Ailsa House

Inspection report

3 Turnberry House, The Links,
4400 Parkway, Whiteley
Fareham
PO15 7FJ
Tel: 0333 321 0942
www.phlgroup.co.uk

Date of inspection visit: 11 Sep to 12 Sep 2019
Date of publication: 19/11/2019

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This service is rated as Requires Improvement overall.

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Ailsa House on 11 and 12 September 2019 as part of our inspection programme.

The service has a registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes but repeat evidence of incidents was found to indicate that dissemination of learning to the entire staff work-force was not adequate.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- The service completed audits but we found limited evidence of disease-specific audits.
- On review of the service's performance data, we found the service was not in line with expected national targets.
- Full compliance with staff training could not be established, particularly in relation to clinical staff training records.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Staff felt respected and well looked after by the service, in line with the service's values.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The provider worked in partnership with external stakeholders to develop its services and identify ways to improve.

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

- Ensure care and treatment is provided in a safe way to patients
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

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

- Review how audits are undertaken so they are appropriate, relevant and help drive improvement.
- Continue to review patient feedback to identify areas for improvement.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC Inspection Manager, a second CQC inspector, a GP specialist advisor, a practice manager specialist advisor and a pathways call handler specialist advisor.

Background to Ailsa House

Ailsa House is a registered location of Partnering Health Ltd (PHL) and is currently registered with the Care Quality Commission (CQC) to provide the following regulated activities:

- Diagnostic and screening procedures,
- Transport services, triage and medical advice provided remotely,
- Treatment of disease, disorder or injury.

These regulated activities are delivered via:

- An out of hours GP home-visiting service, previously known and inspected by CQC as Hampshire Doctors on Call.
- A call centre service supporting the South Central Ambulance Service (SCAS) NHS 111 service since June 2019. This is a subcontracted arrangement whereby staff at Ailsa House form part of the virtual telephony platform for NHS 111 and take a proportion of the total number of calls.
- A telephone-based definitive clinical assessment service to support triage following an NHS 111 contact.

The main address for Ailsa House is also the head office for PHL and is based at:

3 Turnberry House

The Links

4400 Parkway

Whiteley

Fareham

PO15 7FJ.

To support the out of hours GP home-visiting service which covers a wide georgraphical area in Hampshire, the service has additional storage facilities and car parking spaces at the following locations:

- PHL Hub, 2nd Floor, Best Practice South, 26-30 London Road, Cowplain, Waterlooville, PO8 8DL.
- Nicholstown Surgery, Royal South Hants Hospital, Brittons Terrace, Southampton, SO14 0YG.
- Lymington & New Forest Hospital, Wellworthy Road, Lymington, SO41 8QD.
- Friarsgate Badger Farm Surgery, Badger Farm, Winchester, SO22 4QB.
- Forton Medical Centre, Whites Place, Gosport, PO12 3JP.

How we inspected this provider

During our visit we:

- Spoke with the registered manager, board level directors, service managers and a selection of employees.
- Reviewed provider documents and policies.
- Visited the additional home-visiting service base sites at in Cowplain, Waterlooville; Royal South Hants Hospital, Southampton; Lymington and New Forest Hospital, Lymington, and Badger Farm, Winchester.
- Observed the call centre service.
- Reviewed feedback from patients, via the provider's own patient feedback exercises.
- Reviewed feedback from external stakeholders.

The provider supplied background information which was reviewed prior to the inspection. We did not receive any information of concern from other organisations.

Due to the nature of the service, CQC comment cards could not be collected in a way that maintained patient confidentiality so no cards were received during this inspection.

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?

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires improvement

Are services safe?

