Wellington 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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focused follow up inspection at Wellington House (known locally as Somerset Doctors Urgent Care) on 24 August 2017.

Following our comprehensive inspection at Wellington House NHS on 24 and 25 April 2017 the location was rated as inadequate for the Out of Hours service with an inadequate rating for the safe, effective and well led domains, good for caring and requires improvement for responsive. We rated the NHS 111 service as requires improvement with requires improvement rating for safe and effective, good for caring and responsive and inadequate for well-led. Our levels of concern following this inspection were significant and we placed the provider into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

Summary of findings

The serious concerns were such that we took further steps to ensure the provider made changes to the governance of the service to reduce or eliminate the risks to patients. The provider was required to make improvements in respect of these specific deficits, as outlined in the warning notices of 17 May 2017 to be completed by 18 August 2017.

We issued warning notices in regard to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance and Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment.

This focused follow up inspection was undertaken on the 24 August 2017 to assess if the regulatory breaches had been met in regard to the warning notices. Other areas of non-compliance were planned to be reviewed at a later date by a comprehensive inspection when the provider has had time to implement all the changes required.

The provider had taken steps to ensure the significant concerns that had been found in relation to the warning notices for Regulations 12 and 17 had or were in the process of being addressed. For example we found evidence that the concerns around emergency medicines, calibration of clinical equipment, health and safety relating to risk assessments and COSHH (control of substances harmful to health) and complaints had been rectified. Infection prevention and control measures had been improved.

The provider had implemented changes to the management and administration system for safer recruitment and for mandatory learning and development. However there were still gaps in the safer recruitment process such as pre-employment references and the completion of mandatory training such as safeguarding, basic life support, fire safety and evacuation and infection, prevention and control had not been completed by all staff. With regard to medicine management, the systems to securely store and monitor medicines including controlled medicines remained inadequate. The service had not met all the National Quality Requirements used to monitor safe, clinically effective and responsive care which meant patients' care needs continued to not always be assessed and delivered in a timely way. Further concerns remained unmet, the implementation of an overarching governance framework for systems and processes, including the action plan following our previous inspection concerns, required attention to improve the quality and safety of the services and to mitigate risks relating to the health, safety and welfare of staff and service users.

In addition we found new concerns with infection prevention and control measures such as such as spillage and contamination relating to used sharps. There was limited evidence of learning being embedded in policy and processes; for example, there were ongoing incidents of missing blank prescriptions and blank prescriptions not being held securely. Additional concerns around patient confidentiality were raised with the service.

There were also areas of service where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that all patients are treated with dignity and respect.
- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure that serious incidents, deaths or safeguarding referrals are subject to statutory notifications to the Care Quality Commission.

The provider should:

- Complete resulting actions from the health and safety risk assessment relating to lone working as a priority.
- Enable staff at Out Of Hours sites staff to easily identify which equipment has been calibrated and which equipment they need to re-calibrate regularly such as blood glucose monitors and which is safe to use.

In this situation with the issuing of warning notices, we returned to check the progress the provider was making in regard to the key concerns. The service remains under special measures until we have returned to carry out a

Summary of findings

comprehensive inspection at the end of this six month period after the initial report was published. If the service has failed to make sufficient improvements the CQC will consider taking steps to cancel the provider's registration.

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?

Inadequate

At our last inspection on 24 and 25 April 2017 we rated the safe domain as inadequate for providing safe services and improvements must be made.

We saw some improvements however; the provider was not always providing care and treatment in a safe way. There was limited evidence of sustained learning from significant events that prevented reoccurrence of events. For example, security and safe storage of blank prescriptions and medicines. Significant events that required statutory notification to the CQC were not always completed.

The provider had implemented a new recruitment policy and had implemented a new management and administration system for recruitment. However we saw gaps where some recruitment checks had not been completed.

Checks relating to infection prevention and control measures and clinical equipment required improvement in some areas and action plan timescales for implementation of improvements had not always been met.

Are services well-led?

Inadequate

At our last inspection on 24 and 25 April 2017 we rated the well-led domain as inadequate.

