Wellington House

Quality Report

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

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?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

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Overall summary

We carried out an announced comprehensive inspection at Wellington House (known locally as Somerset Doctors Urgent Care) Out of Hours service on 24 and 25 April 2017. Overall the service is rated as inadequate.

We found the service inadequate for providing safe, effective and well-led services. The service requires improvement for responsive services. We found the service good for providing caring services.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. However, reviews and investigations were not thorough enough. Policy timelines had been missed. There was little evidence of learning being embedded in policy and processes.
- Systems, processes and practices to keep people safe had significant gaps and were a cause of concern. For example, there was a lack of the required level of safeguarding training provided for staff, infection prevention control arrangements did not keep people safe, arrangements for managing medicines including emergency medicines was not robust, there was an insufficient system for oversight of risk assessments and health and safety checks. The communication of access to emergency equipment was in need of improvement due to the variations in provision in each OOH treatment centre and the arrangements to undertake all necessary professional employment checks for all staff before employment commences were not always in place or were not recorded.
- Patient's care needs were not always assessed and delivered in a timely way according to need. The service had not met all the National and Local Quality requirements. For example, waiting times for some clinical assessments. The provider told us they had submitted a recovery action plan to the service commissioners.
- Arrangements to monitor quality were not robust enough to support improvement.
- There was a system in place at the Out Of Hours (OOH) sites that enabled staff access to patient records. However some staff told us they had

difficulty accessing the system due to the internet connection. OOH staff provided other services such as the local GP practices and hospital services with information following contact with patient's as was appropriate.

- The service closely monitored training and continuous professional registration of agency staff. However there were significant gaps in recording and monitoring staff training for employed staff. In addition staff had not always received training for their roles. For example, chaperone and driver safety training.
- Staff did not always receive performance reviews or appraisals.
- Patient's said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. However there were significant gaps in patient complaint management.
- The service worked proactively with other organisations and providers to develop services that supported alternatives to hospital admission where appropriate and improve the patient experience.
- The OOH sites were easily accessible. However access for people with a hearing impairment could be improved. The vehicles used for home visits were clean and well equipped.
- There was a leadership structure. However the overarching governance framework for systems and processes required attention to improve the quality and safety of the services and to mitigate risks relating to the health, safety and welfare of staff and service users.
- The provider was aware of the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. Systems were in place for notifiable safety incidents and complaints however the arrangements to ensure this information was shared with staff to ensure appropriate action was taken were inconsistent.

The areas where the provider must make improvements are:

- Ensure there are robust and effective systems and processes to assess, monitor and improve the quality and safety of the services provided and to assess monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk arising from the carrying on of the regulated activities. Such as staff training, recruitment processes medicines management, systems for health and safety checks, infection prevention control including the decontamination of clinical equipment and safe management of healthcare waste and improved access to emergency equipment.
- Ensure adequate staffing levels are in place to provide timely access to the service for all patients. To include appropriate and timely 'comfort calls'.
- Ensure staff receive regular appraisals and/or performance reviews. To include regular auditing of clinician consultations in line with the Vocare GP face to face audit process policy.
- Ensure complaints and significant events are dealt with consistently with clear explanations of actions taken and the identification of learning or sharing of learning. Analysis of trends and themes should result in improvements of care and learning embedded in policy and processes.
- Ensure that serious incidents, deaths or safeguarding referrals are subject to statutory notifications to the Care Quality Commission.

The areas where the provider should make improvement are:

- The service should evidence safety checks for clinical equipment including use of clinicians own equipment.
- Review or carry out clinical audits including re-audits to ensure improvements in clinical care and other processes have been achieved.
- Improve the accessibility to the service for patients with a hearing impairment.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key questions or overall, we will take action in line with our enforcement procedures to begin the process of

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preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The service is rated as inadequate for providing safe services and improvements must be made.

Systems, processes and practices did not always keep patients safe. There was limited monitoring of safety and limited evidence that learning from events was embedded in policy and processes. In addition the provider's serious incident policy timelines had been missed.

Substantial or frequent staff shortages increased risks to patients who used services; we saw rotas consistently contained unfilled shifts. Records for recruitment checks were incomplete. For example, there was a lack of evidence of checks with an appropriate professional body. We found evidence that the provider had employed a Doctor who had not applied to be registered with the NHS England Performers List.

Checks relating to the infection control, clinical equipment and medicines were not adequately managed.

Are services effective?

Inadequate

The service is rated as inadequate for providing effective services, as there are areas where improvements should be made.

There was insufficient assurance in place to demonstrate care and treatment was effectively monitored. There was very limited monitoring of patients outcomes of care and treatment,

including limited clinical audit. Data showed the service was not meeting the National Quality Requirements (performance standards) for GP Out Of Hours services for NQR12. The NQR are used to show the service is safe, clinically effective and responsive.

Not all staff we spoke to had received training relevant to their roles such as basic life support, safeguarding, infection control and chaperone training. Training documentation was poor. Non-clinical staff told us they had not received an appraisal or performance review.