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

- **The provider could not provide adequate assurances that clinical personnel used in the delivery of its services had completed safeguarding training appropriate to their role.**
- **Dissemination of learning from previous significant events was not fully assured.**

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 service worked with other agencies to support patients and protect them from neglect and abuse. The call centre service worked jointly with the South Central Ambulance Service (SCAS) to provide the NHS 111 service which SCAS held the contract for. The provider's call centre was an additional site, intended to add resilience to the SCAS service, and staff at the call centre had access to the same safeguarding processes as SCAS.
- We saw evidence of 11 safeguarding referrals being completed by staff working in the GP home-visiting service in the 12 months preceding the inspection.
- 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's own policy was to have a DBS check for all staff. We checked five personnel records during the inspection and all five records had evidence of a completed DBS check.
- We found that not all staff had received up-to-date safeguarding and safety training appropriate to their role. During a review of the service's training log we found evidence of non-compliance with safeguarding and safety training across both clinical and non-clinical staff. For example, we found 78% of clinical staff were compliant with their expected safeguarding children training, and 71% of clinical staff were compliant with their expected safeguarding adult training.
- 91% of non-clinical staff were compliant with their expected safeguarding children training, and 88% of non-clinical staff were compliant with their expected safeguarding adult training.
- The service told us they felt it was likely that clinical staff had completed appropriate safeguarding training elsewhere through other clinical employment. However, despite evidence of repeated chasing by the service, evidence of completing such training had not been provided by staff, so the service were not able to assure us that staff they employed to carry out their services were appropriately trained. We asked the service to provide information as to what they planned to do next, in order to assure themselves that staff undertaking their work were appropriately trained. However, the information was not received within the indicated timescales.
- Staff we spoke to during the inspection demonstrated they knew how to identify and report concerns. We were staff who acted as chaperones were trained for the role and had received a DBS check. We were told the drivers that supported the out of hours GP home-visiting service could act as chaperones. During a conversation with one driver, we were told they had not received any chaperone training but they had not been asked to be a chaperone before. The provider's chaperone policy did not refer to drivers specifically, although the possibility of requiring a chaperone during a home consultation was considered possible.
- There was a system to manage infection prevention and control (IP&C). A review of the provider's IP&C policy did not initially identify who the IP&C lead was. This was immediately rectified by the provider.
- On review of a selection of IP&C audits, we found audits had been completed but they did not always appear

relevant. For example, a hand hygiene audit was undertaken in April 2019 at the call centre with six non-clinical members of staff. Out of a total of six questions in the audit, four had been ticked as not applicable, due to the staff being non-clinical. A further element of the audit established the call centre did not require taps with a 'no-touch' technique to turn the taps off, as no clinical work took place at the call centre.

- The provider had service level agreements with each of its host sites for its GP home-visiting service bases in relation to the management of healthcare waste.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions, this also included the maintenance of the cars used in the GP home-visiting service. We were told equipment and medicines boxes for the GP home-visiting service were checked on a weekly basis.
- The provider told us equipment boxes were provided as standard for the GP home-visiting staff but did not include stethoscopes, thermometers and pulse oximeters. Instead, clinicians could choose to use their own equipment or request it from the main store. Such equipment was not automatically provided. We spoke with several clinical staff members who told us they preferred to use their own equipment when visiting patients at home. Staff followed appropriate infection control procedures for their own equipment, but the provider had no evidence of this.

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. A call centre manager post had been created and recruited to improve oversight of the call centre service, including the clinical assessment service. This was due in part to the nature of the separate working arrangements from the main NHS 111 contract holders, SCAS.
- There was an effective system in place for dealing with surges in demand. There was dedicated rota team who monitored the demand of the services and adjusted the rotas accordingly. Clinical staff were able to sign up to rotas for the call centre service, the clinical assessment service and the GP home-visiting service, electronically. The completed rotas were then approved by the service managers.
- The provider told us they managed seasonal peaks by 'ramping up' headcounts and backfilling absences thereby ensuring available resource across all competencies within the services for general and specialist roles. We were told the provider benefitted from access to clinical competencies in Hampshire such as mental health and palliative care nurses when required. For unexpected peaks in demand the provider increased planned shorter shift lengths, slid shift start and finish times, rescheduled any planned training to release staff to assist with the demand and communicated with staff not scheduled to work to ask for assistance.
- There was an effective induction system for temporary staff tailored to their role. Prior to working for the service, locum staff were required to provide evidence of registration, DBS, completed training and references. We saw evidence of this information being collected.
- 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.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate medical indemnity arrangements in place.

