Wellington House

Quality Report

Wellington House
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This service is rated as Inadequate overall. The service was rated as inadequate at our previous inspection in April 2017.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Inadequate

Are services well-led? – Inadequate

Following our comprehensive inspection at Wellington House on 24 and 25 April 2017 the location was rated as inadequate for the Somerset Out Of Hours (OOH) service with an inadequate rating for the safe, effective and well led domains, good for caring and requires improvement for responsive. Our levels of concern following that 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 of publication of the previous report to avoid CQC taking steps to cancel the provider's registration.

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. On 17 May 2017 we issued two 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. The provider was required to make improvements in respect of these specific deficits with a date to be compliant by 18 August 2017.

A focused follow up inspection was undertaken on the 24 August 2017 to assess if the regulatory breaches had been met in regard of the warning notices. We did not find full compliance with the warning notices and we issued further warning notices in regard of: Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment; Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance and Regulation 18 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Staffing. The provider was required to meet the requirements of the warning notices, issued on 28 September 2017, by 15 November 2017.

We inspected the service on three days. A comprehensive inspection was carried out on the 16 and 17 November 2017 as part of an announced comprehensive inspection. In addition as part of this visit, we carried out an unannounced inspection on 11 November 2017 to Shepton Mallet Hospital and Bridgwater Hospital two of the five Somerset OOH treatment sites following information of concern received by the CQC.

Summary of findings

Prior to our inspection the CQC had met regularly with the provider in meetings led by Somerset Clinical Commissioning Group to discuss actions in relation to the provider's improvement plan and to have an oversight of actions undertaken by the provider in relation to the warning notices issued by us. Our key findings from this inspection were as follows:

- We found insufficient improvements had been made to manage risks relating to the health, welfare and safety of people, including completion of training for basic life support, fire safety and evacuation and infection prevention and control.
- With regard to medicine management, the systems to securely store and monitor prescriptions and medicines including controlled medicines remained inadequate.
- Patients care needs continued to not always be assessed and delivered in a timely way according to need. The service had not met all the National and Local Quality Requirements used to monitor safe, clinically effective and responsive care. For example, waiting times for some clinical assessments, and safe staffing levels did not show sustained improvement.
- Since our previous inspection in August 2017 there had been substantial changes within the leadership team. The registered manager and the regional director for the service were no longer in post. We found there were areas where the management of the service required further improvement and stability. The provider had installed a transitional management and support team at Wellington House to address the failings of the service. The team had identified several areas for improvement however, at the time of the inspection, not all of these actions had been implemented.
- The provider had taken steps to implement some changes in relation to the significant concerns set out in the warning notices but had not met the requirements. However the implementation of an overarching governance framework for systems and processes, including the action plan following our previous inspection concerns were not effective enough to sustain the quality of the service and to promote continued local development and improvement.

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

Importantly, the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure that serious incidents, deaths or safeguarding referrals are subject to statutory notifications to the Care Quality Commission.

The provider should:

- Consider implementing a process or audit to monitor the process for seeking and recording consent.
- Improve the accessibility to the service for patients with a hearing impairment.

This service was placed in special measures in August 2017 in order for the provider to take steps to improve the quality of the services it provided. We found insufficient improvements have been made such that there remains a rating of inadequate for safe, effective and well-led. In addition the responsive domain has now been rated as inadequate. Therefore we are taking action in line with our enforcement procedures to impose conditions on the registration of the Wellington House location for Somerset NHS 111 and Somerset OOH services. This will lead to a variation of the conditions of the registration.The service will be kept under review and if needed measures could be escalated to urgent enforcement action.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- 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

- Consider implementing a process or audit to monitor the process for seeking and recording consent.
- Improve the accessibility to the service for patients with a hearing impairment.

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 three GP specialist advisers, two CQC inspectors and an inspection manager.

Background to Wellington House

Wellington House is part of the Vocare Group. This service provides a GP led Out of Hours (OOH), known locally as Somerset Doctors Urgent Care (www.somersetduc.nhs.uk) and provide a service 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. 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. 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 significant proportion of the Somerset population do not have access to their own transport, particularly in Sedgemoor, West Somerset and Taunton Deane.

The GP led Out of Hours service provides telephone triage and face-to-face consultations to patients across Somerset and is accessed through NHS 111. 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 (OOH) service there are five OOH sites which open at varying times and days; the locations are:

- 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 receive contact with the service each weekday and 550 patients receive contact at weekends.

Inadequate

Are services safe?

