Carlisle

Quality Report

Cumberland Infirmary
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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 service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Carlisle (Cumbria Health on Call) on 30th November, 2016. Overall the service is rated as outstanding.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and an effective system in place for recording, reporting and learning from significant events.
- Risks to patients were assessed and well managed.
- Patients' care needs were assessed and delivered in a timely way according to need. The service met the National Quality Requirements.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- There was a system in place that enabled staff access to patient records, and the out of hours staff provided other services, for example the local GP and hospital, with information following contact with patients as was appropriate.
- The service managed patients' care and treatment in a timely way.
- Information about services and how to complain was available and easy to understand.
- Improvements were made to the quality of care as a result of complaints and concerns.
- The service had good facilities and was well equipped to treat patients and meet their needs. The vehicles used for home visits were clean and well equipped.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw some areas of outstanding service:

- The provider was highly responsive to the the needs of the predominantly rural population. For example, a pilot for telehealth appointments had recently been completed. This had reduced the average time for patients in rural areas to be seen for either a routine base or home visit from 146 minutes to 32 minutes. They worked closely with other service providers, such as North West Ambulance Service (NWAS), for whom

Summary of findings

they provided GP-triage. NWAS told us the most recent data showed that in 93% of cases when this service was used, a hospital admission was avoided for the patient.

- The leadership, management and governance assured the delivery of high quality care, and supported learning and innovation throughout the organisation. Leaders had an inspiring shared purpose and motivated staff to succeed. Staff we spoke to told us the executive team were highly approachable, and that this had a positive effect on staff morale.
- Governance and strategy were proactive and innovative. The provider had been proactive in addressing the specific recruitment difficulties faced by the service in this geographical area. As a result of a collaborative recruitment drive six new salaried GPs had been employed. This in turn improved capacity to meet demand and safety, as reliance on agency staff was sometimes as low as 5% of shifts per week.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The service is rated as good for being safe.

- The service used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on a thorough analysis and investigation.
- Information about safety was highly valued and was used to promote learning and improvement.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- When things went wrong patients were informed in keeping with the Duty of Candour. They were given an explanation based on facts, an apology if appropriate and, wherever possible, a summary of learning from the event in the preferred method of communication by the patient. They were told about any actions to improve processes to prevent the same thing happening again.
- The out-of-hours service had clearly defined and embedded system and processes in place to keep patients safe and safeguarded from abuse.
- When patients could not be contacted at the time of their home visit or if they did not attend for their appointment, there were processes in place to follow up patients who were potentially vulnerable.
- There were systems in place to support staff undertaking home visits. Staff had access to a range of communication equipment to ensure they could contact each other.
- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The service is rated as good for being effective.

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that the service used these guidelines to positively influence and improve the service and outcomes for patients.

Summary of findings

- Clinical audits demonstrated quality improvement.
- CHoC was a member of Urgent Health UK (UHUK), which provided external audit of the service, and benchmarked performance against 23 other out of hours care providers in England. At the two most recent audits in 2015 and 2016, CHoC was given a rating of "highly commendable", which is the highest of five ratings available. Only four providers currently have this rating.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The service is rated as good for being caring.

- We observed a strong patient-centred culture.
- CHoC commissioned Healthwatch Cumbria to carry out a survey into patient satisfaction between September 2016 and November 2016. From 1,676 respondents they found that 91% of patients were either very satisfied or satisfied with their overall experience.
- CHoC ranked ninth highest out of all of the 211 clinical commissioning group (CCG) areas in England for patient satisfaction with their overall experience of the service in 2014.
- Views of external stakeholders were very positive.
- Feedback from the large majority of patients through our comment cards and questionnaires, and collected by the provider was very positive.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- There were systems in place to ensure that patients were kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.

Are services responsive to people's needs?

Outstanding

The service is rated as outstanding for being responsive.

- Services were tailored to meet the needs of the local population, and the involvement of other organisations and the local community was integral to how services were planned.

Summary of findings

- A number of services were in place to meet the needs of the predominantly rural population. For example, a pilot for telehealth appointments had reduced the average time for patients in rural areas to be seen for either a routine base or home visit from 146 minutes to 32 minutes. This pilot was now being rolled out to other areas.
- The provider offered GP-led triage for paramedics, to allow them to receive advice from CHoC GPs if they were unsure whether or not to admit a patient to hospital. During the in-hours period, the CHoC control room also acted as a single point of access for paramedics to contact GPs. Hospital admission had been avoided in 93% of cases where paramedics had used this service, reducing unnecessary hospital stays for patients.
- In 2014, CHoC ranked second highest across all of the 211 clinical commissioning group (CCG) areas in England for the number of patients who responded that they knew how to contact the out of hours service.
- The service had good facilities and was well equipped to treat patients and meet their needs.
- The service had systems in place to ensure patients received care and treatment in a timely way and according to the urgency of need.
- Information about how to complain was available and easy to understand and evidence showed the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. Complaints were investigated by the member of the executive and/or management team who was deemed most appropriate for the case, such as the medical director, senior clinical nurse lead, or the chief executive.