Are services caring?

Good

The service is rated as good for providing caring services.

Feedback from the large majority of patients through our comment cards and collected by the provider was very positive. Patients said

Summary of findings

they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients were not always kept informed with regard to delays to their care and treatment throughout their visit to the Out Of Hours service.

Are services responsive to people's needs?

Requires improvement

The service is rated as requires improvement for providing responsive services.

Although the service had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified. We found patients were not always treated according to urgency of need.

Patients could get information about how to complain. We saw themes and trends around complaints such as delays and cancellations in care and access to treatment. It was unclear how analysis of trends resulted in improvement of care.

Are services well-led?

Inadequate

The delivery of high-quality care was not assured by the leadership and governance in place at the service. There was no contingency to ensure governance arrangements were managed effectively when key management staff were absent such as health and safety. Significant issues that threaten the delivery of safe and effective care were not adequately managed. Staff told us they had not received regular performance reviews and did not have clear objectives.

Summary of findings

What people who use the service say

We looked at various sources of feedback received from patients about the Out Of Hours service they received. Patient feedback was obtained by the service on a monthly basis through the NHS Family and Friends Test.

Data from the service for the period of December 2016 and March 2017 showed positive feedback from the 135 patients who completed a NHS Family and Friends feedback form at one of the Out Of Hours sites. The percentage of patients who were extremely likely or likely to recommend the service was between 79% and 95%.

The national GP patient survey (July 2016) asks patients about their satisfaction with the out-of-hours service. The results are provided at a local clinical commissioning group level. The results were from the July 2016 publication, collected during July to September 2015 and January to March 2016 and relate to both the NHS 111 and this out-of-hours service and were aggregated across the area:

- 66% of respondents provided a positive response of how quickly care from NHS service received compared to the national average of 62%.
- 90% of respondents provided a positive response to having confidence and trust in the person or people seen or spoken to which was comparable to the national average of 90%.
- 72% of respondent had a positive opinion of their overall experience of NHS service when the GP surgery was closed compared to the national average of 70%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 57 comment cards of which 48 were positive about the standard of care received. Patients commented on the accessibility of the service and availability of appointments and the quality of care and treatment from staff.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure there are robust and effective systems and processes to assess, monitor and improve the quality and safety of the services provided and to assess monitor and mitigate risks including the decontamination of clinical equipment and safe management of healthcare waste
- Ensure adequate staffing levels are in place to provide timely access to the service for all patients. To include appropriate and timely 'comfort calls'.
- Ensure staff receive regular appraisals and/or performance reviews. To include regular auditing of clinician consultations in line with the Vocare GP face to face audit process policy.
- Ensure complaints and significant events are dealt with consistently with clear explanations of actions taken and the identification of learning or sharing of learning. Analysis of trends and themes should result in improvements of care and learning embedded in policy and processes.
- Ensure that serious incidents, deaths or safeguarding referrals are subject to statutory notifications to the Care Quality Commission.

Action the service SHOULD take to improve

The areas where the provider should make improvement are:

- The service should evidence safety checks for clinical equipment including use of clinicians own equipment.
- Review or carry out clinical audits including re-audits to ensure improvements in clinical care and other processes have been achieved.
- 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 two GP specialist advisers, four CQC inspectors, a member of the CQC medicines team, a service manager specialist adviser and an inspection manager.

Background to Wellington House

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

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

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

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

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

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

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

Detailed findings

Bridgwater Community Hospital Bower Lane, Bridgwater, TA6 4GU

Minehead Community Hospital Luttrell Way, Minehead, TA24 6DF

Musgrove Park Hospital Parkfield Drive, Taunton, TA1 5DA

Shepton Mallet Community Hospital Old Wells Road, Shepton Mallet, BA4 4PG

Yeovil District Hospital Higher Kingston, Yeovil, BA21 4AT

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

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

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

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 24 and 25 April 2017. During our visit we:

- Spoke with a range of staff including the regional clinical director, regional director, clinical support manager, operations manager, group operations director, a pharmacy technician, drivers, receptionists, a nurse practitioner, GPs and administrative support staff.
- Inspected the Out Of Hours premises including four of the five Out Of Hours sites (Bridgwater, Taunton, Shepton Mallet and Yeovil).
- Looked at the vehicles used to take clinicians to consultations in patient's homes, and we reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.
- Reviewed 57 CQC comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients experiences of care and treatment, we always ask the following five questions:

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

Please note that when referring to information throughout this report, for example any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

Inadequate

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. However the provider had not always notified the Care Quality Commission of significant events that require statutory notifications. Prior to our inspection we asked the service to provide a summary of significant incidents for the past 12 months. The document provided did not summarise all incidents logged by the service in a timely way. For example, the summary sheet reported two incidents where investigations commenced in February 2017 which related to incidents occurring in January 2017 and October 2016. The provider was made aware of the October 2016 incident via a patient complaint in November 2016 and it was unclear of the rationale for a delayed significant event investigation.

