Cudmore House

Quality 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 service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cudmore House (Cornwall Health Ltd) on 24 and 25 January 2017. Overall the service is rated as good.

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 which 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.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- 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 worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- 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.
- Prescription security was highly developed and ensured all prescriptions were accounted for in each location.

Summary of findings

- Medicines storage in vehicles had been developed to support security, integrity of packaging and maintaining medicines effectiveness in fluctuating temperatures.
- A children's review service was being developed following local provider research showing more effective patient treatment could be provided by the out of hours service.

We saw one area of outstanding service:

The urgent care car (UCC) was an innovation to meet the needs of patients in a county without an out of hours district nursing service. The UCC car was staffed by an experienced driver and an urgent care practitioner (UCP) who supported a range of patients who met specific criteria (blocked catheters, deaths, urinary tract infections and end of life care). This enabled other clinicians to focus on the more complex, unwell patients. In a two month period the UCC had responded to 61 urgent non-complex cases, and enabled the service to meet its national quality requirements such as response times in 99% of its cases.

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 providing safe services.

- There was an effective system for reporting and recording significant events. A wide range of events was reported. They were systematically assessed and dealt with.
- Lessons were shared to make sure action was taken to improve safety. There was evidence of outstanding collaboration with other healthcare services in implementing systems to avoid the recurrence of certain events.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- There were clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.
- Medicines management was well managed.

Are services effective?

Good

The service is rated as good for providing effective services.

- Data provided by the service showed the service met the National Quality Requirements (the minimum standards for all out-of-hours GP services) to help ensure patient needs were met in a timely way
- Staff assessed needs and delivered care in line with current evidence based guidance. A range of methods were used to help ensure that clinicians kept up to date.
- Clinical audits demonstrated quality improvement and as well organisational performance also focussed on individual clinician's decisions.
- Staff had the skills, knowledge and experience to deliver effective care and treatment. There was a consistent focus on ensuring staff had completed mandatory training. There were appraisals and personal development plans for staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. The service was seeking innovative approaches to accessing relevant patient information in conjunction with other providers, through the use of a new computer system which provided wider access to records.

Summary of findings

- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improved the patient experience.
- A children's review service was being developed following local provider research showing more effective patient treatment could be provided by the out of hours service.

Are services caring?

Good

service is rated as good for providing caring services.

- Feedback from patients, recorded in writing, and in person during the inspection and also collected by the provider was very positive.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- 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.
- 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?

Good

The service is rated as good for providing responsive services.

- The service engaged with the NHS England Area Team and local clinical commissioning groups to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment and data showed most patients were seen or contacted in a timely manner
- The treatment centres had good facilities and were well equipped to treat patients and meet their needs. Patients we spoke with and comment cards we received showed that patients were happy with the service provided.
- Results from the National GP Patient Survey were in line with similar services.
- There were examples of the service responding quickly to issues raised by patients outside of the complaints system.
- Information about how to complain was available and easy to understand and evidence showed that the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

- The urgent care car (UCC) was a successful innovation in the provision of out of hour's services. Between 2 December 2016 and 21 January 2017 the UCC had responded to 61 urgent non-complex cases, thereby freeing up the capacity of other out of hours service clinicians to help patients with more complex cases. The UCC enabled the service to meet its national quality requirements such as response times in 99% of its cases.

Are services well-led?

Good

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

- The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision, it was well understood and staff were committed to it.
- There was a clear leadership structure and staff felt supported by management. This was evident at local level and board level. Staff were always able to contact senior managers and senior managers were visible across the organisation.
- Governance framework was strong and supportive of managers.
- The service worked systematically with other organisations to improve safety and care.
- The service had recruited additional non-executive directors, with expertise in clinical governance and human resources, to provide increased independent challenge in holding the service to account.
- Staff turnover, amongst employed staff, was low. Staff told us they valued their contribution to the organisation and felt that they were making a difference.
- The organisation complied with the requirements of the duty of candour and encouraged a culture of openness and honesty. Senior clinical staff personally met with patients and/or families to provide explanations when things had gone wrong.
- The Health and Safety manager for the service provided regular business continuity training days for staff. We looked at the agenda for these and saw they included table top exercises on computer failures, vehicle accidents, severe weather and unexpected spikes in demand for the service. There were contingencies in place for a large number of possible scenarios. Staff told us they found these exercises extremely useful.

Summary of findings

What people who use the service say

We looked at various sources of feedback received from patients about the out of hour's service they received. Results from the national GP Patient survey for July 2016 compared the service with similar out of hour's providers nationally. The survey measured the following key areas:

- Impression of how quickly care from NHS service received was 66%, which was higher than the national average of 62%.
- Confidence and trust in person seen or spoken to was 89% which was comparable with the national average of 90%.
- Overall experience of out of hour's service was 72% which was higher than the national average of 69%.