Are services well-led?

Outstanding ☆

The service is rated as outstanding for being well-led.

- The service had a clear vision with quality and safety as its top priority.
- High standards were promoted and owned by all service staff and teams worked together across all roles.
- Leaders had an inspiring shared purpose, strove to deliver and motivated staff to succeed. For example, staff told us that the medical director was involved in supporting staff and offering learning opportunities, and would suggest cases for nurse practitioners to treat, under their supervision, to increase their knowledge base.

Summary of findings

- There was a high level of constructive engagement with staff and a high level of staff satisfaction. In response to a staff survey, the provider was actively pursuing ways to improve staff well-being and encourage staff retention. For example, a salary sacrifice scheme which was set up with a medical indemnity provider in an attempt to reduce the cost to clinicians of paying for cover.
- In response to difficulties recruiting GPs to out of hours services, the provider had become a Tier 2 sponsor, which allowed them to recruit medical staff who had trained in the UK but who required a visa to work here. The provider believed they were the only out of hours service in England to have become a Tier 2 sponsor.
- The provider was aware of and complied with the requirements of the duty of candour, encouraging a culture of openness and honesty. The service had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The provider used innovative approaches to gather feedback from people who used services and the public. They had commissioned Healthwatch Cumbria to conduct a survey which gathered the views of 1,676 patients. They also used the website I Want Great Care (www.iwantgreatcare.org) to gather feedback from patients.
- The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear and proactive approach to seeking out and embedding new ways of providing care and treatment, and we saw multiple examples of this during the inspection, such as the telehealth pilot, the pharmacy triage pilot, and working with the ambulance service to reduce demand.

Summary of findings

What people who use the service say

We looked at various sources of feedback received from patients about the out-of-hours service they received. The National GP Patient Survey asks patients about their satisfaction with the out-of-hours service. Data from the GP national patient survey published in July 2016 found:

- 71% of patients felt they had received care quickly from the service, compared to the national average of 62%
- 76% of patients felt their overall experience of the service was good, compared to the national average of 70%
- 91% of patients said they had confidence and trust in the people seen or spoken to, compared to the national average of 90%

An analysis of National GP Patient Survey data from 2014 showed that Cumbria Health on Call (CHoC) ranked in the top ten of all out of hours providers in England for patient satisfaction for each of the five questions asked. For example, 69% of patients responded that they knew how to contact the out of hours service. This was the second highest number across all of the 211 clinical commissioning group (CCG) areas in England. CHoC was also rated highest for patient satisfaction with out of hours provision across the eight CCGs which form part of their local area team.

CHoC commissioned Healthwatch Cumbria to carry out a survey into patient satisfaction between September 2016 and November 2016. From 1,676 respondents they found that:

- 91% of patients were either very satisfied or satisfied with their overall experience of CHoC
- 88% of patients at base visits, and 83% of patients at home visits, thought the wait was as expected or shorter.
- 94% of patients at base visits, and 93% of patients at home visits, felt reassured by the doctor or nurse they were seen by.
- 92% of patients felt involved in decisions made about their treatment.

CHoC used the website I Want Great Care (www.iwantgreatcare.org) to gather feedback from patients. At the time of inspection, the service at Carlisle had a rating of five stars (out of five) from 568 reviews.

We also gathered patient feedback at the seven sites we visited during our inspection of CHoC. We spoke to 21 patients in total, all of whom were satisfied with the service provided.

Outstanding practice

- The provider was highly responsive to the the needs of the predominantly rural population. For example, a pilot for telehealth appointments had recently been completed. This had reduced the average time for patients in rural areas to be seen for either a routine base or home visit from 146 minutes to 32 minutes. They worked closely with other service providers, such as North West Ambulance Service (NWAS), for whom they provided GP-triage. NWAS told us the most recent data showed that in 93% of cases when this service was used, a hospital admission was avoided for the patient.
- The leadership, management and governance assured the delivery of high quality care, and supported learning and innovation throughout the organisation. Leaders had an inspiring shared purpose and motivated staff to succeed. Staff we spoke to told us the executive team were highly approachable, and that this had a positive effect on staff morale.
- Governance and strategy were proactive and innovative. The provider had been proactive in addressing the specific recruitment difficulties faced by the service in this geographical area. As a result of a collaborative recruitment drive six new salaried GPs had been employed. This in turn improved capacity to meet demand and safety, as reliance on agency staff was sometimes as low as 5% of shifts per week.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.**The team included a second CQC Inspector, a GP specialist advisor and a Practice Nurse specialist advisor.

