Cudmore House

Inspection report

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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?	Requires Improvement
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? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection of Kernow Health CIC, Cornwall's NHS 111 and GP out of hours services at Cudmore House on 7, 8 and 9 March 2022. We undertook this inspection at the same time as CQC inspected a range of urgent and emergency care services in Cornwall. To understand the experience of GP Providers and people who use GP services, we asked a range of questions in relation to urgent and emergency care. The responses we received have been used to inform and support system wide feedback.

A summary of CQC findings on urgent and emergency care services in Cornwall

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Cornwall below:

Cornwall

The health and care system in this area is under extreme pressure and struggling to meet people's needs in a safe and timely way. We have identified a high level of risk to people's health when trying to access urgent and emergency care in Cornwall. Provision of urgent and emergency care in Cornwall is supported by services, stakeholders, commissioners and the local authority and stakeholders were aware of the challenges across Cornwall; however, performance has remained poor, and people are unable to access the right urgent and emergency care, in the right place, at the right time.

We found significant delays to people's treatment across primary care, urgent care, 999 and acute services which put people at risk of harm. Staff reported feeling very tired due to the on-going pressures which were exacerbated by high levels of staff sickness and staff leaving health and social care. All sectors were struggling to recruit to vacant posts. We found a particularly high level of staff absence across social care resulting in long delays for people waiting to leave hospital to receive social care either in their own home or in a care setting.

GP practices reported concerns about the availability of urgent and emergency responses, often resulting in significant delays in 999 responses for patients who were seriously unwell and GPs needing to provide emergency treatment or extended care whilst waiting for an ambulance. GPs also reported a lack of capacity in mental health services which resulted in people's needs not being appropriately met, as well as a shortage of District Nurses in Cornwall.

Overall summary

A lack of dental and mental health support also presented significant challenges to the NHS111 service who were actively managing their own performance but needed additional resources available in the community to avoid signposting people to acute services. The NHS111 service in Cornwall worked to deliver timely access to people in this area, whilst performance was below national targets it was better than other areas in England.

Urgent care services were available in the community, including urgent treatment centres and minor illness and injury units and these services were promoted across Cornwall. These services adapted where possible to the change in pressures across Cornwall. When services experienced staffing issues, some units would be closed. When a decision was made to close a minor injury unit (MIU) the trust diverted patients to the nearest alternative MIU and updated the systems directory of services to reflect this. However, this carried a potential risk of increased waiting times in other minor injury units and of more people attending emergency departments to access treatment. This had been highlighted on the trust's risk register.

Due to the increased pressures in health and social care across Cornwall, we found some patients presented or were taken to urgent care services who were acutely unwell or who required dental or mental health care which wasn't available elsewhere. Staff working in these services treated those patients to the best of their ability; however, patients were not always receiving the right care in the right place.

Delays in ambulance response times in Cornwall are extremely concerning and pose a high level of risk to patient safety. Ambulance handover delays at hospitals in the region were some of the highest recorded in England. This resulted in people being treated in the ambulances outside of the hospital, it also meant a significant reduction in the number of ambulances available to respond to 999 calls. These delays impacted on the safe care and treatment people received and posed a high risk to people awaiting a 999 response. At the time of our inspection, the ambulance service in Cornwall escalated safety concerns to NHS England and NHS Improvement.

Staff working in the ambulance service reported significant difficulties in accessing alternative pathways to Emergency Departments (ED). When trying to access acute assessment units, staff reported being bounced back and forth between services and resorting to ED as they were unable to get their patient accepted. Many other alternative pathways were only available in specific geographical areas and within specific times, making it challenging for front line ambulance crews to know what services they could access and when. In addition, ambulance staff were not always empowered to make referrals to alternative services. The complexity of these pathways often resulted in patients being conveyed to the ED.

Hospital wards were frequently being adapted to meet changes in demand and due to the impact of COVID-19. There was a significant number of people who were medically fit for discharge but remaining in the hospital impacting on the care delivered to other patients. The hospital had created additional space to accommodate patients who were fit for discharge but were awaiting care packages in the community; however, staff were stretched to care for these patients.

Delays in discharge from acute medical care impacted on patient flow across urgent and emergency care pathways. This also resulted in delays in handovers from ambulance crews, prolonged waits and overcrowding in the Emergency Department due to the lack of bed capacity. We found that care and treatment was not always provided in the ED in a timely way due to overcrowding, staffing issues and additional pressure on those working in the department. These delays in care and treatment put people at risk of harm.

In response to COVID-19, community assessment and treatment units (CATUs) had been established in Cornwall. These wards were designed to support patient flow, avoid admission into acute hospitals and provide timely diagnostic tests and assessments. However, these wards were full and unable to admit patients and experienced delayed discharges due to a lack of onward care provision in the community.

Overall summary

Community nursing teams had been recently established to support admissions avoidance and improved discharge. This work spanned across health and social care; however, at the time of our inspections it was in its infancy so we could not assess the impact.