The NHS friends and family survey asked patients about their satisfaction with the out-of-hours service. The results of this survey were displayed on the NHS Choices website. Results over the last 12 months showed that of 491 respondents, 91% were likely or extremely likely to recommend the out of hours service to their friends and family.

We gathered the views of patients using the out-of-hours service during our inspection. We spoke with 10 patients during the inspection. All 10 patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Patients commented on the swift response of the service, helpful telephonists, receptionist and the caring and professional GPs and nurses.

Outstanding practice

The urgent care car (UCC) was an innovation to meet the needs of patients in a county without an out of hours district nursing service. The UCC car was staffed by an experienced driver and an urgent care practitioner (UCP) who supported a range of patients who met specific criteria (blocked catheters, deaths, urinary tract infections and end of life care). This enabled other clinicians to focus on the more complex, unwell patients. In a two month period the UCC had responded to 61 urgent non-complex cases, and enabled the service to meet its national quality requirements such as response times in 99% of its cases.

Cudmore House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included an Inspection Manager, four Inspectors, an Assistant Inspector, two GP specialist advisers, a member of the CQC medicines team, a service nurse specialist adviser, and a service manager specialist adviser.

Background to Cudmore House

Cudmore House is the registered location for the out-of-hours GP service provided for Cornwall by Cornwall Health Limited.

Cornwall Health Limited is owned by two organisations in partnership; Devon Doctors which is a social enterprise and Kernow Health a community interest company. Cornwall Health Limited provides urgent medical care and advice out-of-hours for patients in Cornwall. The service is contracted by the NHS Kernow clinical commissioning group. The service provides primary medical services outside of usual working hours (out-of-hours or OOH) when GP practices are closed. This includes overnight and during weekends, when practices are closed. The service covers a population of approximately 550,000 people. During the summer months this population increases significantly.

Cornwall Health Limited is part of the Devon Doctors group which provides shared services, such as finance and human resources services, across the South West.

Most patients access the out-of-hours service via the NHS 111 telephone service. This service is undertaken by a different service provider and calls arrive electronically at Cudmore House after being triaged by that provider. Patients may be seen by a clinician at a local primary care treatment centre, at home or by telephone consultation depending on their needs. Some patients are able to access the primary care centres by walking in or are referred from the hospital accident and emergency departments or other urgent care centres.

Cornwall is a predominantly rural and semi-rural area in which over 40% of the population live in settlements of less than 3,000 population. The Indices of Multiple Deprivation 2015 datashow Cornwall is now ranked 143 out of 326 local authority areas for deprivation (where 1 is having the highest proportion of the population living in the most deprived neighborhoods). The datashows that 5% of neighborhoods in Cornwall are among the most deprived in England. Approximately 17% (15,200) of children in Cornwall live in poverty. Life expectancy for both men and women is in line with the national average.

Cudmore House (Cornwall Health Ltd) has ten active locations registered with CQC and is registered to provide the following regulated activities: transport services, triage and medical advice provided remotely, treatment of disease, disorder or injury.

Clinicians, Advanced Nurse Practitioners and Advanced Paramedics work from Cudmore House to offer telephone consultations to patients. There is a treatment centre to see patients at Cudmore House. We visited Cudmore House during our inspection. The additional treatment centres which are used to provide care to patients are:

West Cornwall Hospital, St Clare Street, Penzance, Cornwall, TR18 2PF (visited during inspection)

Newquay Hospital St Thomas Road TR7 1RQ

Falmouth Hospital, Trescobeas Road TR11 2JA

Detailed findings

St Austell Hospital Porthpean Road PL26 6AD (visited during inspection)

Bodmin Hospital Boundary Road PL31 2QT

Launceston Hospital Link Road PL15 9JD

Liskeard Hospital Clemo Road PL14 3XD

Helston Hospital, Meneage Road, TR13 8DR (visited during inspection)

Stratton Community Hospital Lane EX23 9BR

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.

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 24 and 25 January 2017. During our visit we:

- Spoke with a range of staff (10 GPs, 12 administrators or support staff, 12 managers, four drivers) and spoke with 10 patients and their representatives who used the service.
- Observed how patients were provided with care and talked with carers and/or family members
- 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

There was an effective system in place for reporting and recording significant events.

- There was a policy on what constituted a significant event and how this should be reported. The policy and the reporting forms were available on the services intranet and staff we spoke with knew how to access them. The incident recording form supported the recording of notifiable incidents including complying with 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 or treatment).
- The service used an NHS recognised proprietary risk management system to manage the reports. Reports were escalated to board level.
- We saw evidence that when things went wrong with care or treatment, patients of families were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to help to prevent the same thing happening again.

