Cambridge and Peterborough IUC Services

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	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Overall summary

The findings of this review relate to the overall system of care provision in this area and are not all specific to this provider alone. The following details the findings of this system wide review:

A summary of CQC findings on urgent and emergency care services in Cambridge and Peterborough .

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 Cambridgeshire and Peterborough below:

Cambridgeshire and Peterborough

Provision of urgent and emergency care in Cambridgeshire and Peterborough was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, urgent care, acute, mental health, ambulance services and in care homes and domiciliary care agencies (social care). Staff had worked very hard under sustained pressure across health and social care services. Staff reported feeling tired and frustrated due to the sustained pressure and the impact this had on their wellbeing and on the delivery of training.

We identified a need for more capacity in primary care to meet people's needs in Cambridgeshire and Peterborough. We found some concerns in relation to access for patients trying to see or speak to a GP; however, other services proactively reviewed patients' attendance at emergency departments and took action to reduce avoidable attendances and improve access to appointments.

We visited a primary care unit run by an acute trust; whilst this was working well, we were told it was addressing an issue in access to primary care and was a short-term solution. We were told of a GP liaison service which enabled GPs and Consultants to work together to discuss individual patient needs. This service had successfully supported a significant number of people to stay at home or to access an alternative pathway and avoid going to an Emergency Department.

Access to NHS111 services for people in Cambridgeshire and Peterborough was generally in line with or better than elsewhere in England. Performance was closely monitored and there were plans in place to address staff shortages, and there was a successful on-going recruitment campaign.

System partners in Cambridgeshire and Peterborough had been part of a collaborative project to launch a Virtual Waiting Room within the Cambridge and Peterborough region. The initiative aimed to help patients who call NHS 111 receive the care they need while alleviating the pressure on Emergency Departments (EDs).

Staff working in ambulance services reported a significant volume of calls which were inappropriate for a 999 response and could have been dealt with in primary care or urgent care services. Staff also reported a high number of elderly people seeking support through emergency services because they felt their care packages were insufficient and did not meet their needs.

Ambulance crews also highlighted their frustrations with the variation in pathways at different hospitals across Cambridgeshire and Peterborough and that ambulance crews were not prioritised for accessing alternative pathways. By streamlining pathways and handover arrangements, ambulance crews felt they could be more efficient.

Overall summary

For many complex reasons, including ambulance handover delays and staffing shortages, there were not enough crewed ambulances to respond to 999 calls within national targets. This posed a risk to people in the community waiting for a 999 response.

Staffing shortages in some Emergency Departments impacted on the delivery of safe and effective care. Staff were not all up to date with mandatory training and did not always assess risks appropriately.

We visited a mental health service and found it met the needs of people who presented in the Emergency Department or transferred between acute and mental health services. However, staff within Emergency Departments reported problems in accessing mental health services and were not able to make referrals 24 hours, seven days a week. This impacted on the ability to provide appropriate care and treatment and moving patients to the appropriate service.

Whilst we found some examples of collaborative working focused on developing system wide resilience, we found Emergency Departments remained under significant pressure. Patients experienced significant waiting times in these departments and staff reported the challenges of caring for patients within the department for such long periods of time. Some staff felt too much risk was accepted and held within emergency departments and didn't always feel supported by system leaders.

Same Day Emergency Care pathways aimed to relieve the pressure from Emergency departments. However, these services also experienced staff shortages, and some were only available during set times. Opportunities were lost to use admission avoidance pathways for the frail and elderly and increasing the risk of patient harm such as falls and skin pressure damage'

Delays in discharge for patients in hospital were significant and impacted on their health and wellbeing. Staffing issues were also impacting on the social care provision in Cambridgeshire and Peterborough; although there were beds available in care homes, there was not always enough staff to enable admissions. The staffing issues were also present in domiciliary care agencies which reduced the availability of care at home.

Staff working across health and social care reported poor discharge processes. Staff working in care homes and domiciliary care services reported that patients were often discharged late at night and with insufficient information to ensure a safe transfer of care.

Staff working in these services also reported significant delays in ambulance responses, however they gave very positive feedback in relation to welfare calls received by GPs or 111 and 999 call handlers.

We found a lack of knowledge across social care services in relation to managing deteriorating patients. By increasing staff awareness, services may be able to meet people's needs without needing to request emergency services.