Our findings

At our previous inspection undertaken on 24 and 25 April 2017 we rated the safe domain as inadequate. Our substantial concerns with some aspects in the safe domain led us to take further steps to ensure the provider made changes to reduce or eliminate the risks to patients.

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

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. We issued further warning notices in regard to:

- Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment.
- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.
- Regulation 18 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Staffing.

We rated the service as inadequate for safe. At this inspection we found:

Safety systems and processes

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

- The provider had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. Although the provider conducted safety risk assessments we saw a situation where staff had been directed to undertake new processes, without an effective and comprehensive risk assessment in place to identify, understand and address the risk to the health and safety of patients and staff. This meant the service was not following the organisations policy.
- The provider had systems to safeguard children and vulnerable adults from abuse. At our previous inspection undertaken in April 2017 we saw that safeguarding referrals had not resulted in statutory notifications to the Care Quality Commission. We previously spoke to the service about their legal duties to notify us and issued warning notices. We have not received those requested statutory notifications. We reviewed the incident reporting system and found that the service continued to fail to notify us of safeguarding incidents and to be compliant with the required Regulation by 15 November 2017.
- The service worked with other agencies to support patients and protect them from neglect and abuse. For example, clinical staff told us about referrals they had made to child protection services. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Most staff had received up-to-date safeguarding and safety training appropriate to their role. Staff we spoke to knew how to identify and report concerns. It was unclear if all staff who acted as chaperones were trained for the role. 96% of receptionists had received chaperone training. However despatchers covered OOH sites when no reception cover was available and we received contradictory information around which of the despatchers who undertook reception roles had completed chaperone training. Collaborative evidence of training completion was not available. All staff who undertook reception duties including chaperone roles had received a DBS check.
- There was an improved system to manage infection prevention and control measures. At the Out of Hours (OOH) sites we saw areas that continued to require improvement such as dirty medical equipment boxes, dust and debris in vehicles that house medical equipment and a lack of clinical disinfectant wipes to clean equipment.
- We found some medical equipment with no evidence of calibration. During this inspection an asset register of clinical equipment was put in place and the medical equipment we had found to be out of date removed and

where possible replaced. We were unable to verify this during our inspection. Spare equipment at the OOH sites was not always available. Medical devices such as Volumatics (used to ensure patients get optimum medicines for their asthma) and Pulse Oximeters (used to measure blood oxygen levels) were missing from equipment boxes. This meant clinicians may not have access to the correct equipment to monitor and treat patients. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- 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. However safe staffing levels were not always achieved. For example, on 30 October 2017 we saw Bridgwater OOH did not have any clinical cover from 7pm until 8am which meant patients may have had to travel to another OOH site if they required a face to face appointment when one was not available locally.
- We reviewed the OOH rota for September and October 2017 and saw vacancies within the rota for OOH clinicians. The workforce shift analysis carried out by the provider confirmed there were unfilled shifts and gaps within clinical staffing which impacted on the service being able to provide a timely service. Since our previous inspection in August 2017 unfilled clinical shifts remained at approximately 20% (excluding the Minehead Hospital OOH site which had 87.5% unfilled shifts). In September 2017 there were unfilled shifts and gaps within clinical staffing of 18% which showed a slight reduction. During September 2017 the Minehead OOH site had 100% unfilled shifts. This showed an increase in unfilled shifts at Minehead OOH site from 87.5% in the period July and August 2017.
- For November 2017 we saw improved clinical shift fill for the weekends pre and post our inspection however there was no evidence that this was sustainable as there continued to be unfilled shifts after this time. The service had produced a remedial action plan where shortfalls in staffing had been identified however the service had failed to show sustained improvement in staffing..
- 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 our previous inspections we raised concerns with the service as this meant staff had not undertaken the necessary fire evacuation training in order for them to identify alarm systems and evacuation processes specific to locations where the OOH service was being provided. We spoke with the management team and staff who worked at OOH sites who told us the service had not implemented site specific fire evacuation training. During this inspection fire safety training was organised for one of the five OOH sites.
- During our inspection we spoke with a member of staff who had not worked at their assigned OOH site before. Staff there were unaware of an induction process to ensure that new members of staff was aware of processes to manage risks specific to that site such as a medical emergency or a fire.
- Clinical staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. We found emergency equipment was kept in separate locked cupboards to emergency medicines. This meant that in an emergency staff had to access a locked room and two separate locked areas within this room in order to collect equipment to treat patients in a medical emergency.
- At our previous inspections non-clinical staff we spoke with had told us they had not received face to face 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. Staff we spoke with continued to tell us they had not received face to face BLS training including use of the defibrillators. We were provided with an email to show that three non-clinical and one clinical BLS face to face training event had taken place in August 2017. A register of the staff names and job roles who had attended the training was not available. This meant we were unable to clarify how many non-clinical staff had received the recommended training to adequately respond to a life threatening situation such as a cardiac arrest or choking.