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.

Requires improvement

Are services safe?

- 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.

Appropriate and safe use of medicines

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

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks. The service kept prescription stationery securely and monitored its use. Arrangements were also in place to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately.
- The out of hours GP home-visiting service had access to medicine boxes. Each box was colour-coded to indicate if it was fully stocked, stocked with some items used but with stock still sufficient or stock needed replacing before next use. We checked a sample of equipment boxes used and compared the contents with the provider's checklist. We found no tourniquets in the boxes we checked although these were listed to be included. We found an ancillary kit in one of the cars with out of date solutions for injections, but the main medicine box had in date stock. The ancillary kit was immediately removed as it was not required.
- During our inspection, we found opioid medicines were being used in the GP home-visiting service but the provider had not considered having a stock of Naloxone. (Naloxone is used to counteract the effects of opioids on a patient's respiratory effort). Since inspection, the provider had produced an operational guideline on the use of Naloxone which included clinicians having access to Naloxone whenever an opioid medicine was required.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Staff prescribed, administered and supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- Palliative care patients were able to receive prompt access to pain relief and other medication required to control their symptoms.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, such as SCAS.

Lessons learned and improvements made

The service learned and told us it made improvements when things went wrong. However, we found evidence of repeat issues during the inspection that had previously been identified by the service.

- 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. We saw evidence of 144 incidents reported in the previous 12 months. Themes of incidents included out of date medicines, prescription errors, data breaches, staffing issues, patients waiting for call backs. The service learned and shared lessons, identified themes and took action to improve safety in the service. Clinical staff we spoke to reported that they received brief summaries of learning from significant events but felt this could be more detailed and outline specific learning. However, we continued to find out of date medicines or solutions for injections during our inspection despite being told learning from similar incidents had been shared previously.

Requires improvement

Are services safe?

- 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. For example, the provider had created a workstream to improve communication which included weekly meetings for the communication workstream team, updates, informal huddles, monitoring of appropriate actions and RAG-rating of progress. (RAG-rating is a traffic light system used to illustrate progress against a set target, for example Green would indicate a completed target).

Requires improvement

Are services effective?

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

- **The service did not consistently meet expected targets relating to response times for its GP home-visiting service.**
- **The service was unable to provide specific data relating to its own NHS 111 call answering performance as well as individual staff performance in relation to that same service.**
- **Records relating to staff training demonstrated low levels of compliance specifically for clinical staff and limited evidence of provider assurances.**

Effective needs assessment, care and treatment

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

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- Telephone assessments were carried out using a defined operating model. Staff were aware of the operating model which included transfer of calls from call handler to a designated clinician.
- The service's Definitive Clinical Assessment Service (DCAS) was part of the provider's initiative to ensure patients had access to the right clinician at the right time. An initial triage by a call -handler would establish whether or not a clinical review was required. If required, an appropriate clinician would make contact with the patient to address their reason for contacting the service.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans, guidance or protocols were in place to provide the appropriate support, as long as the patient's own GP had submitted such information to the provider. We saw no evidence of discrimination when making care and treatment decisions.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

- From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to their clinical commissioning group (CCG) on their performance against the standards which includes: audits; response times to phone calls: whether telephone and face to face assessments happened within the required timescales: seeking patient feedback: and, actions taken to improve quality.
- For the out of hours GP home-visiting service, we saw data to demonstrate urgent home visits completed within two hours was consistently maintained between 80% and 93% from April 2018 to July 2019. In the same time period, routine home visits completed within six hours was maintained between 79% and 92%. The expected target for both urgent and routine home visits has been set by NHS England to be 95% or above. We were unable to establish why the service was not consistently meeting the expected targets.
- Since inspection, the provider told us from June 2019 there had been changes to the Out of Hours contract to an Integrated Urgent Care Service which saw home

visiting fragmented to four contracts. Only one of the home visiting contracts are measured on NQR requirements of urgent and routine. The three remaining contracts are based on quality requirements.