Prior to our inspection the Care Quality Commission liaised with the service over three incidents. The service failed to provide an adequate response which resulted in a Section 64 letter to the provider to request documents and information outside of the inspection process. Following this we continued to request information not always receiving a prompt reply.

- The service had a lead person for significant events who had recently undergone root cause analysis training to enable better investigation of incidents and identify points of failure.
- Staff told us they would inform the operations manager of any incidents and there was a recording form available on the service's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). Two members of staff advised us they had reported incidents and had not received updates or conclusions from the service. This was corroborated by us during the inspection.
- Serious incident policy timelines had been missed however the service had recognised this and since appointed a governance assistant to manage all significant events and incidents including an on going action plan to clear the backlog. We were told the Vocare serious incident policy was amended following learning of delays in reporting events locally to improve timelines of investigation and being signed off by the local clinical lead rather than the organisations medical director.
- We saw evidence that when things went wrong with care and treatment, patients were usually informed of the incident, received support, an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again.
- We saw evidence the service carried out an analysis of some of the significant events and learning had been disseminated to staff although there was little evidence of learning being embedded in policy and processes.
- We looked at three significant events which related to clinical management. We saw actions had been taken in regard to the themes around a lack of comprehensive records and provision of support by the service to improve performance.
- Relevant MHRA alerts/NICE guidance/patient safety alerts would be communicated to GPs through the clinical director's newsletter.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities. However not all staff we spoke to had received training on safeguarding children and vulnerable adults relevant to their role. We were told GPs were trained to child safeguarding level 3 although the training matrix was not fully completed and the provider was unable to provide evidence to support this.
- Prior to the inspection we spoke to Somerset Clinical Commissioning Group who confirmed the training provided by them was at level 3 however staff had been provided with refresher training rather than the

expected foundation training, and that they had made this known to the provider, meaning some staff had not received training at a level necessary for their role in the protection of children from abuse and/or neglect.

- We were told by the local leadership team that staff at the Out Of Hours (OOH) sites were not expected to provide a chaperone service to patients and non-clinical staff such as drivers and receptionists were not provided with chaperone training. This was in contradiction to the provider's own Chaperone Policy which stated 'all patients should be made aware a chaperone can be made available for any consultation or procedure involving a health professional'. We saw a sign offering patients a chaperone service at one of the four sites we visited. We spoke to both drivers and receptionists at the OOH sites and they told us they may be expected to act as a chaperone for example, if a clinician was attending a home visit, the patient was vulnerable or a risk to others or a female patient required an intimate examination with a male Doctor. Other members of staff told us that they had acted as a chaperone when this had been requested of them. These staff told us they had not received training for this role.
- We observed the premises to be clean and tidy except for one site where dirty linen was found at the start of the shift. There was an infection control lead who had not undertaken any specific training relevant to this role. There was an infection control protocol in place. Monthly infection control checks were undertaken at the sites. It was unclear how the service implemented actions from these checks to address any improvements identified as a result. We asked to see the annual infection control audits for the service. We were told they had not been undertaken which was contrary to the Vocare infection control policy. We spoke to non-clinical staff at the sites who told us they had not received any infection prevention and control training including handwashing. We saw the service had only recorded evidence for immunisation against Hepatitis B for one nurse. This meant the service did not have oversight of up to date immunisation against infectious disease for all staff.
- Staff at the OOH sites told us patient urine samples were tested in consulting rooms and the urine disposed of in clinical waste bags. This did not follow the Department of Health, Health Technical Memorandum 07-01: Safe management of healthcare waste. Staff were also unaware of any procedures for cleaning and decontaminating clinical equipment when dirty, used by an infectious patient or at the end of each shift. Specimens should be disposed of correctly and in line with the host hospital policy. In addition policies such as NHS professionals Standard Infection Control Precautions clearly state how specimens should be managed: 'Items containing fluid, particularly those containing blood/body fluids, that have to be disposed of should first have the contents solidified in order that they are safe to transport.'
- Prior to inspection we advised the provider we would look at organisational governance and management on the first day of inspection. We asked to see the staff files and were told that we were unable to do this as the person responsible was not there. On the second day of our inspection we reviewed documentation for eight members of staff. Information was made available to us through paper documents and electronic files. We saw the tracking document for each new recruit which indicated when key documents had been received. We tracked the recruitment and documentation for eight staff working in the service. We found evidence that some recruitment checks had been completed however, the records were incomplete and the provider was unable to locate all the documentation. For example, evidence of satisfactory conduct in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service were not available for all staff for whom it would be required. Since the inspection, despite Vocare being given the opportunity to demonstrate appropriate recording of information in staff files, no further recruitment evidence had been submitted.
- The local lead for recruitment was unable to locate information and told us they were unaware of the NHS performers list. We found evidence that the provider had employed a salaried Doctor who had not applied to be registered with NHS England Performers List. This list ensures Doctors practising in the NHS are suitably qualified, have up to date training, have appropriate English language skills and have passed other relevant

checks such as with the Disclosure and Barring Service and the NHS Litigation Authority. This meant the Doctor was working within general practice without NHS England approval.