The reasons for delayed discharge are complex and we found that discharge processes should be improved to prevent delays where possible. However, we recognise that patient flow across the Urgent and Emergency Care pathway in Cornwall is significantly impacted on by a shortage of staffed capacity in social care services. Staff shortages in social care across Cornwall, especially for nursing staff, are some of the highest seen in England. This staffing crisis is resulting in a shortage of domiciliary care packages and care home capacity meaning many people cannot be safely discharged from hospital. A care hotel has been established in Cornwall providing very short-term care for people with very low levels of care needs; this is working well for those who meet the criteria for staying in the hotel, however this is a relatively small number of people.

Without significant improvement in patient flow and better collaborative working between health and social care, it is unlikely that patient safety and performance across urgent and emergency care will improve. Whilst we have seen some pilots and community services adapted to meet changes in demand, additional focus on health promotion and preventative healthcare is needed to support people to manage their own health needs. People trying to access urgent and emergency care in Cornwall experience significant challenges and delays and do not always receive timely, appropriate care to meet their needs and people are at increased risk of harm.

At this inspection we found:

- The service had clear systems to keep people safe and safeguarded from abuse. Staff were proactive around reporting safeguarding concerns and worked with other agencies to protect people from abuse and harm.
- The service learned and made improvements when things went wrong. Data demonstrated the service had a low threshold for reporting significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses and they worked closely with other agencies to resolve issues when things went wrong.
- The service had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, there were end to end audits completed monthly of clinicians, where the patient journey was followed from initial call being listened to and reviewed against the patient notes until the NHS 111 part of the patient journey was completed.
- We observed staff treating patients with kindness, respect and compassion.
- The service responded to COVID-19 demands and had introduced new systems to support people in accessing appropriate care and treatment in line with national guidelines and best practice guidance.
- Leaders had a clear strategy around supporting the local healthcare economy and had the ability to respond quickly when required to meet those changing needs within the economy. There was a strong culture of innovation evidenced by the creation and implementation of new processes, projects and pilot schemes.

We saw one area of outstanding practice:

- The service had supported the local community in Stratton. The community hospital in this area did not have 24-hour clinical cover at the Minor Injury Unit, this meant the patients had to travel over an hour to other hospitals if required. Kernow Health CIC had supplied a clinician within the hospital for the full GP out of hours period (18.30 to 08.00 Monday to Friday and all-day weekends and bank holidays) to support the local community, this is now commissioned.

The areas where the provider **must** make improvements as they are in breach of regulations are:

Overall summary

- Ensure care and treatment must be provided in a safe way for service users

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

- The service should develop systems to routinely capture patient experience to support development of the service.
- The service should ensure timescales for responses to complaints are met and managed in accordance with their policy.
- The service should review their systems and policies in place in relation to the safety of lone workers.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC Inspection Manager, a GP specialist adviser, a member of the CQC medicines team and a team of CQC inspectors who visited the main location and a sample of treatment centres, where care and treatment was delivered by the service throughout Cornwall.

Background to Cudmore House

Cudmore House is the registered location for the NHS 111 and out-of-hours services provided by Kernow Health CIC and provides NHS 111 services and out-of-hours primary medical services to patients in Cornwall when GP practices are closed. The operations centre is located at Cudmore House at:

Kernow Health CIC
1st Floor Cudmore House
Oak Lane
Truro
Cornwall
TR1 3LP

Tel: 01872226714

Cornwall's Integrated Urgent Care Service (IUCS) is provided by Kernow Health CIC. Kernow Health CIC is owned by shareholders from every GP practice in the county and operates as 'NHS Cornwall 111'. They have held the contract to provide this service since 30 November 2017. The contract has recently been extended until 31 March 2026.

The provider is registered to provide the following regulated activities: Transport Services, Triage and medical advice provided remotely. Treatment of disease, disorder or injury.

The organisation also provides a school aged immunisation service, a children's eating disorder service and hosts the Cornwall training hub which secures funding to support general practice with the entire employee lifecycle. However, these services were not inspected during this inspection.

The service is commissioned by Cornwall Clinical Commissioning Group and covers a population of approximately 550,000 people across the county of Cornwall. The population increases to up to 1.5 million in the summer months with visitors to Cornwall and the Isles of Scilly. The increase in population occurs for a longer period between Easter and October half term due to the popularity of Cornwall as a second home and holiday destination.

This was the first inspection of this service. We undertook site visits and interviews over the three days of inspection.

The organisation subcontracts the telephony and NHS Pathways aspect of the NHS111 service. The clinical assessment service (CAS) and face to face aspects of the IUCS are delivered from Cudmore House and nine other treatment centres across Cornwall.

Patients access the out-of-hours service via the NHS 111 telephone service. Patients may be seen by a clinician at one of the nine primary care treatment centres, receive a telephone consultation or a home visit, from a clinician being driven by a driver in one of their fleet of 4x4 liveried vehicles, depending on their needs. The majority of patients access the service via NHS 111.