Background to Carlisle

Carlisle Cumbria Health on Call (CHoC) provides out of hours GP services from:

- Cumberland Infirmary, Newtown Road, Carlisle, CA2 7HY.

We visited this site during our inspection. These premises are operated and managed by North Cumbria University Hospitals (NCUH) NHS Trust. The consulting rooms and reception are situated on the ground floor and with easy access to the accident and emergency department of the hospital. The service operates in the evenings, overnight and at the weekends. The service gives telephone advice, sees people at the location by appointment and makes home visits. The service employs GPs, nurse practitioners and nurses.

Carlisle is one of seven locations registered by CHoC to provide out of hours services in Cumbria. On average, 1045 patients use the service each week. CHoC provides care, treatment and support from Monday to Friday from 18:30 to 08:00, and on Saturday and Sunday from 08:00 to 08:00 for some 499,000 people over a land mass of 2,613 square miles. Cumbria is the second largest county in England and represents 48% of the land mass of the North West. Across Cumbria 51% of the population live in rural areas. There are 73 people per square kilometre on average.

In terms of patient population, there are above average numbers for all age groups over 50 and below average for all groups below 45. Average life expectancy for both males and females is close to the national average (males 78.6 years, females 82.2 years, compared to the national average of 78.9 and 82.8 years respectively) however this does not reflect the large variation within Cumbria itself, where the life expectancy in the most deprived areas for men is 13 years lower, and for women eight years lower, than people in the least deprived areas. 56.3% of the population reports having a long-standing health condition (national average 54%). In terms of ethnicity, the population is 98.5% white (national average 85.4%) with the lowest percentages of any CCG area in England of patients from black/black British, mixed, or other ethnic groups (0.1%, 0.5% and 0.1% respectively).

We previously inspected Carlisle CHoC in July 2013. We were not rating services at that time, however we found CHOC to be compliant with all regulations.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 30 November 2016.

During our visit we:

- Spoke with a range of staff including a GP, nurse practitioner, reception, drivers and team leaders.
- Inspected the out of hours premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- Looked at the vehicles used to take clinicians to consultations in patients' homes, and we reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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

Please note that when referring to information throughout this report, for example any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

People were protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things went wrong.

- Staff told us they would inform the service manager of any incidents and there was a recording form available on the service's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again. Often this was done by the chief executive, or another member of the executive team.
- The service carried out a thorough analysis of the significant events and ensured that learning from them was disseminated to staff and embedded in policy and processes. This was done directly with staff involved via telephone calls, meetings or emails, and more broadly though team manager meetings and organisational newsletters.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the service. For example, following a road traffic incident it was identified that one or two items of equipment moved around in the cars. Processes were put in place to ensure all cars were packed in a standard way and all equipment was secured.

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and services in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level three. The whole team was engaged in reviewing and improving safety and safeguarding systems. The service's computer system ensured that all cases where safeguarding concerns were suspected would be reviewed by a lead member of staff for safeguarding. After each patient contact, the patient record could not be completed without a safeguarding question being answered, to ensure this was at the forefront of clinicians' minds.
- All staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. (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). Training had recently been rolled out to staff and a new chaperone policy had been put in place to ensure staff fully understood their role.
- The service maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The service shared the accident and emergency premises at the hospital. All cleaning and infection control arrangements were carried out by the North Cumbria University Hospitals NHS Trust. The provider had systems in place to ensure appropriate standards were maintained and to regularly review the arrangements with the trust.
- There was a system in place to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body, appropriate indemnity and the appropriate checks through the Disclosure and Barring Service. The provider employed an office manager who put in place systems to check that all new employed and sessional staff had the relevant documents and training in place.

Medicines Management

Good

Are services safe?

