Nestor Primecare Services Limited t/a Primecare Primary Care - Birmingham

Quality Report

Nestor Primecare Services Limited
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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

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Summary of findings

Overall summary

Nestor Primecare Limited provides out-of-hours primary care service for a population of approximately 1.5 million when GP practices are closed. The service is provided from five primary care centres. The service is run from Crystal Court in Birmingham.

We found that although there were lots of good policies and procedures in place, staff were not always aware of them or working in accordance with them.

We were concerned that the management of medicines was not robust. Policies and procedures for the handling of medicines and prescriptions were not consistently followed which increased the risk from unauthorised access. Recording mechanisms did not provide a clear audit trail as to how medicines had been used and audits were not undertaken to ensure medicines and prescriptions could be accounted for.

Information about how to complain was not available and patients were unable to provide anonymous feedback about the service they received.

A lack of staff at some primary care centres meant that reception staff could not support the GP or speak to patients in confidence without leaving the waiting room unattended and access to the premises un-manned.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There were some aspects of the way in which the provider managed the service that were not safe. Although the service had policies and procedures designed to deliver a safe service we found staff were not always aware of them or working in accordance with them. We were not assured that staff were fully aware of the systems in place for reporting, investigating and learning from significant incidents which occurred and for protecting patients from the risk of harm.

We were concerned that the management of medicines was not sufficiently robust. Medicines and prescription pads could not fully be accounted for.

We found good recruitment processes in place to ensure all staff (including agency staff) were of suitable character and had appropriate skills for their role.

Are services effective?

Overall effective care was being provided although there was scope for improvement.

There were regular audits of doctors' consultations which helped to maintain standards of clinical care. A number of clinical audits had been carried out, but it was not always evident that the findings were acted on.

Clinicians were supported by a multi-disciplinary team, but low staff numbers seen at one primary care centre did not always support effective care.

Are services caring?

The majority of patients we spoke with described being treated with respect and dignity and felt involved in decisions about their health care. However, we were concerned that systems in place did not fully protect patient confidentiality and that patients did not have access to all the information they needed about the service.

Are services responsive to people's needs?

The systems in place to respond to patients' needs, comments and concerns were not always robust. We found that patient feedback about the service could not be given anonymously. Patients were not made aware of the systems in place for making complaints. Systems for supporting patients who did not speak English were not always clear or fully understood by staff.

Are services well-led?

There were arrangements in place to manage organisational risks and for staff to learn from incidents and complaints received. Staff were give support through induction, mandatory training and regular performance monitoring which helped to identify any risks with staff.

Summary of findings

What people who use the out-of-hours service say

We spoke with eight patients who used the out-of-hours service during our inspection. We also received four comment cards from patients who had used the service.

Most patients were positive about the service but some were not. One patient told us that the quality of doctors could be variable. Another told us they felt rushed through the service.

Areas for improvement

Action the out-of-hours service MUST take to improve

- Improve the management of medicines, including controlled drugs.
- Ensure patients are made aware of the complaints system.
- Ensure all staff are aware of the arrangements for reporting incidents and their responsibilities for doing so.
- Ensure all clinical staff are clear about the local arrangements and their responsibilities for reporting safeguarding concerns to the appropriate local authority.
- Raise awareness with staff to ensure that patients who are unable to speak English can access the service and communicate their needs.
- Review arrangements to ensure patient's confidentiality and privacy are respected at all times.

Action the out-of-hours service COULD take to improve

- Review the high use of agency staff and identify strategies to minimise their usage.
- Take appropriate action to ensure the safety of staff working alone.
- Complete audit cycles in order to demonstrate improvement or learning has taken place.
- Ensure patients and staff have access to information about the chaperone process and policy.
- Work towards improving signposting to support patients to access the primary care centres, particularly those located within hospital grounds.
- Ensure equipment maintenance is kept up to date and staff know where to locate equipment needed in an emergency.

Good practice

Our inspection team highlighted the following areas of good practice:

- Staff were provided with case studies for various patient health complaints via a staff newsletter which helped to spread good and consistent practice among staff.

Nestor Primecare Services Limited t/a Primecare Primary Care - Birmingham

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included a variety of specialists, including a practice nurse, two practice managers and an expert by experience (a person who has experience of using this particular type of service, or caring for somebody who has).

