinicians working in urgent care. The audits reviewed clinicians' record keeping and assessed whether care and treatment was safe and conformed to best practice and were used to embed learning and improvement.
- FCMS governance and quality and safety teams had oversight of all audits out throughout all their urgent treatment services which led to a consistent approach to monitoring care and treatment.

Effective staffing

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

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered mandatory health and safety topics as well as organisational topics. A safeguarding induction programme was also completed by all new staff. Service specific induction and ongoing training was also provided. For example, health care assistants had to complete a training workbook and competency check for a range of minor injury treatments, including wound management, management of burns, application of a plaster cast, splints and eye irrigation.

Good

Are services effective?

- Training records showed that staff were up to date with annual mandatory training with a robust system in place to notify staff when update training was due. Staff had all received the new mandatory training in learning disability and autism and the clinical manager was also a trainer in basic life support.
- The clinical manager had recently created an urgent care practitioner (UCP) training and competency framework as this was not available within the organisation. This training framework has subsequently been rolled out across FCMS's other urgent care locations.
- The clinical manager ensured they worked with newer clinicians to provide on the job clinical supervision and support.
- The service ensured that two advanced clinical practitioners were on duty every day. If demand was higher than expected or there was an unexpected absence the clinical manager offered 'onsite' support, working alongside the clinical team and in the event they were not onsite telephone support and assessment was provided to patients. Additional support was also available from Morecambe Urgent Treatment Centre.
- FCMS and the clinical manager for service prioritised the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- On the job clinical supervision and one to one support was routinely available for all clinicians and staff. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.
- FCSM ensured the competence of staff employed in advanced roles by undertaking a comprehensive system auditing clinical consultation records against a set criterion to review clinical decision making and the quality of the patient written record. This included reviewing the prescribing of non-medical prescribers. The provider implemented a recognised system to monitor clinical competence of all the clinicians employed. Newly employed clinicians had 100% or at least a minimum of 30 clinical records audited initially, which reduced incrementally as the records audited met the required safe standard. Clinicians received feedback regarding the quality and content of their clinical records, and we saw that this provided opportunities for them to reflect on their performance. This in turn supported the clinician with their revalidation with their professional registration.
- Staff received feedback regarding the outcomes from the audit of their consultation records and where performance was below the expected standard, systems of support including additional training were agreed.
- FCSM, the clinical leaders and the whole team at RMIU recognised good work or individual 'tough times' of the team members by passing a 'awesome cup' between them.
- Staff feedback received by CQC prior to this inspection was wholly positive.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services when they were referred. Care and treatment for patients in vulnerable circumstances was coordinated with other services. Staff communicated promptly with patient's registered GP so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established pathways for staff to follow to ensure patients were referred to other services for support as required.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients referred to the service. An electronic record of all consultations was sent to patients' own GPs.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Good

Are services effective?

Helping patients to live healthier lives.

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

- The service identified patients who may be in need of extra support. The clinical manager had provided training on possible hidden trauma for those with an injury over the age of 65. Similarly, collaborative work with the clinical pharmacist based within the local PCNs, had been set up to review patients with an history of falls and prescribed certain types of medicines with a view to reducing the risk of future falls.
- Where appropriate, staff gave people advice so they could self-care. For example people who attended with a wound, were advised to contact the Treatment room service if additional care such as wound dressing was required. Similarly, people were advised to seek medical help if a person developed symptoms of an infection.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patient needs could not be met by the service, staff redirected them to the appropriate service for their needs. Clear protocols for pathways to different care and treatment services were in place.
- Clinical team members had reached out to the local schools to offer visits for small groups of children to show them around the minor injury unit, to help teach them about injuries, first aid and AEDs with a view that the children will raise awareness locally about RMIU and have some knowledge on how to respond to a minor injury.

Consent to care and treatment

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

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

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social, and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Rossendale Minor Injury Unit was a walk in service for people with a minor injury and as such did not offer a routine appointment system. People calling the service were provided with clear information about the scope of the services they offered.
- RMIU directed patients following care and treatment to a web address and QR code where patients could leave feedback. The web site IWantGreatCare logged patient feedback and provided monthly reports to FCMS.
- Results of the IWantGreatCare feedback logged on the website and received by the service between August 2022 and October 2023 showed:
  - 729 reviews had been submitted and the service was rated five stars.
  - IWantGreatCare awarded Rossendale Minor Injuries Unit “a certificate of excellence” in 2023.
  - For the 3 month period July to September 2023 94% of 296 patient feedback response rated the service 5 stars. Patients written comments indicated issues with access to the Xray facility (provided and managed by another provider) was a factor that influenced their overall feedback about the service.
  - Patient feedback was monitored and where a theme was identified this was discussed with staff and patient feedback monitored for improvement.

Involvement in decisions about care and treatment

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

- Most people who used RMIU were from the local community and most people spoke English. However, interpretation services were available for patients who did not have English as a first language and other communication aids to support people with sensory disabilities such as hearing impairment were supported.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- RMIU recognised that some patients would prefer to attend the service for treatment at a less busy time and in response to feedback offered an appointment facility if it was safe for the patient.
- Staff helped patients and their carers with alternative treatment and support services if RMIU was unable to provide this.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

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

Good

Are services responsive to people's needs?