- All of the files we reviewed had recorded some type of interview process and photographic evidence of identity which had been confirmed at interview. We saw the tracking document for each new recruit which indicated when key documents had been received. We saw recruitment documentation had been sought and obtained for locum clinical staff from the agency that provided the staff. This allowed the service to closely monitor training and continuous professional registration of locum staff.

Medicines Management

- The service had arrangements for managing medicines including emergency medicines (including obtaining, prescribing, recording, handling, storing, security and disposal). The service carried out regular medicines audits, to ensure prescribing was in accordance with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored, but the monitoring systems in place were not adequate to be able to track their use. GPs used purple prescriptions (used by OOH providers to record items supplied directly to a patient and not dispensed through a community pharmacy) when using medicines from the vehicles however they did not always complete the prescription meaning it is not always possible to reconcile which medicines had been used for what person unless individual patient records were audited.
- We were informed that PGDs were not used in this Vocare service (Somerset) for patients but were available should it be required. We did not find any PGDs such as an Influenza PGD for providing staff with Influenza vaccination.
- 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. We found the record books for the controlled drugs register for Schedule 2 medicines at the OOH sites were not always completed correctly and in line with legislation for managing and using controlled drugs. For example, one record book did not have the medicine name recorded on the pages relevant to that medicine. At one site we saw inconsistencies with reconciliation of an ampoule of Diamorphine which had been given to another site. There were appropriate arrangements in place for the destruction of controlled drugs.
- We spoke to staff and looked at medicines at the OOH sites. We found evidence that clinicians prescribing and supplying medicines were sometimes not giving patients medicines in their original packaging which meant patients were receiving medicines without labels with directions for usage. The risk for patients was that they received medicines which were not easily identified with the name and dose and without a guidance leaflet which identified any potential side effects.
- Processes were in place for checking medicines, including those held at the service and also medicines for the Out Of Hours vehicles. However we found out of date medicines at one OOH site. We saw the services were not using the findings from their audits effectively, Therefore the arrangements for managing medicines including emergency medicines was not robust and in line with the providers own policy. Arrangements were in place to ensure medicines and medical gas cylinders carried in the Out Of Hours vehicles were stored appropriately. Medicines were stored in tamper evident boxes. Medicines identified as at risk of misuse, were subject to additional security.

Monitoring risks to patients

We saw that the provider did not have an oversight of risk assessments and safety checks for monitoring and managing risks to patient and staff safety. Risk assessments and health and safety documentation was not easily located and on 24 April 2017 staff were unable to advise us what risk assessments were in place and what actions had been undertaken with regards to an external health and safety review conducted in September 2016.

- There had not been a health and safety lead in post since March 2017 and an interim position to oversee health and safety risks has been appointed. Most of the documentation was found for 25 April 2017, it was noted

that the health and safety matrix was amended in the presence of the inspector. We found there was little evidence during the inspection of an established system or process to regularly assess and monitor risk and safety.

- There were organisational policies in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in an area accessible to all staff. At the time of our inspection when we looked at the poster we found it did not identify a local health and safety representative. This was raised with the registered manager. Subsequent to the inspection we were informed that the health and safety representative's name had been added. In addition there was no oversight of accidents which had occurred locally. The provider told us that staff accidents were recorded on a datix system, however the inspection team were not provided with the datix report for staff accidents, and when asked staff were unable to find a record of local accidents. Fire drills had taken place at the Wellington House location however the provider was unable to evidence how many staff had attended these. Staff at Out Of Hours (OOH) sites advised us they had not participated in host site training around fire evacuation and safety.
- There was a system in place to ensure non-clinical equipment was maintained to an appropriate standard and in line with manufacturers' guidance such as annual servicing of electrical equipment at the headquarters at Wellington House. We found the service did not have a system for ensuring all clinical equipment was checked to ensure the equipment was safe to use and it was working properly. There was no list of clinical equipment owned by the service, where these were located and when calibration was due. At the OOH sites we found clinical equipment that had no evidence of checks being undertaken such as a date examined sticker. When we visited one site we saw evidence that clinical equipment had been calibrated the same day as our planned visit however a paediatric oxygen saturation monitor had not undergone checks. At another site there was no evidence of calibration for some of the equipment such as an oxygen saturation monitor and a sphygmomanometer.
- Clinical staff we spoke to told us they would use their own equipment and took responsibility for ensuring it was calibrated. We were told the provider did not ask for evidence of this. This meant there was no oversight of what equipment out of that supplied was being used and no records to show they were fully functional.
- The service had a variety of other processes in place to monitor safety of the Wellington House premises such legionella (Legionella are bacteria which can contaminate water systems in buildings). We found that COSHH risk assessments for items used by the contract cleaners, were kept in the cleaning cupboard accessed by them. However, safety data sheets for the control of substances hazardous to health (COSHH) had not been completed for the cleaning products purchased by the service such as dishwashing powder.
- In addition there was no oversight of accidents. All incident forms were centrally collated and kept at provider level. However, no record was kept at Wellington House or the Out Of Hours sites of incidents that had occurred locally. Prior to the inspection we requested a copy of organisations liability insurance. This and the required display copy at the location on 24 April did not cover this service. The provider informed us this issue was later rectified.
- Drivers told us they had recently commenced a system by way of a checklist at the beginning of each shift to ensure the safety of the out of hours vehicles. These checks included vehicle safety checks and a record of equipment. Staff showed us checklists but told us they were unsure how their comments were actioned.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups. The service had difficulties recruiting GPs. They employed 21 salaried GPs and relied on sessional GPs for additional shift fill. We looked at the rota for past and future shifts. We saw the service did not have a consistent shift fill rate for clinicians. We saw GPs worked double shifts to cover the evening services at OOH sites. This meant if a GP was unwell the service would lose one site and two clinical shifts. Following concerns raised by GPs during the Christmas period around shortages of clinicians and patient safety the service met with staff and the Local Medical Committee to devise a plan for Easter. We saw