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, an alert received on 7 January 2017 concerned a certain medicine and was received by email. This email was forwarded to the relevant senior manager, as no confirmation of receipt was received by 6pm that day; it was then transmitted to their deputy in line with the flowchart process. This member of staff then forwarded it to all team leaders and placed it on the intranet for all staff to view and raise their awareness of the actions required. It was the responsibility of all staff to check for updates when they came on duty. We observed that this took place.

Since February 2016, the system had been reviewed and streamlined with all alerts going to both Devon Doctors and Cornwall Health rather than both services separately. Another example included a patient safety alert received on 24 October 2016. The flowchart process had been followed and a SPM (Special Patient Message) added to the computer system used by the service, Adastra. (Adastra is a computer based patient record shared by out of hour's organisations, some hospitals, 999, NHS 111, and GP services to ensure information can be communicated quickly and effectively). The alert related to a warning about a named patient who was seeking to fraudulently obtain controlled drugs from multiple sources across the region. The raised awareness meant staff could identify the patient if they approached the service inappropriately

Overview of safety systems and processes

There were clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse, which included:

- Arrangements 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 nominated lead member of staff for safeguarding.
- The service had completed safeguarding audits, against Section 11 of the Children Act 2004. This was a self-assessment of the degree to which the organisation was meeting its obligation to safeguard and promote the welfare of children. Whilst these were self-assessments they were sent to the relevant local safeguarding children board via Kernow clinical commissioning group (CCG) that was under a duty to ensure the arrangements were appropriate. The relevant boards had accepted the audits and thus provided a degree of independent scrutiny of arrangements for safeguarding children.
- Staff we spoke with 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. We saw all other staff were trained to safeguarding children level two. Staff who had no direct contact with vulnerable people had safeguarding training if it was felt that this would enhance their role.
- There were notices at the primary care out of hour's treatment centres advising patients that chaperones were available if required. Drivers had all received chaperone training and understood their roles and responsibilities with regard to this. Due to the nature of

out of hour's work, visiting patients at their homes during anti-social hours, drivers could be called upon to act as chaperones. Staff who acted as chaperones were trained for the role and 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).

- The primary care out of hour's centres maintained appropriate standards of cleanliness and hygiene. The centres were clean and tidy. There was an infection control clinical lead responsible for local standards and training.
- Quarterly and annual infection control audits were undertaken and we saw the issues raised were actioned and there were improvements as a result. For example, the replacement of hand wash basins, clinical waste bins and general maintenance such as repainting some areas. The primary care out of hours treatment centres were located within other NHS properties with limited control over their environment. We saw written evidence that Cornwall Health Limited had received undertakings from local hospitals that they would take action on any issues identified.
- We inspected six vehicles used to deliver the service. These were all clean and subject to a cleaning schedule daily and a quarterly deep clean. Written evidence seen by the inspection team confirmed this cleaning routine took place.
- There was a system in place to ensure equipment was maintained to an appropriate standard and in line with manufacturers' guidance, for example, the servicing of vehicles. Equipment such as pulse oximeters and nebulisers had been calibrated annually, most recently in January 2017. Written schedules showed the next due dates for calibration of all equipment.
- We saw schedules for the regular servicing and maintenance of all the vehicles maintained by the service. Checks were made at the start of each shift by drivers and any defects logged for rectification. Repairs and servicing was organised centrally by the provider. Vehicles less than three years old were maintained by the car dealerships. Older vehicles were maintained by local specialist garages. Drivers kept mileage, fuel, defect and equipment logs. We saw written evidence that monthly management checks were made on these systems by way of audits. The system was well organised.
- We reviewed three 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.

Medicines Management

- The arrangements for managing medicines, including emergency medicines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). None of the medicines used required refrigeration. Most of the clinicians had qualified as independent prescribers and could therefore prescribe medicines for specific clinical conditions. The service had appointed a Controlled Drug Accountable Officer (CDAO), a lead clinician who had received specialist training for this role. They were in contact with the local CD intelligence network to promote good practice.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use. Controlled drugs were stored securely and there was a system to record when staff accessed them. All the medicines we checked were in date.
- 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 both in the treatment centres and in the vehicles. There was a detailed system in place to ensure prescription security including; logging prescription numbers at the point of delivery; logging numbers of prescriptions sent to treatment centres as well as a double signing process to audit dispatch and arrival of prescriptions; and logging the use of each prescription by the treatment centre and vehicle GPs, including cross referencing to patients, to account for each individual prescribed item.
- Patient Group Directions (PGDs) were used by paramedics to supply or administer medicines without a

prescription. PGDs in use had not been ratified in accordance with the Medicines and Healthcare products Regulatory Agency guidance. These had been signed by GPs and authorising personnel but not by a pharmacist. This was corrected immediately when brought to the attention of management. An updated process was implemented during the inspection to ensure medicines were used in accordance with Human Medicines Regulations 2012.