Background to Nestor Primecare Services Limited t/a Primecare Primary Care - Birmingham

Nestor Primecare Limited provides out-of-hours primary care services when GP practices are closed. The service provided covers a population of approximately 1.5 million. Patients access the out-of-hours service either via the NHS 111 telephone system or directly if their GP practices has subcontracted with them to provide the out-of-hours service on their behalf. There are approximately 40 GP practices that have subcontracted their out-of-hours service to Nestor Primecare Limited.

Crystal Court is the main office for Nestor Primecare Services Limited Birmingham. This is where calls are received and triaged from patients. Patients who need to be seen by a clinician are referred by appointment to one of five primary care centres located in Birmingham, Sandwell, Dudley and Wolverhampton or are seen as a home visit. The provider also carries out telephone consultations as part of the out-of-hours service.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients' 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 had received from the out-of-hours service and asked other organisations to share their information about the service.

Detailed findings

We carried out an announced visit on 26 March 2014. During our visit we spoke with a range of staff including the registered manager, senior managers, general practitioners and administrative staff. We also spoke with patients who used the service and their family members.

We visited primary care centres at Nestor Primecare primary care centres in Birmingham and Sandwell and observed how people were being cared for. We observed telephone triage systems and reviewed personal care or treatment records of patients. We also looked at vehicles used to transport the general practitioners to consultations in the patient's home.

Are services safe?

Summary of findings

There were some aspects of the way in which the provider managed the service that were not safe. Although the service had policies and procedures designed to deliver a safe service we found staff were not always aware of them or working in accordance with them. We were not assured that staff were fully aware of the systems in place for reporting, investigating and learning from significant incidents which occurred and for protecting patients from the risk of harm.

We were concerned that the management of medicines was not sufficiently robust. Medicines and prescription pads could not fully be accounted for.

We found good recruitment processes in place to ensure all staff (including agency staff) were of suitable character and had appropriate skills for their role.

Our findings

Significant events

The provider had arrangements in place to report significant incidents that occurred during the provision of out of hours care. An internet based reporting system was available to staff for the reporting of accidents, incidents and complaints. Senior staff told us about the corporate clinical governance structure in which incidents were discussed and learning identified. The provider reported that there had been 12 serious incidents in the provision of out-of-hours services during 2013. One GP we spoke with told us that they had seen learning from incidents shared with staff through the staff newsletter.

However, not all staff were consistently aware how to report incidents that may occur. Only one member of staff was able to tell us how to access the online incident reporting form. Other staff told us that they would refer the issue to the duty or line manager to act on. We saw that guidance had been produced which explained to staff how to use the reporting system but this had only just been published in March 2014 and staff were not aware of it. Other guidance available to GPs relating to incident reporting did not fully explain where to find or how to use the incident reporting system. The management of serious incidents protocol we were provided with did not relate to an out-of-hours or primary medical service.

Staffing and staff recruitment

The out-of-hours service was predominantly staffed by GPs who were contracted to deliver patient care. Senior staff told us that it was their preference to employ GPs who also worked during the day as GPs in local practices. The service used locum doctors to fill any shortfalls in the delivery of the out-of-hours service and during 2013, locum doctors were used to cover between 7.9 per cent to 21 per cent of clinical hours each month. The registered manager advised us that in the majority of cases these shortfalls were filled by locums from their internal locum agency who they used on a regular basis although external agencies were sometimes used. Reliance on agency staff can place additional risks to patients and the service as agency staff may not be familiar with the policies and processes of the service.

The provider had well established systems in place for the recruitment of new staff which were set out in the staff recruitment policies and processes. This included a three part interview process which required new and agency staff to demonstrate their competence, language and communication skills for the role. We looked at the recruitment files for two GPs and a nurse and saw evidence that appropriate pre-employment checks had been undertaken. Senior staff told us that agency staff went through the same checks as contracted staff. Staff that had not provided all the relevant documentation could not work for the service until all documents had been received.

Records were maintained to show that relevant documents had been received from staff and for ongoing monitoring purposes such as continued registration with professional bodies. Each week the clinical service manager received reports of documents that were due to expire within the next 31 days, staff were notified and if not received the rota team were notified to prevent staff from being offered shifts. Senior staff advised us that they also had a clinical alert register which was used to prevent restricted GPs from working for the service.

