Wellington House

Quality Report

Wellington House - Vocare
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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.

Summary of findings

Ratings

Overall rating for this service	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive to people's needs?	**Good** 
Are services well-led?	**Inadequate** 

Summary of findings

Contents

Summary of findings

Overall summary

We carried out this announced comprehensive inspection of Wellington House (known locally as Somerset Doctors Urgent Care) NHS 111 and Out of Hours service on 24 and 25 April 2017. NHS 111 is a 24 hours a day telephone based service where people are assessed, given advice or directed to a local service that most appropriately meets their needs. For example, this could be to their GP, an out-of-hours GP service, walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, late opening pharmacy, or self-care home management advice.

This site provides services to the whole county of Somerset; the call centre received NHS 111 calls and was co-located with the Out of Hours call centre, we inspected the NHS 111 service located at Wellington House in Taunton.

Overall the service is rated as requires improvement. We found the service requires improvement for providing safe and effective and inadequate for well-led services. We found the service good for providing responsive and caring services.

Our key findings were as follows:

- The provider had taken steps to ensure all staff underwent a recruitment and induction process to help ensure their suitability to work in this type of healthcare environment. However, the provider was unable to produce the required documentation to demonstrate their recruitment policy and procedure had been followed. As a result they could not demonstrate the qualifications and experience of fitness of all the staff employed.
- The service had not met all the National Minimum Data Set and Local Quality requirements for example, failure to achieve the percentage of calls answered within the 60 second time period (standard eight). Appropriate action was undertaken where variations in performance were identified however there was evidence that improvement was not sustained.
- Staff were supported in the effective use of NHS Pathways which is a triage software utilised by the National Health Service to triage public telephone calls for medical care and emergency medical services.
- We found there was no regular consistent auditing of calls which is part of their NHS 111 contract. The service recognised this was an area for quality improvement and had a remedial plan in place however; there had not been an audit programme in place for the previous six months.
- We observed and listened to calls which demonstrated that people experienced a service that was delivered by dedicated, knowledgeable and caring staff.
- People using the service were supported effectively during the telephone triage process. Consent to triage was sought and their decisions were respected. We observed staff treated people with compassion and responded appropriately to their feedback.
- Clinical advice and support was readily available to call advisors when needed. Care and treatment was coordinated with other services and other providers.
- Evidence of learning from internal incidents and complaints was limited.
- There was an overarching governance framework across the NHS 111 service, however this was not co-ordinated and there appeared to be confusion about areas of responsibility.
- Arrangements to monitor quality were not robust enough to support sustained improvement.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The provider was aware of the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. Systems were in place for notifiable safety incidents however the arrangements to ensure this information was shared with staff to ensure appropriate action was taken were inconsistent.

The areas where the provider must make improvements are:

- To ensure there are robust and effective systems and processes to assess, monitor and improve the quality and safety of the services provided and 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.

Summary of findings

- To undertake all necessary professional employment checks for all staff before employment commences.
- To ensure an accessible and organised system for oversight of risk assessments and safety checks and access to emergency equipment such as first aid and fire safety equipment.
- To ensure that statutory notifications are sent to the Care Quality Commission.
- To ensure staff have regular call auditing, including clinician consultations, in line with Vocare policy.
- To ensure that governance arrangements support sustained improvement.
- To ensure complaints and significant events are dealt with consistently and any learning is shared.

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?

Requires improvement

The provider is rated as requires improvement for providing safe services and improvements must be made.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, lessons learned were not communicated widely enough to support improvement.
- Risks to people who used services were assessed to keep people safe.
- Staff took action to safeguard people and were aware of the process to make safeguarding referrals. All calls with safeguarding concerns were “warm transferred” (a direct call transfer where the caller was kept on the telephone) to a clinician to progress. However the provider could not demonstrate that all clinical advisors had attended recent safeguarding training.
- Clinical advice and support was readily available to call advisors when needed.
- Recruitment records for clinical advisors were incomplete as were records of safeguarding training.
- The provider could not provide assurance that health and safety was adequately implemented at the site.

Are services effective?

Requires improvement

The provider is rated as requires improvement for providing effective services and improvements must be made.

- The service had not met all the National Minimum Data Set (standard eight) and Local Quality requirements for example, failure to achieve the percentage of calls answered within the 60 second time period. Action was undertaken where variations in performance were identified however, there was evidence that improvement was not sustained.The provider told us they had submitted a recovery action plan to the service commissioners with a trajectory for improvement by the end of August 17.
- Staff were trained to ensure safe and effective use of NHS Pathways. We found the call auditing programme did not meet contractual requirements.The provider told us call auditing had recently been delayed due to increase training of new staff but there was an action plan in place to rectify the backlog by the end of May 2017.