The out-of-hours service is provided at nine treatment centres:

1. Cudmore House, Oak Lane, Truro, TR1 3RP (visited during inspection)
2. West Cornwall Hospital, St Clare Street Penzance TR18 2PF (visited during inspection)
3. Helston Community Hospital, Meneage Road, Helston, TR13 8DR
4. Newquay Community Hospital, St Thomas Road, Newquay, TR7 1RQ
5. St Austell Community Hospital, Porthpean Road, St Austell, PL26 6AA (visited during inspection)
6. Bodmin Community Hospital, Boundary Road, Bodmin, PL31 2QT (visited during inspection)
7. Liskeard Community Hospital, Clemo Road, Liskeard, PL14 3XD
8. Launceston Community Hospital, Link Road, Launceston, PL14 9JD

9. Stratton Community Hospital, Stratton, Bude EX23 9BR

The service additionally to the nine treatment centres also sees patients during the holiday season on an adhoc basis at Falmouth Hospital as required.

The GP out of hours period is defined as 18:30 to 08:00 on weekdays and the whole of weekends, bank and public holidays. The 111 service operates 24 hours a day, all year round.

During the inspection we visited the services based at Penzance, St Austell, Bodmin and Truro. We also visited further office space and the medicines store in Roche.

Requires Improvement

Are services safe?

We rated the service as requires improvement for providing safe services because:

- Infection Prevention and Control Systems did not provide assurance of effectiveness in reducing the risk of cross infection to people using the service and staff.
- The service did not always have reliable systems for appropriate and safe handling of medicines.

Safety systems and processes

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

- The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse. The safeguarding lead explained there was a low threshold for reporting concerns that focused on prevention. Approximately 80 safeguarding referrals had been made in total for adults and children at risk over a 12-month period. The service had identified themes which included increased mental health concerns for children and young people during the pandemic, domestic violence and addiction increased through county lines (the practice of trafficking drugs into rural areas and smaller towns, away from major cities, traffickers recruit vulnerable and school age children).
- Safeguarding referrals were logged and tracked on a nationally recognised electronic recording system. Staff took additional steps outside of the responsibility of the NHS 111 and out-of-hours service to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. All referrals to the local authority safeguarding team were followed up by the safeguarding lead. The provider demonstrated clear communications with other agencies when handing over care of patients to the emergency department or back to their registered GP.
- Staff checks at the time of recruitment were carried out by the local NHS acute trust including Disclosure and Barring Service (DBS) checks. (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).
- All staff had completed safeguarding and safety training appropriate to their role, all clinicians were trained to Level 3 and all non-clinicians were trained to Level 2. There was a clinical commissioning group (CCG) lead as a point of contact who was trained to level 4. Clinicians had also received broader training to raise awareness about human trafficking, female genital mutilation (FGM), domestic violence and preventing radicalisation. Staff knew how to identify and report concerns. Staff who acted as chaperones (drivers and receptionists) 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 from the provider as part of their induction and refresher training.

We found the system to manage infection prevention and control (IPC) did not provide sufficient assurance of the effectiveness of the reduction of risk in some areas.

- We observed staff complied with the policies and procedures to reduce the risk of COVID-19 infection. For example, staff wore personal protective equipment (PPE) such as gloves and aprons, that was disposed of and replaced between seeing patients. The service provided 'hot' COVID-19 appointments for patients with a suspected positive result in a designated area.
- Staff received annual infection control and prevention training. Further training had been provided for COVID-19.
- IPC audits were carried out at all sites every six months. However, these did not provide assurance of the effectiveness of hand hygiene, adherence to procedures such as IPC use or cover IPC arrangements when vehicles and staff were visiting people at home. We asked the provider for evidence of an IPC annual review and any recommendations actioned but did not receive this during the inspection or afterwards.

Requires Improvement

Are services safe?

- The provider ensured facilities and the equipment they provided were safe, and that equipment was maintained according to manufacturers' instructions. The storage and supply of medical equipment provided by the service was calibrated and Portable Appliance Testing (PAT) was completed. Blood pressure machines, defibrillators and pulse oximeters were checked by drivers daily. However, the service gave clinicians the option of using their own equipment but had no assurance procedures in place to ensure Portable Appliance Testing (PAT) and calibration had been completed on this equipment. Prior to COVID-19, clinicians had the opportunity to bring their equipment into Cudmore House over a one-week period for Portable Appliance Testing (PAT) and calibration but this had not been resumed.

However, we did see evidence of IPC adherence in regard to:

- The main location and sites inspected had systems in place ensuring the premises and equipment was cleaned between patient consultations. At the start of the Covid-19 pandemic the service had introduced two private 'hot-hub' ambulances to provide extra capacity to the affected locations as needed. This allowed clinicians to separate the 'hot-hub' ambulance (which were used to deliver care and treatment to COVID-19 risk patients), to cold (areas used to deliver care and treatment for patients not known to be at risk of COVID-19) in the treatment centre. Utilising the ambulances in this way allowed staff to implement a straightforward deep clean process in order to promote infection prevention and control of COVID-19.
- Contracts were in place at the treatment centres to ensure they were cleaned to NHS Standards, and regular audit was undertaken to ensure compliance.
- Training records demonstrated high compliance of staff having completed an annual IPC update, for example 95.31% of clinical and 87.63% of non-clinical staff had completed IPC training.
- Staff told us that extra time was built into the appointment system enabling them to clean all surfaces between patients.
- Alcohol gel was located throughout the buildings with signage prompting people to use it.
- People had to enter buildings via use of an intercom. There was a one-way system in place throughout each site and people attending for an appointment were asked to wait in their vehicle where possible.
- National guidance was followed to reduce patient footfall during the COVID-19 pandemic. Patients were able to use online services to access video and telephone consultations.
- There were systems for safely managing healthcare waste.