The delivery of high-quality care was not assured by the leadership, governance or culture in place at the service. Significant issues that threaten the delivery of safe and effective care were not adequately managed. For example, substantial or frequent clinical staffing shortages within the Out Of Hours service led to breaches of National Quality Requirement 12 for face to face clinical assessments and increased risks to patients who used services and patients were not always treated according to urgency of need. Comfort calls in relation to delays were not always timely. Adequate clinical audits to ensure improvements in clinical care and other processes were required.

Patients could get information about how to complain. We found the complaint system to be detailed and appropriate although we saw themes and trends around complaints such as delays and cancellations in care and access to treatment.

Summary of findings

The provider had implemented a new management and administration system for statutory and mandatory training however gaps within training such as infection, prevention and control, fire safety and evacuation, basic life support and safeguarding led to risks.

Patient information and confidentiality was not always maintained at all times.

Summary of findings

Areas for improvement

Action the service MUST take to improve
Importantly, the provider must:

- Ensure that all patients are treated with dignity and respect.
- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure that serious incidents, deaths or safeguarding referrals are subject to statutory notifications to the Care Quality Commission.

Action the service SHOULD take to improve
The provider should:

- Complete resulting actions from the health and safety risk assessment relating to lone working as a priority.
- Enable staff at Out Of Hours sites staff to easily identify which equipment has been calibrated and which equipment they need to re-calibrate regularly such as blood glucose monitors and which is safe to use.

Wellington 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 a specialist GP advisor, a second CQC inspector and an inspection manager.

Background to Wellington House

Wellington House is known locally as Somerset Doctors Urgent Care (part of the Vocare Group). This service provides the 24 hour NHS 111 service and GP led Out Of Hours (OOH) care for a population of approximately 540,000 patients in the Somerset region. They also provide the 24 hour NHS 111 service across the whole of Somerset. Somerset Doctors Urgent Care Ltd. (SDUC) is a private limited company. Vocare deliver GP Out Of Hours and urgent care services to more than 4.5 million patients nationally.

The population of Somerset is dispersed across a large rural area. The County of Somerset covers a large geographical area and incorporates five District Councils; Mendip, Sedgemoor, South Somerset, Taunton Deane and West Somerset. One in four people live in one of Somerset's largest towns: Taunton, Yeovil and Bridgwater (Somerset JSNA, 2011).

Areas of multiple deprivations in Somerset are found within the towns as well as more remote rural areas. Patterns of deprivation in rural areas are strongly influenced by distance to services. Around 95% of Somerset's population are White British. Outside of the UK and Ireland the most common countries of birth across all districts are Poland, Germany, South Africa, India and the Philippines. There are a growing proportion of residents across Somerset who have settled from abroad.

There are around 3,400 households (1.5% of all households) in Somerset in which the household members do not speak English as their first language. Members of these household may require language support when accessing services. There is a high proportion of single pensioner households in West Somerset (remote parts of the County) and a higher prevalence of single parent households in Mendip, Sedgemoor and Taunton Deane than the Somerset average. A significant proportion of the Somerset population do not have access to their own transport, particularly in Sedgemoor, West Somerset and Taunton Deane. Almost a fifth (19%) of Somerset residents rate themselves as being limited in activities of daily living (Census 2011). Residents in Sedgemoor and West Somerset are likely to have higher health care needs than the Somerset average.

Young families and older people tend to access OOH services more commonly than other age groups. Younger families tend to live in north east parts of the County and closer to towns.

The GP led Out Of Hours service is accessed through NHS 111, providing telephone triage and face-to-face consultations 24 hours a day to patients across Somerset. This service is based at the organisation's headquarters at Wellington House, in Taunton.

Wellington House provides Out Of Hours care between 6.30pm and 8am Monday to Friday. At weekends and bank holidays the service provides 24 hour access. As part of the Out Of Hours service there are five OOH sites which open at varying times and days:

Detailed findings

- Bridgwater Community Hospital Bower Lane, Bridgwater, TA6 4GU
- Minehead Community Hospital Luttrell Way, Minehead, TA24 6DF
- Musgrove Park Hospital Parkfield Drive, Taunton, TA1 5DA
- Shepton Mallet Community Hospital Old Wells Road, Shepton Mallet, BA4 4PG
- Yeovil District Hospital Higher Kingston, Yeovil, BA21 4AT

During our inspection we visited the headquarters in Taunton along with four of the five Out Of Hours sites (Bridgwater, Taunton, Shepton Mallet and Yeovil).