Summary of findings

- Daily, weekly and monthly monitoring and analysis of the service performance was measured against key performance targets and shared with the clinical commissioning group (CCG) members. Account was also taken of the ranges in performance in any one time period.
- Staff received annual appraisals and personal development plans were in place; call advisors had the skills, knowledge and experience to perform their role, however we found that the yearly mandatory training for this group of staff had not always been completed.
- The training records for clinical advisors were incomplete and the provider could not demonstrate their clinical competence.
- Staff ensured consent, as required, was obtained from people using the service and appropriately recorded. There was an effective system to ensure timely sharing of patient information with the relevant support service identified for the patient and their GP.
- People's records were well managed, and, where different care records existed, such as special notes, information was coordinated.
- Staff used the Directory of Services (which was an online directory of local services with information about opening hours) to direct people to the appropriate services.
- Capacity planning was a priority for the provider. The provider undertook detailed call level forecasting to enable them to ensure adequate staffing levels could be delivered.

Are services caring?

Good

The provider is rated as good for providing caring services.

- People using the service were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We observed staff treat people with kindness and respect, and maintained the caller's confidentiality.
- We heard staff listened carefully to information that was being told to them, confirmed the information they had was correct and supported and reassured callers when they were distressed.
- Staff obtained the patient's consent when it was necessary to share information or had their call listened to.
- We found that the provider met contractual obligations when seeking people's feedback.

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services.

Summary of findings

- The service had long and short-term plans in place to ensure staffing levels were sufficient to meet anticipated demand for the service.
- There was a comprehensive complaint system and all complaints were risk assessed and investigated appropriately. There was a designated person and team responsible for handling complaints. However, learning from complaints was not consistently shared with staff.
- Action was taken to improve service delivery where gaps were identified.
- Care and treatment was coordinated with other services or providers.
- Staff were alerted, through their computer system, to people with identified specific clinical needs and special notes or any safety issues relating to a patient.
- The service engaged with the clinical commissioning group to review performance, agree strategies to improve and work was undertaken to ensure the Directory of Services (DOS) was kept up to date. (The DOS is a central directory about services available to support a particular person's healthcare needs and this is local to their location).

Are services well-led?

Inadequate

The provider is rated as inadequate for being well-led and improvements must be made.

- 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.
- The provider had a vision but not all staff were aware of the vision and their responsibilities in relation to it. There was a documented leadership structure and most staff felt supported by management.
- We found the arrangements for quality assurance were not strong enough to support sustained improvement.

Wellington House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a lead CQC Inspector. The team included a second CQC inspector, a CQC inspection manager and three specialist advisors with experience of NHS 111 services and NHS Pathways training and a pharmacist.

Background to Wellington House

Wellington House, known locally as Somerset Doctors Urgent Care (part of the Vocare Group), provides the 24 hour NHS 111 service across the whole of Somerset. It is co-located with the GP led Out of Hours, and serves a population of approximately 540,000 patients. 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 (taken from Somerset joint strategic needs assessment (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 is 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.

Establishment staffing structure:

Call advisors: 22 whole time equivalent

Clinical advisors: 11 whole time equivalent

Calls received per month:

Current Activity:

c.3100 calls per week

c.300 calls each weekday

c.1600 calls each weekend

Pathways training was in-house with dedicated trainers

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people's experiences of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we held about the NHS 111 service and asked other organisations such as the clinical commissioning groups (CCGs), who contracted the service, to share what they knew about the service. We also reviewed the information which the provider submitted before our visit as well as other information which was in the public domain.

We carried out an announced inspection to Vocare- SDUC NHS 111 on 24 and 25 April 2017. We were unable to speak directly with people who used the service. However, with peoples' consent we listened to calls.

During our visit we:

- Visited the call centre based at Wellington House, Taunton.
- Observed call advisors and clinicians carrying out their role at both locations during periods of peak activity.
- Spoke with a range of clinical and non- clinical staff, such as; call advisors, clinicians, team managers, clinical supervisors, clinical and non-clinical coaches, senior managers, a lead trainer which included NHS Pathways training, and the clinical governance team.
- Reviewed NHS Pathways, Directory of Services (DoS) details and other documentation related to the running of the service.

Please note that when referring to information throughout the report this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Summary of findings

The provider is rated as requires improvement for providing safe services and improvements must be made.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, lessons learned were not communicated widely enough to support improvement.
- Risks to people who used services were assessed to keep people safe.
- Staff took action to safeguard people and were aware of the process to make safeguarding referrals. All calls with safeguarding concerns were "warm transferred" (a direct call transfer where the caller was kept on the telephone) to a clinician to progress. However the provider could not demonstrate that all clinical advisors had attended recent safeguarding training.
- Clinical advice and support was readily available to call advisors when needed.
- Recruitment records for clinical advisors were incomplete as were records of safeguarding training.
- The provider could not provide assurance that health and safety was adequately implemented at the site.

Our findings

Safe track record

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

- Significant events which met the threshold for a Serious Incident or Never Event were declared and investigated in accordance with the NHS England Serious Incident Framework 2015. The provider shared information at provider and commissioner forums and cooperated with investigations when required such as local authority safeguarding investigations. Over the past year the provider had recorded one significant incident for this service which was still under review.
- Staff told us they would inform the team leader of any incidents or concerns and there was a recording form available on the provider's computer system for staff to record incidents. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that service/provider of services must follow when things go wrong with care and treatment).