We rated the service as good providing responsive services.

Responding to and meeting people's needs

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

- The FCMS and the team at RMIU understood the needs of its population and tailored services in response to those needs. RMIU had a specific focus to treat people attending the service with a minor injury. The provision of the minor injury service helped relieve pressure on the emergency departments in the local area.
- FCMS had a positive relationship with its commissioners for the service and we received feedback indicating RMIU offered a flexible service which was responsive to demand.
- The clinical manager had highlighted to the Xray service provider the benefits to the local population if service provision was also available until 8pm each evening.
- The RMIU had responded to patient feedback and now offered an appointment to patients (when clinically safe to do so) if there was a long wait for treatment within the service.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. All patients attending the unit were triaged by a clinician and a prioritisation system was in place dependent on the urgency of the patient's health condition.
- The clinical manager had agreed and formalised with other health care provider clinical pathways to ensure patient who health care needs were not assessed as having a minor injury were supported to attend the most appropriate type of services for treatment of their need.
- RMIU was located in a purpose built health centre that offered several different health care services. The unit shared a reception area with a GP practice. Space to expand the service was limited.
- The service was responsive to the needs of people in vulnerable circumstances. The clinical information record systems flagged patients who were vulnerable. Staff were vigilant and responsive to the needs of the patient flagging concerns to other health care professional as appropriate and ensuring appointments were provided to the patient.

Timely access to the service

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

- Patients were able to access care and treatment at a time to suit them. The service operated daily from 8am until 8pm, including Bank Holidays.
- Patients could access the service as a walk in-patient. Patients did not need to book an appointment.
- Patients were seen on a first come first served basis, although the service had a system in place to facilitate prioritisation according to clinical need where more serious cases or young children could be prioritised as they arrived. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. Patients had timely access to initial assessment, Xray results, diagnosis, and treatment.
- FCMS monitored service delivery and achievement and data was available to us which showed that RMIU saw 10981 patients from October 2022 to September 2023.

    - RMIU was staffed with to meet an average monthly demand of 849 cases. Demand for the service outstripped planned capacity for consecutive months May to September 2023. People attending were in May 1058, June 1175, July 982, August 1002, and September 1042
    - Key performance indicators for the RMIU service was to see and treat patients within a maximum time of 4 hours. Data supplied by FCMS showed for the average wait time for patients from arrival at the unit to consultation was 50.3 minutes for the year to August 2023.

Good

Are services responsive to people's needs?

  - Data for September 2023 for example showed that 1042 patients attended RMIU of which 99.7% of patients were seen within the 4 hour KPI. The data showed 0.29% of patients waited more than 4 hour. This equated to 3 patients and the reasons for this were due to issues outside of the control of the unit. referrals to other clinical services including ophthalmology and plastics.
- When the unit was busy people whose treatment needs were less urgent were offered an appointment to return later the same day.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs. The clinical manager for the service had actively met with other health providers to develop and agree mutual standard operating procedures to ensure patients whose needs were not appropriate for the service at RMIU were supported to attend the right health care setting. Patient safety was a priority for the Clinical manager and team at RMIU.
- Referrals and transfers to other services were undertaken in a timely way. The standard operating procedures facilitated the safe and effective transfer of patients.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately. Patient feedback was valued and underpinned FCMS ethos and quality improvement agenda.
- The complaint policy and procedures were in line with recognised guidance. In 12 months to October 2023 the service had received 8 complaints including written and verbal ones. Discussion with the registered manager, and the governance lead demonstrated that complaints were used as tools to improve service quality and to support staff development.
- We reviewed one complaint in detail. This complaint was logged as a serious untoward event and subject to a root cause analysis review to identify why and how the concern arose and what actions were required to mitigate further risk of reoccurrence. We viewed the anonymised response to the complainant and this detailed the investigation, the outcome of this, and the actions taken in response to the findings. The final letter to the complainant contained a full apology and demonstrated openness and transparency in line with the Duty of Candour when detailing the investigation findings. The patient was also advised of their right to escalate their complaint to the Parliamentary Ombudsmen should they remain dissatisfied with the response they received.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant.
- The service learned lessons from individual concerns and complaints and from analysis of trends, with a view to improve the delivery and quality of care.
- Patients compliments were also logged and reviewed as part of the RMIU quarterly review report.

Good

Are services well-led?

Leadership capacity and capability

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

- Evidence from this inspection a model of consistent leadership that was underpinned with a strong ethos and strategy of learning and improving service quality with the patient central to all the services delivered.
- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it. They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- FCMS valued and encouraged staff to aspire and develop. Effective processes to develop leadership capacity and skills, including planning for the future leadership of the service were well developed and established.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients. The clinical manager for RMIU was proud to tell us that they had contributed to developing the mission statement for the service. This stated, “To nurture an environment of inspiration, innovation and disruption so that the people within our world receive exceptional care for this generation and the next”. All staff we spoke with understood the mission statement and were committed and invested to delivering a quality service for patients.