- Alongside the service performance data, we saw evidence of individual clinician performance data which was used to provide a summary of a clinician's shifts and performance in telephone triage, clinics and home visits. This was used to determine if a clinician was working within expected benchmark targets. Each clinician received a monthly report, covering the previous six months of service.
- The call centre service is part of a subcontracted arrangement with South Central Ambulance Service (SCAS) to provide the NHS 111 service. We were told staff at the service formed part of the virtual telephony platform alongside SCAS staff and therefore, took a proportion of the total number of calls. This arrangement came into effect as of June 2019.
- We were told SCAS provided daily, weekly and monthly monitoring data to the service, including daily monitoring of calls received by each call handler. We reviewed the 111 NHS Combined Contract Conduit Quality Performance Monthly Contract Report provided by the service which they had received from SCAS. This was dated from April 2019. We checked information gathered from June 2019 onwards which was in line with the contract arrangements with the service. However, the service was not able to differientate between its own data and that which related to SCAS.
- From the performance report, we saw the 'Not Ready Time' data, which had a target of less than 20%, had reduced from 35.34% in June 2019 to 22.78% in July 2019. This demonstrated an improvement in the number of staff that were ready and available to take calls, so had been amended to a green RAG-rating.
- Performance data that had been RAG-rated as amber included the percentage of calls received that had been transferred to 999, that were required to be less than 10%, were recorded as 12.06% in June 2019 and 12.85% in July 2019.
- Performance data that had been RAG-rated as red, and required significant improvement, included warm transfers and time waiting for warm transfers. (Warm transfers refers to the transfer of a patient to a clinician while the patient remains on the phone). For example, warm transfers had a target of 85% of calls to be transferred while the patient was on the call; in June 2019 this was recorded as 7.14% but in July 2019 this had was recorded to have decreased to 0.33%. While time waiting for warm transfers had a target of 99% of calls to be transferred within 60 seconds; in June 2019 this was recorded to be 92.31% but in July 2019 this had dropped to 87.50%.
- In relation to patient call backs within 10 minutes, which had a target of 50%, in June 2019 this was recorded as 20.55% and this had improved to 24.73% in July 2019.
- Where the service was not meeting the target, the provider had put actions in place to improve performance in this area. For example, the service had implemented a new tool to monitor the real time performance of each call handler and were actively recruiting call centre shift managers to cover the call centre 24 hours a day to improve performance.
- Through direct feedback from SCAS, we were told the service continued to require additional support and training from SCAS for the newly introduced service until the service became more self-sufficient with its own oversight structure.
- The service made improvements through the use of completed audits. This included call handler audits as well as clinical audits for the out of hours GP visiting service, such as antibiotic prescribing. Clinical audit had a positive impact on quality of care and outcomes for patients but there was limited evidence of disease specific related audits that had improved quality of treatement. For example, relating to specific care of urinary tract infections or respiratory conditions.
- There was clear evidence of action to resolve concerns and improve quality in relation to the call handling service for triage and the GP home-visiting service. For example, the introduction of a pop-up alert had improved non-safety netting performance from 43% to 0% from March to July 2019. (Safety netting is the process of giving patients advice in case of worsening symptoms or follow up advice).
- Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles, but there were gaps in training that the provider considered necessary.

Requires improvement

Are services effective?