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. There was limited evidence from the provider to show this information or lessons from incidents were shared and action was taken to improve safety.

Complaints, concerns, health care professional feedback, significant events and non-compliant call audits were reported on in a monthly clinical governance report. We saw evidence of 268 incidents recorded over the past year (2016-2017); these were categorised and there was evidence of co-operation between agencies to resolve issues such as incorrect ambulance requests. The incidents were reviewed at the monthly NHS 111 and clinical commissioning group meetings, known as the 'Integrated Urgent Care Board'. We reviewed minutes of these most recent meetings. Following these, the provider was able to consider if there were any themes identified and then undertook any changes needed; for example, updating local operating policies which are circulated to staff.

Overview of safety systems and processes

Requires improvement

Are services safe?

The service had some systems, processes and practices in place to keep people who used the service safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff and clearly outlined who to contact for further guidance if staff had concerns about a person's welfare. The provider was aware of their responsibility in respect of 'working together to safeguard children' (2015). This is guidance on inter-agency working to safeguard and promote the welfare of children. For adults, this included the Care Act 2014, the Department of Health's guidance for professionals (March 2015) on Female Genital Mutilation and Safeguarding and the Prevent strategy. However, due to incomplete training records it was not clear if all staff had completed the required training to the recommended level.

In the area where calls were received there was a noticeboard, containing 'hot topic' information such as raising staff awareness to the signs of mental illness in patients of all ages. Information was available on staff work stations and detailed the different access pathways required for staff to use depending on the specific area that a patient lived in. Referrals were made by clinicians or team managers. Call advisors sought advice and support from a team leader if they had a safeguarding concern identified during a call. All calls with a safeguarding concern were "warm transferred" (a direct call transfer where the caller was kept on the telephone) to a clinician to progress the issue; this meant some calls were, at times, ended by the call advisor and then a verbal "hand over" to the clinician made so they could then determine whether a safeguarding issue was relevant. For February and March 2017 a total of 14 adults and three children were subjects of safeguarding referrals. Contributions were made to safeguarding meetings when required; however, we had not received any statutory notifications as required under the Care Quality Commission Regulations 2009 Regulation 18 from the provider relating to safeguarding referrals.

- Call advisors triaged patient calls by use of a clinical decision support system (NHS Pathways). This guided the call advisor to assess the patient based on the symptoms they reported when they called. Supporting this clinical decision tool was the directory of services (DoS) which identified appropriate services for the patient's care. Staff confirmed they received comprehensive training and regular six monthly updates on the NHS Pathways; their competencies were assessed prior to handling patient telephone calls independently through call monitoring and observation by a mentor.
- NHS Pathways is a triage software utilised by the National Health Service to triage public telephone calls for medical care and emergency medical services. Staff told us their NHS Pathways training included recognising concerning situations such as domestic violence or intoxication and that there was guidance in how to respond, this included discussing real case scenarios during the induction period to give new staff a good awareness of potential areas for concern. Clinical advice and support was readily available to staff when needed. Staff told us the team leaders and clinical advisors offered support.
- Staff had access to special patient notes and care plans, which included supporting information on people identified as frequent callers and those on end of life pathways. Staff were clear about the arrangements for recording patient information, maintaining records and making use of additional information.
- As soon as a call was received by a call advisor, a patient record was established including name, age and address. We heard staff check information for accuracy whilst at the same time reassuring the caller. Information was recorded directly onto the computer system and all calls were recorded to enable information verification and quality management. Staff were clear about the arrangements for recording patient information and maintaining records.
- The provider used the Department of Health approved clinical decision support system NHS Pathways. (This is a set of clinical assessment questions to triage telephone calls from people and is based on the symptoms reported when they call. The tool enabled a specially designed assessment to be carried out by a trained member of staff who answers the call.) We observed that when the assessment was completed a disposition outcome and a defined timescale were identified to prioritise the patients' needs. We noted that call advisors' were careful to check any ongoing referral had been sent from their system to the receiving organisation or staff member for action.

Requires improvement

Are services safe?

- Call advisors and clinicians also had direct access to a supervisor for support or advice if needed during a call through their telephony system. For example, we observed an advisor dealing with a difficult situation, who was able to directly call a team leader for support by raising her 'advice' notice. This allowed staff members who were having difficulty in managing a call to receive immediate assistance. Staff also accessed the advice of clinicians where the patient was not satisfied or did not accept NHS Pathway outcome or disposition.
- There were clear processes in place to manage the transfer of calls, both internally within the service, and to external providers, to ensure a safe service.
- Call response times, waiting times, abandoned call data were closely monitored throughout each shift and staff were deployed to manage demand at peak times. Team leaders had oversight of call types and these were triaged to ensure that those callers with more urgent needs were prioritised to ensure patient safety.