On average the service receives 900 referrals per week via NHS 111. Of these an average of 70 patients received contact with the service each weekday and 550 patients receive contact at weekends.

The regional clinical director is a GP who works in this role two days per week. There is 171 clinical staff of which 165 are GPs. The remaining six are nurse practitioners or emergency care practitioners. All are either employed by the service or provide sessional work. There is 51 operations staff including receptionists, a clinical manager and a regional clinical and non-clinical director. In addition 27 drivers are employed.

Why we carried out this inspection

We undertook this focused inspection on 25 August 2016 and visited the service to follow up the warning notices for breaches of Regulation 12 of The Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment and Regulation 17 of The Health and Social Care Act (Regulated Activity) Regulations 2014, good governance, to ensure patients who used the service were safe.

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 also held regular meetings with Somerset Clinical Commissioning Group, NHS England and the provider. We carried out an announced visit on 24 August 2017.

During our visit we:

- Spoke with a range of staff including the regional clinical and non-clinical director, assistant regional director and clinical support manager, the clinical manager, administrative and operations staff such as a driver, rota administrator and base lead manager. We also spoke to the provider's project coordinator and head of recruitment.
- Visited the local headquarters for the service which housed the NHS 111 service and two of the five Out Of Hours bases.

Please note that when referring to information throughout this report, this relates to the most recent information available to the Care Quality Commission at that time.

Inadequate

Are services safe?

Our findings

At our previous inspection on 24 & 25 April 2017 we rated the Out Of hours (OOH) service as inadequate and the NHS 111 service as requires improvement for providing safe services as systems, processes and practices did not always keep patients safe. Our substantial concerns with some aspects in the safe domain led us to take further steps to ensure that the provider made changes to the governance of the service to reduce or eliminate the risks to patients. The provider was required to make improvements in respect of these specific deficits, as outlined in the warning notices of 17 May 2017 with a compliant date of 18 August 2017.

We issued warning notices in regard to:

• Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

• Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment.

During our follow up inspection of 24 August 2017 we saw some improvements however, the provider was not always providing care and treatment in a safe way.

Safe track record and learning

There was a system in place for reporting and recording significant events. However the provider had not always notified the Care Quality Commission of significant events that require statutory notifications. Following this focused inspection we continued to request information but did not always receive a prompt reply and were not provided with all of the information we requested. In addition, during this inspection we looked at the administrative system for incident reporting within the service and incidents regarding allegations of physical abuse by a health care professional in another organisation; missing controlled medicines and evidence of requests from the Police for confidential patient data in the form of call recordings. To date statutory notifications relating to these issues have not been received by CQC.

- We saw evidence some learning had been disseminated to staff although there was little evidence of learning being embedded in policy and processes.

Overview of safety systems and processes

The service had clearly defined provider-level policies and processes in place to keep patients safe and safeguarded from abuse however these were not always followed:

- During our previous inspection not all staff we spoke to had received training on safeguarding children and vulnerable adults relevant to their role. We saw the provider had implemented a new, improved e-learning training system with easier staff access and comprehensive training packages. We reviewed the data of completion of training within the new e-learning training system and saw that not all staff had completed the mandatory safeguarding training. For example, none of the advanced nurse practitioners and only 42% of clinical advisors had received relevant safeguarding training for their role. Most GPs had level three children's safeguarding training.
- At our previous inspection we were told by the local leadership team that staff at the Out Of Hours (OOH) sites were not expected to provide a chaperone service to patients and non-clinical staff such as drivers and receptionists were not provided with chaperone training. Members of staff had told us that they had acted as a chaperone when this had been requested of them. 33% of receptionists and 19% of drivers had since undertaken online chaperone training. Staff told us they did not feel confident with their role and ability to act in the interest of the patient. There was no evidence training was then consolidated with them.
- At our previous inspection we raised concerns around infection prevention and control (IPC) measures. We had observed the premises to be clean and tidy except for one site where dirty linen was found at the start of the shift. We had spoken to non-clinical staff at the sites who told us they had not received any infection prevention and control training including handwashing. At this inspection we looked at the e-learning training system data and saw not all staff had received IPC training such as; 25% receptionists, 50% of advanced nurse practitioners and GPs and 54% of drivers. This meant staff may not have an overview on the key elements of IPC. At the two Out Of Hours (OOH) sites we visited we found procedures for containers which enable the safe storage and disposal of all categories of sharps waste had not been followed, we found a box which had not been put together correctly, had been overfilled and was still in use. This presented a risk of spillage and contamination.