extra triage resources were made available to support the busy Easter period. These were remote triage positions filled across the provider's service as the local service had difficulties recruiting GPs to undertake triage work.

Arrangements to deal with emergencies and major incidents

- Non-clinical staff we spoke to at the Out Of Hours sites told us they had not received basic life support training (BLS), including use of an automated external defibrillator. We looked at the services training matrix in which the provider Vocare recommend BLS training took place every 18 months for reception staff. Drivers or drivers with reception duties were not expected to undertake BLS training. It was not evident whether training had taken place for clinical and non-clinical staff as the local training matrix was not populated. We spoke to staff at Wellington House and they were unable to provide evidence of BLS training.
- The service had a defibrillator available in the Out Of Hours vehicles and Oxygen with adult and children's masks. We found one vehicle had out of date defibrillator pads. One driver was told us they were uncertain when oxygen cylinders should be replaced. Emergency medicines used to treat medical emergencies in diabetes and sedatives for seizures were not always available at OOH sites. This meant clinicians may not be able to treat diabetic and epileptic emergencies. We spoke to a driver and clinician who were unable to easily locate the medicines used to treat Hypoglycaemia within the OOH vehicles. This meant in an emergency the medicine would not be easily found for fast administration.
- The five OOH sites had different systems within the host sites when dealing with a medical emergency. For example, a resuscitation team was available at Yeovil District Hospital. At Bridgwater Hospital a defibrillator was stored in the minor injuries until 11pm when it was relocated on a ward. We spoke to staff who were unsure of the procedure in an emergency and did not know how to access the defibrillator. This included how a clinician would alert staff to an emergency within their consultation room.
- A first aid kit was available at the Wellington House location.
- The provider had been provided with a corporate business continuity plan to deal with emergencies which might interrupt the smooth running of the service. This included loss of mains power, loss of utilities, loss of staffing, evacuation of the building and loss of the Directory of Services. The service could operate if required from other locations which provided call handling services. This provided increased resilience and mitigated the risk of any potential loss of service. The registered manager was in the process of producing a local business continuity plan specific to the Wellington House site and its staff team.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

- The service had systems in place to keep all clinical staff up to date through the monthly clinical director's newsletter. Staff had access to guidelines from National Institute for Health and Care Excellence (NICE) at most of the Out Of Hours sites however some sites did not have internet access and there were no paper based guidelines.
- It was unclear if the service monitored that these guidelines were followed through patient record audits.
- Access to medicines reference sources were available at the OOH sites and in the vehicles.

Management, monitoring and improving outcomes for people

From 1 January 2005, all providers of out-of-hours services have been 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 the clinical commissioning group on their performance against 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.

The service had been experiencing clinician shortages through 2016 into 2017. The service had alerted their commissioners to the difficulties and had maintained an open dialogue with the commissioners whilst recruitment was undertaken. We found evidence that the service had reviewed the use of the service to identify peaks and troughs in demand to enable appropriate numbers of staff to be planned into the service.

The service was performance measured against National Quality Requirements (NQRs) and included:

NQR 2. Providers must send details of all Out of Hours (OOH) consultations (including appropriate clinical information) to the practice where the patient is registered by 8.00am the next working day. Where more than one organisation was involved in the provision of OOH services, there must be clearly agreed responsibilities in respect of the transmission of patient data. The inspection team looked at data for NQR12 which covered the period October 2016 to March 2017. The service met 100% of this target during this time period.