Staffing

- Prior to inspection we advised the provider we would look at organisational governance and management on the first day of inspection. We asked to see the staff files and were told that we were unable to do this as the person responsible was not there. On the second day of our inspection we reviewed documentation for four members of staff. Information was made available to us through paper documents and electronic files. We saw the tracking document for each new recruit which indicated when key documents had been received. We tracked the recruitment and documentation for four staff working in the service. We found evidence that some recruitment checks had been completed however, the records were incomplete and the provider was unable to locate all the documentation. For example, evidence of satisfactory conduct in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service were not available for all staff for whom it would be required. No further recruitment evidence had been submitted.
- We saw recruitment documentation had been sought and obtained for agency locum clinical staff from the agency that provided the staff. This allowed the service to closely monitor training and continuous professional registration of locum staff.
- Staff were provided with a safe environment in which to work, height adjustable work stations, specialised chairs and IT equipment were available to staff where appropriate. We were told staff undertook display screen awareness training as part of their induction although this was not documented within the training system. The call centre was clean; desks were spaced appropriately to ensure that call advisors were not distracted by other calls.

Monitoring safety and responding to risk

- Shift rotas were planned and implemented using a workforce management tool and staff were scheduled to work against forecasted/anticipated levels of demand. Staff skill mix was monitored daily and any shortfalls highlighted and acted upon. Rotas were prepared in advance to ensure enough staff were on duty. Arrangements were in place to assist in managing staffing levels at times of high demand such as bank holidays.
- The management, resourcing and supervising team leaders maintained a continual oversight of staffing levels and call demand on the service. This was measured across previous known levels of demand on the service. The staffing levels were adjusted where possible to meet the demand, for example, the service increased the numbers of staff available at weekends and bank holidays. Shift start times and lengths could be adjusted and breaks were planned to times of predicted lower demand within health and safety guidance on safe working.
- The service maintained a constant surveillance over the levels of demand on the service and monitored the numbers and conditions of the people waiting for a clinical advisor to call them back. Where possible calls taken by call advisors requiring further advice were warm transferred to a clinician but where this was not possible, the call was put into a call back queue which was monitored. This queue was assessed and some calls were prioritised to receive a clinical advisor call back within ten minutes; others to receive a call back within two hours depending on the presenting clinical need. We observed the service worked with another Vocare NHS 111 call centre location in Staffordshire so if callers were experiencing any delays, staff could support each other and provide calls for people from a different location to reduce the delay to the patient's assessment.

Requires improvement

Are services safe?

- We saw the local management did not have an oversight of risk assessments and safety checks for monitoring and managing risks to patient and staff safety. Risk assessments and health and safety documentation was not easily located and on 24 April 2017 staff were unable to advise us what risk assessments were in place and what actions had been undertaken with regards to an external health and safety review conducted in September 2016. There had not been a health and safety lead in post since 31 March 2017, the registered manager confirmed that a staff member was overseeing health and safety risks for an interim period. Most of the documentation was found for 25 April 2017, it was noted that the health and safety matrix was amended in the presence of the inspector. We found there was little evidence during the inspection of an established system or process to regularly assess and monitor risk and safety.
- There were organisational policies in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in an area accessible to all staff. At the time of our inspection when we looked at the poster we found it did not identify a local health and safety representative. This was raised with the registered manager. Subsequent to the inspection we were informed that the health and safety representative's name had been added. Fire drills had taken place at the Wellington house location however the provider was unable to evidence how many staff had attended these.
- All electrical equipment was checked to ensure the equipment was safe to use. The service had a variety of other processes in place to monitor safety of the premises such legionella (Legionella are bacteria which can contaminate water systems in buildings). We found that COSHH risk assessments for items used by the contract cleaners, were kept in the cleaning cupboard accessed by them. However, safety data sheets for the control of substances hazardous to health (COSHH) had not been completed for the cleaning products purchased by the service such as dishwashing powder.
- In addition there was no oversight of accidents which had occurred locally. The provider told us that staff accidents were recorded on a datix system, however the inspection team were not provided with the datix report for staff accidents, and when asked staff were unable to find a record of local accidents. Prior to the inspection we requested a copy of organisations public liability insurance. The document provided and the required display copy at the location on 24 April 2017 did not cover this service as they were out of date.The provider informed us this issue was later rectified.

Arrangements to deal with emergencies and major incidents

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

- The provider had been provided with a corporate business continuity plan to deal with emergencies that might interrupt the smooth running of the service. This included loss of mains power, loss of utilities, loss of staffing, evacuation of the building and loss of the Directory of Services. The service could operate if required from other locations which provided call handling services. This provided increased resilience and mitigated the risk of any potential loss of service. The registered manager was in the process of producing a local business continuity plan specific to the Wellington House site and its staff team.

Requires improvement

Are services effective?

(for example, treatment is effective)

Summary of findings

The provider is rated as requires improvement for providing effective services and improvements must be made.