Risks to patients

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. The service had completed demand modelling for summer/winter and bank holiday periods for both the 111 and the GP out of hours face to face and telephone triage staffing models. There were systems in place for dealing with surges in demand. They held daily meetings with the subcontractor who provided the 111 service, to review the incoming demand for the 111 service.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Staff knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Systems were in place to manage people who experienced long waits e.g. clinicians checking the queue, comfort calling patients to ensure they were not worsening.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse and we observed clinicians within their call centre completing calls with clear guidance of what to do if their symptoms worsened.

Requires Improvement

Are services safe?

- When there were changes to services or staffing levels, the service assessed and monitored the impact on safety. We observed the despatch team, based within the call centre, were in frequent contact with all treatment centres and drivers of mobile vehicles, so they could respond to changing situations quickly. A small number of clinicians working overnight and weekends told us that they could at times run with unfilled shifts, and on occasions some staff did not have enough experience. Rotas were planned 3 months in advance, with minimum and 100% staffing levels based on historic data, and current trends. There was a demand management plan in place which was enacted by service delivery managers or shift managers in liaison with the on-call management team. The service identified potential surge in demand by attendance at daily system escalation calls to understand pressure from other services. They used heatmap analysis of cases coming into the clinical assessment service to ensure the rota is aligned to the demand.

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.

Appropriate and safe use of medicines

Staff did not always consistently follow systems and processes for the safe handling of medicines at some sites we visited.

- There were systems, policies and procedures for managing medicines, including medical gases, emergency medicines, equipment, and controlled drugs. However, they were not always complied with by staff at treatment centres and within mobile vehicles.
- The fleet of 4x4 liveried vehicles (vehicles with company flashing to identify they are transporting clinicians), complied with the company's medicines management and controlled drugs policies to safely transport equipment and medicines. We observed that controlled drugs when issued where noted in the controlled drug logbook, and other medicines in the vehicles was recorded via the computer within the patients notes when issued. However, on one occasion we observed one of the usual liveried vehicles was unavailable. To replace this vehicle, a company pool vehicle was in use which did not have an appropriately secured safe located in the vehicle to transport controlled drugs (CDs) or fixings to transport an oxygen cylinder safely. We shared this information with the provider who said they would take action to address this immediately by adding a cable lock in the equipment list for the pool cars so that the CDs safe could be secured safely into the vehicle if those pool cars had to be used.
- We observed effective ordering, storage and transportation systems at the medicines store in Roche and appropriate record keeping in place once medicines where transferred to the treatment centres. However, we observed a mixture of practices across the four treatment centres we visited. At the St Austell treatment centre, we observed the medicines cupboard was open on our arrival which meant that medicines were not safely stored and could be accessed by unauthorised persons. At the Penzance treatment centre the equipment in a clinician's bag was not labelled to show it had been checked and there was a controlled drug error identified in the controlled drugs log which had no record to explain details of the error. In Truro and Bodmin treatment centres the controlled drugs were correctly stored and recorded, and the drugs cupboards were tidy, with equipment and drugs appropriately labelled. Within the medicines management policy there was appropriate systems in place for controlled drug errors to be reported.
- The service carried out regular audits of telephone consultations and outcomes of the call for the patient, which identified prescribing was in line with best practice guidelines for safe prescribing.

Requires Improvement

Are services safe?

- The service provided a palliative care line, open 24 hours each day, for patients and carers with palliative care emergencies. This avoided patients and carers from having to navigate through the 111 system and allowed patients prompt access to pain relief and other medications required to control their symptoms.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues, including the ongoing COVID-19 pandemic.
- The service monitored and reviewed activity. This helped it to understand risks both within the service and more widely across Cornwall and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, including the local emergency department at the acute trust, GP out-of-hours, NHS 111 service, emergency NHS ambulance and urgent care services. The provider was involved in a serious case review about a child's care, which identified learning for all partner organisations. Key learning points were shared with staff at clinical meetings and through the internal communications systems such as the staff bulletin every two weeks, specific clinical issues where shared in clinical notice with links to clinician training.
- In areas such as infection prevention and control and medicines storage improvements need to be made.