Prior to our inspection we received information of concern that some GPs were working excessively long hours at their own GP practice and then for the out-of-hours service in the evening and overnight. Senior managers told us that GPs were able to work a maximum of 60 hours per week and we saw that staff were reminded of this in their induction. Staff underwent quarterly reviews in which they were required to provide a self-declaration of hours worked

outside of the out-of-hours service which enabled the service to monitor hours worked. We saw documentary evidence that staff hours had been reduced to prevent staff from working excessive hours. The provider had mechanisms in place to identify staff that may potentially be working excessive hours.

Cleanliness and infection control

We saw that infection prevention and control audits had been carried out within the last year to identify any risks associated with cross infection at the primary care centres. However, some issues noticed during our inspection such as sharps containers without appropriate labelling and disposable curtains without dates had not been identified in the audits. It was also not clear what action had been taken as a result of these audits in order to minimise identified risks.

Primary care centres were located in shared premises including local hospitals and GP practices. We did not see the contractual arrangements for the cleaning of these premises as the member of staff responsible had left the service.

Safeguarding patients from harm

There were policies in place for safeguarding children and vulnerable adults from abuse. These contained information to support staff in recognising and identifying abuse. Senior staff advised us that the policies were available on the intranet. Safeguarding training was compulsory for all staff and records were maintained to ensure staff training in this area was kept up to date.

However, we were not satisfied that staff were clear about their role and responsibilities for reporting safeguarding concerns. We did not see any local authority contact information available so that staff could refer safeguarding concerns in a timely manner. Staff suggested two different names as the safeguarding lead for the service and various answers as to what they would do if they had to report a safeguarding concern. The registered manager advised us that no safeguarding referrals had been made in the last year.

Medicines

We saw that medicines were stored in a secure environment in a central location when not in use and released to primary care centres and for GPs carrying out home visits.

A colour coded tagging system was used to identify whether medicines had been used from the drug bags and needed to be replaced. The tagging system in place was confusing and counter-intuitive as yellow tags meant the drug bag was ready to go and green where a medicine had been used and needed replacing. We were advised that the system had not been changed because to do so would cause confusion among staff. However, we spoke with one GP who was not aware of this tagging system in place.

We saw that four of the drug bags in the central store and one at a primary care centre had no tag. We asked senior staff what records were available to show what medicines had been used and who they were administered to. We were advised that these were recorded on the Adastra IT system. However, the provider was unable to provide us with any evidence of audits or checks carried out to show that medicines used could be accounted for. In one bag we examined, we saw that one drug was missing, but no records existed to determine how it had been used.

We looked at how controlled drugs were managed. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We saw home office licenses were in place for the possession of these drugs. The drugs were appropriately stored in a cabinet accessed by a key code. The code was changed and the drugs were checked each time the controlled drugs cabinet was opened. Records showed that code changes and an audit of controlled drug stocks had been carried out four times in the last month.

Staff told us that they were aware of the processes in place for obtaining controlled drugs. The provider's standard operating procedures stated that the controlled drugs register must be completed by a doctor and countersigned by the duty manager. However, since the controlled drugs register was opened on the 6 August 2013, there had never been two signatories where a controlled drug had been removed and did not include information relating to which patient the medicines had been administered to.

We looked at how prescriptions pads were issued to clinical staff. Prescription pads are controlled stationery because stolen prescriptions may be used to unlawfully obtain medicines. Records of prescriptions issued were not being signed by a GP as required. Senior staff advised us that prescription pads were allocated to a primary care centre rather than an individual GP. There were no records of any unused prescriptions being returned centrally or records

showing how many prescriptions had been used. During the inspection at one primary care centre we found three prescription pads and a large quantity of computer prescription documents in a cupboard which the staff could not account for.

Staff Safety

We visited a primary care centre during our inspection which was located in a GP health centre. We saw that there was controlled access into the premises. When patients arrived at the door they were requested to confirm their identity and appointment before being allowed inside. The receptionist explained that there was a panic button if they needed assistance from any other staff in the building. However, when we arrived, the receptionist was the only member of staff on the premises and there were patients waiting in the waiting area. The receptionist told us that they were left to lock up the premises on their own after the GP had left to go home. Another member of staff who was visiting the primary care centre told us that they used to work at the primary care centre as a receptionist but had stopped doing so because they did not feel safe.