- The arrangements for managing medicines at the service, including emergency medicines and vaccines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). The service carried out regular medicines audits, with the support of the local CCG medicines management team, to ensure prescribing was in accordance with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- The service held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had standard operating procedures in place that set out how controlled drugs were managed in accordance with the law and NHS England regulations. These included auditing and monitoring arrangements, and mechanisms for reporting and investigating discrepancies. The provider held a Home Office licence to permit the possession of controlled drugs within the service. There were also appropriate arrangements in place for the destruction of controlled drugs.
- Processes were in place for checking medicines, including those held at the service and also medicines bags for the out of hours vehicles.
- Arrangements were in place to ensure medicines and medical gas cylinders carried in the out of hours vehicles were stored appropriately. Medicines were not stored in the cars unless they were in use.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The service had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Clinical equipment that required calibration was calibrated according to the manufacturer's guidance.
- There were systems in place to ensure the safety of the out of hours vehicles. Checks were undertaken at the beginning of each shift. These checks included the equipment on board, the lights and indicators of the vehicle and the communication systems within it. The driver told us the vehicles were fitted with tyre sensors to alert if there was a problem with tyre pressure and there was an agreement with a local tyre firm for swift replacement. All of the vehicles used were 'all wheel drive' to cope with the rural area. Records were kept of MOT and servicing requirements. We checked two of the vehicles with the drivers and found they complied with their safety tests. The vehicles were fitted with GPS so that their speed and location could be tracked. This improved safety for drivers and clinicians, as the control room always knew where the cars were located.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The inspection team saw evidence that the rota system was effective in ensuring that there were enough staff on duty to meet expected demand. The provider had become a Tier 2 sponsor, which meant they were allowed to recruit from a wider pool of medical staff by being eligible to employ doctors who trained in the UK but who needed a visa in order to gain employment. In 2016, this meant the provider was able to employ six new salaried GPs, doubling the number of salaried GPs employed by the provider, which in turn reduced their reliance on agency staff. The provider set a limit of 15% of shifts per week being carried out by agency doctors. We saw evidence that not only did the provider mostly remain within this limit, but that on occasion the number of agency doctors used in a week was as low as 5%. The provider employed nurse practitioners, and did not use agency nursing staff. The provider believed they were the only out of hours service in England to have become a Tier 2 sponsor.

Arrangements to deal with emergencies and major incidents

The service had adequate arrangements in place to respond to emergencies and major incidents.

- There was an effective system to alert staff to any emergency.
- All staff received annual basic life support training, including use of an automated external defibrillator.
- The service had a defibrillator available on the premises and oxygen with adult and children's masks.
- Emergency medicines were easily accessible and all staff knew of their location. All the medicines we checked were in date and stored securely.

Good

Are services safe?

- The service had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. This plan had proved effective during the severe flooding suffered in Cumbria in December 2015. The service was able to continue operating, and to support other services in the area. We saw that the plan had been reviewed thoroughly following this event to look for further improvements.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best service guidelines.

- The service had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The service monitored that these guidelines were followed.

Management, monitoring and improving outcomes for people

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 the service is safe, clinically effective and responsive. Providers are required to report monthly to the clinical commissioning group on their performance against standards which includes 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.

We saw that the most recent results (July-September 2016) which showed the provider was meeting these requirements overall. There were two areas where the provider was outside of the target range for part of that requirement. However, they were aware of these and we saw evidence that attempts were being made to address these:

- NQR 8: Initial telephone calls.

On the initial telephone call to the service, no more than 0.1% of calls should be engaged, and no more than 5% calls abandoned - Pass.

In terms of time taken for the call to be answered by a person, all calls must be answered within 60 seconds of the end of the introductory message which should normally be no more than 30 seconds long. Where there is no introductory message, all calls must be answered within 30 seconds – 92% of all calls in this period (target 95%).

We saw that this figure was improving month on month, and could also be explained by the number of people incorrectly contacting the service using a phone line other than 111. This number was being given to some patients in error, and the provider was carrying out work at the time of inspection to reduce the number of people who used the number.

- NQR 12: Face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

Emergency: Within 1 hour – Over the course of 2016 the provider had achieved 89% (target 95%) of base appointments within one hour, and 82% (target 95%) of home visits.

Urgent: Within 2 hours - Over the course of 2016 the provider had achieved 95% (target 95%) of base appointments, and 91% (target 95%) of home visits.

Less urgent: Within 6 hours - Over the course of 2016 the provider had achieved 100% (target 95%) of base appointments, and 99% (target 95%) of home visits.

We looked at performance against the one-hour target and found that it was a relatively small sample of patients each month who required these appointments (compared to those making up the other targets). This meant that missing the one-hour deadline on only one or two occasions each month had a greater impact on the percentages recorded against this target. For example, in February 2016, 21 patients were triaged as requiring a one-hour appointment; three of these were missed, meaning the provider achieved 85% against this target. In April 2016, 22 patients were triaged for one-hour appointments and one missed the target. This difference of two patients increased performance to 95% and put them just within target for that month. In some months, due to the low numbers, the provider would have to see every patient within the timeframe to avoid dropping below the target set.

Over the course of 2016, 380 patients were offered a one-hour home appointment, of which 67 missed the target. We looked at a sample of 12 of these misses, and found that on average the target was missed by 18 minutes (nearest miss was five minutes, longest was 41 minutes).

Good

Are services effective?