Inadequate

Are services safe?

- Previously staff told us they were unaware of procedures to clean and decontaminate clinical equipment when dirty, used by an infectious patient or at the end of each shift. A new procedure had been implemented since our last visit however we found a glucometer used to test a person's blood glucose level was blood stained. We spoke to staff who advised us there was a process to check and decontaminate equipment at the start of each shift. The checking tool for the day we visited was not available at the OOH sites. We asked how staff would clean the equipment and were advised they would use equipment that did not disinfect the devices. The impact of this was the system for cleaning and disinfecting equipment put patients at risk as the equipment was not cleaned immediately after use. And some staff with the responsibility to decontaminate and clean equipment had not received the relevant infection prevention and control training.
- At our previous inspection OOH staff told us patient urine samples were tested in clinical rooms and the urine disposed of in clinical waste bags. We saw evidence that a system and procedures had been put in place to allow the safe disposal of clinical waste. However there was no evidence that a system was in place to check staff followed the correct procedures.
- We asked to look at the organisations overall infection prevention and control (IPC) measures. We looked at the IPC audit completed on 21 June 2017, the CQC improvement action plan and the organisations health and safety action plan. We saw the three plans had differences in relation to actions and outcomes. For example, staff told us they checked equipment at the start of the shift whereas the action plan stated staff completed this at the start and end of a shift. In addition data within the plans for levels of IPC staff training completed were different from the data available from the training system.
- Previously we reviewed personnel files of which related to OOH and NHS 111staff. We found evidence a significant number of recruitment checks had not been completed.
- During this visit we saw the provider had implemented a new recruitment policy and had implemented a new management and administration system for recruitment. The provider had employed additional staff to undertake a full audit of staff files and this was still work in progress. We reviewed 13 files for staff at Wellington House and found gaps where some recruitment checks had not been completed. For example, interview summaries, details of appraisals, application forms and references. One senior member of the leadership team did not have an application form or interview notes and had commenced employment without references. In the absence of the provision of evidence of safe recruitment the provider could not demonstrate that an effective system was in place to assess monitor and mitigate risks relating to recruitment. We also noted that where the provider had staff who had been transferred from a predecessor organisation there were gaps in documentation but part of the new system these had been requested.

Medicines Management

- At our previous inspection we found the blank prescription forms and pads were securely stored, but the monitoring systems in place were not adequate to be able to track their use. At this inspection we reviewed changes the service had made to the security arrangements for blank prescriptions which had been introduced. At one OOH site we found the audit record for individual blank prescriptions was not completed fully and one prescription was missing. We spoke to the Registered Manager who told us that there continued to be gaps in logging prescriptions. This was evidenced in the administrative system for incident reporting within the service which detailed incidents of missing blank prescriptions and blank prescriptions not being securely stored at various OOH sites when the service was closed. For example, the incident log for 22 May 2017 detailed prescriptions being found left out and the computer left on allowing unauthorised access to information; on 6 June 2017 a blank prescription pad had been left out in a treatment room; on 8 July 2017 a blank prescription was missing from an OOH site and on 19 July 2017 two blank prescriptions were unaccounted for at an OOH site. The Wellington House performance and operations report for June 2017 details prescription pads not being securely stored at one OOH site. These incidents meant prescriptions were not being recorded, handled or stored securely.
- Prior to our inspection we were notified by NHS England that prescriptions were being used fraudulently and that these prescriptions had been obtained from the Somerset OOH service (Wellington House). We received a Statutory Notification from the provider six weeks after they had been alerted to fraudulent use of prescriptions.

We requested further information regarding the incident which was not received prior to our inspection. The service later notified us that additional prescriptions had been stolen from an OOH site. This demonstrated prescriptions were not being handled or stored securely allowing them to be obtained by members of the public.