- The service had not met all the National Minimum Data Set (standard eight)and Local Quality requirements for example, failure to achieve the percentage of calls answered within the 60 second time period. Action was undertaken where variations in performance were identified however, there was evidence that improvement was not sustained.The provider told us they had submitted a recovery action plan to the service commissioners with a trajectory for improvement by the end of August 17.
- Staff were trained to ensure safe and effective use of NHS Pathways. We found the call auditing programme did not meet contractual requirements.The provider told us call auditing had recently been delayed due to increase training of new staff but there was an action plan in place to rectify the backlog by the end of May 2017.
- Daily, weekly and monthly monitoring and analysis of the service performance was measured against key performance targets and shared with theclinical commissioning group (CCG) members. Account was also taken of the ranges in performance in any one time period.
- Staff received annual appraisals and personal development plans were in place; call advisors had the skills, knowledge and experience to perform their role, however we found that the yearly mandatory training for this group of staff had not always been completed.
- The training records for clinical advisors were incomplete and the provider could not demonstrate their clinical competence.
- Staff ensured consent, as required, was obtained from people using the service and appropriately recorded. There was an effective system to ensure timely sharing of patient information with the relevant support service identified for the patient and their GP.
- People's records were well managed, and, where different care records existed, such as special notes, information was coordinated.
- Staff used the Directory of Services (which was an online directory of local services with information about opening hours) to direct people to the appropriate services.
- Capacity planning was a priority for the provider. The provider undertook detailed call level forecasting to enable them to ensure adequate staffing levels could be delivered.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Wellington House assessed needs and delivered care using the NHS Pathways algorithm which reflected current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- We saw that the service had systems in place to ensure all staff were kept up to date. Staff had access to relevant clinical guidelines, and with NHS Pathways used this information to deliver care and treatment that met peoples needs. We saw the provider used varied means of communicating these guidelines to staff which included team meetings, workshops, printed information on workstations and information boards in the rest area.
- All call advisors and clinicians completed a mandatory training programme to become licensed in using the NHS Pathways software. When training was completed both call advisors and clinicians should be subject to a structured quality assurance programme in line with the requirements of any clinical decision support system (CDSS) licence. This should be a process which not only identifies where specific staff have gaps in skills and knowledge but also must allow for continuous improvement of all staff. The audit process should identify key areas where either additional training, modifications to existing training or feedback to software providers are needed. We saw the provider had recently trained an experienced call advisor to undertake call auditing however we were told that call auditing had not taken place as a regular occurrence and there was a backlog for call advisors dating to December 2016. The provider told us call auditing had recently been delayed due to increase training of new staff but there was an action plan in place to rectify the backlog by the end of May 2017.
- We asked about NHS Pathways audit levelling sessions for the internal auditors but were told that auditing standards were overseen nationally by the responsible officer and reported back to the local team. However, the audit process itself should be quality assured, as a minimum; there should be both internal and external review of auditors.
- The provider also sent recordings of calls which formed part of complicated complaints or significant incidents to NHS Pathways for review.
- Real time performance was monitored and action taken where performance of the service was at risk of performing below the expected standard one example being delays in answering calls within agreed timescales. Actions taken included changes in break times, contacting off duty staff members to rearrange their upcoming shift and offering overtime to staff to work beyond their present shift finish time.
- When staff were not able to make a direct appointment on behalf of the patient, clear referral processes were in place and seen by the inspectors. These were agreed with senior staff and a clear explanation was given to the patient or person calling on their behalf.
- Staff told us they had easy online access to policies, procedures, e-learning and supporting information such as Toxbase (a primary clinical toxicology database of the National Poisons Information Service) and hot topics (NHS Pathways updates).
- Call advisors had access to Language Line for people who did not have English as their first language.

Management, monitoring and improving outcomes for people

The service monitored its performance through the use of the National Minimum Data Set, as well as compliance with the NHS 111 Commissioning Standards.

The provider was issued with a Contract Performance Notice (CPN) by the Somerset Clinical Commissioning Group (CCG) in May 2016 because of the provider's failure to achieve the percentage of calls answered within the 60 second KPI (standard eight) from 26 February 2016. The provider demonstrated there had been progress in meeting the KPI relating to responsiveness of the service for calls answered within 60 seconds and percentage of calls abandoned after 30 seconds. However, the standard was only met for a short period therefore a new CPN was issued in December 2016. The remedial action plan (RAP) trajectory was due to be completed on the 6 March 2017. The target agreed within the trajectory failed to be

achieved and the remedial action plan trajectory was revised to achieve 95% by 30 May 2017. Due to the failure of the RAP the CCG had applied financial sanctions until such time the revised trajectory was delivered and sustained.

Data for calls answered within 60 seconds (for which the national target is 95%) Showed

for Somerset:

- December 2016, 86% of calls answered within 60 seconds, which was similar to the England average of 86%
- January 2017, 93% of calls answered within 60 seconds, which was better than the England average of 88%
- February 2017, 87% of calls answered within 60 seconds, which was lower than the England average of 90%

Data for calls abandoned (the national target is less than 5%) showed:

For Somerset:

- December 2016, 3% which was better than the England Average of 4%
- January 2017, 1% which was better than the England average of 3%
- February 2017, 2% which was similar to than the England average of 2%

The provider's performance in other areas showed:

- Data for Priority call back between 1.10.16 and 24.4.17 for Somerset was 47% of callers were called back in 10 minutes. (National data was 37% for February 2017)
- Home management (Dx25 disposition) for Somerset from October to end March 2016 was 3.9%. (National data was 6.1% for February 2017).