(for example, treatment is effective)

The provider told us that the geography of the area had impacted on their ability to meet the one-hour target. As well as being predominately rural, the mountains and lakes meant that journeys between destinations often took longer by road than they might in other parts of the country. They felt that tourism in the Lake District in the summer months had an impact, and we saw that performance dipped for the months of July and August. We also saw from the data that the areas where the target was being missed most often coincided with the most rural and mountainous parts of the county. This had impacted on the provider's ability to meet the target for base appointments also, as we saw evidence that base visits within the one-hour timeframe had been offered but declined by patients who felt they were unable to make the journey to the base within that time. We saw minutes of meetings with the local clinical commissioning group (CCG), who acknowledged the difficulty of meeting these targets in Cumbria. The CCG told us that they asked CHoC to report on the one-hour target, but did not performance manage them against it due to the geographical challenges and the impact that the small number of patients had on the overall target.

The provider had been pro-active in attempting to improve on performance against these targets by increasing staffing, which they had done by employing six additional salaried GPs who were now in post. They had made changes to staff rotas to meet demand. They had also recently implemented improved technology which helped them to monitor demand in real time. This meant work could be shared more effectively between clinicians. We saw examples of this during the inspection, when one service was able to triage calls for another area which was experiencing increased demand. They had also invested in systems which allowed them to correlate the times entered by clinicians with the arrival time recorded by the vehicles' satellite navigation systems, to ensure that figures obtained were accurate.

There was evidence of quality improvement including clinical audit.

- Since 2011, CHoC had been a member of Urgent Health UK (UHUK), which provided external audit of the service, and benchmarked performance against 23 other out of hours care providers in England. At the two most recent audits in 2015 and 2016, CHoC was given a rating of "highly commendable", which is the highest of five ratings available. Only four providers currently have this rating.
- The performance of each clinician was audited monthly, and results were displayed in a clinician dashboard online tool. The medical and nursing staff reviewed these dashboards with the medical director/clinical nursing lead and used them to aid their learning.
- We looked at a sample of seven clinical audits completed in the last two years and found these had led to improvements. For example, audits into abdominal pain and headaches in OOH patients had led to additional training for clinicians to improve diagnosis and treatment. Also, an audit of antibiotic prescribing had led to an overall reduction in prescribing these medications, including a 29% reduction in a type of antibiotic commonly associated with causing vomiting and diarrhoea.
- GPs who worked for the service and completed clinical audits at their usual practices as part of their revalidation could, where relevant, share these with other clinicians at the quarterly CHoC clinical meetings.
- Findings were used by the service to improve services. For example, recent action taken as a result included improving the systems for checking stocks of medication to ensure that it was within its use-by date.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The service had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff were also supported to work alongside other staff and their performance was regularly reviewed during their induction period. GP registrars who trained at practices in Cumbria and did shifts with CHoC as part of that training received five days additional training from the provider which was specific to out of hours care. These registrars also had a trainer present with them during shifts to support them.
- Training was provided in conjunction with relevant external services. For example, the provider worked with the North West Ambulance Service to offer training to staff around patient triaging.

Good

Are services effective?

(for example, treatment is effective)

- The service could demonstrate how they ensured role-specific training and updating for relevant staff. Nurses told us they felt very supported, had enough training opportunities to maintain and progress their skills and were supported in reflective practice. Staff told us that the medical director was involved in supporting staff and offering learning opportunities. We were told by several members of the nursing staff that the medical director often worked shifts on the out of hours service and would suggest cases for nurse practitioners to treat, under their supervision, to increase their knowledge base.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, and clinical supervision. All staff had received a recent appraisal or had one booked to be completed within the next few weeks.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. The provider also had plans to open their own training academy for their staff and external agencies. We saw work on the academy taking place during the inspection.
- Staff involved in handling medicines received training appropriate to their role.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system.

- This included access to as required 'special notes'/summary care records, which detailed information provided by the person's GP. This helped the out of hours staff in understanding a person's need.
- The service shared relevant information with other services in a timely way, for example when referring patients to other services.
- The provider worked collaboratively with other services. Patients who could be more appropriately seen or followed up by their registered GP or an emergency department were referred on.
- The service worked closely with staff in the hospital A&E department. Across the whole service, CHoC had received 3099 referrals from A&E in the past year, helping to lower the demand on emergency care.
- A clinical co-ordinator was based at the provider headquarters. This person had full access to the computer system used by the GP practices in the county, and therefore could access full patient records. If clinicians needed to check patient records, they could contact the clinical co-ordinator, who could pass the information securely to the clinician.
- There was a direct telephone line which patients who had a special note on their records (such as patients at the end of life) could call to contact the service without the need to contact NHS 111.
- The provider offered GP-led triage for paramedics during the out-of-hours period, as well as being a single point of contact for paramedics to contact the patient's own GP in-hours. This service allowed paramedics to receive advice from a GP if they were unsure whether or not to admit a patient to hospital. The most recent results provided by NWAS showed that in 93% of cases where paramedics had used this service, patients had not been admitted. This resulted in a reduction of unnecessary admissions to hospital for patients, and reduced strain on secondary care services in the area. We were told by NWAS that the average rate of admission avoidance produced by all providers across the region was approximately 87%. The use of the service had increased significantly since its introduction in February 2014, from 81 cases per month to 705 cases in January 2017.