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered such topics as governance and assurances, information management and technology, and policies and procedures.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required. In relation to the call centre service, this included direct telephone access to clinical support staff based at the headquarters of SCAS, who were the contract holders for the NHS 111 service. This allowed for non-clinical call handlers to have quick access to clinically trained staff in case they encountered a call which required additional clinical support.
- The provider understood the learning needs of staff and provided protected time and training to meet them. However, up to date records of skills, qualifications and training were not complete. We reviewed a training log kept by the provider which showed gaps in compliance with training across all areas of expected training modules, for both clinical and non-clinical staff. For example, we found non-clinical had completed an overall level of training achieving 93%, such as 95% had completed fire safety training, while 93% had completed Basic Life Support training, health & safety training and information governance training. In contrast, clinical staff had achieved an average of 53% of completed training. For example, 35% had completed infection prevention and control and 38% had completed information governance training.
- The compliance of clinical staff with completed Basic Life Support training could not be established during the inspection. We requested evidence to be sent to us post-inspection, but this analysis was not received.
- The training log also did not take account of the training that self-employed clinical staff had undertaken elsewhere. As a result, the provider could not demonstrate that it had adequate assurances that all its employees and the self-employee clinical staff had access to had completed appropriate training modules in line with its own training policy. Staff were encouraged and given opportunities to develop.
- The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider had introduced a new system to support the timely completion of staff appraisals. We saw evidence that nine staff had not received an annual appraisal but these were booked to take place over the next few months. The provider told us they had recently had a large recruitment drive so many staff were not yet due an appraisal. These staff had received informal feedback during their probation period in line with the provider's own policy.
- 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.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, 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. 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. 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 SCAS, as contract holders of the NHS 111 service, with specific referral protocols for patients referred to the service. An electronic record of all consultations was sent to patients' own GPs.

Requires improvement

Are services effective?

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

Consent to care and treatment

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

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

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. 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.
- Due to the nature of the service that we inspected, we were unable to gather comment cards in a manner which maintained patient confidentiality. Instead, we could only review the provider's own patient feedback exercises. The provider shared a selection of feedback Patient Experience feedback survey results with us.
- During the six-month period between December 2018 to May 2019, between 55%-83% of respondents who used the GP home-visiting service, said they would be extremely likely to recommend the service to others, while a maximum of 3% said they would be extremely unlikely to recommend it.
- During the same time period, between 52%-78% of respondents using the definitive clinical assessment service, said they would be extremely likely to recommend the service to others, while a maximum of 8% of respondents said they would be extremely unlikely to recommend it.
- We observed a selection of calls being taken during our inspections. We found call handlers treated callers with kindness and respect during these calls. However, the service could not demonstrate how patient feedback was sought for the NHS 111 element of the call centre, as this was led by SCAS.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. Call handlers had access to translation services, and type-talk technology for callers with a hearing impairment. The GP home-visiting service had access to information in easy read formats, to help patients be involved in decisions about their care.
- From a review of the provider's own patient feedback exercises, patients reported that 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.
- During the six-month period from December 2018 to May 2019, results relating to the patients accessing the GP home-visiting service confirmed between 81%-98% of patient respondents felt the clinician listened to them; between 86%-98% felt they were given enough time to discuss their health need with a clinician, and between 95-98% felt the clinician explained the reason for any treatment or action in a way they could understand.
- During the same time period, result relating to patients accessing the definitive clinical assessment service confirmed between 82%-97% of respondents felt the clinician listened to them; and between 86%-94% felt they were given enough time to discuss their health need with a clinician.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality, dignity and privacy at all times.
- During the period from December 2018 to May 2019, results relating to patients being treated with dignity and respect when using the GP home-visiting service, between 93%-100% respondents confirmed this happened.

Good

Are services caring?

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

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs.

- The provider understood the needs of its population and tailored services in response to those needs. The provider engaged with commissioners to secure improvements to services where these were identified.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. The provider confirmed these needed to be initially shared with the service by the patient's own GP before the service had access to specific additional information.
- Care pathways used by the service 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 were appropriate for the services delivered. The call centre was a newly built premises and appropriately equipped for the service it provided. The GP home-visiting sites, away from the head office location, were equipped appropriately for the service provided and included secure storage and car parking.
- The service made reasonable adjustments when people found it hard to access the service.
- The service was responsive to the needs of people in vulnerable circumstances.