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. Data demonstrated the service had a low threshold for reporting 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. Feedback was shared with staff; we saw feedback from one serious incident shared with the full team via a twice monthly bulletin.
- There were adequate 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.
- The provider maintained an electronic log of incidents. This showed that between September 2021 and 31 January 2022 there had been 4 serious incidents. For example: A significant event had been upgraded to a serious incident when a patient's condition deteriorated after being given treatment for joint pain. The investigation, dissemination of learning and evidence of embedded change was clearly documented. Minutes of meetings also demonstrated the provider had oversight of this process and assurance of changes made. For example, clinicians had been made aware of the associated risks when administering medicines for joint pain.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to share alerts with all members of the team including sessional and agency staff.
- The provider took part in monthly end to end reviews and enabled representatives from other organisations to participate. Learning was used to make improvements to the service. Staff told us that by following the patient journey through the wider service it allowed for open conversations with partnering 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 which demonstrated clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored these guidelines through an audit process.
- NHS 111 is subcontracted by Kernow Health CIC to an established NHS 111 call centre where Cornwall patients telephone assessments are carried out using NHS Pathways (this is a national operating model with a clinical assessment algorithm based on the patients reported symptoms). This resulted in a number of different outcomes, of which over 77% of calls went through further clinical validation/review by a clinician.
- When GP surgeries were closed, the Kernow Health CIC Integrated Urgent Care service system enabled patients to make a single call to obtain an appointment during the GP out of hours period. Patients made an initial call to NHS 111 where call handlers and clinical advisors assessed the patient based on the information provided. Patients who required further advice or assessment were passed to the Clinical Assessment Service based at Cudmore House. The Clinical Assessment Service is a multidisciplinary group of clinicians who work out of the call centre, a treatment centre or from home. After triage, the calls are either closed with the patient provided with advice, referred to another service or offered a face to face appointment at a treatment centre or a home visit. Information and details of the patient were passed from the subcontractor through a clinical software programme.
- The treatment centres were located so that a patient should not need to travel further than 30 miles to be seen, at the time of the inspection (weekday evenings) a number of the centres were not required to routinely open e.g. Helston, Newquay and Launceston. In the peak holiday period, patients also had access to a further treatment centre at Falmouth Community Hospital which could be opened when needed.
- The service offered direct telephone access to Cudmore House for specific callers to avoid any delay going via NHS111. For example, healthcare professionals including Paramedics and District Nurses working in the community who required urgent clinical triage for a patient, carers and patients with palliative care emergencies and care homes. There was also an allocated telephone line for patients who had been removed from their surgery lists due to challenging behaviours. Kernow Health CIC had a specific pathway to ensure those patients were seen in an appropriate location in an appropriate time scale.
- During the GP out of hours period, Kernow Health CIC was responsible for providing medical cover to community hospitals. They provided care and treatment to patients who were unwell on a ward or who needed assessment and clerking into the hospital.
- Patients who required clinical assessment were assessed. This included their clinical needs and their mental and physical wellbeing. Where the patient's need could not be met by the service, staff redirected them to the appropriate service for their needs. For example, dental services, emergency department, mental health crisis line and the patients own GP practice. Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The services clinical system stored special patient (flagging) notes shared by the patients GP in case they needed to access care during the GP out of hours period. For example, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions, domestic violence concerns, and to support patients with learning disabilities and palliative care patients. The system also provided information on how patients with hearing disabilities had chosen to be contacted for example: text talk.
- We saw no evidence of discrimination when making care and treatment decisions.

Good

Are services effective?

- Arrangements were in place to deal with repeat callers in real time. An alert was placed on the system to identify patients who had called three times and highlight any patients whose condition could be worsening. There was a system to identify frequent callers in real time, discussions took place in multidisciplinary meetings to support clinicians in understanding the frequent callers GP out of hours care requirements going forward.

Monitoring care and treatment

- The service had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, there were audits completed each month of the assessment, care and treatment provided to patients by individual clinicians. Through the training hub, clinicians were offered the opportunity to take part in a broad variety of training.
- From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show if the service is safe, clinically effective and responsive. Providers are required to report monthly data to their clinical commissioning group (CCG) on their performance against the standards which included: audits; response times to phone calls: whether telephone and face to face assessments happened within the required timescales: seeking patient feedback: and actions taken to improve quality. Providers of NHS 111 services are required to submit call data every month to NHS England by way of the Minimum Data Set (MDS). The MDS is used to show the efficiency and effectiveness of NHS 111 providers. We saw the most recent NQR/MDS results for the service (October – December 2021) which showed the provider was meeting the following national performance indicators:

We reviewed the providers attainment of percentage of patients recommended for self-care at the end of clinical input against the performance indicator of above or equivalent to 15%. We found that;

- October 2021 Cornwall 49.88% - National 23.97%
- November 2021 Cornwall 49.89% - National 24.13%
- December 2021 Cornwall 49.22% - National (unknown currently)

We reviewed the providers attainment of proportion of calls initially given a category 3 or 4 ambulance disposition that are spoken to by a clinical advisor or clinician within 30 minutes, against the performance indicator of above or equivalent to 50%. We found that;

- October 2021 Cornwall 77.65% - National 37.88%
- November 2021 Cornwall 80.19% - National 39.20%
- December 2021 Cornwall 78.66% - National (unknown currently)
- We saw the most recent *NQR/MDS* results for the service (October – December 2021) which showed the provider was not meeting the following national performance indicators. However, they were performing significantly better than the national average:

We reviewed the providers attainment of proportion of patients receiving a call back by a clinician within 20 minutes, against the performance indicator of above 90%, We found that;

- October 2021 Cornwall 60.42% - National 31.12%
- November 2021 Cornwall 64.86% - National 31.41%
- December 2021 Cornwall 59.58% - National (unknown currently)

We reviewed the providers attainment of proportion of patients who were offered a call back by a clinician in over 20 minutes and up to an hour inclusive, against the performance indicator of above 90%, We found that;

- October 2021 Cornwall 76.64% - National 35.03%

Good

Are services effective?

