Wellington House

Inspection 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 location	Good
Are services well-led?	**Requires improvement**

Overall summary

This service is rated as Good overall. (Previous inspection 05 2018 – Requires Improvement).

The key questions are rated as:

Are services well-led? – Requires Improvement

We carried out an announced focused inspection of the Somerset NHS 111 service at Wellington House on 10 January 2019. This was to review the quality of the service following four previous inspections carried out at the service in May 2018 and April, August and November 2017 where we issued warning notice's as a result of finding significant areas of concerns.

On 16 May 2018 an announced focused follow-up inspection was carried out. We found the delivery of high-quality care was not assured by the leadership and governance in place at the service. Significant issues that threaten the delivery of safe and effective care were not adequately managed. There was limited evidence that actions to address previous CQC concerns had resulted in sustained improvement to the service. Insufficient improvements had been made such that there remained a rating of inadequate for well-led. Following that inspection, we issued a further warning notice in respect of:

- Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

At this inspection we found:

- There was evidence that actions to address previous CQC concerns had resulted in improvement to the service.
- There was improvement and stability within the local and regional leadership team who demonstrated prioritisation of previous non-compliance.
- Significant issues that threatened the delivery of safe and effective care had been reviewed and managed. For example, overnight calls had been diverted to central call centres where sufficient staffing ensured the service delivery within the required call targets.
- There were improvements in national Minimum Data Set requirements with service performance in line with national averages although in some areas these remained below national target levels.
- Patients were mostly able to access care and treatment from the service within an appropriate timescale for their needs.
- There was evidence of continuous learning and improvement at all levels of the organisation. The service had processes in place to learn and share lessons from safety incidents. Reviewing learning to improve performance was limited to call-auditing and individual staff reviews.
- The provider had implemented new governance systems and processes to measure the quality of the service and to promote continued development and improvement of the service. At the time of our inspection this was new and therefore limited evidence to show effectiveness.
- Incidents and complaints were not always completed within provider policy timescales and processes to identify and manage these risks were not effective. This meant limited evidence that duty of candour had been applied in a timely manner.
- The provider had a planned audit programme and we saw some evidence of quality improvement work.
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The area where the provider **must** make improvements as they are in breach of regulations:

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

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

- Consider a formal system to demonstrate evidence of how learning from incidents and quality improvement work has been embedded and improved quality of care delivery.
- Continue to develop the programme of audits to identify impact on patient care.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC Inspection Manager, and a CQC inspector.

Background to Wellington House

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Wellington House is part of Vocare Limited. This service provides a NHS 111 service for a population of approximately 540,000 patients in the Somerset region. Vocare deliver GP Out of Hours and urgent care services to more than 4.5 million patients nationally.

Wellington House Somerset NHS 111 is a telephone based service where people are assessed, given advice and directed to a local service that most appropriately meets their needs. It operates 24 hours, 365 days a year from Queen Street, Taunton, Somerset TA1 3UF. The location is registered with the Care Quality Commission under the Health and Social Care Act 2008 to provide the following regulated activity: Transport services, triage and medical advice provided remotely.

It is co-located with the NHS 111 service for Cornwall & the Isles of Scilly. The local management team also provide governance of NHS 111 for Devon, Wiltshire, Bath and NE Somerset and Swindon CCG areas.

Requires improvement

Are services well-led?

We rated the service as requires improvement for leadership.

At our last inspection on 16 May 2018 we rated the well-led domain as inadequate. We were concerned about:

- The service was working towards becoming compliant with the regulations but had undergone major changes in the local and regional management structure. This meant they were not firmly established and were too new to have a measurable impact.
- Responsibilities, roles and systems of accountability to support good governance and management were not fully in place. For example, there was limited evidence related to how audits contributed to service improvements; there was a backlog of incident investigations with limited processes for sharing and embedding any learning and risk to patient safety which could result in similar events occurring in future; gaps within the completion of the provider's statutory and mandatory training uptake were evident.
- Previous inspections from November 2017 had led the provider to make recovery trajectory plans. These had not succeeded by the expected date because of inadequate call advisor and clinical advisor staffing levels.
- Evidence of quality improvement work and clinical audits which have a positive impact on quality of care delivered and outcomes for patients was limited.
- Processes to identify, understand, monitor and address current and future risks including risks to patient safety had failed to address the issues identified on previous inspections in order to achieve compliance with the regulations.
- The NHS England Minimum Data Set (MDS) is used to show the efficiency and effectiveness of NHS 111 provider's. MDS results for the service showed the provider had not meeting performance indicators for four of the national quality requirements. As a result, the provider was subject to a Contract Performance Notice (CPN) issued by Somerset Clinical Commissioning Group.
- There was no progress within the service's CQC action plan around engagement with patients' through a patient participation group.

At this inspection we found:

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The provider had completed a consultation to restructure management and regional leadership. People were in post who were able to provide evidence the structure was embedded. This included a regional and local clinical director.
- Since our previous inspection the leadership team demonstrated autonomy and ability to drive change locally such as the introduction of a clinical lead within the staffing model. The clinical lead acted as a 'floor walker' during peaks in service demand. This enabled them to support clinical staff and improve clinical validation. (Clinical validation is the review of a call handler assessment and functions to improve further treatment responses without reducing quality and safety).
- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and had action plans in place to address these.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management were accessible throughout the operational period, with an effective on-call system to support staff.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The South West regional leadership team had developed local vision, values and strategy jointly with staff to support delivery of high quality care and promote good outcomes for patients. The provider monitored progress against delivery of the strategy. This complemented the national organisational vision and set of values.