The service worked with other service providers to meet patients' needs and manage patients with complex needs. They sent out-of-hours notes to the registered GP services electronically by 8am the next morning.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Good

Are services effective?

(for example, treatment is effective)

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

CHoC commissioned Healthwatch Cumbria to carry out a survey into patient satisfaction between September 2016 and November 2016. This was in response to difficulties in obtaining feedback from a broad population. From 1,676 respondents they found that:

- 91% of patients were either very satisfied or satisfied with their overall experience of CHoC
- 94% of patients at base visits, and 93% of patients at home visits, felt reassured by the doctor or nurse they were seen by.
- 93% of patients were very satisfied or satisfied with the welcome received upon attending for an appointment at a base site.

The National GP Patient Survey asks patients about their satisfaction with the out-of-hours service. An analysis of National GP Patient Survey data from 2014 by NHS England showed that Cumbria Health on Call (CHoC) ranked in the top ten of all out of hours providers in England for patient satisfaction for each of the five questions asked. For example:

The study found that CHoC ranked ninth highest out of all of the 211 clinical commissioning group (CCG) areas in England for patient satisfaction with their overall experience of the service.

CHoC was also rated highest for patient satisfaction with out of hours provision across the eight CCGs which form part of the local area team.

Data from the most recent National GP Patient Survey, published in July 2016, showed the service continued to perform above national averages. For example:

- 76% of patients felt their overall experience of the service was good, compared to the national average of 70%
- 91% of patients said they had confidence and trust in the people seen or spoken to, compared to the national average of 90%

CHoC used the website I Want Great Care (www.iwantgreatcare.org) to gather feedback from patients. At the time of inspection, the service at Carlisle had a rating of five stars (out of five) from 568 reviews. Commonly used words by patients in the reviews included 'excellent', 'kind', 'caring', 'reassuring' and 'brilliant care'.

We gathered patient feedback at the seven sites we visited during our inspection of CHoC. We spoke to 21 patients in total, all of whom were happy with the service provided.

Care planning and involvement in decisions about care and treatment

Patients told us through their comment cards they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

The service provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. This was accessed by staff contacting the headquarters of the service.
- Information leaflets were available in easy read format.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were tailored to meet the needs of the local population, and the involvement of other organisations and the local community was integral to how services were planned. The provider engaged with commissioners to secure improvements to services where these were identified.

- A number of services were in place to meet the needs of the predominantly rural population. For example, telehealth appointments had recently been introduced following a successful pilot of the service, meaning patients could have video consultations with clinicians at other sites from a venue closer to their home. This had reduced the distance patients needed to travel for appointments, giving the patients additional choice in where they could be seen. Previously, the average time for patients in rural areas to be seen for either a routine base or home visit was 146 minutes. During the telehealth pilot, patients could be seen by a doctor in an average of 32 minutes. This service was offered in collaboration with a local NHS trust.
- The provider offered GP-led triage for paramedics during the out-of-hours period, as well as being a single point of contact for paramedics to contact the patient's own GP in-hours. This service allowed paramedics to receive advice from a GP if they were unsure whether or not to admit a patient to hospital. The most recent results provided by the North West Ambulance Service (NWAS) showed that in 93% of cases where paramedics had used this service, patients had not been admitted. This resulted in a reduction of unnecessary admissions to hospital for patients, and reduced strain on secondary care services in the area. We were told by NWAS that use of the CHoC service by paramedics had increased from 81 cases in February 2014 to 705 cases in January 2017, and that the average rate of admission avoidance produced by all providers across the region was approximately 87%.
- Clinicians at the service provided physical care to patients staying in community mental health wards overnight.
- All of the vehicles used were 'all wheel drive' to cope with the rural area. They were also fitted with GPS so that their speed and location could be tracked. This improved safety for drivers and clinicians, as the control room always knew where the cars were located. This could also be used to manage demand when required.
- During the widespread flooding in Cumbria during December 2015, CHoC worked closely with other local services, such as the mountain rescue service, to ensure patients could still be reached by clinicians. The fire brigade helped to take doctors by boat to parts of the county which were cut off by water.
- In response to a high volume of calls to the service from patients with queries about their medication, the provider had started a pilot scheme of having clinical pharmacists on hand to answer calls. This freed up time for doctors on shift to continue seeing patients. As the pilot had only recently begun, there were no results available at the time of inspection.
- To tackle high demand, the provider had recently implemented improved technology which helped them to monitor demand in real time. This meant work could be shared more effectively between clinicians, reducing waiting times for patients. We saw examples of this during the inspection, when one service was able to triage calls for another area which was experiencing increased demand.
- There was a direct telephone line which patients who had a special note on their records (such as patients at the end of life) could call to contact the service without the need to contact NHS 111.
- Home visits were available for patients whose clinical needs which resulted in difficulty attending the service.
- There were accessible facilities, a hearing loop and translation services available.
- Staff confirmed that the service did not discriminate regarding patients age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief. The facilities were suitable to meet the needs of patients with impaired physical ability.