We observed some local and system escalation meetings and found there was limited, if any action taken in response to issues and risks escalated.

We carried out an announced focused inspection at Cambridge and Peterborough IUC Services on 15 March 2022. We are mindful of the impact of COVID-19 pandemic on our regulatory function. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

This focused inspection was carried out using our Pressure Resilience methodology which meant that we did not use all the key lines of enquiry and the report has not been rated.

Overall summary

The service was last inspected in July 2018 when it was rated as Good throughout. This inspection of Cambridge and Peterborough IUC Services NHS 111 and out-of-hours formed part of a system review of urgent and emergency care provision in Cambridge and Peterborough.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen.
- The service had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The service was generally within the target range for any indicator and they actively monitored their performance.
- There was an effective system to manage infection prevention and control.
- The service respected and promoted patients' privacy and dignity.
- The service had an experienced leadership team with the capacity and skills to deliver high-quality, sustainable care.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

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- The service had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The service was generally within the target range for any indicator and they actively monitored their performance.
- There was an effective system to manage infection prevention and control.
- The service respected and promoted patients' privacy and dignity.
- The service had an experienced leadership team with the capacity and skills to deliver high-quality, sustainable care.

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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 two inspection managers and two further CQC Inspectors, and a GP specialist adviser.

Background to Cambridge and Peterborough IUC Services

The integrated NHS 111 and out-of-hours service for Cambridge and Peterborough is provided by HUC (formally known as Herts Urgent Care).

HUC is a Social Enterprise; a not for profit organisation with no shareholders and where any surpluses are re-invested into the service. The headquarters for HUC is in Welwyn Garden City, Hertfordshire.

Cambridge and Peterborough IUC Services operates NHS 111, out-of-hours and a variety of other services including primary care centres in other areas. Cambridge and Peterborough IUC Services commenced delivery of the integrated NHS 111 and out-of-hours service for Cambridge and Peterborough in November 2016.

NHS111 is a 24 hours-a-day telephone and online service where patients are assessed, given advice or directed to a local service that most appropriately meets their needs. For example, their own GP, an out-of-hours GP service, walk-in centre, urgent care centre, community nurse, emergency dentist or emergency department. GP out-of-hours services provide care to patients who require medical attention outside of normal GP opening hours. Generally, out- of -hours service operates from 6.30pm until 8am Monday to Thursday, and 6.30pm Friday until 8am Monday and all public holidays. Patients access the out-of-hours service via NHS 111 where the information provided is assessed and triaged and patients receive an appropriate response based on their clinical needs. This can be in the form of a clinical telephone assessment, referral to the patient's own GP, a home visit from a clinician or an appointment for the patient to attend an out-of-hours base. The service provides care to a population of approximately 1.1 million people residing in the area and is commissioned by Cambridge and Peterborough Clinical Commissioning Group.

The area has two acute NHS Trusts, one NHS mental health trust and 88 NHS GP practices.

The Cambridge and Peterborough IUC Services operates the NHS111 contact centre from the Peterborough City Care Centre. Out-of-hours services in Cambridge and Peterborough area are delivered from six primary care centres located in Peterborough, Ely, Cambridge, Doddington, Huntingdon and Wisbech. Not all these primary care centres are open every day during the out-of-hours period. As part of this inspection we visited Peterborough City Care Centre and the Out of Hours bases in Peterborough and Cambridge. The service is registered with the CQC to provide the regulated activities of Treatment of disease, disorder or injury, triage and medical advice provided remotely, Diagnostic and screening procedures.

Inspected but not rated

Are services safe?

Safety systems and processes

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

- 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. 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 provider actively monitored any patient contact involving child protection and safeguarding adults. They differentiated between, and reported on, the various types of safeguarding concerns, including (amongst others) domestic abuse, emotional abuse and self-harm. During January 2022, 101 safeguarding alerts were raised, of which 32 related to children/young adults. Clinical advisors were involved in all safeguarding referrals and the provider had encouraged staff including clinical staff to become safeguarding champions. The service undertook detailed reviews of cases and the outcomes.
- The service worked with other agencies, such as social services and emergency services to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The provider undertook checks of the General Medical Council register to ensure doctors working at the service were registered; if this wasn't the case a doctor would not be allowed to work. Checks for nurses registered with the Nursing and Midwifery Council were also in place.
- At January 2022 between 93% and 95% of staff had received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. The provider told us where the level was below 91% managers were made aware and action was taken to ensure all mandatory training was completed. Safeguarding training was prioritised during the first three months of employment for new staff.
- There was an effective system to manage infection prevention and control.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. 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. There were around 1100 staff employed across HUC and because calls could be answered outside of the Cambridge and Peterborough area it was not possible to give a definitive head count for the Peterborough location. The provider told us there were around 65 health advisors and 25 clinical advisors. There was an on-going recruitment campaign and at the time of the inspection they had been successful in filling the upcoming training courses for this staff group.
- There was an effective system in place for dealing with surges in demand. The provider monitored and reacted to staff resources and patient demand to ensure calls were answered and managed effectively and safely.
- There was an effective induction system for all staff tailored to their role.