We saw that the provider had a lone working policy which offered staff guidance on safe working. Risk assessments were undertaken on staff who worked alone. We looked at the risk assessment for the receptionist at the health centre we had visited. We saw that the risk assessment which was carried out in January 2014 had highlighted some of the issues we had found but no action had been taken. The risk assessment also included no date by which time actions would be completed

Availability of equipment

We saw that equipment used by clinicians looked clean and in good condition. We looked at service histories for some of the medical equipment such as the defibrillator, pulse oximeter and blood pressure monitor which showed that they had not been checked within the last year. At one primary care centre we saw that equipment checks had highlighted a missing pulse oximeter, although we were told a spare was available and staff were not aware if there was a defibrilator available. This did not provide assurance that equipment checks were always effective and that equipment would be available and in good working order if needed.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall effective care was being provided although there was scope for improvement. There were regular audits of doctors' consultations which helped to maintain standards of clinical care. A number of clinical audits had been carried out, but it was not always evident that the findings were acted on. Clinicians were supported by a multi-disciplinary team, but low staff numbers seen at one primary care centre did not always support effective care.

Our findings

Audits

We saw that audits were routinely carried out on consultations undertaken by the GPs. The audits were carried out using the Royal College of General Practitioners clinical audit toolkit. Senior staff advised us that any GPs with an audit score below a defined level would be placed on a risk register and the level of monitoring increased. In addition, all GPs new to the service (including agency GPs) had their first five consultations audited. The GPs we spoke with told us that they received feedback about their performance from these audits. The audit team were also benchmarked to identify any inconsistencies in their scoring of the audits.

We saw that the provider had carried out various audits of the service within the last year including infection control, medicines management and staffing at the primary care centres. However, it was not clear what action, if any, had been taken as a result of these audits and completion of the audit report tools did not consistently state which primary care centre or service they were referring to.

Outcomes for patients

We looked at how clinical staff received updates relating to best practice or safety alerts they needed to be aware of. Senior staff told us that best practice information was disseminated to staff through the patient safety newsletter. One GP we spoke with confirmed that they received these. We saw that the patient safety newsletters detailed case studies of patient health complaints which included best practice guidance from the National Institute for Health and Care Excellence (NICE). The provider's induction manual for newly recruited GPs also included information on the management of conditions such as meningitis, diabetes and end of life care.

Senior staff advised us that any safety alerts received were directed towards the lead for policies and systems or if they related to medicines these were directed to the Head of Medicines Management so that they could be incorporated into relevant guidance.

GPs were required to demonstrate that they were up to date with mandatory training in life support, child protection, safeguarding vulnerable adults and mental capacity. This helped to ensure that GPs had a level of understanding in these areas.

Staffing

We saw that the GP rotas were issued three months in advance which gave time for shifts to be filled and alternative arrangements made if necessary. Senior staff advised us that they had looked at trends in demand for the service and had identified peaks in triage at specific times in the day which they tried to accommodate in the staff rota.

We visited two primary care centres and saw that staffing levels consisted of one GP and a receptionist. This level of staffing meant that if the receptionist was needed to assist the GP as a chaperone, speak to a patient in confidence or wanted a comfort break the reception would be left unattended. This could put patients at risk if there was no one to answer the secure doors as they arrived or notice if a patient was deteriorating.

Information sharing

Clinical staff told us that they were able to access information about any previous visits the patient had made to the service. We were told the service received 'special notes' information for patients who may be likely to access the out of hours service due to their health condition.

Information about patients who used the out-of-hours service was shared with their usual GP. The standard was for the information to be transferred by 8am the day after the patient had been seen. We saw from monthly performance data that in most cases this standard was being met.

Are services effective?

(for example, treatment is effective)

National Quality Requirements

Performance data for the last 12 months showed that the service was mostly meeting the national quality requirements (NQRs) for waiting times. NQRs are a set of standards specific to the delivery of out-of-hours services. We spoke with one receptionist who was aware of the need to meet these standards.

Are services caring?

Summary of findings

The majority of patients we spoke with said they were treated with respect and dignity and felt involved in decisions about their health care. However, we were concerned that the systems in place did not fully protect patient confidentiality and that patients did not have access to all the information they needed about the service.