- Clinical staff we spoke with knew how to identify and manage patients with severe infections, for example sepsis. We observed that there was additional information on work stations and in the OOH diagnostic boxes relating to sepsis identification.
- Staff told patients when to seek further help such as if there condition changed or worsened.

Information to deliver safe care and treatment

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

- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with up to date evidence-based guidance. However clinicians told us, during times of high demand or limited clinical support, patients could wait longer to receive appropriate care and treatment. This meant we could not be assured that patient safety was not affected.

Safe and appropriate use of medicines

Systems and arrangements for appropriate monitoring and safe storage did not always minimise risks.

At our April 2017 inspection we found the monitoring systems in place for blank prescription forms and pads were not adequate to be able to track their use. Following that inspection we were notified by NHS England that prescriptions were being used fraudulently and that those prescriptions had been obtained from the Somerset OOH service. During our August 2017 inspection we reviewed changes the service had made to the security arrangements for blank prescriptions at four OOH sites and found detailed incidents of missing blank prescriptions as well as incomplete tracking records.

At this inspection we found the new tracking system showed improved documentation of the distribution of green prescriptions (used to prescribe medicines dispensed by a community pharmacy) that were given to patients. The system continued to demonstrate concerns with the tracking of these prescriptions. For example, we found individual green prescriptions were missing from the packs given to clinicians for use on site and there was no entry in records to show whether these had been issued to patients. A process had not been implemented to track individual purple prescription forms (used by OOH providers to record items supplied directly to a patient and not dispensed through a community pharmacy). This meant it was not always possible to reconcile which medicines had been used for what person unless individual patient records were audited.

During our August 2017 inspection we were concerned by evidence within the incident reporting processes that showed medicines were being left unattended and medicines cupboards were being left opened in the out of hours sites. In November 2017 Somerset Clinical Commissioning Group advised us they had found a medicines cupboard at one OOH site left unlocked with the key in place within a room that was left open despite a key code access. We visited four OOH sites and found one site where the door to the medicines room was open and the key in place in the medicines cupboard. At two other sites keys to the medicines cupboard were left unattended in the cupboard doors. One member of staff told us they had recently found room with medicine cupboards unlocked and opened. Another member of staff told us they had arrived for an evening shift to find the medicines cupboard had been left open since 8am when the previous shift had left. This meant medicines had been accessible to people visiting the hospital site during the day and when the area was used for a different service.

Processes were in place for checking medicines, including those held at the service and also medicines for the Out of Hours vehicles. Staff did not keep dated recordings of stock level checks and we could not find full evidence that the stock level checking system was fully implemented. During our visits to OOH sites we found a stock list for medicines at the OOH sites were not always available. Medicines boxes within vehicles did not routinely carry a list of medicines they contained. We were provided with a medicines list that did not reflect the medicines we found in the vehicle boxes.

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. At the time of our inspection Vocare did not have a head of medicines management. This meant there were no clear lines of responsibility and accountability for controlled drugs within the service.

At our previous inspections we found the record books for controlled drugs (CD) for Schedule 2 medicines at Somerset OOH sites were not always completed correctly and in line with legislation for managing and using controlled drugs. During this inspection, at one OOH site we found inconsistencies with the completion of the Schedule 2 and 3 record books for medicines such as Diazepam, Tramadol and Diamorphine. For example, entries for removal or additions of medicines were not always completed correctly. This meant the service was not complying with the UK controlled drugs legislation and regulations the safe management of controlled drugs. There were not robust systems and processes in place to provide assurance that the controlled drugs management system were safe.

We also had difficulty locking the CD cupboard and had to seek assistance from a member of non-clinical staff to lock the door. We were told by staff that the difficulty with the lock had been reported approximately three months previously. Following our inspection the provider has confirmed the cupboard lock had been rectified.

Staff prescribed, administered or supplied medicines to patients. They told us they gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship

The CQC received a number of statutory notifications in which the provider identified that some patients requiring end of life care did not receive prompt access to pain relief and other medicine required to control their symptoms due to the service failing to meet home visit timescales. The service was aware of the difficulties they faced in relation to delays in care provision. A comfort call process was in place to manage these delays however the service was not meeting the agreed performance target set between Vocare and Somerset CCG.