- On the day of this inspection we spoke to staff at the host site for one of the OOH services. They advised us their reception staff had found the key to the medicines cupboard at the OOH site in the door and the cupboard unlocked. This was confirmed via the incident reporting system, and by the Wellington House performance and operations report for July 2017. During our visit to this site we saw there was no process in place whereby OOH staff checked the rooms prior to leaving. We looked at the administrative system for incident reporting within the service and saw records which indicated that medicines had also been left unsecured at other OOH sites. For example, on 7 June 2017 medicines had been left out in a consulting room. This further demonstrated medicines and prescriptions were not stored securely.
- The service held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had standard operating procedures in place that set out how controlled drugs were managed in accordance with the law and NHS England regulations. These included auditing and monitoring arrangements, and mechanisms for reporting and investigating discrepancies. The provider held a Home Office licence to permit the possession of controlled drugs within the service. Previously we had found the record books for the controlled drugs register for Schedule 2 medicines at the OOH sites were not always completed correctly and in line with legislation for managing and using controlled drugs. At one site we saw inconsistencies with reconciliation of an ampoule of Diamorphine which had been given to another site. During this inspection we found the registers for controlled drugs (CD) of Schedule 2 medicines at OOH sites we visited were not always completed correctly and in line with legislation for managing and using controlled drugs.
- Medicines identified as at risk of misuse, were subject to additional security. However at one OOH site we saw inconsistencies with the completion of the blue medicines record books for scheduled medicines such as Diazepam and Tramadol. We looked at the administrative system for incident reporting within the service and saw incidents relating to missing medicines. For example, we saw two entries where boxes of codeine tablets were missing from stock and one entry where Tramadol was found to be missing from a sealed envelope. The CQC have not received statutory notifications with regards to these incidents and there is no evidence that they were reported to the Police. This meant incidents, which may affect someone's health, safety and welfare or could require a criminal investigation were not reported appropriately.
- We looked at the medicines stock including emergency medicines at the OOH sites we visited and within the vehicles. We saw that clinicians prescribing and supplying medicines were giving patients medicines in their original packaging which meant patients were receiving medicines which were easily identified with the name and dose. All medicines we checked were in date and stored appropriately in tamper evident boxes.

Monitoring risks to patients

Previously we had found that the provider did not have an oversight of risk assessments and safety checks for monitoring and managing risks to patient and staff safety. During this inspection we saw:

- There was a health and safety policy available with a poster in an area accessible to all staff. Risk assessments and health and safety documentation were easily located and Control of Substance Hazardous to Health (COSHH) sheets and product data sheets were in place. A health and safety lead was not in post however, we saw the service had an interim lead and plans for a new member of staff to undertake comprehensive health and safety training.
- Fire drills had taken place at the Wellington House location and the provider had been able to evidence how many staff had attended these. Staff at Out Of Hours (OOH) sites had previously advised us they had not participated in host site training around fire evacuation and safety. At this inspection there was no evidence that staff at OOH sites had undertaken the necessary fire evacuation training in order for them to identify alarm systems and evacuation processes specific to locations. The staff we spoke to on the day were unable to tell us what the procedure was. We saw the OOH sites had the host organisations overarching fire evacuation & shelter policy but this was not specific

to each hospital. The provider's action plan against our warning notices stated there would have been 1:1 communication on fire evacuation with all staff however we found no evidence this had happened.