Culture

- Staff felt respected, supported and valued. They were proud to work for the service. Leaders and managers acted on behaviour and performance consistent with the vision and values.

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- The provider was aware of and had processes to ensure compliance with the requirements of the duty of candour. However, openness, honesty and transparency had not always been consistently demonstrated when responding to incidents and complaints.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year.
- The service had implemented coaching development plans to support staff where areas of improvement were required. This had led to positive staff feedback around support and mentoring.
- There was an emphasis on the well-being of all staff. For example, staff were involved in regular meetings and kept up to date with newsletters, a shared learning board and an education centre in the office had information for them to access.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out and understood. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- The location acted as the regional office with a dedicated governance administrator on site.
- Local governance processes fed into national reporting; this had improved oversight of the service performance and the local management team were delegated to take decisions which impacted directly on the service. For example, closure of the service at night. However effective scrutiny and timely investigation of incidents and complaints were not always achieved. We found no evidence of performance management when staff accountable for incident investigations did not complete them in line with the providers policy.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established policies, procedures and activities to ensure safety such as daily risk meetings and monthly local quality meetings to assure themselves that they were operating as intended. Although minutes demonstrated the service were aware of delays in investigations of incidents, mitigating reasons or further actions were not captured.
- There was a comprehensive process of continuous clinical and non-clinical call auditing used to monitor quality within Somerset NHS 111. We saw where performance fell below the required standard that staff had coaching plans, which included staff development to support them.

Managing risks, issues and performance

Since our previous inspection the provider had in agreement with Somerset Clinical Commissioning Group a contract variation. This meant since December 2018 they provided 50% service provision with a limited reduction in staffing. This was above the requirements within the recovery action plan.

- There was evidence of improved processes to identify, understand, monitor and address current and future risks, issues and performance. For example, regional and national quality and safety meetings and regional workforce planning. We saw meeting minutes demonstrated actions were taken to improve these areas with the exception of incident and complaint management.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their telephone consultations and referral decisions. The provider had recently undertaken a quality assessment of the service. Themes from this filtered into the quality assurance strategy.
- Leaders had oversight of incidents and complaints through regular monitoring and quality processes. We found the provider had a backlog of incident investigations. Root cause analysis was not always completed within the provider policy timelines.
- We reviewed incident logs and saw incidents from June 2018 through to January 2019 remained under investigation and incomplete. For example, 22 incidents including safeguarding were raised in August 2018, five

remained open; in November 2018 26 incidents were raised and four remained open. Following inspection, the registered manager provided evidence to address two incidents we were concerned around.

- Evidence around lessons learnt showed significant improvement. Some staff we spoke with were able to discuss how policies or practice had been changed as a result of incidents. The service was unable to demonstrate how the embedding of learning locally was audited and could result in similar events occurring in future.
- We reviewed patient complaints between September and December 2018 and found not all complainants received an investigation response within agreed timeframes. We found the governance team requested daily updates from staff assigned to investigate a complaint and highlighted concerns through the daily meetings although rationale for delays in completion were not recorded.
- Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.
- We noted there had been an improvement in performance against the national quality requirements since December 2018 when the re-negotiated contract performance was implemented. Providers of NHS 111 services are required to submit call data every month to NHS England by way of the Minimum Data Set (MDS). The MDS is used to show the efficiency and effectiveness of NHS 111 providers. We saw the most recent MDS results for the service (for the period October 2018 to December 2018). Whilst there had been some improvements, the provider was not meeting performance indicators for all the National Quality Requirements, however they were consistent with national performance.
- Since the contract variation from December 2018 data for call abandonment (when the caller terminates the call before the service answers) had significantly improved to 3.6% or below. (Between October and November 2018 average abandonment rates were between 2% and 14% with two weekends showing abandonment rates between 18% and 23%).
- There was evidence that one to one performance management and supervision for individual staff was taking place regularly. Staff who worked remotely were supervised locally. The service could demonstrate adequate supervision took place and testing of learning such as 'hot topics' was demonstrated.
- An annual clinical audit plan was in place. Following our previous inspection, we found learning from audits within the region had been acted on resulting in a positive impact on quality of care and outcomes for patients. For example, the national minimum data set identified a higher than average ambulance disposition. The provider had reviewed and taken action to resolve the issue. However, we found they did not always complete the audit cycle to demonstrate performance improvement.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

Engagement with patients, the public, staff and external partners

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

- At our previous inspection the service was aware that engagement with patients was limited and had intended to establish a patient participation group. There were also plans to gather a full and diverse range of patients' views and concerns using technology such as telephone text surveys. We found evidence of a patient engagement exercise through Healthwatch which had provided feedback and comments about the

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service. The comments were general but were used to inform future engagement such as attendance at community events to promote and educate the public about the role of the service.
- Staff were able to describe to us the systems in place to give feedback. Staff who worked remotely had a contract with the local service and were engaged and able to provide feedback such as through supervision. The provider had recently undertaken a staff survey and although not specific to the location, the findings were fed back to staff.
- Engagement with external partners was firmly embedded such as the local NHS England forum.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the service. For example, there was evidence that the service met with ambulance and urgent care providers regularly to monitor the high ambulance and emergency department dispositions.
- The service made use of internal reviews of incidents and complaints. Learning was shared within the region however there was no formal system to understand the impact of the learning on quality improvement.
- There were systems to support improvement and innovation work.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: with regards to timely investigations of incidents and complaints including applying duty of candour in a timely manner.This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.