Track record on safety

The service had improved the governance and oversight of safety since our previous inspections:

- There were risk assessments in relation to safety issues. A local health and safety lead had recently been appointed and actions resulting from our previous inspections were completed. For example, an independent health and safety risk assessment had taken place at each of the OOH sites. Resulting actions included on-going monitoring for lone working including regular contact from shift supervisors and the introduction of safety devices staff can trigger for an emergency response.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations and monitored by Somerset Clinical Commissioning Group. For example, the service reviewed referrals to the ambulance service in a twice weekly meeting with the ambulance service provider.
- We were given evidence of their involvement in the winter contingency planning for the Somerset area with other health and social care providers. However, it was also noted that the provider did not have their own winter contingency plan for Wellington House in the event of a winter emergency situation, such as staff not being able to get to work in the event of inclement weather.
- Some areas such as complaints and lessons learnt from significant incidents required further improvements such as the wider sharing of learning across the service.

Lessons learned and improvements made

- The provider had processes for reviewing and investigating when things went wrong. We looked at the incident reporting system and saw delays within Vocare processes for the completion of incident investigations. For example, since August 2017 approximately 21% of incident investigations had not been completed in line with their own stated policy.
- There was a system for recording and acting on significant events and incidents. Although we saw that not all incidents were recorded. For example, minutes from a Somerset OOH site team meeting indicated an incident where a child was booked into the Somerset OOH site without there being a clinician on duty. This incident was not found within the incident system which meant the service were unable to take action and learn lessons to improve the service.
- Although the regional clinical director had arranged clinical sessions at other Vocare locations to share

lessons and recommendations following a series of failures to recognise significant clinical warning signs, there was little evidence that learning from safety events were shared routinely across the organisation. For example, when incident investigations related to a Somerset patient but the staff involved worked in another of Vocare's organisations the incident was listed on the local service's incident system but they did not have access to the action plan and lessons learnt that resulted from the incident being investigated elsewhere.

- There was no clear process in place for sharing any learning with staff following an incident or complaint to improve the service. On the occasions that information was shared with staff there was no system to confirm staff had read the recommendations or had changed practice as a result.
- Staff we spoke with understood their duty to raise concerns and report incidents and near misses. Two clinicians told us they had raised incidents to the service via the incident reporting process and had not received feedback of any actions, outcome or learning.
- We saw that reflective statements completed by staff as part of the incident process were not always completed. In addition no records are kept that the feedback or learning from incidents took place.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 24 and 25 April 2017 we rated the effective domain as inadequate. Our substantial concerns with some aspects in the effective domain led us to take further steps to ensure that the provider made changes to the service to reduce or eliminate the risks to patients. 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. We issued further warning notices in regard of:

- Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment.
- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.
- Regulation 18 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Staffing.

We rated the service as inadequate for effective. At this inspection we found:

Effective needs assessment, care and treatment

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

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed through clinical consultation reviews.
- Additional telephone assessment training had been provided by the regional clinical director at another Vocare location; however, staff in Somerset had not yet received this training. We were told the service was working with Somerset Education Trust to provide dangerous diagnosis training to clinicians.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example, the patient record system had special notes for those patients requiring specific care.
- There was a system in place to identify frequent callers and patients with particular needs, for example, patients requiring palliative care, and care plans/ guidance/protocols were in place to provide the appropriate support. We saw no evidence of discrimination when making care and treatment decisions.
- Technology and equipment were used to improve treatment and to support patients' independence. For example, OOH clinicians had access to vital information within GP patient records via Emis web. (Emis web is an integrated patient record system used in Somerset for all patient GP records).

Monitoring care and treatment

From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQR) for out-of-hours providers. (The NQR are used to show the service is safe, clinically effective and responsive). Providers are required to report monthly to their clinical commissioning group (CCG) on their performance against the standards which includes: audits; response times to phone calls: whether telephone and face to face assessments happened within the required timescales: seeking patient feedback: and, actions taken to improve quality).

We looked at the NQRs, which provide a clear and consistent way of assessing performance as they help inform our decisions about the quality of care. In particular we looked at the indicator for the National Quality Requirement (NQR) 12 which provides timescales for patients to receive face to face clinical appointments following a definitive clinical assessment (whether in an OOH site or in the patient's place of residence). We looked at these as our previous inspections had shown the service was not compliant with these targets. We looked at data for September and October 2017 with regard to NQR12. We saw there were177 occasions when the target had not been met September 2017 and 178 occasions in October 2017. This led to the local clinical commissioning group requesting a review of these failures to meet the required targets. As a result four cases were being investigated

Inadequate

Are services effective?