Inspected but not rated

Are services safe?

- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Systems were in place to manage people who experienced long waits.
- HUC has increased the use of service advisors in order to support with calls that do not need a health advisor to carry out a full pathways assessment e.g., prescription requests, dental concerns or calls from healthcare professionals allowing calls to be answered by the appropriately trained member of staff'. When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- 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. For example, a delay in the time to call back patient with red flag symptoms. All incidents were logged on the central system, investigated and learning shared to all staff via the regular newsletter.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.
- The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service.

Inspected but not rated

Are services effective?

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely received the effectiveness and appropriateness of the care provided. The service was generally within the target range for any indicator and they actively monitored their performance.

- Although the service was not always meeting the target percentage of calls into the NHS 111 service answered within 60 seconds, it closely tracked the level of performance when compared to both the East of England and national averages. The provider consistently performed well against these averages.
- The call abandonment rate (where a call is abandoned by the caller) had remained generally near or better than the England average. For example, in December 2021 the national average was 19.6% and the Cambridge and Peterborough IUC Service rate was 12.1%.
- The service was generally meeting its locally agreed targets as set by its commissioner in respect of the out-of-hours service. The service had a higher proportion through the CCG area that called 111 when their GP practice was closed. The service percentage was 59% of patients called compared to 56% nationally.
- In April to December 2021 the service consistently met the 50% target rate of clinical input into call. For example, 57% of patients in December 2022 had clinical input.
- The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. For example,
- An audit relating to medicines prescribed outside of the HUC limits demonstrated improvement. In January 2021 the percentage of medicines prescribed outside of the limits was 3.4% this fell to 2.6% in December 2021. The service had oversight of the medicines prescribed and provided feedback to the prescriber.
- Health Advisor audits and Clinical Advisor audits showed no significant concerns identified. HUC Health Advisors had achieved an average audit score of 95%, and Service Advisors had achieved an average audit score of 97%.
- Clinicians achieved over 98% compliance on Controlled Drug prescribing.
- Antibiotics prescribing was covered in the audit report with the focus on Urinary Tract Infections. Clinicians achieved 93.3% compliance for antibiotics against prescribing guidance.

The provider continued to feedback on an individual basis to staff and via the staff newsletter 'Clinical Matters' sent to all clinicians any prescribing discrepancies.

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 patient pathways and triage.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- 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. We noted the provider supported managers both new and current with sessions (they were called bootcamps) to ensure they were skilled in areas such as performance management and supervising. In addition, they provided learning assessments with a focus to understand staff learning styles and needs. In particular they identified any staff who may have dyslexia and ensured they had correct equipment such as screens with appropriate colours for easier reading and identification of information.

Inspected but not rated

Are services effective?

- The service provided staff with 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.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. The clinical workforce was shown to be effective and had a positive impact, with outcomes including recommending self-care, issuing repeat medicines, referral to primary care, ambulance and dental services.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services. Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action with patient consent. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established pathways for staff to follow to ensure callers were referred to other services for support as required for example to pharmacists and dental services. The service worked with patients to develop personal care plans that were shared with relevant agencies.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients. An electronic record of all consultations was sent to patients' own GPs to ensure they had oversight of any treatment or advice given by the out-of-hours service.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.
- Issues with the Directory of Services were resolved in a timely manner.

Helping patients to live healthier lives

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

- The service identified patients who may be in need of extra support.
- Where appropriate, staff gave people advice so they could self-care. Systems, including NHS Pathways were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given through the timely notification of a patients contact with the service, provided they gave consent to do so.

Consent to care and treatment

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

- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Inspected but not rated

Are services effective?

- The provider monitored the process for seeking consent appropriately.