NQR 12: Providers must ensure that face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed: Emergency: Within 1 hour; Urgent: Within 2 hours; Less urgent: Within 6 hours. Somerset Clinical commissioning group issued a Contract Performance Notice on 27th March 2017 relating to the non-compliance of NQR12b, c, e and f and shift fill levels. The inspection team looked at data for NQR12 which covered the period October 2016 to March 2017. The provider is currently not meeting:

- NQR12b: Presenting at base: Clinical Assessment for all urgent care patients within 2 hours (GP OOH; October to December 2016 average 81.8% and January to March 2017 average 83.3% with a target of 95%).
- NQR12c: Presenting at base: Clinical Assessment for all urgent care patients within 6 hours (GP OOH; October to December 2016 average 92.75% and January to March 2017 average 92.4% with a target of 95%).
- NQR12e: Home Visits: Clinical Assessment for all urgent care patients within 2 hours (GP OOH; October to December 2016 average 78.3% and January to March 2017 average 76.5% with a target of 95%).
- NQR12f: Home Visits: Clinical Assessment for all urgent care patients within 6 hours (GP OOH; October to December 2016 average 86.6% and January to March 2017 average 87.4% with a target of 95%).

Six Local Quality requirements (LQRs) were also used to measure the performance. Five of the six targets were consistently met. The provider is currently not meeting the target LQR2: The service has a safe and effective system for prioritising clinical assessment of other calls within 120 minutes of the call being answered. From January to March 2017 an average 71% of the 95% target was met. A remedial action plan was in place. Prior to our inspection we received information from Somerset CCG about the commissioned service. They advised us the provider was

not meeting the LQR2 target. To clarify the challenge a discussion was undertaken with Somerset CCG who confirms that LQR2 is measured by them and they have made this clear to the Provider.

There was some evidence of audit.

- The provider had a national rolling audit programme that looked at assurance across the services. They also had a face to face clinical audit policy to measure clinical practice against evidence-based standards. The policy directed these to take place in the form of a video recording of three clinical consultations. During our inspection we saw no evidence these had taken place.
- We were told clinical practice was measured by a monthly audit of 50 random case notes from face to face consultations. We reviewed two of the audit records. GPs received feedback if there were any concerns and then further sets of notes were audited. However there were no clear overall findings that were used for shared learning and the level of activity was insufficient to show effective quality monitoring.
- In addition a national clinical call review audit policy was in place to ensure there was consistent standardised and appropriate assessment of triage calls. The policy states new clinicians should have five random calls reviewed within the first three months (three telephone advice and two home visits). Existing clinicians (doctors and nurses) should have four random calls reviewed (two telephone advice and two home visits) annually. During our inspection we saw evidence those telephone calls that were audited received a satisfactory outcome.
- Locally a number of audits had been undertaken. These included a comfort calling audit. Patients are required to receive a comfort call when timescales for home visits and clinician call backs had not been met. The highest percentage of comfort calls undertaken was in July and October 2016 where 72% of the target was met. Since December 2016 training had been implemented however targets remained low. We saw little evidence of additional measures being put in place to improve expected outcomes. We saw the comfort calling audit had a quarterly cycle and looked at the results from May to December 2016. We saw there had been an improvement since May 2016 when 38% of patients received a comfort call whilst awaiting clinician contact however calls remained below the 95% target. This information is based on evidence provided at the inspection including comfort calling audits and re-audits which state: The target for this should be 100% compliance. After discussion with Somerset CCG they confirm the RAG rating for this is 95% and above. Although this is an improvement to previous information there is evidence that this has not been consistently achieved.
- The audits we looked showed a clear outline of the problem and a clear audit plan with audit cycle measuring whether there was change or not. It was not always clear how findings were used to improve services through implementation of results and on-going monitoring. However there was little evidence of audits of clinical work taking place. For example, monitoring of prescribing patterns of clinicians. An audit of antimicrobial prescribing had taken place in June 2016 where good practice and areas of improvement were identified. However an action plan and the conclusion to repeat the audit in six months had not been completed.
- The service attended external meetings such as the Urgent and Emergency Care Clinical Assurance Committee and the Somerset sepsis group.

Effective staffing

- The service had an induction programme for all newly appointed clinical staff to undergo shadow shifts prior to working alone. We were told about this by the regional clinical director and this was confirmed by staff however we did not see any documented evidence of this or any additional training completed as part of the service induction.
- We were told the learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. The nine Out Of Hours (OOH) site staff we spoke to told us they had not received an annual appraisal or performance review by the service. We were told 50% of salaried GPs had received a performance review since the provider held the contract.
- We reviewed the management system for training. We spoke to four members of the leadership team about the recording and provision of training. We found the current training records were not up to date. For

example, training for staff in safeguarding was not fully populated. We asked a member of staff responsible for completing the training record and they were unable to provide us with evidence of numbers of staff trained in safeguarding and the level of training staff had received. We spoke to staff who worked at the OOH sites including five drivers and four receptionists. They all advised us that they had not received statutory training such as basic life support, annual infection control and prevention or for four drivers, safe driving training. One receptionist was able to discuss and evidence on-line safeguarding training with the service. We spoke to a member of staff involved in handling medicines who had received training appropriate to their role.

- The provider had a virtual learning network for clinicians. We looked at the system and saw relevant topics were available such as identifying red flags.

Coordinating patient care and information sharing

The National Quality Requirement (NQR 3): Providers must have systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness).