Access to the service

On average, 1045 patients used the service at Carlisle each week, and it operated from Monday to Friday from 18:30 to 08:00, and on Saturday and Sunday from 08:00 to 08:00.

Patients could access the service via NHS 111. The service did not see 'walk in' patients and those that came in were told to ring NHS 111 unless they needed urgent care in which case they would be stabilised before referring on.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

There was a 'walk in' policy which clearly outlined what staff should do when patients arrived without having first made an appointment, and made patient safety the priority. Staff were aware of the policy and understood their role. There were arrangements in place for people at the end of their life so they could contact the service directly, without the need to call NHS 111 first.

Feedback received from patients and from the National Quality Requirements scores indicated that in most cases patients were seen in a timely way.

Data from the National GP Patient Survey published in July 2016 showed the service was performing above national averages. For example:

- 71% of patients felt they had received care quickly from the service, compared to the national average of 62%

An analysis of National GP Patient Survey data from 2014 showed that Cumbria Health on Call (CHoC) ranked in the top ten of all out of hours providers in England for patient satisfaction for each of the five questions asked. For example, 69% of patients responded that they knew how to contact the out of hours service. This was the second highest number across all of the 211 clinical commissioning group (CCG) areas in England.

A patient satisfaction study commissioned by CHoC and completed by Healthwatch found that patients were happy with access to the service. From 1,676 responses between September 2016 and November 2016 they found that:

- 88% of patients at base visits, and 83% of patients at home visits, thought the wait for appointments was as expected or shorter.

The service had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

This was done by telephoning the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need.

Listening and learning from concerns and complaints

There was an active review of complaints and concerns, as well as how these are managed and responded to. People who used services were involved in the review of their complaint.

- The complaints policy and procedures were in line with the NHS England guidance and their contractual obligations.
- There was a designated responsible person who co-ordinated the handling of all complaints in the service.
- We saw that information was available to help patients understand the complaints system.

We looked at a range of complaints received in the last 12 months and found these were dealt with in a timely way. There was openness and transparency when dealing with the complaint, for example patients were contacted by the member of the executive team investigating the complaint to discuss the outcome. Both formal and informal complaints were logged and reviewed every two weeks by the medical director, senior clinical nurse lead and the chief executive. They were then investigated by the member of the executive and/or executive team who was deemed most appropriate for the case. Lessons were learnt from individual concerns and complaints and also from analysis of trends. Action was taken to as a result to improve the quality of care. All complaints were presented at the bi-monthly clinical governance meeting so that lessons learned could be shared. Staff fully understood the complaints procedure and their role in this.

Are services well-led?

Outstanding ☆

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The leadership, governance and culture were used to drive and improve the delivery of high-quality, person-centred care. The service had a clear vision to achieve this and to promote good outcomes for patients.

The provider had four core values, these were:

- Clinically focused - Everything every one of us does is for the patient
- Responsive - We listen and we respond quickly in a patient focussed way
- One Team - We work together to provide a high quality service which is organised and consistent, and in partnership with both the local Acute and Community Trusts
- High Standards - We provide skilled professionals working to the highest standards who are passionate about improving patient care

Staff we spoke to were extremely positive about their experience of working for CHoC and knew and understood the values.The service had a comprehensive strategy and supporting business plans that reflected the vision and values and were regularly monitored. The strategy had been devised with staff at a company away day and had meeting the needs of patients in a rural, sparsely populated community as their main aim. Working in partnership with other services, developing staff and increased use of technology were also key aims of the strategy, and we saw evidence that this was being put into practice during our inspection.

We also saw evidence that the provider was keen to share practice with other providers. For example, members of the leadership team had given a presentation about their learning from the telehealth pilot to other providers of out of hours care who were members of Urgent Health UK.