Our findings

Patient confidentiality

Patients' confidentiality was not always supported. Patients booking in for their appointment at the primary care centre were asked for confirmation of their details including their name, address and date of birth which could be overheard by other patients in the waiting room. Staffing levels at the primary care centre did not allow for patients who wished to hold a private conversation with the receptionist. Boxes used for completed patient surveys and containing patient's personal information were left in boxes which staff advised us were emptied once per week. At one primary care centre, the reception computer displayed patient clinical information as well as appointments and due to the shape of the reception desk this was partially visible to patients. However, at another primary care centre we saw that the receptionist was careful to lock the computer when leaving the reception area. Systems in place did not fully protect patient's confidentiality and in some instances put their personal information at risk.

Respect and dignity

Most patients described being treated with respect and dignity, were satisfied with the information they had been given and felt involved in decisions about their care and treatment. We saw reception staff speaking with patients in a polite and helpful manner.

We saw that there was a chaperone policy in place which provided guidance to staff about the role of the chaperone. The policy stated that the chaperone policy should be advertised but in the two primary care centres we visited this was not the case and some of the staff were not aware of the policy. We spoke with one receptionist who had an understanding of the role of the chaperone and confirmed that they had received training in this area however to carry out this duty would leave the reception area unstaffed.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The systems in place to respond to patients' needs, comments and concerns were not always robust. We found that patient feedback about the service could not be given anonymously. Patients were not made aware of the systems in place for making complaints. Systems for supporting patients who did not speak English were not always clear or fully understood by staff.

Our findings

Patient views

The provider routinely sought feedback from patients who used the service. Feedback was reported to commissioners as part of the contract monitoring arrangements. We saw that patients were encouraged to complete the survey when they had used the service. The contract monitoring reports indicated that 90 per cent of patients were satisfied with the service overall.

We were concerned about the arrangements for gaining patient feedback. Patients were not given the opportunity to provide anonymous feedback. We saw reception staff handing patient surveys to patients in which they had already inserted the patient's name, age, gender, usual GP surgery and call number. The forms asked patients to complete the survey while they waited to be seen which meant they would not be able to provide a full response to the questions asked. We also saw a postal survey where patients could provide feedback by post anonymously however the return address of this form was one no longer used by the provider.

Most comments received from patients during our inspection were positive about the staff although we did receive two comments where one patient described the doctors seen as variable and another patient that told us they didn't feel listened to.

Access to services

We found the location of both the primary care centres difficult to find and comments from patients indicated that they had also had difficulties. There was a lack of signage to help patients find the primary care centre located within a local hospital. The two primary care centres we visited were accessible to patients who may have mobility difficulties.

There was limited information in the waiting rooms for patients who used the service. At the two primary care centres we visited there was no information available such as advising patients how to make a complaint or how to request a chaperone. We observed all information displayed within the service was only displayed in English.

We asked two GP's on duty how they managed patients that did not speak English. Both GP's told us that this had not been an issue with them and one GP told us they spoke more than one language. Neither of the GPs were aware how to access the interpreter or translation service if needed. We also spoke with a call handler and listened into an out-of-hours call. The call to the service was made by a person on behalf of the patient because the patient did not speak English. When the call handler asked questions about the patient the person calling responded without consulting the patient. At no point did the call handler offer the patient an opportunity to speak with them directly or a translation service.

Staffing

We saw that the GP rotas were issued three months in advance which gave time for shifts to be filled and alternative arrangements to be made if necessary. Senior staff advised us that they had looked at trends in demand for the service and had identified peaks in triage at specific times in the day which they tried to accommodate in the staff rota.

We asked senior staff how they managed to cover for unexpected staff shortages such as staff sickness. We were advised that there was some flexibility in the organisation to manage demand and if needed staff could contact the on-call manager to obtain authorisation for an agency GP. Some of the support staff also worked flexibly and would take on other roles to cover for staff shortages. For examples drivers were trained as receptionists and team leaders would act as drivers for the GPs.

Vulnerable patients

We spoke with two clinicians about the management of patients with mental health issues who may be at their most vulnerable when attending the service. The GPs we spoke with were aware of the local referral routes into the mental health service.