- The inspection team saw evidence that GPs provided the Out Of Hours (OOH) service with 'special notes' electronically which the service could access. These 'special notes' provided additional care and treatment for patients such as those receiving end of life care, complex cases and medicines misuse. All OOH sites had access to EMIS Web, a clinical IT system hosting patients own GP records. This allowed clinicians to check recent GP contacts and provide a continuity of care. However some staff told us they had difficulty accessing the system due to the internet connection.

  The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system.

- The provider used an electronic patient record system called Adastra. The service encouraged clinicians to access patient's own electronic GP records.
- The service shared relevant information with other services in a timely way, for example when referring patients to other services. The organisation also provided the NHS 111 service which meant sharing of information around service pressures was standard practice. For example, we spoke to a team leader who worked in both of the services. They told us they regularly liaised with their OOH / NHS111 counterpart and encouraged staff to assist the other service at times of pressure.
- The service worked collaboratively with other services. Patients who could be more appropriately seen by their registered GP or an emergency department were referred. If patients needed emergency specialist care, the OOH service, could refer to specialties within the hospital.
- The service worked with other service providers to meet patients needs and manage patients with complex needs. It sent OOH notes to the registered GP services electronically by 8am the next morning.

Consent to care and treatment

Staff sought patients consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

85% of the 57 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt that staff offered an efficient service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

The service received patient feedback in the form of the NHS Family and Friends Test. Patients were asked to provide feedback at the end of their visit. Results from December 2016 to March 2017 showed that between 79% and 95% of patients would recommend the service.

The national GP patient survey (July 2016) asks patients about their satisfaction with the Out Of Hours service. The results showed:

- 90% of respondents provided a positive response to having confidence and trust in the person or people seen or spoken to which was comparable to the national average of 90%.
- 72% of respondent had a positive opinion of their overall experience of NHS service when the GP surgery was closed compared to the national average of 70%.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards we received showed 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.

The service provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services 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.
- Information leaflets were available in easy read format.
- There were no facilities for people with hearing impairment or those that required sign language interpretation.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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 service reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified.

- Home visits were available for patients whose clinical needs resulted in difficulty attending the service. Although these were not always timely and in line with national requirements.
- A translation service was available. Access to a hearing loop system and to British sign language (BSL) interpreters were limited. Advanced booking is required for BSL interpreters.
- The Out Of Hours sites were easily accessible to patients who used a wheelchair and for pushchairs with level access throughout, electronic doors, wide passage ways and accessible toilets were available.
- The provider supported its sister service (the NHS 111 service) at times of increased pressure by helping with the clinician call back queue.
- Health care professionals who required medical advice could call the service and receive a call back from a GP within a specified timescale.

Access to the service

The service was open 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 and on bank holidays.

Patients could access the service via NHS 111. The service did not see 'walk in' patients and those that came in were told to ring NHS 111 unless they needed urgent care in which case they would be assessed before referring on.

Feedback received from patients from the Care Quality Commission comment cards indicated that in most cases patients were seen in a timely way. 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 in a timely manner. Data showed those timescales for patients required to be seen within two or six hours were not being fully met.

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 along with an algorithm as a system 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. During busy times or when the service was disrupted the provider had a system in place to 'comfort call' a patient back. These comfort calls supported callers awaiting a home visit or a clinical call back within a timescale which might not be met or when there may be changes which required an appointment to be changed. Patients also received a call back when a home visit had been recommended as the course of action required.

Quarterly comfort call audits were undertaken following patient complaints about waiting times for the service, recorded service incidents around breaches of timescales for patient contact and a significant event of which the results showed that comfort calling/contacting the patient would have changed the outcome. Results of the audits show from May to December 2016 between 38% and 72% of patients requiring a call back from the service to advice of delays and to check for a worsening of symptoms were contacted by the service which is below the 95% target.

Listening and learning from concerns and complaints

Prior to our inspection we requested evidence of complaints received within the past year. These were not provided and during the inspection there was some initial difficulty in locating information regarding complaints.

The service had a system in place for handling complaints and concerns.

- Its complaint policy and procedures were in line with the NHS England guidance and their contractual obligations.
- The service had recently appointed an administrative team who co-ordinated the handling of all complaints. We spoke to the team as well as the designated responsible person for complaints within the service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- We looked at the complaint summary for the complaints received since between April 2016 and March 2017. We also looked in depth at three of the complaints received. Following patient feedback in a CQC comment card we also asked the provider to provide information regarding this complaint.
- We saw gaps in information contained within the reporting system. Some complaints were not dealt with consistently and there were not always clear explanations of actions taken, identification of learning or sharing of learning. However the most recent complaints were dealt with in a timely way.
- We were told the regional clinical director (RCD) investigated all clinical complaints however we saw the designated responsible person sent out final correspondence to the public without RCD oversight. One of the complaint letters we looked at had inaccuracies around medicines which would have been identified by a clinician.
- We saw themes and trends around complaints such as delays and cancellations in care and access to treatment. It was unclear how analysis of trends resulted in improvement of care.
- We saw that information was available to help patients understand the complaint process on the website. Advice and signposting was limited at the OOH sites.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The service had a clear vision to deliver high quality care and promote good outcomes for patients.