(for example, treatment is effective)

under the provider's serious incident policy. The service was unable to demonstrate ongoing improvement in timescales for patients to be seen since our previous inspections, and how clinical capacity was impacting on timescales for patients to have a face to face appointment.

Since our inspection in April 2017 there was some improvement in some areas such as NQR12 c: which is that a clinical assessment at an OOH site should be undertaken for all urgent care patients within 6 hours. Other areas such as NQR12e: a clinical assessment for all urgent care patients would be undertaken at the patient's home within two hours showed deterioration. Targets for NQR12b,e,f were below the 95% contracted target:

- Data showed that in September 2017 88.9% of patients at higher risk were seen within two hours at an OOH site (NQR12b) against a target of 95%. In October 2017 this reduced to 82.7%.
- In September 2017 70.3% of patients at higher risk requiring a home visit were seen within two hours against a target of 95%. In October 2017 this reduced to 67.5%.In September 2017 the service had provided 51% less home visits when compared to contract expectations for the area.
- The OOH service had its busiest periods over a weekend when patients did not have access to their own GP service. Data provided by the service indicated that most of the breaches in meeting targets occurred during weekends.

The service was meeting five of the six locally agreed quality targets (LQR) as set by its commissioner. The service continued to not fully meet the target LQR2: the service has a safe and effective system for prioritising clinical assessment of calls other than an emergency within 120 minutes of the call being answered. Although the service could demonstrate an improvement in meeting the target since August 2017, data showed that in September and October 2017 81.9% of patients received a call back within the timescale.

Since our previous inspection an organisational lead for clinical audit had been appointed. We reviewed the evidence for clinical quality improvement through clinical audit and found that an audit programme had been introduced since our previous inspections but this mostly contained quality assessment processes such as infection, prevention and control and vehicle audits. We saw medicines audits, which demonstrated clinical effectiveness to meet national standards, such as antimicrobial prescribing. There was little evidence, with the exception of clinical assessment of individual performance, of audits that measured clinical outcomes and best practice to improve the quality of care. Audits were not always dated and authored and timescales for action not recorded. There was a lack of evidence as to how the service was empowering and engaging all clinical staff to participate in clinical audits to analyse and identify opportunities to drive improvements in quality of care.

At our previous inspection we told the provider the level of activity for auditing both face to face consultations through patient record audits and clinical call audits were insufficient to effectively monitor the quality of work of each clinician working within the service. During this inspection we saw that the service had reviewed the regularity by which the GP call and notes audits were carried out. Clinicians confirmed these had been increased and personal reports had been sent to them.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. For clinicians working remotely, the service had produced a guide to Somerset to help them understand patient demographics and local geography.
- The provider ensured that all staff including GP registrars worked within their scope of practice and had access to clinical support when required. The service had recently appointed four GPs to act as leads and to support the clinical performance processes.
- Up to date records of skills, qualifications and training were not easily corroborated. For example, the provider's training system did not did not correlate with evidence or collaborate within staff files such as certification or confirmation of attendance at training. Although we saw improvements in completion of the provider's mandatory training the service did not provide evidence that staff had attended all the training as listed on the matrix. For example, there was approximately a 62% completion for infection, prevention and control training.

Inadequate

Are services effective?

(for example, treatment is effective)

- The provider had a process to provide staff with ongoing support; this included appraisal. Information relating to most staff appraisal, provided pre-inspection, could not be corroborated onsite and we were told by the provider's support team that it was inaccurate.
- At our inspection in April 2017 50% of salaried GPs had received a performance review within the last two years. We spoke with the clinical director who showed us that 98% of salaried GPs had now completed the process. Clinicians told us they had received a recent performance report.
- The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making.

There was a clear approach for supporting and managing staff when their performance was poor or variable. For example, It had been recognised as part of a significant event process that one clinician had missed potential life threatening symptoms during a telephone consultation. This clinician was involved in a supportive process to review their performance.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- There were established pathways for staff to follow to ensure callers were referred to other services for support as required. For example, if a patient required admission to hospital or a home visit by a district nurse.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and where possible took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them.

Helping patients to live healthier lives

Staff told us they supported patients to manage their own health and maximise their independence.

- The service identified patients who may be in need of extra support. For example, those patients who were isolated or vulnerable.
- Where appropriate, staff gave people advice so they could self-care.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

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

Good

Are services caring?

Our findings

At our previous inspection on 24 and 25 April 2017 we rated caring as good.