- 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. During our inspection we found that the service used controlled drug registers effectively to monitor the usage and security of these medicines. Counter signatures from second authorised members of staff were in place and all medicines were stored securely. Checks were in place to ensure replacements were made prior to medicines reaching their expiry dates. 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. Whilst the service was not required by law to appoint a controlled drugs (CD) accountable officer they were in contact with the local CD intelligence network to promote good practice
- Processes were in place for checking medicines, including those held at the service and also medicines bags for the out of hour's vehicles. All the medicines we checked were in date.
- Arrangements were in place to ensure medicines and medical gas cylinders carried in the out of hours vehicles were stored appropriately. Each vehicle had colour coded bags for the equipment used and tough clear plastic cases for medicines. The colour coding and storage was the same for each vehicle at each location. Each bag and box had a surface mounted laminated contents list which aided easier access to medicines or equipment. Random samples of medicines and equipment stored for use in vehicles showed they were in date, recently calibrated and fit for use. All medicines were securely stored in the treatment centres and vehicles. Separate storage and security arrangements were in place for controlled drugs; these met safety and storage requirements.

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 with posters in areas accessible to all staff that identified local health and safety representatives, such as in staff kitchen areas. 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. The service had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings).
- 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 detailed external checks such as lights, tyre condition and damage assessment as well as internal checks on equipment and medicines. Records were kept of MOT and servicing requirements. We checked the vehicles and found all appeared very clean, fit for purpose and appropriately serviced.
- 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 to manage peaks and troughs of service demand.
- The inspection team saw evidence that the rota system was effective in ensuring there were enough staff on duty to meet expected demand. This met National Quality Requirement number seven (NQR 7).
- NQR7 states that providers must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as Saturday

and Sunday mornings, and the third day of a Bank Holiday weekend. Through close liaison and joint working arrangements with their Devon Doctors colleagues, the provider also had contingency policies for those circumstances in which they may be unable to meet unexpected demand.

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 defibrillators available within each vehicle and on each premises and oxygen with adult and children's masks. First aid kits and accident books were available.
- Emergency medicines were easily accessible and all staff knew of their location. All the medicines we checked were in date and stored securely.
- 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. The Health and Safety manager for the service provided regular business continuity training days for staff. We looked at the agenda for these and saw that they included table top exercises on computer failures, vehicle accidents, severe weather and unexpected spikes in demand for the service. There were contingencies in place for a large number of possible scenarios. Staff told us they found these exercises extremely useful.

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) evidence based 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.
- The staff who undertook baseline observations when patients arrived at the service had information relating to normal values and vital signs, which enabled them to easily escalate concerns to clinicians.
- Clear recording in patient notes ensured staff were fully informed of the treatment provided should the patient need to return to the service.

Management, monitoring and improving outcomes for people

Out of hours providers have been required to comply with the National Quality Requirements (NQR). The NQR are used to show the service is safe, clinically effective and responsive. Some of these NQRs are no longer requiremnts but we saw evidence that the provider still used them to monitor quality. The provider reported monthly to the clinical commissioning group on their performance against these standards which include audits, whether telephone and face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

Cornwall Health Limited consistently met the National Quality Requirements. For example, under NQR 4, providers should audit a random sample of patient contacts. The audit process must be led by a clinician, appropriate action must be taken on the results of those audits and regular reports of these audits should be made available to the clinical commissioning groups (CCGs). We saw that the service regularly audited a random sample of patient contacts and appropriate action was taken on the results of those audits. Regular reports of these audits were made available to the Kernow CCG (clinical commissioning group). The audits included hourly, daily, weekly and monthly activity and demonstrated the service had acted upon the results to ensure cases had been dealt with appropriately. The sample provided sufficient data to review the clinical performance of each individual working within the service. This audit was led by a clinician with extensive experience in providing out of hours care and, where appropriate, results had been shared with the CCG and the multi-disciplinary team that delivered the service.

The service had also taken action to change staff rostering arrangements to ensure sufficient staff were on duty during times of peak demand, such as Saturdays between 10am and 2pm.

We saw evidence of complete cycle audits for telephone calls, engaged and abandoned calls which were completed as an internal exercise;

- No more than 0.1% of calls were engaged and 3% of calls had been abandoned (target of 5% or lower). 100% of calls had been answered within 60 seconds of the end of the introductory message.

Cornwall Health Limited had carried out telephone clinical assessments and the identification of immediate life threatening conditions. The service had a system for identifying all immediate life threatening conditions and those calls were passed to the South West Ambulance Service ambulance service within 3 minutes.

The service demonstrated that they had a clinically safe and effective system for prioritising calls.