- November 2021 Cornwall 80.04% - National 33.65%
- December 2021 Cornwall 78.40% - National (unknown currently)

Where some of the services minimum data sets statistics were below the required national targets, these reflected the pressure on the system as a whole due to COVID-19 pandemic rather than against Kernow CIC as an individual provider.

The service also met three out of four locally agreed targets as set by the commissioner outcomes for December 2021.

- Treatment centre opening hours against agreed schedule - 100% against target of 99%
- Patients should not have to travel more than 30 miles from home to treatment centre - 96.1% against target of 95%
- Percentage of life-threatening calls transferred to ambulance service within 3 minutes - 100% against target of 95%
- Patients seen within a treatment centre should be seen within 30 minutes of appointment time or their arrival, whichever is later was slightly below target at 94.13% against a target of 95%
- The service made improvements through learning from 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. The service had a comprehensive range of clinical audits including sepsis, urinary tract infections and treatment audit (UTI), upper respiratory tract infection audit, lower respiratory tract infections audit. All audits were summarised in the bulletin to all staff, there were also individual actions, and reminders generated as appropriate. Improvements were considered as a result of audits. However, infection prevention control audits (IPC) did not provide sufficient assurance of the effectiveness of the reduction of risk in some areas.
- The service was actively involved in quality improvement activity. For example, the provider had completed a trial in February 2022, with the ambulance service to clinically validate all non-injury falls. The outcome of this trial has enabled a private non-emergency ambulance to be sent out within an hour for patients meeting certain criteria, where previously the patient may have waited several hours.

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 such topics as safeguarding children and adults, principles of health and safety, fire safety, infection control, moving and handling, equality and diversity, information governance, deprivation of liberty, basic life support and anaphylaxis.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required. At weekends they allocated a lead clinician for the clinical assessment service (CAS). This role also supported clinical supervision.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. Kernow Health CIC managed the training hub and academy for the area and had a comprehensive set of training opportunities available for staff to apply for through a formal procedure. Clinical assessment service (CAS) staff had a training manual with standard operating procedures.
- The provider ensured staff had access to ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. Clinical audits were carried out for new staff on a monthly basis, which helped identify any training needs required during the induction period.
- The service had clinical ambassadors to help and supervise the team with clinical supervisions, reflections and work questions.

Good

Are services effective?

- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records which showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. For example, by providing a direct palliative care telephone line and by undertaking the ambulance falls trial. Staff communicated promptly with patient's registered GP to ensure 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 refer patients to other services for care, treatment and 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.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people who required them. Staff were empowered to make direct referrals for patients to other services.
- Issues with the Directory of Services (DOS) were resolved in a timely manner. (DOS is a system embedded within the clinical software to identify which is the most appropriate service to send the patient to by considering factors as service type, geography, age etc). The service told us the issues were mainly related to remote geography, which made it difficult to direct a patient to the correct service.

Helping patients to live healthier lives

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

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

Consent to care and treatment

The service obtained consent to care and treat 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 provided patients with timely support and information. There were arrangements and systems to support staff to respond to people with specific health care needs. For example, end of life care and those who had mental health needs.
- The organisation recognised it did not have a robust system to capture patient experience. However, at the time of our inspection the provider was trialling texting patients to obtain feedback on their experience of the service provided. The service also planned to create a patient participation group (PPG). A PPG is a group of patients, carers and staff who meet to discuss issues and patient experience to improve the service.
- Due to the ongoing COVID-19 pandemic we did not speak with patients or provide comment cards to gather patient feedback. However, patients had the opportunity to feedback on the service via the Kernow Health CIC website feedback-about-your-experience section or since August 2021 via careopinion.org.uk, through which the provider has received three contacts. The organisation had received 30 compliments over the last 12 months.

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).
- Interpretation services were available for patients who did not have English as a first language and there were systems available to support patients who are hard of hearing with text type or video calls. Video calls were used to support patients with learning disabilities.
- For patients with learning disabilities or complex social needs, we saw that family, carers and/or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand,

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.

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

The service responded to COVID-19 demands effectively and introduced new systems to support people in accessing appropriate care and treatment.