We rate the service as good for caring.

Kindness, respect and compassion

Staff we observed treated patients with kindness, respect and compassion.

- Staff displayed an understanding and non-judgmental attitude to all patients.
- We observed receptionists giving people they telephoned to book appointments at OOH sites clear information.
- There were arrangements in place to respond to those with specific health care needs such as end of life care and those who had mental health needs. We saw most of these patients received care in a timely way such as attending a patient requiring end of life care however there were exceptions. For example, when the service failed to meet the timescales required for urgent home visits for patients with end of life care needs such as pain management.
- We spoke to three patients who told us they had been treated with kindness and respect.

Involvement in decisions about care and treatment

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

- Interpretation service's were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Previously in April 2017 we told the service they should make improvements for people with a hearing impairment as there were no facilities available such as a hearing loop system. At this inspection we saw access to people with hearing impairment had not improved. British sign language interpreters could be booked via a specialist service. We spoke to this service who advised us that advanced booking rather than on the day interpreters were available.
- We spoke with three patients who told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff had access when necessary to the services NHS 111 DOS. The DOS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- There was no specific process or audit to monitor the process for seeking consent.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 24 and 25 April 2017 we rated the responsive domain as requires improvement. Our substantial concerns with some aspects in the responsive domain led us to take further steps to ensure that the provider made changes to the service to reduce or eliminate the risks to patients.

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 eliminating risks to patients. We issued further warning notices in regard to:

- Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment.
- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.
- Regulation 18 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Staffing.

We rated the service as inadequate for responsive. At this inspection we found:

Responding to and meeting people's needs

We found the service was not always responsive to patients' needs. Identified patient needs were not always being met in a timely manner as data in this report indicates.

- The provider engaged with commissioners to secure improvements to services where these were identified. For example, an action plan had been produced to improve the responsiveness of the service to meet patient's needs. It was too early to identify if this was having an impact.
- The facilities and premises were appropriate for the services delivered with the exception of people with hearing impairment.
- Home visits were available for patients whose clinical needs resulted in difficulty attending the service. Although data showed these were not always timely or undertaken in line with national requirements.
- The service was responsive to the needs of people in vulnerable circumstances. For example, health care professionals caring for vulnerable people could call the service and receive a call back from a GP within a specified timescale.

Timely access to the service

Patients were not always able to access care and treatment from the service within an appropriate timescale for their needs.

- The service operated between 6.30pm to 8am Monday to Friday, and from 6.30pm on a Friday night to 8am on the following Monday morning for weekends. On bank holidays the service operated until 8am the following day.
- Patients could access the Out Of Hours service via NHS 111. The service did not see walk-in patients and a 'walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.
- The NHS 111 service directed the Out of Hours (OOH) service to call back some patients within timescales. The clinician calling back used their clinical knowledge and experience to assess the next course of clinical action required and the urgency of the need for medical attention for the patient's symptoms to be managed. This could be telephone advice, an appointment at an OOH site or a home visit. Data from the local Quality Requirements showed that the service was not always meeting the 95% target for prioritising clinical assessment of calls other than an emergency. Since our last inspection there was evidence of some improvement since the introduction of a remote team of clinical staff employed to respond to these calls. Performance rates, available since our previous inspection, did not show a month on month increase. For example data showed performance was 80.7% in July 2017, 73.1% in August and 81.9% in September and October.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- Patients did not always have timely access to clinical diagnosis and treatment. National quality requirements (NQR) data obtained from the service regarding timescales for face to face consultations showed the service was able to meet the targets around seeing an emergency either at an Out of Hours site or at home and seeing non-urgent patients at an OOH site in a timely manner. Data showed those timescales for those required to be seen within two hours for a consultation in an OOH site or those who were required to receive a home visit were not being fully met. For example, targets for NQR12b: patients at higher risk are to be seen within two hours at an OOH site was 88.9% in September 2017 and 82.7% in October 2017 which was below the contracted 95%. Staff at the OOH sites we spoke to concluded this was due to unfilled shifts which impacted on them providing timely and responsive patient care.
- Where patients were experiencing a delay for an assessment or treatment there were arrangements in place to 'comfort call' a patient to ensure their condition had not changed or worsened and to support patients awaiting a home visit or a clinical call back within a timescale which might not be met. Patients also received a call back when a home visit had been recommended as the course of action required.
- Previously we had issued warning notices as comfort calls in relation to delays were not always timely. Comfort calling rates achieved were 49.5% in August 2017, 69% in September 2017 and 61.3% in October 2017 indicating there had been no sustained improvement since our inspection visit in August 2017 and subsequent warning notices. These rates remain below the 95% agreed performance target set between Vocare and Somerset CCG and showed a reduction in calls being made when compared to data provided at previous CQC inspections. We saw evidence that attempts were being made to address this issues such as an improvement plan, provision of staff training and support from other Vocare OOH sites.
- We saw in September 2017 there were increased unfilled shifts from an average of approximately 87% to 100%. This meant patients may have had a considerable distance to travel to see a clinician if they required a face to face consultation. In addition the rural geography and lack of public transport further limits access to the service.
- The results from the NHS Patient Survey published in July 2017 showed that the service was performing similarly to the national average. The results showed 61% of patients thought the time taken to receive care was about right and 67% had a good or fairly good experience of the OOH service.