Timely access to the service

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

- The call centre service, supporting the NHS 111 service, ran 24 hours a day, seven days a week, and the definitive clinical assessment service ran alongside this. The GP home-visiting service ran overnight from 7pm until 8am, Monday to Friday, and then from 6.30pm on a Friday to cover the whole weekend and bank holidays as appropriate.
- Patients could access the GP home-visiting service via the NHS 111 service or by referral from the definitive clinical assessment service. Patients did not need to book an appointment.
- 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 manage the waiting list and to support people while they waited. The service performed 'comfort calls' to patients who were recorded as waiting a long time for a clinical call back. (Comfort calls is the term used for a call to patient to check on them, to make sure the patient had not deteriorated or to see if the patient had improved and no longer required clinical assistance).
- The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services.
- Patients with the most urgent needs had their care and treatment prioritised.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately. Where applicable, complaints led to significant event investigations so that the service was assured all areas of a complaint were appropriately addressed.
- The complaint policy and procedures were in line with recognised guidance. 42 complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, staff have been reminded to inform patients of expected times for call-backs to take place within.We saw staff reflected on information received from

Good

Are services responsive to people's needs?

complaints and changed how they communicated with patients. Process changes were made at the call centre to ensure all calls waiting for a call-back were addressed in a timely manner.

Good

Are services well-led?

We rated the service as good for providing well-led services.

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.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them, for example we saw extensive evidence of risk registers and action plans to address identified risks. These included a Brexit continguency plan as well as a future strategy plan to build and grow the service appropriately, and a winter resilience workstream and policy to ensure services could be maintained should adverse winter weather occur.
- The provider had identified additional daily challenges such as communication issues, diverse workforce and the need for call centre managers. We saw evidence of workstreams to address these challenges and improvement plans relating to the ongoing development of the definitive clinical assessment service.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. We saw evidence of leaders and directors participating in call centre shifts to support the demand of the service, including weekends. Staff we spoke to told us leaders, managers and directors were all approachable and maintained a visible presence. Staff said the leaders did not feel hierarchical and they were easy to talk to about any issues or concerns.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use. The provider's escalation policy included a director, as well as an operational manager, being on-call 24hours a day, seven days a week.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with patients, staff and external partners. This included the development of the core values of the service, such as respect, caring, teamwork, accountability, efficiency and fun. Staff were also asked to contribute to what they considered 'good' to look like for their service.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy. This was supported via the provider's strategy document. A review of this document demonstrated that the strategy addressed each part of the provider's business, the risks associated to each part, a review of what had been delivered and any outstanding aims that have not yet been achieved.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values. Due to the nature of the service, this was mainly done via email. Clinicians not directly employed by the provider had access to dedicated email accounts which they told us was helpful for communication. We spoke with clinicians who accepted work for the service but were self-employed who reported there had been a reduction in the number of clinical meetings held, and they told us they would prefer to have more moving forward to feel more involved. Overall, this particular staff group confirmed general communication had improved since the provider's previous inspection, with emails and updates that were organised and relevant.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service. Staff told us the culture

Good

Are services well-led?

felt vibrant which enthused staff to be involved and contribute to wave of achievement the provider was aiming to deliver. Staff were aware that work still needed to be done to achieve the final goal.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. The provider had a whistleblowing policy and a Freedom to Speak Up guardian, and staff we spoke to knew how to access both.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals as they fell due. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. The provider had a designated Well-being Officer which staff could access for debriefing if they had dealt with a difficult situation. Staff told us they felt looked after by management and often received take-away meals and ice creams during their shifts to maintain the service's sense of fun and to make staff feel valued.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.
- There were positive relationships between staff and teams. Staff we spoke to told us they felt respected, they felt like they were treated as individuals and their own personal needs were taken into account, such as shift pattern changes for childcare purposes. One member of staff described this relationship as 'fantastic'.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, we found evidence which showed these were not fully embedded.