Effective staffing

Staff had the skills, knowledge and experience to deliver an effective service.

- The provider had an induction programme for all newly appointed staff. This covered such topics as information governance, health and safety, NHS Pathways training, safeguarding, call control, mental health awareness, performance and quality assurance processes, communication requirements and specific procedures relating to their place of work. We were told by call advisors they completed mandatory training e-learning modules such as equality and diversity and work station health and safety awareness, before they started operationally within their new role. However we found that the yearly mandatory training such as child safeguarding for the call advisors had not always been completed.
- We observed the training records for clinical advisors were incomplete and the provider could not demonstrate their clinical knowledge was up to date. We saw training post induction had only been recorded for two clinical advisors; only one clinical advisor had a date recorded for basic life support training. We noted this had been raised in the clinical advisor meeting (February 2017) for action by the clinical services manager, however no follow up date for training was recorded in subsequent minutes for March 2017.
- Call advisors told us their learning needs were identified through a system of appraisals, one to one meetings and reviews of service development needs. These staff had individual personal development plans and access to appropriate training to meet their learning needs and to cover the scope of their work. The call advisors and team leaders we spoke with had had an appraisal within the last 12 months.
- The provider ensured training was available to staff, for example, we were told about a university led training course to promote mental health awareness which two staff told us they had attended; and the provider had recently held a sepsis awareness day however, the records of who had attended were incomplete.

Working with colleagues and other services

Staff worked with other services to ensure people received co-ordinated care.

- The provider was aware of the times of peak demand and had communicated these to the ambulance service. This included the arrangements to alert the ambulance service when demand was greater than expected. It was recognised that the clinical decision support tool used in NHS 111 produced high rates of ambulance dispositions that may not always be necessary. The provider had an ambulance validation line.
- We reviewed a report detailing 'green 1' ambulance validation (a request for an ambulance to attend with a response time of 20 minutes) between September 2016

Requires improvement

Are services effective?

(for example, treatment is effective)

and April 2017. The service had 7126 green ambulance dispositions; 64.1% were validated by the clinical advisors (4565). This initiative provided the service with reassurance that ambulance despatch requests were appropriate.

- There were arrangements in place to work with social care services including information sharing arrangements. Evidence was seen that information was available to ensure that safeguarding concerns followed the correct referral pathway for each of contracted local authority areas.
- Staff knew how to access and use patient records for information and when patient or health professional directives may impact on another service for example, advanced care directives or do not attempt resuscitation orders.
- The provider had systems in place to identify 'frequent callers' and staff were aware of any specific response requirements. The provider had a clear operating procedure to deal with these and when required had met with these individuals to explain the purpose of the 111 service. They encouraged the individuals to contact other services which could be more appropriate for their needs. They also explained the impact their frequent calls may have on other people trying to contact the service.
- Information about previous calls made by people was available so staff could access this information and discuss any relevant issues with people and assist them in the decision making for that specific call.

Consent

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, Deprivation of Liberty Safeguards 2007 and Gillick competency for children and adolescents. Staff had received training in these areas as part of their induction and as part of their on-going development.
- Access to patient medical information was in line with the patient's consent. We listened to calls to the service in the centre. Throughout the telephone triage assessment process the call advisors checked the patient's understanding of what was being asked. People were also involved in the final disposition (outcome) identified by the NHS Pathways and their wishes were respected. Should a patient decline the final disposition their call was transferred to a clinician for further assessment.
- Staff were also aware of when they may need to share information against the patient's wishes, such as in cases where people were suicidal and threatening to harm themselves, or where others may be at risk. Staff were also aware of patient confidentiality when information related to a third party and when this had been breached we saw it recorded as an incident and then investigated.

Good

Are services caring?

Summary of findings

The provider is rated as good for providing caring services.

- People using the service were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We observed staff treat people with kindness and respect, and maintained the caller's confidentiality.
- We heard staff listened carefully to information that was being told to them, confirmed the information they had was correct and supported and reassured callers when they were distressed.
- Staff obtained the patient's consent when it was necessary to share information or had their call listened to.
- We found that the provider met contractual obligations when seeking people's feedback.

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to people calling the service and treated them with dignity and respect.

- Staff were provided with training in how to respond to a range of callers, including those who may be abusive. All the caller interactions we heard were non-judgmental and treated each patient as an individual whatever their circumstances. We spoke with call advisors about the frequent callers who explained that they dealt with them in the same way as all other callers.
- The Wellington House NHS 111 service was part of the NHS England- GP Patient Survey published in July 2016 for Out of Hours services. This contained aggregated data collected from April-September 2016.In the Somerset Clinical Commissioning Group area 86% of patients had confidence and trust in the NHS service staff; 70%England average of 67%.
- The provider informed us that they undertook the NHS Friends and Family test (combined) for the NHS 111 and Out of Hours service and reported this monthly. We saw that for the period 01/02/2017 to 28/02/2017 the responses indicated 90% would recommend the service.
- The provider undertook the contractual telephone six monthly telephone survey of people who had used the service. The results for the period covering October 2016 – April 2017 from 174 respondents were that 3% of respondents were dissatisfied with the service siting timeliness as an issue, whilst 93% were satisfied with the service with comments about the direct access to information and the skill of call advisors dealing with anxious people.