Cornwall Health Limited met NQR 10 (Face to Face Clinical Assessment) by the effective identification of immediate life threatening conditions. The service had a system for identifying all immediate life threatening conditions and, once identified, those patients were passed to the most appropriate acute response (including the ambulance service) within three minutes in all cases.

The service had a clinically safe and effective system for prioritising patients, which met the following standards:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre.
- Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre.

Good

Are services effective?

(for example, treatment is effective)

At the end of these assessments, audits showed that the patients were clear of the outcome, including the timescale within which further action will be taken and the location of any face-to-face consultation.

We listened to 20 telephone calls. For example, one call involved an out of hour's GP assessing a patient and heard an effective assessment of a patient with a potential life threatening condition within target timescales. We heard how the GP asked a range of clinically probing questions to ascertain the severity of the condition; how an urgent face to face assessment was arranged and how ongoing treatment was put on standby pending the patients arrival. A thorough patient examination confirmed the GPs concerns and an immediate hospital admission was arranged. Whilst the patient was being transferred to hospital the GP liaised with the hospital consultant to ensure they were fully briefed about their findings and the needs of the patient. The carer for the patient stated they were fully informed of the condition, the potential risks, the urgency of the situation and the next steps in the care and treatment needed.

The service met NQR 11 as they ensured that patients were treated by the clinician best equipped to meet their needs, (especially at periods of peak demand such as Saturday mornings), in the most appropriate location. Where it was clinically appropriate, patients were able to have a face-to-face consultation with a GP, including at the patient's place of residence.

The service met NQR 12 as evidence showed that face-to-face consultations whether in a centre or in the patient's place of residence had been started within the following timescales, after the definitive clinical assessment had been completed:

- Emergency: Within one hour.
- Urgent: Within two hours.
- Less urgent: Within six hours.

We saw that reporting was provided on a daily basis with a variety of information included to enable the operations team to review the previous day in detail and make decisions for the coming days. Data for October 2016 showed that the service had met NQR 10 (Face to Face Clinical Assessment) by the effective identification of immediate life threatening conditions. For example:

- 95.7% of urgent calls received a face to face consultation within two hours.
- 97.8% of less urgent calls received a face to face consultation within six hours.

There was evidence of quality improvement including clinical audit.

- There had been 20 clinical audits undertaken in the last two years, 12 of these were completed audits where the improvements made were implemented and monitored. Complete cycle audits included safeguarding audits, infection control audits, hand washing audits, medicine and prescription audits and sore throat audits.
- The service participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the service to improve services. For example, information about patients' outcomes was used to make improvements. These improvements included avoiding winter weekend hospital admissions for children. Following local research by the provider with local GP practices it was noted unnecessary hospital admission for children could be avoided through additional reviews by the out of hours service. Where a child was ill but not sufficiently unwell to require admission and where the local GP had assessed the child between 3pm and 6:30pm; a review was arranged with the out of hours service. This review would assist in monitoring the patient and increase the GPs confidence of not needing to make an early hospital admission whilst reassuring the patient about their ongoing monitoring of treatment. This service was intended to be supported by the Clinical Commissioning Group but had not yet been agreed; however, the service had self-funded the pilot and were delivering the service until CCG sign off. Anecdotally the impact of the service had been the reduction in need for hospital admission for children. Data was not yet available to evidence the service's impact.

The provider had a system in place to randomly audit a sample of patient contacts to show appropriate action had been taken. We saw that regular reports of these audits were made available to the CCG. These included a 'case slip' audit. For example, In each calendar year, all clinicians working were subject to a minimum audit of 10 random case slips to ensure certain criteria were followed during triage calls. This includes six checks which include ensuring clinical staff take a full medical history, offer appropriate advice, take sufficient notes and give further safety advice.

Good

Are services effective?

(for example, treatment is effective)

A report is produced and an audit then undertaken by the auditors within the Governance team. The result of this audit was either satisfactory or for further review. The audit cycle was repeated each financial year. There were 133 clinicians to be audited, all of whom had received a complete cycle audit check. Of the 835 consultations audited to date only 2% needed further review.

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. This included when trainee doctors carried out placements at the treatment centres. We saw induction packs were tailored to job specific roles. These packs included relevant information for each role, such as GP, Advanced Nurse Practitioner, Emergency Paramedic, driver or receptionist. New staff we spoke with told us these had been useful on joining the organisation.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff. For example, training for telephone consultations included theory and practical training and end of life support training. Advanced Nurse Practitioners (ANP) who undertook this role were signed off as competent and had received appropriate training in clinical assessment. New staff were also required to undertake the new Care Certificate introduced nationally to equip them with the skills and knowledge for their role.
- 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 an appraisal within the last 12 months as well as regular clinical support and supervision.
- 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.
- Staff involved in handling medicines received training appropriate to their role.