Responding to and meeting people's needs

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

- The provider understood the needs of its population and tailored services in response to those needs. For example, during the COVID-19 period it introduced two ambulances which could be placed where they were most needed at the time, outside their treatment centres to allow clinicians to see patients who had tested positive or were displaying symptoms of COVID-19. Utilising the vehicles in this way enabled deep cleaning to be carried out between patients, whilst they continued to see other patients within the clinic.
- The provider engaged with commissioners to secure improvements to services where these were identified. For example, the support provided by the service to the Stratton Minor Injuries Unit (MIU); to Kernow Health CIC, have now been separately commissioned to provided staff to run community treatment clinics within the MIU to provide care and treatment to any walk-in patients who had a minor injury or illness, as well as patients who are booked through the 111 /GP out of hours triage consultation system.
- The service had a system in place which alerted staff to any specific safety or clinical needs of a person using the service.
- The facilities and premises were appropriate for the services delivered. All the treatment centres, apart from the site at Cudmore House in Truro, were based within local hospitals, Service line agreements were in place to ensure cleaning and general maintenance was carried out. Truro treatment centre was located within Cudmore House. At the time of our inspection, all facilities were clean and tidy, clinical waste bins had been emptied and sharps bins were used appropriately.
- The service made reasonable adjustments when people found it hard to access the service. All treatment centres were accessible under the Disability Discrimination Act.
- The service was responsive to the needs of people in vulnerable circumstances.

However,

- The clinics did not always have two means of access/exit and not all clinic rooms had a panic alarm system in an appropriate place for lone working clinicians. Drivers and clinicians, we spoke with were not aware of any panic alarms or systems to alert other staff in the building. This meant there was a risk to staff if a patient displayed challenging or violent / aggressive behaviour. Staff told us they would call security if necessary and said they did not work alone in the clinic.
- There was not appropriate signage to the GP out of hours treatment centre in St Austell.

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 NHS 111 service operated 24 hours per day, seven days per week and the GP out of hours service operated between 18.30 and 08.00 Monday to Friday and 24 hours at weekends and on bank holidays.
- Patients accessed the GP out of hours service through the NHS 111 service. The service did not see walk-in patients, with the exception of, Stratton Minor Injuries Unit. However, if a 'Walk-in' patient presented, there was guidance to

support staff on the action to take. For example, referring the patient to a Minor Injury Unit, calling NHS111 to obtain an appointment or if the patient required to be seen urgently, they would request immediate support from the clinician. There was clear signage at all treatment centres to ring NHS 111 if the Minor Injuries Unit was closed. All staff were aware of the policy and understood their role ensuring that patient safety was a priority.

- Patients had timely access to initial assessment, test results, diagnosis and treatment. We saw the most recent national Key Performance Indicator (KPI) results for the service (for October to December 2021) which showed the subcontractor on behalf of the provider was not meeting the following indicators. However, they were performing significantly better than the national average:
  - We reviewed the providers attainment of the proportion of calls abandoned against the performance indicator of less than or equivalent to 3%; and for October 2021, they performed at 22.66% (The national performance was 27.63%), for November 2021 they performed at 6.26% (The national performance was 21.62%) for December 2021 they performed at 14.47% (the national performance was 23.60%)
  - We reviewed the providers attainment of the average speed to answer calls against the performance indicator of less than 20 seconds and for October 2021, their average wait to answer a call was 437.49 seconds (Nationally the average wait was 664.91 seconds), for November 2021 their average wait to answer a call was 115.56 seconds (Nationally the average wait was 492.87 seconds) for December 2021, the average wait to answer a call was 233.12 seconds (Nationally the average wait was 579.28 seconds).
- We saw the most recent local target results for the service (December 2021) which showed the provider was not always meeting the following indicators.
- The providers average time to respond to an urgent clinical assessment was 36.78 minutes the local target was less than 20minutes,
- The providers average time to respond to a routine clinical assessment was 100.76 minutes the local target was less than 60 minutes to answer,
- The providers attainment for the number of urgent palliative care line calls receiving a call back from a clinician within 10 minutes was 84.42%, the local target was greater than 95%.
- The providers attainment for the number of mobile healthcare professional calls receiving a call within 20 minutes was 87.79%, the local target was greater than 95%.

Where some of the services statistics were below the required national targets, these reflected the pressure on the wider system due to COVID-19 pandemic.

- The service was able to present the Cornwall workforce strategy overall, their local organisational strategy and explain the actions they were taking to mitigate the results, to try and increase the staff capacity in the future.
- Waiting times, delays and cancellations were minimal and managed appropriately. Where people were waiting a long time for an assessment or treatment there were arrangements in place to reduce the risks to patients. For example, the clinical assessment service lead clinician who was responsible for monitoring and oversight of patients waiting for care and / or treatment, focused on specific calls that needed upgrading and identified high priority cases.

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. However, not all complaints were managed within their policy timeframe.

- Information about how to make a complaint or raise concerns was available via the website or via a health or clinical advisor. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised national guidance. Nine complaints had been received in the last six months. We reviewed three complaints and found that two had not been responded to or addressed within the service timescales, two were satisfactorily handled and the third, initially had errors, but was finally satisfactorily resolved.

Good

Are services responsive to people's needs?

- 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 also from analysis of trends to improve the quality of care. However, it was not always clear if information was shared for the purpose of learning as a result of an individual concern with the wider team. For example; we observed a clinician using generic calming terms of endearment during a telephone consultation, when we had observed that familiar terminology had been previously highlighted as part of a complaint and we have not seen feedback to all staff to advice of the inappropriateness of this.

Good

Are services well-led?