Are services responsive to people's needs?

(for example, to feedback?)

Complaints

There were arrangements in place for the management of complaints received about the service. Systems were in place helped to ensure patients received a timely response to their complaint.

Information received from the provider showed that there had been 103 complaints received during 2013. From the sample of complaints seen we saw that they had been appropriately investigated. Responses sent to the patients gave details of who to contact if they were unhappy with the provider's response to their complaint. Evidence seen demonstrated that the provider took time to investigate and respond to complaints raised about the service.

Patients were not always made aware of the complaints process. We visited two primary care centres, neither had any information advising patients about how to make a complaint.

Are services well-led?

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

Summary of findings

There were arrangements in place to manage organisational risks and for staff to learn from incidents and complaints received. Staff were give support through induction, mandatory training and regular performance monitoring which helped to identify any risks with staff.

Our findings

Leadership and culture

Senior managers told us that there were established governance arrangements at corporate level and a range of policies and procedures that were kept up-to-date to support the smooth running of the service. However, there was a difference between what we were told at senior level and what was actually happening. Clinical staff were not always aware of policies and procedures in place. Monitoring and checks to ensure the safe provision of services were not always being carried out.

Management of staff

Senior staff advised us that new staff received induction training and an induction manual. The induction manual provided comprehensive information to support clinicians new to the service in their duties as well as some clinical information around the care and treatment of patients with specific health conditions. Induction training provided staff with a consistent base knowledge when working for the service.

If a need was identified through the interview process, clinical staff were given shadowing and mentoring opportunities before working alone. However, familiarisation of the local premises used for the out-of-hours service, location of equipment, or local referral processes were not routinely included in the induction. We spoke with one GP who could not recall having received an induction.

Senior staff told us that it was more difficult sometimes to do an induction for agency locum doctors who were brought in at short notice and that they tried to give some information over the telephone or they would receive an induction from the receptionist they were working with.

Use of external agency staff could have implications for the quality of care patients receive as they may not be familiar with the premises, location of equipment and local referral processes.

There were processes in place for monitoring GP performance. Quarterly clinical performance reviews were carried out on clinical staff in which they were scored against various criteria including hours worked, evidence of professional development, professional conduct and behaviour, reliability and clinical audit results. Staff who did not perform well were placed on the risk register and we saw evidence of staff undergoing closer monitoring in the provider's performance reports. Feedback was given to GPs on their performance.

Learning from complaints and incidents

Complaints and incidents were discussed at corporate level through the clinical governance structures. This helped ensure they were seen and discussed by staff who were able to influence any necessary changes as a result. There were arrangements in place for staff to learn from complaints and significant events that had occurred at the service. Staff received information via a 'patient safety newsletter' in which comprehensive case studies were presented with information and learning to support staff in their work. From the newsletters see we saw case studies relating to the management of patients presenting with specific conditions.

Quality Monitoring

Quarterly performance monitoring reports were produced and submitted to the clinical commissioning groups (CCGs) who contracted with them. We saw that the reports included information around the national quality requirements (NQRs) for out-of-hour services. The registered manager advised us that they also met with the CCGs in person to discuss performance issues although frequency of these meetings varied between the CCGs.

Minimising Risk

We saw that there were corporate arrangements for clinical governance and high level clinical risks were managed through these structures.

We saw that there was a disaster recovery plan which identified action to be taken in the event of systems failure at a primary care centre. This would enable the service to continue while systems were being restored.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, requirements relating to workers. There was no evidence of audits carried out or a clear audit trail to ensure medicines used could be accounted for. Policies and procedures were not followed for the receipt of controlled drugs and prescription pads and for the securing drug bags after use to minimise the risk of unauthorised access. Regulation 13

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, requirements relating to workers. There was no evidence of audits carried out or a clear audit trail to ensure medicines used could be accounted for. Policies and procedures were not followed for the receipt of controlled drugs and prescription pads and for the securing drug bags after use to minimise the risk of unauthorised access. Regulation 13

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, supporting workers. Patients who used the service were not made aware of the complaints policy and sytems in place with which to raise their concerns. Regulation 19. (2)(a)

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, supporting workers. Patients who used the service were not made aware of the complaints policy and sytems in place with which to raise their concerns. Regulation 19. (2)(a)