Coordinating patient care and information sharing

Cornwall Health Limited met NQR 2 by sending details of all Out Of Hours consultations (including appropriate clinical information) to the practice where the patient was registered by 8am the next working day. Where more than one organisation was involved in the provision of OOH services, there were clearly agreed responsibilities in respect of the transmission of patient data. The service had recently introduced a new computer system designed for information sharing between health agencies.

The service complied with NQR 3 by having systems in place to support and encourage the regular exchange of up-to-date and comprehensive information including care plans, between all those providing care to patients with predefined needs, for example, patients with terminal illness.

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 required 'special notes' which detailed information provided by the person's GP. This, alongside notes from previous service contacts by patients and local patient knowledge, helped the out of hour's staff in understanding a person's needs.
- The service shared relevant information with other services in a timely way; for example, when referring patients to other services such as hospitals or mental health teams.
- The provider worked collaboratively with the NHS 111 provider in their area, for example, in utilising their resources to support patients in West Devon where Devon services were fully utilised or travel logistics made their involvement more appropriate.
- The provider worked collaboratively with other services. Patients who could be more appropriately seen by their registered GP or an emergency department were referred. If patients needed specialist care, the

Good

Are services effective?

(for example, treatment is effective)

out-of-hours service, could refer to specialties within a hospital. Staff also described a positive relationship with the mental health and district nursing team if they needed support during the out-of-hours period.

- Patient notes were seen to be detailed. The clarity of the notes meant the service was able to ensure continuity of treatment where different staff were on duty.

The service worked with other service providers to meet patients' needs and manage patients with complex needs.

Consent to care and treatment

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

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Evidence confirmed that 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 referred to special notes for previously recorded capacity assessments and where not available assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

Results from the national GP Patient survey for July 2016 compared the service with similar out of hour's providers nationally. The survey measured the following key areas relevant to this domain:

- Confidence and trust in person seen or spoken to was 89% which was comparable with the national average of 90%.
- Overall experience of out of hour's service was 72% which was higher than the national average of 69%.

The NHS friends and family survey asks patients about their satisfaction with the out-of-hours service. The results of this survey are displayed on the NHS Choices website. Results over the last 12 months showed that of 491 respondents, 91% were likely or extremely likely to recommend the service to their friends and family.

We observed members of staff were calm, courteous and very helpful to patients and treated them with dignity and respect. Children were equally respected and involved in their assessment and were reassured by the GPs who saw them.

- 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.
- Drivers had all been trained as chaperones and understood their roles with regard to supporting patients with dignity and respect. Patients we spoke with commented on the helpful and caring drivers who had treated them with courtesy and kindness.

All of the 10 patients we spoke with said they felt that the out of hours team offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

Comments included details such as GPs and clinical staff responding compassionately when patients needed help and providing support when required. Patients also commented on the courteous and helpful drivers who delivered the urgent medical practitioners safely to patient's addresses, often in rural areas during the hours of darkness.

We found relevant information was available to patients at out of hours treatment centres and on the Cornwall Health Limited website. For example on dementia, healthy eating, winter well-being, bereavement, EConsult (to consult a GP online), sepsis and a wide range of other subjects. There were signposting systems in place to direct patients to the relevant support available. For example, easy to understand information about how to access the service. Patients we spoke with told us they found this showed the service had considered their needs in a useful and respectful way.

One of the national quality requirements included feedback of patient experience. Results from the provider's own survey carried out between 2015 and 2016 showed that 92% of patients thought the service was excellent or good and 6% acceptable.

Care planning and involvement in decisions about care and treatment

Patients told us 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. Patients told us about prompt access to additional services and about how the GPs ensured they knew what to expect and who they would be seeing. Patient feedback from the comment cards we received was also positive and aligned with these views.

Cornwall Health Limited complied with NQR 5 by conducting a monthly audit of a random sample of patients' experiences of the service and had taken appropriate action on the results of those audits. Monthly patient feedback surveys conducted by the service showed that between July to September 2016, 96% of the 341 respondents felt they had received a good or excellent service, and they felt they had been involved with care planning and decision making where appropriate. Regular reports of these audits were made available to Kernow CCG.

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

Good

Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available in a range of other languages.
- Information leaflets were available in easy read format.
- Facilities for people with hearing impairment such as hearing aid induction loops. It was difficult for any out of hours provider to provide British Sign Language (BSL) interpretation because interpreters need to be booked days in advance. The service provided access to the BSL alphabet and signposted patients to resources such as the signed videos on NHS Choices.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Cornwall Health Limited met national quality requirement 13 by supporting patients unable to communicate effectively in English. The service provided telephone translation services and could supply an interpretation service within 15 minutes of initial contact. Cornwall Health Limited had also made appropriate provision for patients with impaired hearing or impaired sight. For example, with information available in braille format and talk type telephone systems.