- There was a clear vision and set of values. The whole team at RMIU embodied FCMS values of: “Oompf!; Awesome; Fun; Humble; Go-getting and Brave”. Further information displayed within the staff area reminded everyone that “Our patients are at the very heart of what we do at RMIU. But everyday ask yourself these very important questions”. The display then referenced the five key questions used in this report and asked staff to reflect on each these areas. Staff commitment to delivering a safe, effective, caring service underpinned FCMS’s strategy and supporting business plans to achieve a well led, responsive service to people in the local community.
- Staff we spoke with confirmed they were consulted and participated in developing and delivering FCMS’s vision, values and strategy.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The team at RMIU embodied FCMS principles and implemented strategies to collaborate and work in partnership to ensure patient care and treatment was safe and effective within healthcare landscape of the local community it served.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.

Good

Are services well-led?

- It was clear the FCMS's ethos and culture recognised their staff as a precious commodity that they nurtured and supported to develop and aspire, which in turn enabled the delivery of safe, effective quality care to people attending their services.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. All staff spoken with understood the importance of identifying incidents and these were seen as a tool to learn, develop and improve the quality of the service they provided.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. The complaint response letter we viewed clearly demonstrated openness and candour with an apology and a plan to prevent or mitigate reoccurrence in the future.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for training, professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. Staff were supported when they were involved in a traumatic incident, complaint or investigation.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between teams based at FCMS locations within Lancashire and this provided opportunities to work collaboratively and offered additional layers of resilience to offer support both in person and remotely.
- The clinical manager for RMIU also fostered partnership working with the other health service located within Rossendale Primary Health Care Centre raising the profile and awareness of the service they offered. Likewise the clinical manager was the driving force in facilitating the standard operating protocols with a range of other healthcare services developing safe pathways of care for patients who needed support at other locations.
- In addition, other members of the clinical manager's team had reached out to the local schools to offer focused education visits to children to raise awareness of the services provided by RMIU, teach some first aid including how to use an automated external defibrillator (AED)

Governance arrangements

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

- Quality and safety was embedded within the overall corporate governance arrangements for FCMS with the objective to deliver safe, effective responsive care and treatment to people in the local communities they served.
- The quality improvement agenda supported the team at RMIU to deliver a quality service.
- A culture of trust, openness, respect and caring was evident among leaders at all levels and the different staff teams.
- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Good

Are services well-led?

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider had processes to manage current and future performance of the service. Performance of clinical staff was monitored supportively within a culture of learning and development and this was demonstrated through audit of their consultations, prescribing and clinical decisions.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- Leaders had oversight of patient safety alerts, incidents, and complaints. Systems were established to identify trends, which in turn was used to improve service quality and patient outcomes.
- Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local Integrated Commissioning Board (ICB) as part of contract monitoring arrangements.
- Regular meetings were undertaken to review service delivery and performance. Minutes from meetings including the monthly “Lancashire Clinical Governance Meeting” were available.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. A clinical audit plan was in place and this included medicine audits, wound care audits and treatment for animal bites.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information, which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, innovations in facilitating agreement to pathways of care (standard operating protocols) for patients whose needs could not be met by RMIU.

Good

Are services well-led?

- Staff were able to describe to us the systems in place to give feedback. These included using the IWantGreatCare, providing a feedback form and a QR code so that patients could give feedback online.
- The clinical manager for the service had attended a patient participation group (PPG) meeting (undertaken at a local GP practice) in July to inform patients and the wider community of RMIU and the service they offered. Feedback from patients from the PPG was positive and the clinical manager was scheduled to attend another meeting in November 2024.
- Staff told us they felt part of the team, were listened too and were supported on the job and with their personal and professional development. The FCMS newsletter recognised personal staff achievements and celebrated good news stories.
- Feedback from commissioners of the service was positive.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- Continuous learning and improvement at all levels within the service underpinned the organisation quality improvement strategy. FCMS regarded its staff as a precious resource, who were supported to deliver the safest care and treatment to people living in the local communities the organisation served.
- There was a strong culture of innovation evidenced by the clinical manager and members of their team. This included working collaboratively with a range of healthcare professionals to implement an agreed strategy to review older patients whose prescribed medicines influenced their anticholinergic burden and potential increased risk of falls.
- Outreach work had commenced with the local schools and a PPG to raise awareness of RMIU, first aid and the use of AEDs. Similarly standard operating protocols had been facilitated by the clinical manager so agreed pathways to alternative safe care and treatment were in place for patients who had different needs than those provided by RMIU.
- Staff training and development were considered essential and valued. The clinical manager had developed an urgent care practitioner induction and competency training framework and a training lecture on 'Silver Trauma'. The importance of which were recognised by the organisation and shared across all its locations.
- Quality improvement and governance frameworks enabled the service to make use of internal and external reviews of incidents, complaints, patient feedback and compliments. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.