Inspected but not rated

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff were mindful of patients' personal, cultural, social and religious needs.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs. Patients were able to select a direct transfer option on the telephone to link in with either the end of life care or the mental health services. Both these services were run by separate organisations and therefore HUC did not hold any data on these calls.
- We spent time in the care coordination centre and heard staff on calls displaying an understanding and non-judgmental attitude to callers.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

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

Inspected but not rated

Are services responsive to people's needs?

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, the provider had a process for reviewing the homeless and traveller communities.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service through the use of summary care records and access to 'Share My Care' aimed at data sharing, coordinating and collaboration in end of life care.
- Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises we inspected were appropriate for the services delivered.
- The service was responsive to the needs of people in vulnerable circumstances. There was a policy in place for the review of patients with acute mental illness and suicidal ideation. The patients were able to select a direct transfer through to the mental health service. This service was run by an organisation outside of HUC and therefore they did not have any data on the outcomes of these calls.
- The service recorded approximately 429,276 received NHS 111 (including 15,422 relating to dental concerns) calls during the 2020-21 calendar year, of which around 19,000 resulted in either face to face primary care centre or home visit consultations by the out-of-hours service. We noted 34,961 calls had been directly routed to the mental health trust in the year 2021. We discussed this with HUC who were unable to provide outcome information on those calls as the mental health line and support is provided by a different organisation.
- The service made reasonable adjustments when people found it hard to access the service for example those with a hearing impairment and whose first language was not English.

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 NHS111 service operated 24 hours a day, on every day of the year.
- Patients could access the out- of- hours service via NHS 111. The service did not see walk-in patients and a 'Walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response. The receptionists informed patients about anticipated waiting times.
- Call volume during the period April to December 2021 was relatively stable but call abandonment rate declined from July 2021 to December 2021. The mean call answering time for 2021/22 was 345 seconds (the target response is 20 seconds) and for the period July 2021 to December 2021 was 508 seconds.
- This poor performance was recognised and in main part due to the volume of calls and the challenges of staffing during the COVID-19 pandemic and restrictions. HUC performance was still better than most of providers in the East of England. Patients generally had timely access to initial assessment, test results, diagnosis and treatment in the out-of-hours service. The latest data we had showed that; In January 2022 73.5% of patients with a disposition to have a face to face appointment were seen within two hours at a primary care centre and for those with a disposition of six hours it was 97.9%. The target for both indicators is 95%. In the same period, patients with a disposition to be seen at home within two hours was 70.7% and for a six-hour disposition it was 95.7%. The target for both indicators is 95%.

Inspected but not rated

Are services responsive to people's needs?

The service told us that challenges of some rural and remote housing plus some staff shortages during COVID-19 had led to some longer waiting times. HUC were aware of the lower performance and where possible had deployed additional resources and staff. Where the service was not meeting the target, the provider was aware of these areas and we saw evidence that attempts were being made to address them.

- 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 prioritise and manage activity and to support people while they waited.
- Patients with the most urgent needs had their care and treatment prioritised using NHS Pathways assessment tool.

Inspected but not rated

Are services well-led?

Leadership capacity and capability

- 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. The provider was planning active involvement in the Integrated Care System review.
- The provider had a good grasp of the issues facing integrated urgent care and had good interaction with acute accident and emergency, secondary care and ambulance services.
- They were knowledgeable about issues and priorities relating to the quality and future of services. Employing and training additional staff to address the staffing shortages in the contact centre was a good example of how the provider had identified the challenges to the service and had taken positive action to address them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use. Staff we spoke with confirmed this to be the case.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider had processes to manage current and future performance of the service. Performance of 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.
- 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

Inspected but not rated

Are services well-led?

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information, which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses, such as ensuring the correct skill mix of staff to be available to ensure patients were directed to the correct clinical staff or self-help without delay.
- The service used information technology systems to monitor and improve the quality of care.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- There were systems to support improvement and innovation work. The provider had been part of some significant projects and had, as result been award a national award. For example; In collaboration with Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), Cambridge University Hospital NHS Foundation Trust (CUHFT), Northwest Anglia NHS Foundation Trust (NWAFT) and others, they launched the Virtual Waiting Room within the Cambridge and Peterborough region. The initiative aimed to help patients who call NHS 111 receive the care they need while alleviating the pressure on Emergency Departments (EDs).