The service reviewed the needs of its local population and engaged with its commissioners) to secure improvements to services where these were identified.

- 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.
- The provider supported other services at times of increased pressure. For example, by maintaining contact with neighbouring accident and emergency units and seeing their patients during times of peak demand.
- The urgent care car (UCC) was an innovation in the provision of out of hours services, partly in response to the fact that Cornwall is one of only two counties in England without an out of hours district nursing service. Based on the concept of right care, right time, right place, right clinician, the UCC helped match resources to demand at busy times. Staffed by an experienced driver and an urgent care practitioner (UCP), the UCC was tasked to support a range of patients which met specific criteria (catheters, deaths, urinary tract infections, end of life care) This enabled other clinicians to focus on the more complex, unwell patients. Evidence showed that the innovation had been successful. Between its launch on 2 December 2016 to 21 January 2017 the UCC had responded to 61 urgent non-complex cases, thereby freeing up the capacity of other out of hours service clinicians to help patients with more complex cases. The UCC enabled the service to meet its national quality requirements such as response times in 99% of its cases.
- The service was flexible in supporting other areas by utilising their resources to support patients in other treatment areas where services were fully utilised or travel logistics made their involvement more appropriate. For example, using St Austell services instead of Truro services where poor road access would cause delays in seeing patients.
- Patients told us that the service provided excellent palliative end of life care. Cornwall Health Limited had produced information leaflets on palliative care and instigated the urgent care car which often supported these patients. The service had a special notes system which enabled a palliative care patient's GP to provide special notes to the out of hour's service explaining their treatment and wishes. Cornwall Health Limited also provided a palliative care specific telephone line and worked closely with local GP practices and palliative care nurses.
- Cornwall Health Limited was in the process of undertaking aplanned review service for children. Following local research by the provider with local GP practices it was noted unnecessary hospital attendances/admissions for children could be avoided through additional reviews by the out of hours service. Where a child was ill but not sufficiently unwell to require admission and where the local GP had assessed the child a review could be arranged with the out of hours service. This review would assist in monitoring the patient and increase the GPs' confidence of not needing to make an early hospital admission whilst reassuring parentsabout the ongoing monitoring of their child. The service started in December 2015, without additional funding, and continued to be provided. A similar service for adults at risk of admission was set up in December 2016 and initial feedback back from clinicians was that the service had prevented anumber of admissions to hospital.
- Further additional services, where Cornwall Health would take direct streaming of calls regarding children under the age of 5 or patients over the age of 75, without initial management by NHS 111, was being discussed with theClinical Commissioning Group. Similar discussions relating to calls from care home staff were currently taking place. These services were being considered as part of Cornwall Health's support to the wider system locally which was under significant pressure.

Survey results showed that the majority of patients thought that the service was responsive to their needs;

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Results from the July to September 2016 patient survey had been positive. 1200 surveys had been sent out and 341 completed. Of those 341 respondents, 94% stated they were likely or extremely likely to recommend the service to friends and family. This was an increase of 4% on the same period in 2015. Triage had been rated by 96% of patients as good, an increase of 1% on the previous year. There had also been improvements in making patients feel at ease, and providing useful advice.
- Patients surveyed had reported a positive experience during home visits. 90% stated they had been informed of the expected arrival time of the out of hour's clinician and informed of any reasons for a delay. 95% had been satisfied with the advice and treatment given during a home visit.

Access to the service

The service was open between 6.30pm and 8am Monday to Friday, and 24 hours day on Saturdays and Sundays and on bank holidays.

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. There were arrangements in place for people at the end of their life so they could contact the service directly.

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

The service used National Quality Requirement (NQR) and other quality indicators which it submitted to the Clinical Commissioning Group (CCG) to monitor the quality of the service patients received. NQRs for GP out of hours services were set out by the Department of Health to ensure these services were safe and clinically effective.

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.

The service achieved this through 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

We saw evidence that Cornwall Health Limited met NQR 6 through operating a complaints system that was consistent with the principles of the NHS complaints procedure and its contractual obligations with Kernow CCG. The service reported anonymised details of each complaint, and the manner in which it had been dealt with, to Kernow CCG. All complaints were audited in relation to individual staff so that, where necessary, appropriate action could be taken.

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. For example, posters and leaflets were displayed at out of hour's treatment centres.

We looked at 28 complaints received in the last 12 months and found these had been satisfactorily handled, dealt with in a timely and transparent way. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, there had been a complaint about the way in which a telephone call had been handled by the provider, with an allegation of rudeness. Cornwall Health Limited's complaints team had fully investigated this and taken forward shared learning with staff and the CCG. The patient had been satisfied with the outcome. GPs described to us how investigations into complaints were thorough and how part of the process was to ensure patients knew how the service changed as a result of their complaint.