We rated the service as good for leadership.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- Leaders 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 and 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. However, some staff completing the CQC staff questionnaire commented that management should be more visible out of hours.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy and there was a demonstrated commitment to system-wide collaboration and leadership.

- The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.
- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values. However, staff completing the CQC staff questionnaire had commented there was a level of isolation felt at remote bases.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Good

Are services well-led?

- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. Staff had not always received regular annual appraisals,19 out of 27 staff confirmed they had completed an appraisal in the last twelve months. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the team and were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. The service had a wellbeing and engagement group representing a cross sector of staff, who were consulted for consensus on new policies. For example, the recently introduced hybrid working and the menopause policy. Staff had been given paid time off to do voluntary community projects such as a beach clean. Staff could raise ideas with the group to support with service delivery. The group produced a newsletter on a monthly basis.
- The service presented long service awards to staff who have completed 10, 15 and 20 years of employment within the service. Awards had included certificates, flowers and chocolates presented by the chief executive officer.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, there were some gaps identified regarding infection prevention and control and safe storage of medicines and equipment.

- 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.
- Leaders had established policies, procedures and activities to ensure safety, however, the service did not always get assurance that they were operating as intended. We observed at remote treatment centres, that policies where not always followed around infection control and medicines management. Oversight of complaints received by the service had not always ensured they were responded to in full or in a timely way.
- Managers held daily meetings with the subcontractor who provided the 111 service, to review the daily incoming demand for the 111 service. They held weekly review meetings, and contract meetings. The subcontractors were monitored on their staffing for Kernow Health CiC telephone consultations. Shift leaders were in regular contact with the subcontractors to ensure oversight of the live situation.

1.

Managing risks, issues and performance

There were processes for managing risks, issues and performance however improvements were required to be made.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. However, there had not been oversight of the risks to staff from patients displaying challenging or violent / aggressive behaviour when working in clinical treatment centres.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders

had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements.

- Clinical 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.
- The providers had plans in place and had trained staff for major incidents including joint plans with their subcontractor.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where all staff had enough 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. At the time of the inspection, the service was implementing a new rota system which would allow better reporting of rota hours, with direct export into clinical management and payroll software, and would provide support with human resource management. This would give them an improved reporting suite.
- 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 staff and external partners to support high-quality sustainable services. However, they did not always involve patients, and the public,

- A full and diverse range of staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. All staff were encouraged to join the employee forum, the quarterly all staff briefing event and departmental meetings. However, the company currently did not have a robust system of collecting patient feedback although they were currently trialling a texting service and were planning to form a patient participation group.
- Staff were able to describe to us the systems in place to give feedback. Staff who worked remotely were engaged and able to provide feedback through department meetings, and line managers. We saw evidence of the most recent staff survey and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was strong culture of innovation evidenced by embedding, using and implementing new processes, projects and pilot schemes during exceptional circumstances arising as a result of the COVID-19 pandemic.

Good

Are services well-led?

- There were systems and processes for learning, continuous improvement and innovation.
- There was a focus on continuous learning and improvement at all levels within the service.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- There was a strong culture of innovation evidenced by the number of pilot schemes the provider was involved in. For example:
  - A GP resilience model to offer support to GP surgeries with daytime telephone triage when they had clinical resilience issues. This project was put to the test in February 2022, due to higher levels of GP absence. The service covered for several days and the vast amount of patients were managed with advice or prescription with a small percentage requiring further review. The service was currently working on formalising a model with trigger points with the Care Commissioning Group (CCG).
  - The service completed a pilot in 2021. Lower category (less urgent) ambulance dispositions were selected and sent by electronic link to the clinical assessment service (CAS) for clinical validation. 80% of these cases were redirected to a more appropriate service. Due to the success of the pilot and extension of the GP out of hours contract, the provision of this service had been extended, initially for a further six months form February 2022.
  - A falls trial took place in November 2021 with the ambulance service, to clinically validate all non-injury falls. This had resulted in the ability for an ambulance to be sent out within an hour for these patients, where previously the patient may have waited several hours.
- The service introduced two private 'hot-hub' ambulances at the start of COVID-19 to allow extra capacity to the correct locations, with a quick deep clean process, allowing clinicians to go from hot (COVID-19 risk patient) hub ambulance, to cold (no COVID-19 risk patient) in the surgery.
- A 'lab in a bag' (LIAB) pilot, resulted from a continuous workload of urgent abnormal blood tests which came to the service to manage when GP surgeries were closed. The innovation was created to identify an admission avoidance pathway by providing an advanced paramedic trained in point-of-care blood testing, this has reduced hospital admissions.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Transport Services, Triage and medical advice provided remotely. Treatment of disease, disorder or injury. **Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment** **How the regulation was not being met:** Care and treatment must be provided in a safe way for service users. • The service had not ensured that their infection prevention and control (IPC) systems where routinely followed. The provider had failed to ensure the proper and safe management of Medicines; • The service had not always ensured appropriate transportation of controlled drugs. • The service had not ensured that their medication storage processes were routinely followed. The equipment being used to care for and treat service users was not always safe. In particular • The service had not ensured where clinicians used their own equipment it was appropriately Portable Appliance Tested (PAT) or calibrated. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.