Listening and learning from concerns and complaints

- Information about how to make a complaint or raise concerns was accessible and it was easy to do.
- The complaint policy and procedures were in line with recognised guidance. We looked at the complaint system provided to us pre-inspection and asked for a copy of complaints on the day of the inspection. The documents provided detailed different complaints made about the service. For example, one complaint in September 2017 around delays in care for a patient awaiting a home visit was recorded on one system and not the other. This meant it was difficult to determine how many complaints the provider had received. One document listed 41 complaints from January 2017 and another document recorded 10 complaints. We found that complaints were mostly satisfactorily handled in a timely way although we saw delays in responses. For example, one complaint relating to care in January 2017, a complaints investigation started in June 2017. We asked why this has not been completed within policy timescales and were advised that the person responsible was 'too busy'.
- Monthly themes and trends around complaints such as delays and cancellations in care and access to treatment were reported to the clinical commissioning group. It was unclear how reporting of trends resulted in analysis and improvement of care as evidence was not available.
- It was unclear how lessons learnt from complaints were fed back to clinical staff in addition to the individual involved in the complaint as there was no process or evidence of this happening in place.
- We also noted that confidential responses to complaints made through PALs were not responded to using appropriate organisational headed paper. Responses were sent with no date or reference number making tracking timeliness difficult.

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 and 25 April 2017 we rated the well-led domain as inadequate. Our substantial concerns 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. 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 we issued further warning notices in regard to:

- Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.
- Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Safe care and treatment.
- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.
- Regulation 18 of the Health and Social Care Act (Regulated Activity) Regulations 2014, Staffing.

We rated the service as inadequate for well-led. At this inspection we found:

Leadership capacity and capability

Previously the local leadership had failed to adequately address the failings of the service. The recent change in local leadership and governance responsibilities did not provide assurance that there was an effective governance framework to support the delivery of the service. Lines of accountability and responsibility within the interim leadership structure were not always clear.

We were notified that from September 2017, the regional director who was the registered manager for the Wellington House location had left their post. The statutory notification advised us that the Vocare CEO and medical officer would each take on the role of registered manager for different regulated activities. We were also advised that one of two members of the leadership team at Wellington House would take on the registered manager role. We spoke to both these members of staff but they were not in a position to update us as to registered manager applications. The organisation has not provided a timeframe when an application from a suitable member of staff will be submitted for this role.

We were provided with information from Vocare that on 6 November 2017, an interim transitional regional director, who had no previous knowledge of the location, had commenced employment at Wellington House to address the failings of the service.

In November 2017 a support team from other locations across Vocare had been mobilised to the Wellington House location to work with staff to implement changes to the service. It was not clear how long this team would be in place or what the permanent organisational structure would be for Wellington House.

The leadership team at Wellington House had undertaken governance of an additional NHS 111 service supplementary to Somerset NHS 111, Somerset OOH and Devon NHS 111. It was not clear how the leaders had the capability or capacity to undertake additional services whilst prioritising non-compliance.

Vision and strategy

- Whilst the provider stated that their vision was to deliver a high quality service and promote good outcomes for people using the service, the management structure in place to implement this was too new to have had a measurable impact.
- Staff we spoke to were aware of the vision, values and strategy and their role in achieving them.

Culture

The lack of leadership and poor governance meant the service did not have a culture of high-quality sustainable care.

- Staff felt respected, supported and valued within the individual OOH sites they worked in. However they told us they felt let down by the overarching leadership of the organisation. This was confirmed by the leadership team who told us staff morale was low.
- They told us they were able to raise concerns. Some staff at the OOH sites felt they did not always receive feedback around incidents and told us that they did not always feel supported by the leadership team.

Are services well-led?