Are services well-led?

Good

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

Our findings

Vision and strategy

The service had a clear vision to deliver high quality care and promote good outcomes for patients. Cornwall Health Limited was owned by two organisations in partnership; Devon Doctors which was a social enterprise, and Kernow Health a community interest company. This not for profit organisation had placed patients at the heart of its activities and this vision was reflected in the positive attitudes of all staff and patients we spoke with.

- The service had a mission statement and staff knew and understood the values.
- The service had a robust strategy and supporting business plans that reflected the vision and values and were regularly monitored.

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 staff were aware of their own roles and responsibilities. We saw evidence that the staffing structure was available in pictorial easy to understand format on the staff intranet.
- Service specific policies were implemented and were available to all staff via an easy to navigate intranet system.
- The provider had a good understanding of their performance against National Quality Requirements (NQR). These were discussed at senior management and board level quarterly. Performance was shared with staff and the local clinical commissioning group as part of quarterly contract monitoring arrangements.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

During our inspection the provider of the service demonstrated they had the experience, capacity and capability to run the service and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

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 patients about notifiable safety incidents. The partners 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 providing a “Weekly Update” bulletin to all staff as well as clinical updates and emails to the clinical team. These bulletins were also provided on the providers intranet with key messages placed on the front screen of the Adastra system for clinical staff attention. The staff we spoke with stated they read the bulletins and were able to demonstrate where they were located.
- Staff told us there was an open culture within the service and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the providers. Staff had the opportunity to contribute to the development of the service.
- Staff safety was maintained for ‘lone working’ by fitting all vehicles with GPS tracking devices. This enabled the provider to locate vehicles and staff in areas which did not have telephone signals if emergency situations arose. CCTV was used in treatment centres to support staff safety and a single button direct dial number connected treatment centres to the call centre.
- Clinical staff showed us performance review documents and explained to us how they compared their

Are services well-led?

Good

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

performance to those staff in similar roles. They told us how this information was then used to improve how they fulfilled their role; for example, in how they responded to triaging patients phone calls. A quarterly summary audit of staff performance was shared with the Clinical Commissioning Group as part of performance monitoring discussions. Analysis of this information was also used by the service to support staff development and learning.

- The Health and Safety manager for the service provided regular business continuity training days for staff. We looked at the agenda for these and saw they included table top exercises on computer failures, vehicle accidents, severe weather and unexpected spikes in demand for the service. There were contingencies in place for a large number of possible scenarios. Staff told us they found this extremely useful.

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

The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. Ways patients could offer feedback were promoted on a dedicated feedback section on the homepage of the website titled 'Your Opinion Matters'. The provider worked with Healthwatch to obtain feedback from their events and campaigns as an independent review of the services. Weekly surveys to patients were sent out by governance team with a stamped addressed envelope. This had achieved a 30% response rate. Feedback was 100% positive.

The provider used the friends and family test which consistently showed that 98% or over of patients were likely or extremely likely to recommend the service. The provider also monitored social media sites for feedback.

- The service had gathered feedback from staff through an annual staff survey, through staff away days and generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, drivers told us that they had suggested the use of strong clear plastic boxes in the vehicles to carry emergency medicines and equipment in order to make it easy for staff to quickly identify the contents of each box and protect the integrity of the medicines stored within. This was particularly important for a service often operating during the hours of darkness, in situations involving stress and urgency. Staff told us they felt involved and engaged to improve how the service was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. The service team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

Cornwall Health Limited had instigated individual clinician audits as a result of shared learning. Each clinician, Advanced Nurse Practitioner and Advanced Paramedic had been audited on case histories, management, prescriptions, safety netting and documentation. A rating was awarded based on these criteria. Following this, shared learning took place on a monthly basis and support put in place in any development areas. For example, by a more experienced mentor listening in to telephone consultations and providing appropriate advice afterwards.

The provider had an "Equipment Working Group" involving staff from all roles across the organisation. The purpose of the group was to identify suggestions for changes or improvements which would improve the service. All ideas were discussed and where it was agreed that patients or the service would benefit from the idea, a trial was implemented. If the trial demonstrated "real world" benefits the idea was then adopted across the service. An example of this was the storage cases for medicines. Staff identified medicines packaging was getting damaged to the point of being unfit to give to patients when stored in standard grab bags; and medicines needed to be destroyed due to the damaged incurred. The suggestion of rigid packing cases was trialled and adopted resulting in patients receiving medicines from undamaged packaging. The service benefitted from easier access to medicines and cost savings through not needing to destroy medicines due to damaged packaging. Similar processes had been used to improve facilities at their Bodmin location and their prescription security.