- 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.
- The provider had a comprehensive governance structure laid out for all of its services provided, as well as a leadership structure for each service.
- The provider had an integrated governance board whose aim was to maintain oversight of governance matters. A quality dashboard was created, reporting by exception, which was reviewed by the board on a monthly basis. The context of the exceptions were reviewed and discussed. The output of the integrated governance board was that governance decisions were made and appropriate actions were taken. These decisions and actions were disseminated to staff appropriately and leaders attended locality meetings to be assured the information was shared.
- Each service under the provider had a governance group and these all reported into the integrated governance board on a monthly basis.
- Leaders were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. There was a clear structure of lead roles for staff to know.
- Leaders had established proper policies, procedures and activities to ensure safety. However, the provider admitted they had encountered ongoing difficulties in obtaining adequate assurances from its diverse workforce in relation to compliance with training for clinicians who worked for other providers.
- The learning from previous significant events was not fully embedded as we found further evidence of out of date medicines and injection solutions during our inspection. This was despite the service raising several significant events relating to out of date medicines in the previous 12 months.

Managing risks, issues and performance

Good

Are services well-led?

There were clear and effective processes for managing risks and issues except in relation to clinical staff training assurances and performance data relating to the NHS 111 service.

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 develop the future performance of the service, but current performance data relating to the NHS 111 service indicated significant improvement was required in order to be in line with expected national targets.

Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. However, the assurances that all clinical staff had completed appropriate training modules were limited.

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 but there was limited evidence of disease-specific audits to support specific improvement to care and treatment outcomes for specific conditions. There was clear evidence of action to resolve concerns and improve quality following incidents or complaints but we found evidence which showed subsequent learning was not fully embedded.

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

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. The data relating to the NHS 111 service was limited as the provider had only joined the contract in June 2019, and the service was in its infancy. Performance information was combined with the views of patients.
- Quality and sustainability of the service were discussed in relevant meetings and staff had access to information afterwards.
- The provider used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care.
- The service submitted data or notifications to external organisations as required. The provider was in the process of submitting new applications to CQC to register new services at different locations in order to promote clarity about the services it provided.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. An evaluation questionnaire was sent to a random selection of patients who had used either the clinical assessment service or the home-visiting service, within one week of a patient's contact. The questionnaire was used to gather information about patients' experiences of the services. Feedback was used to develop services and produce actions or provide feedback to clinicians directly. Examples of changes made included the frequency of comfort calling (when a call handler

contacts a patient waiting for a call-back to ensure the patient has not deteriorated); and improvements to how staff explain the call-back time-frames to patients to avoid misunderstanding and distress.

- Staff were able to describe to us the systems in place to give feedback. This included a quarterly pulse survey which was reported at board level where appropriate actions were taken and reported back to staff. Staff who worked remotely were engaged and able to provide feedback. We saw evidence of the most recent staff survey and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The provider was transparent, collaborative and open with stakeholders about performance. We were told the provider attended monthly meetings with local clinical commissioning groups and key stakeholders, such as SCAS, to discuss performance and future plans.
- SCAS confirmed engagement with the provider was positive but work to develop the emerging service to support SCAS' NHS 111 contract was still required.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the service. The provider had a team dedicated to service development, and had plans to improve its existing services, such as developing an infrastructure to support the introduction of e-Consult, reviewing skill mix within the call centre, electronic prescribing, direct booking, and developing the clinical assessment service.
- Staff knew about improvement methods and had the skills to use them.
- The provider made extensive use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. Staff felt empowered to make changes as appropriate.
- There was a culture of innovation evidenced by the number of pilot schemes the provider was involved in, including its own direct clinical assessment service. There were systems to support improvement and innovation work on a weekly basis to review workstreams, analyse patient demand and assess development progress.
- The provider was involved in the provision of triage training for GP registrars and had developed a training package to support this. (GP registrars are qualified doctors who are undertaking further training to become a fully-qualified GP).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • Dissemination of learning from significant events was not fully assured. For example, repeat evidence of out of date medicine was found during inspection despite previous incidents of out of date medicines being reported. • Performance data was not in line with national expected targets. • Systems to ensure appropriate use of medicines was not fully embedded. This was in breach of Regulation 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • Staff training records were not adequately maintained in order for the provider to be fully assured that all staff were compliant with its training requirements, particularly in relation to safeguarding adults and children, basic life support, infection prevention and control & information governance. This was in breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.