Care planning and involvement in decisions about care and treatment

- We saw that staff took time to ensure people understood the advice they had been given, and the referral process to other services where this was needed. This included where an appointment had been made by the NHS 111 service with another service.

Good

Are services caring?

- We heard people's preferences being accounted for during calls and we observed call advisors checking that people had understood what had been said to them, and that they understood the next steps for their treatment. People were offered information about the healthcare services which were local to them to access.
- We found the service could access special notes or care plans, where the patient's usual GP shared information about their patients who might need to access the local GP out-of-hours service, such as those nearing end of life or those with complex care needs.The use of care plans supported person centred care sharing an individual's wishes in relation to care and treatment. Care plans, where in place, informed the service's response to people's needs, though staff also understood that people might have needs not anticipated by the care plan.

Patient/carer support to cope emotionally with care and treatment

- Call advisors and clinical advisors were clear on the standard operating procedures in place which detailed the actions they would take in the event that a patient declined the final disposition.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The provider is rated as good for providing responsive services.

- The service had long and short-term plans in place to ensure staffing levels were sufficient to meet anticipated demand for the service.
- There was a comprehensive complaint system and all complaints were risk assessed and investigated appropriately. There was a designated person and team responsible for handling complaints. However, learning from complaints was not consistently shared with staff.
- Action was taken to improve service delivery where gaps were identified.
- Care and treatment was coordinated with other services or providers.
- Staff were alerted, through their computer system, to people with identified specific clinical needs and special notes or any safety issues relating to a patient.
- The service engaged with the clinical commissioning group to review performance, agree strategies to improve and work was undertaken to ensure the Directory of Services (DOS) was kept up to date. (The DOS is a central directory about services available to support a particular person's healthcare needs and this is local to their location).

Our findings

Responding to and meeting people's needs

- The service engaged with the clinical commissioning group (CCG) to secure improvements to services where a need for these was identified.
- The service was provided 24 hours a day, 365 days a week.
- The service continually analysed the demand on services and adjusted the levels of staffing according to predicted demand. For example, staff numbers were increased during known busy periods such as weekends, bank holidays and during major sporting events. Flexibility had been built into the system such as flexible start times, and various shift lengths. These were monitored and adjusted as required.
- The provider described the steps they took to ensure that the care pathways were appropriate for people with specific needs. The service had a system in place that alerted staff to any specific safety or clinical needs of a patient, this included special patient notes and patient specific care plans.
- There were translation services available and all staff we spoke with were confident in accessing this service for callers who did not have English as their first language.
- The service used text talk for people with a hearing impairment.

Tackling inequity and promoting equality

- The service engaged with people who were vulnerable and took action to remove barriers when people found it hard to access or use services. For example, during their induction staff had training on factors which could affect access. These included people who needed assistance to communicate or people living with dementia. Other training was provided on areas that could impact on a patient's welfare for example, domestic violence or radicalisation.
- New staff received training in equality and diversity during their induction.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The provider was monitored against the National Minimum Data Set (MDS) (A national tool to benchmark provider performance) overall performance was similar to national averages.
- The telephone system was easy to use and supported people to access advice.
- The service had a dedicated clinical advice line to support clinical advisors.
- People mostly had timely access to advice, including from a call advisor or clinical advisor when appropriate.
- The service prioritised people with the most urgent needs at times of high demand and could triage patients waiting for the call back service in order of priority.

Referrals and transfers to other services were undertaken in a timely way. We saw examples of referrals sent automatically through secure information systems and examples of timely referrals to different health and social care providers. Wellington House NHS 111 call centre was co-located with the Out of Hours service call handling services .The had a positive effect ensuring prompt referrals, for example, the team leaders were trained to work in both services. At the start and during their shift the team leaders liaised with each other to understand effects of calls on each service. They also oversaw the 111 call back queue and would transfer clinical advice calls over to their GPs if there was capacity.

Listening and learning from concerns and complaints

- The provider had a process in place for handling complaints and concerns. Information about how to complain was available and easy to understand and evidence showed the provider responded to issues raised.
- Data since March 2016 provided by Wellington House indicated there were 45 complaints which included feedback from health care professionals. Complaints were categorised and we saw timeliness, communication and staff attitude were the most common concern raised. Appropriateness of referral was the most common reason for health professional's feedback to the organisation and was related to the triage outcome using the NHS Pathway. Complaints were included in the Wellington House Performance and Quality Report monthly report, which was reported externally via the Integrated Urgent Care Board.

We looked at all the complaints received in the last 12 months and sampled one in detail. We found complaints were dealt with openness and transparency. We saw examples of the communication throughout the complaint process to involve and update the complainant about any action being undertaken. In response to patient complaints about issues with attitude and behaviour,the provider set up customer training sessions to improve staff communication skills.