Governance arrangements

The service had an overarching governance framework that supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff.
- The provider had a good understanding of their performance against National Quality Requirements. They had invested in new technology that allowed for the development and use of real-time performance monitoring to improve capacity to meet demand. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group (CCG) as part of contract monitoring arrangements.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The provider demonstrated they had the experience, capacity and capability to run the service and ensure high quality care. There was strong collaboration and support across all staff and a common focus on improving safety, quality of care, and people's experiences. Staff told us the managers were approachable and always took the time to listen to all members of staff. Staff reported they felt they were part of a family, and were respected and valued by managers.

There was a proactive approach to meeting the recruitment problems experienced by services in the area. The provider was a member of the CCG-led Collaborative Recruitment Hub, which worked to encourage recruitment of clinical staff in Cumbria. The provider was active in attending conferences and events nationwide to encourage recruitment to the area. In 2016, the provider was able to employ six new salaried GPs, which in turn meant they reduced reliance on agency staff, as a result of successfully applying to be a Tier 2 sponsor. On occasion the number of agency doctors used in a week was as low as 5%. The provider believed they were the only out of hours service in England to have become a Tier 2 sponsor.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with

Are services well-led?

Outstanding ☆

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

patients about notifiable safety incidents. The provider encouraged a culture of openness and honesty. The service had systems in place to ensure that when things went wrong with care and treatment:

- The service gave affected people an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.
- The service kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- There were arrangements in place to ensure the staff were kept informed and up-to-date. This included feedback on incidents, complaints or safeguarding that staff had reported. Nurses confirmed these were used to support reflective learning. There was a staff newsletter.
- We saw evidence that the medical director was heavily involved in supporting staff and offering learning opportunities. We were told by several members of the nursing staff that the medical director often worked shifts on the out of hours service and would suggest cases for nurse practitioners to treat, under their supervision, to increase their knowledge base.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of staff engagement. Staff at all levels were actively encouraged to raise concerns. They had opportunities to meet regularly and share learning.
- Staff said they felt respected, valued and supported, particularly by the managers at the service. Staff had the opportunity to contribute to the development of the service.
- A salary sacrifice scheme was set up with a medical indemnity provider in an attempt to reduce the cost to clinicians of paying for cover. This was an effort to improve staff well-being and to encourage new staff to join the organisation.

Seeking and acting on feedback from patients, the public and staff

Rigorous and constructive challenge from people who use services, the public and stakeholders was welcomed and seen as a vital way of holding the service to account. The service encouraged and valued feedback from patients, the public and staff. They proactively sought patients' feedback and engaged patients in the delivery of the service.

- The provider used innovative approaches to gather feedback from people who use services and the public. They used the website I Want Great Care (www.iwantgreatcare.org) to gather feedback from patients. The service at Carlisle had a rating of five stars (out of five) from 568 reviews. Commonly used words by patients in the reviews included 'excellent', 'kind', 'caring', 'reassuring' and 'brilliant care'.
- CHoC approached Healthwatch to commission a report gathering broader feedback from patients, in response to difficulties obtaining feedback from a wide population. Between September 2016 and November 2016, Healthwatch spoke to 1,676 patients and found that 91% of patients were either very satisfied or satisfied with their overall experience of CHoC.
- The service had gathered feedback from staff through meetings and one to one discussions, as well as a staff survey. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the service was run.
- Several initiatives had been put in place in response to the staff survey, including "20 days of 20" where staff were encouraged to take part in activities, and social events and award ceremonies. These events were intended to improve staff morale and well-being.
- The provider used social media platforms, such as Twitter, to communicate with patients and gather feedback.

Continuous improvement

The leadership drove continuous improvement and staff were accountable for delivering change. Safe innovation was celebrated. There was a clear and proactive approach to seeking out and embedding new ways of providing care and treatment, and we saw multiple examples of this during the inspection.

- The provider looked to benchmark their performance nationally to drive improvement. Since 2011, CHoC had been a member of Urgent Health UK (UHUK), which provided external audit of the service, and benchmarked against 23 other out of hours care

Are services well-led?

Outstanding ☆

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

providers in England. At the most recent audit in 2016, CHoC was given a rating of "highly commendable", which is the highest of five ratings available. Only four providers currently have this rating.

- There was a strong culture of innovation evidenced by the number of pilot schemes the provider was involved in. These included a telehealth service which had reduced the average time for patients in rural areas to be seen for either a routine base or home visit from 146 to 32 minutes, and a telephone service staffed by pharmacists to answer patients' medication queries.Steps had been taken to increase capacity and meet high demand, including investing in new technology to monitor demand in real time, and taking a proactive and innovative approach to recruitment.
- The provider had recently opened their own training academy. We saw plans for the provider to offer training to external agencies, such as GP practices.
- The provider had met with the "frequent flyer team" from the North West Ambulance Service to explore ways to collaborate on reducing demand on services.