- The provider had a mission statement. Staff we spoke to were not always aware of the mission statement or how their role contributes to achieving it.
- The service had a strategy and supporting business plans that reflected the vision and values and were regularly monitored. In addition the regional director had an action plan to address areas of known concern and risk. Some of these areas were also identified as risks during our inspection.

Governance arrangements

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

- Whilst the provider had a good understanding of their performance against National Quality Requirements they had not responded in a timely manner to the staffing shortages that resulted in them failing to attain the requirements. We noted that a recruitment plan had been put in place. Performance and in particular areas where targets were not being met were discussed monthly with the clinical commissioning group as part of contract monitoring arrangements. The service had produced a remedial action plan where shortfalls had been identified. The version of the action plan initially shown to the inspection team was version 1.1 dated 11.4.17 and was in draft format. The non draft document was dated 25.4.17 and was provided on day two of our inspection, however there was no evidence it had been implemented.
- We saw the comfort calling audit had a quarterly cycle and looked at the results from May to December 2016. We saw there had been an improvement since May 2016 when 38% of patients received a comfort call whilst awaiting clinician contact however calls remained below the 95% target. This information is based on evidence provided at the inspection including comfort calling audits and re-audits which state: The target for this should be 100% compliance. After discussion with Somerset CCG they confirm the RAG rating for this is 95% and above. Although this is an improvement to previous information there is evidence that this has not been consistently achieved.
- The provider offered a wide range of statutory and mandatory training; however the spreadsheet we were shown as evidence of training was incomplete. For example, we saw that staff had undertaken some mandatory training as part of the induction process but the spreadsheet indicated that this had not been updated and was out of date. This was in contravention of the Vocare policy. We were also told about specific workshops for staff such as the sepsis workshop, but no names of attendees had been noted on the training record.
- The systems and processes to identify and manage risks and issues were not always robust. This meant there was not an effective system or process to assess, monitor and improve the quality and safety of the services provided or to assess monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk arising from the carrying on of the regulated activities. For example, the provider could not provide evidence of some recruitment checks in a timely manner and therefore could not demonstrate the suitability and qualifications of their clinical workforce such as with safeguarding training.
- There was limited evidence that analysis of trends in incident reporting and complaints resulted in improvements of care and treatment.

Are services well-led?

Inadequate

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

- The service had produced a remedial action plan where shortfalls had been identified however this had not been implemented at the time of the inspection.
- During the inspection we saw evidence that serious incidents or safeguarding referrals had not resulted in statutory notifications to the Care Quality Commission.

Leadership and culture

There was a local leadership structure with both operational and clinical leads within the service. However some of the responsibilities for the service were managed at organisational level.

There were arrangements in place to ensure the clinical staff were kept informed and up-to-date. This included a monthly newsletter. Staff told us there was an open culture within the service and they had the opportunity to raise any issues and felt confident in doing so. Although 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. Staff at the OOH sites told us they had not met the leadership team and they did not visit the sites to understand what was happening during day-to-day services.

The provider was aware of and had systems in place to ensure 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).This included support training for all staff on communicating with patients about notifiable safety incidents. The provider encouraged a culture of openness and honesty. The service had systems in place to ensure that when things went wrong with care and treatment they gave affected people an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.

Seeking and acting on feedback from patients, the public and staff

The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients feedback and engaged patients in the delivery of the service.

- The service had gathered feedback from patients through the NHS Family and Friends test and demonstrated improved management of complaints. It was unclear how themes from complaints received resulted in improvements to care and treatment. For example, complaints around delays in access and treatment had not led to sustained improvement in 'comfort calling' rates.
- The service had gathered limited feedback from staff through surveys, appraisals or performance reviews. We saw good evidence of the service listening and acting on feedback from clinicians following concerns raised around patient safety during the Christmas period. This resulted in extra support over the Easter period and improved rota fill rates. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management although staff at OOH sites advised us they had very little contact with staff at Wellington House. The leadership team were aware of and looking to address and improve communication with staff.

Continuous improvement

The service maintained a risk register in order to identify and take preventative action and promote service resilience. The risk register actions showed evidence of a focus on improvement at all levels within the practice.

We saw little evidence of a focus on continuous learning and improvement at all levels within the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not do all that was reasonably practicable to ensure staff received performance reviews and/or appraisals that are necessary for them to carry out their role and responsibilities.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12: Safe care and treatment** **The provider had not done all that was reasonably practicable to mitigate the risks to the health and safety of patients receiving care and treatment. In particular:** **Prescription security. The monitoring system to ensure prescription security was not adequate to monitor usage. Clinical staff did not always complete prescriptions to record items supplied directly to a patient.**

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17: Good Governance** **(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.**