We saw some learning from this process for example, following several mis-communications to district nurse teams action was taken to introduce a new process for a 'district nurses queue'. A despatcher received and was allocated referrals to centralise the process and ensure that they were sent to the relevant team. Despite this there was limited evidence that learning from complaints was widespread.

Are services well-led?

Inadequate

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

Summary of findings

The provider is rated as inadequate for being well-led and improvements must be made.

- 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.
- The provider had a vision but not all staff were aware of the vision and their responsibilities in relation to it. There was a documented leadership structure and most staff felt supported by management.
- We found the arrangements for quality assurance were not strong enough to support sustained improvement.

Our findings

Vision and strategy

- The provider had a clear vision to provide a service which was making a difference to people and deliver a high quality service.
- The service had a strategy and supporting business plans that reflected the vision and values and were regularly monitored. In addition the regional director had an action plan to address areas of known concern and risk.

Governance arrangements

Wellington House NHS 111 was 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 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, 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.

We found:

- Whilst the provider had a good understanding of their performance against National Quality Requirements they had not responded in a timely manner to the staffing shortages that resulted in them failing to attain the requirements. We noted that a recruitment plan had been put in place and that appointment of new staff had improved in the three months prior to inspection. Data showed progress in filling vacancies and shifts to bring the service back to a level where quality requirements could be achieved.
- Monitoring the quality of the call handling through auditing was irregular with a backlog dating from December 2016.
- The provider offered a wide range of training opportunities; however the spreadsheet we were shown as evidence of training was incomplete. For example, we saw that staff had undertaken some mandatory training

Are services well-led?

Inadequate

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

as part of the induction process but the spreadsheet indicated that this had not been updated and was out of date. This was in contravention of the Vocare statutory and mandatory training matrix. We were also told about specific workshops for staff such as the sepsis workshop, but no names of attendees had been noted on the training record.

- There was limited evidence that learning from incidents and complaints was widespread; the minutes for meetings of clinical advisors indicated low attendance. However, it was noted from the January 2017 meeting minutes of clinical advisors that they raised that when there was only one clinical advisor on duty 'warm transfers' could be suspended and this could present a clinical risk because of a delay to patients receiving a clinical assessment. No further information was available of how this risk was mitigated.
- 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 clinical workforce such as with safeguarding training.
- Wellington House participated in the Vocare national quality monitoring programme against internal targets as well as clinical commissioning group contractual targets. The service had produced a remedial action plan where shortfalls had been identified. The version of the action plan initially shown to the inspection team was version 1.1 dated 11.4.17 and was in draft format. The non draft document was dated 25.4.17 and was provided on day two of our inspection, however there was no evidence provided to demonstrate it had been implemented

Leadership, openness and transparency

There was a local leadership structure with both operational and clinical leads within the service. However some of the responsibilities for the service were managed at organisational level an example being the reporting of significant events which is overseen at an organisational level. The local leadership team demonstrated they were committed to promoting a culture of working together and openness. Staff we spoke with in a variety of different roles knew who their team members were and there were effective systems of communication and supportive working implemented.

- Staff had access to their team leaders and senior managers.
- Operational staff were clear who to go to for guidance and support. Staff told us the leadership team were supportive.
- There were arrangements in place to provide support to staff in the event of any traumatic event or serious incident. For example, we were told that during staff induction examples of potentially difficult calls or situations were discussed. Staff were advised how to gain support from their line managers. Team leaders were visible and responsive to call advisors. We saw, when needed, staff received immediate assistance and support with calls that were traumatic or required further support. Notices in the communal staff areas highlighted the importance of seeking support and help if they had experienced any difficult or traumatic calls. Staff we spoke with was aware of the 'well-being' support available.
- Statutory Notifications had not been received from the service in respect of significant events, deaths and safeguarding.

Public and staff engagement

The service engaged with the public through the contractual patient surveys, and had a range of options to give feedback or raise complaints of concerns through their website. Views of staff were sought through a range of methods such as supervision meetings, team meetings and included both clinical and non-clinical staff. The staff we spoke with were clear on their role and responsibilities and their contribution to the NHS 111 service to deliver high quality care and promote good outcomes for people.

- Staff were provided with opportunities to feedback formally through one to one meetings, staff surveys, staff forum meetings and yearly appraisals where staff were asked to provide feedback on the working conditions, training and development, and their overall job satisfaction.
- The service had restarted the 'Employee of the month' award in April 2017 and this was promoted in the regional newsletter.
- The provider had commenced a recent staff survey (April 2017) to obtain feedback on morale, key dislikes and key likes for staff as well as the chance to give

Are services well-led?

Inadequate

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

feedback on other issues. We observed there was a supportive culture evident in the call centre and across administrative, managerial and frontline staff. Compliments received about service were shared with staff.

Continuous improvement

There was a focus on contractual target improvement within the service. The service maintained a risk register in order to identify and take preventative action and promote service resilience.

There was a wide range of learning opportunities available to staff, which supported their professional development.

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 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 18 HSCA (RA) Regulations 2014 Staffing The service provider did not do all that was reasonably practicable to ensure staff received performance reviews and/or appraisals that are necessary for them to carry out their role and responsibilities. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.