- At our previous inspection staff working within the OOH sites had told us they felt unsafe as there was a lack of a clear arrangement for lone working for the OOH sites and some of the safety measures in place such as intercom systems and security shutters did not work effectively. Following that inspection an independent health and safety risk assessment had taken place at each of the OOH sites. Resulting actions included a lone working plan however, the completion date for the actions were September 2017 which was after the date we have told the provider they must be compliant.
- There was a system in place to ensure non-clinical and clinical equipment was maintained to an appropriate standard and in line with manufacturers' guidance such as annual servicing of electrical equipment at the headquarters at Wellington House and for the equipment used at OOH sites. On our site visits we found some equipment without evidence of calibration for example, a thermometer and an otoscope. We observed there was equipment missing from one box such as a lubricating sachet, eye drops and urine testing sticks. We also found out of date urine testing sticks within one of the cars. There was no system to calibrate the blood glucose monitors which meant readings may not be accurate.
- All incident forms for accidents that occurred locally were accessible to staff and records reviewed by us had been completed in full and appropriate action had been taken as required.
- 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. The service had difficulties recruiting GPs. They employed 21 salaried GPs and relied on sessional GPs for additional shift fill.
- We reviewed the OOH rota and saw vacancies within the rota for OOH clinicians; the workforce shift analysis confirmed there were unfilled shifts and gaps within clinical staffing which impacted on the service being able to provide a timely service. For example, one OOH site had a fill rate of 81.5% and 73.8% for June and July 2017 respectively. At other OOH sites the fill rates were 88% and 87.7%, and 62% and 72.9% respectively. We looked at the shift rota and found unfilled shifts which led to sporadic shift cover. For example, on a Saturday in August 2017 three out of the four 4pm until 10pm shifts for one OOH site were unfilled. Another OOH site was closed and another had no GP cover from 8am until 11pm. In addition patients could not be directed to a fourth OOH site between 4pm-2am as there was no cover. The daily shift supervisor report for that day stated there were not enough GPs to undertake home triage. For patients this could mean further travel to other OOH sites or the unavailability of a face to face consultation. The service had produced a remedial action plan where shortfalls had been identified however the governance processes for the service had failed to address some of the issues the service faced in a timely manner, such as performance targets, and they had failed to support sustained improvement.
- Staffing for the NHS 111 service also faced recruitment difficulties. Data for the June 2017 monthly performance report showed that the NHS 111 service should have 26 whole time equivalent (WTE) call advisors. 22.8 WTE call advisors were employed in the service (excluding agency) with a 47 % absent rate. For clinical advisors 5.5 WTE were employed out of the 10.6 WTE required. In June 2017 there was an absence of 35%.
- The impact of low staffing levels led to breaches of NQR 12: whereby providers must ensure that face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed: Emergency: Within 1 hour; Urgent: Within 2 hours; less urgent: Within 6 hours. The inspection team looked at data for NQR12 which covered the period May to July 2017. Although there was some improvement in some areas such as NQR12 c: a clinical assessment at an OOH site for all urgent care patients within 6 hours. Other areas such as NQR12e: Clinical assessment for all urgent care patients at home within 2 hours showed deterioration. We saw the operations and performance reports for May 2017 reported 170 breaches of the target, in June 2017 there had been 190 breaches. Targets for NQR12b, c, e, and f remained below the 95% contracted target. For example, the July 2017 performance and operations report showed 87.2% of the target for patients to be

seen within two hours at an OOH site (NQR12b) and 75.6% for patients requiring a home visit to be seen within two hours. This meant patients may not receive timely safe, clinically effective and responsive care.

- On arrival at Wellington House we observed the windows on the ground floor to be open. The building is situated in a public area with a pedestrian pavement around the edge of the building. Staff from the NHS111 service could be heard speaking to patients on the telephone and computer screens were visible. We spoke to the Registered Manager about our concerns for confidentiality. We were advised that window screens were due to be installed however potentially confidential conversations would still be heard by people passing the open windows. During our inspection the windows were not closed. This demonstrated that by their actions Vocare failed to take appropriate action to protect confidential patient information.

Arrangements to deal with emergencies and major incidents

- At our previous inspection non-clinical staff we spoke to had told us they had not received basic life support training (BLS), including use of an automated external defibrillator. Since our previous inspection defibrillators had been made available at each OOH site in addition to those carried within the vehicles.
- During this inspection we looked at the training system data and saw not all staff had received BLS training. For example, 46% of drivers had received e-learning training. The e-learning system included information on defibrillator usage. However staff we spoke to told us they had not received training to use the defibrillators, some of which are new following our previous inspection.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 24 & 25 April 2017 we rated the service as inadequate for providing well-led services for the Out Of Hours and NHS 111 services as the delivery of high-quality care was not assured by the leadership and governance in place at the service. There was no contingency to ensure governance arrangements were managed effectively when key management staff were absent such as health and safety. Significant issues that threaten the delivery of safe and effective care were not adequately managed.

Our substantial concerns with some aspects in the well-led domain led us to take further steps to ensure that the provider made changes to the governance of the service to reduce or eliminate the risks to patients. The provider was required to make improvements in respect of these specific deficits, as outlined in the warning notices by 18 August 2017.

We issued warning notices in regard to:

• Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

• Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment.