Inadequate

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

- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- The provider was aware of and had systems in place around compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- There were organisational policies for providing all staff with the development they need. This included appraisal however, not all staff had received regular annual appraisals in the last year.

Governance arrangements

The recent change in local leadership and governance responsibilities did not provide assurance that there was an effective governance framework to support the delivery of the service. 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 had failed to support sustained improvements.

An organisational chart provided pre inspection did not reflect the current local leadership structure at the time it was sent. And a governance management structure for Vocare supplied on the day of inspection was in the form of a proposal. We found the local lines of accountability within the service were not clear.

In November 2017 Vocare Ltd had been bought by Totally PLC who remain a parent holding company and were a separate legal entity to Vocare. We saw how Totally PLC were assisting the local service to unblock issues to improve governance and regional autonomy. For example, Totally PLC had approved additional staffing over the Christmas period to help ensure patient needs were met.

Managing risks, issues and performance

- The governance systems and processes to identify and manage risks and issues were not always robust. 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. For example, 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.
- Prior to our inspection the CQC met regularly with Vocare and Somerset Clinical Commissioning Group to discuss actions in relation to the previous inspections. We reviewed the latest Vocare action plan. We saw timescales for implementation of changes had improved but had not always been met. For example, the implementation of comfort calls followed patient complaints about waiting times, recorded service incidents around breaches of timescales for patient contact and a significant event which showed that contacting the patient would have changed the outcome was not fully operational .
- Previous concerns around failure to submit CQC statutory notification had resulted in improved submissions, however, there continued to be a delay. For example, we received two statutory notifications in November 2017 for events concerning patient safety in April and May 2017. In addition statutory notifications for safeguarding discussed with the service pre and during our inspection in August 2017 remained outstanding. These omissions implied the service was failing to fulfil their legal duty to inform CQC of serious incidents that affect patient safety.
- The service had failed to achieve compliance with Regulations 12, 17 and 18 by the date specified as outlined in the warning notices issued on 28 September 2017 to be compliant with the required Regulations by 15 November 2017.
- Leaders had an understanding of service performance against the national and local key performance indicators. Performance was regularly discussed with the local clinical commissioning group as part of contract monitoring arrangements; however, processes to manage current performance in regard to delivering timely care when treatment was deemed as urgent had not improved leading to continued risks to patients.
- The service had produced a recovery action plan, prior to our first inspection in April 2017 however, the clinical commissioning group had not signed this off as an agreed final action plan due to continued staff vacancies within the service. Ratification had been sought from the Vocare Board and staff we spoke with told us the plan had been implemented to achieve the necessary staffing numbers.

Appropriate and accurate information

The service acted on appropriate and accurate information.

Are services well-led?

Inadequate

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

- Quality and sustainability were discussed in relevant meetings where staff had sufficient access to information but this was not always acted on.
- The service used national and local indicators to monitor performance and the delivery of quality care which they reported on monthly. It was unclear how management and staff were held to account for poor continued performance.
- We found that there were inconsistencies in the evidence provided to us. Information provided pre-inspection was not always up-to-date and we found some information contradictory. For example, information relating to staff appraisal could not be corroborated onsite and we were told it was inaccurate. During inspection we made repeated request for information, for example, we asked on three occasions for a copy of significant events and complaints for November 2017 and these were not provided.
- The service submitted data or notifications to external organisations such as Somerset Clinical Commissioning group as required. Statutory notifications to CQC were not always timely.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

- There was limited evidence of systems in place for staff to give feedback or be involved in service development. Staff told us they were unclear about who was in the support team and their purpose.
- We saw there was a locally produced bi-monthly newsletter, a monthly clinician's newsletter and from July 2017 a monthly base meeting at four of the OOH sites. The provider had planned a staff survey and were aware that staff engagement was an area for improvement.
- The service encouraged patients to provide feedback through the NHS Friends and Family test. Forms were available at each OOH site. Results from 93 responses in September 2017 showed 94% would recommend the service to family or friends. The service received 29 responses since October 2017 with a recommendation rate of 83%.
- Through Somerset Clinical Commissioning Group the service engaged with other urgent care services such as the ambulance and local NHS hospital Trusts.

Continuous improvement and innovation

Since our inspection in April 2017 the service had been focused on an action plan to improve systems and processes. We saw little evidence of a focus on continuous learning and improvement at all levels within the service.

- The service had made use of an independent two day external review of cases which resulted in recommendations for the service. Although recommendations had been implemented it was unclear how learning was shared and used to make improvements in standards of care.
- The service was involved in a pilot with a local University for antimicrobial prescribing and stewardship