During our follow up inspection of 24 August 2017 we saw some improvements however, the provider was not always operating and implementing effective systems or process to assess, monitor and improve the quality and safety of the services. There were not always effective systems for assessing, monitoring and mitigating risks relating to the health, safety and welfare of service users and others who may be at risk.

Governance arrangements

Wellington House Out Of Hours (OOH) and NHS 111 is a registered location for Vocare Limited, a large national organisation, with strategic and operational policies and procedures in place. The service had an overarching governance framework that supported the delivery of the national strategy. This outlined the structures and procedures in place. Locally clinical governance procedures and reporting pathways were established and regular clinical governance meetings were undertaken by the senior management team. However, during our previous inspection we found the governance processes for the service had failed to address some of the issues the service faced in a timely manner, such as performance targets, and risks to patients where they had failed to support sustained improvement.

- The provider had a good understanding of their performance against National Quality Requirements but they had not responded in a timely manner to the staffing shortages that resulted in them failing to attain the requirements. Performance monitoring arrangements were in place with the clinical commissioning group. Somerset Clinical Commissioning group had previously issued a Contract Performance Notice on 27th March 2017 relating to the non-compliance of NQR12b, c, e and f and shift fill levels.
- A recovery action plan had been developed by Vocare however the clinical commissioning group had not signed this off due to continued staff vacancies within the service.
- At our previous inspection we saw evidence of a provider-level programme of clinical and internal audit, used to monitor quality and to make improvements however audits of the service did not always support improvement such as comfort calling. Comfort calling rates continue to remain below the 95% target.
- We continued to see little evidence of additional measures being put in place to improve expected outcomes and saw evidence that staffing rates for NHS 111 and for clinicians within the Out Of Hours (OOH) service remained low with high absences in some areas.
- We looked at the available clinical audits which should be improved. An audit of the quality of post event messages indicated poor safety netting. We saw evidence a message around safety netting was within the July clinical newsletter however quality improvement actions had not been recorded within the audit.
- At our previous inspection we were told fifty face to face patient records are audited each month and Out Of Hours clinicians had five calls to patients audited every six months. We told the provider this level of activity was insufficient to effectively monitor the quality of work of each clinician working within the service. We were told the service had reviewed the regularity by which the GP call audits were carried out however evidence looked at showed call auditing levels remained the same. There had been no increase in activity of monitoring or risk

Are services well-led?

Inadequate

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

assessments in place to evidence the provider's decision making. There continued to be little evidence that clinical audit processes were driving improvement in patient outcomes or those improvements were implemented and monitored.

- We saw there had been an improvement in the backlog of call auditing for the NHS 111 service with reviews for call handlers now being achieved.
- Prior to our inspection the CQC had met monthly with Vocare to discuss actions in relation to the warning notices dated 17 May 2017 and the CQC NHS 111 and Out Of Hours (OOH) reports published 4 August 2017. The service had produced an action plan where shortfalls from our previous inspection had been identified. We reviewed the most up to date version of the action plan where actions had been marked as green to indicate they were met. However during our inspection we found evidence that actions had not always been completed, which was contradictory to the evidence supplied prior to inspection.
- The provider offered a wide range of statutory and mandatory training with a new and improved e-learning management system and a focus on continuous learning and improvement at all levels within the service. The training system data showed some improvements in staff completing the required training. Whilst we saw improvement to the number of staff completing the appropriate training, overall not all staff had fully completed their mandatory e-learning. Compulsory training is essential for the safe and efficient delivery of care and poor completion rates equate to an increase to organisational risks and in some cases non-compliance with national policies and government guidance.
- The governance systems and processes to identify and manage risks and issues were not always robust. This meant there was not an effective system or process to assess, monitor and improve the quality and safety of the services provided or to assess monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk arising from the carrying on of the regulated activities. For example, the provider could not provide evidence of some recruitment checks in a timely manner and therefore could not demonstrate the suitability and qualifications of their workforce. Reported significant events such as loss of blank prescriptions from the service had not led to an overall improvement in the safety and security of blank prescriptions.
- We found the detail within the complaint system was consistent and all sections of the reporting system were completed.
- Prior to and during this inspection we saw evidence that serious incidents including safeguarding referrals, had not resulted in statutory notifications to the Care Quality Commission.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person had not ensured the privacy of service users.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.