Care UK – NHS 111 South West

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.

Summary of findings

Ratings

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

Summary of findings

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Overall summary

We carried out this comprehensive inspection of Care UK – NHS 111 South West service on 27 and 28 September 2016. NHS111 is a 24 hours a day telephone based service where people are assessed, given advice or directed to a local service that most appropriately meets their needs.

Care UK – NHS 111 South West provides services to the areas of Bristol, South Gloucestershire, Bath and North East Somerset, Wiltshire and Gloucestershire. Care UK – NHS 111 South West has one call centre which manages calls for these areas, we inspected this call centre which is located at Lime Kiln Close on the outskirts of Bristol.

Our key findings were as follows:

- There were systems in place to help ensure patient safety through learning from incidents and complaints about the service. All opportunities for learning from internal incidents and complaints were used to promote learning and improvement.
- The provider had taken steps to ensure all staff underwent a thorough recruitment and induction process to help ensure their suitability to work in this type of healthcare environment.
- The provider had developed a mobile phone 'app' that allowed senior managers to access real time information relating to call handling within the call centres. This allowed senior managers to support team managers at times of unexpected demand.
  - Staff were supported in the effective use of NHS Pathways. Regular audits of calls to the service monitored quality and supported improvement. Where issues were identified remedial action was taken and the employee was supported to improve.
  - People experienced a service that was delivered by dedicated, knowledgeable and caring staff.
  - People using the service were supported effectively during the telephone triage process. Consent to triage was sought and their decisions were respected. We observed staff treated people with compassion, and responded appropriately to their feedback.
  - Clinical advice and support was readily available to health advisors when needed. Care and treatment was coordinated with other services and other providers.
  - There was an overarching governance framework across the NHS 111 service, which supported the delivery of their strategy and good quality care. This included arrangements to monitor quality and identify risk.
  - Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
  - Risk management was embedded and recognised as the responsibility of all staff.
  - The provider was aware of and complied with 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 key staff ensured this information was shared with staff to ensure appropriate action was taken.
  - There was a strong focus on continuous learning at all levels.

We saw an area of Outstanding practice:

The Care UK – NHS 111 South West had implemented a system called 'The Bridge' which provided a clinician an overview of calls waiting for a clinical call back. The clinicians used a risk assessment tool which supported their clinical reasoning and decision making to ensure calls were correctly prioritised and people were called back within the recommended timeframe. The system had been implemented by the team and shared across the organisation; they had audited 'The Bridge' calls and demonstrated the impact on people who used the service as in April 2015, 11.7% of callers were referred to Emergency Departments whilst by January 2016 this was reduced to 7.9% because clinical advisors were able to assess and direct people more appropriately.

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?

Good

The provider is rated as good for providing safe services.

- Safety was seen as a priority.
- Service performance was continuously monitored and reviewed and improvements implemented.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- All opportunities for learning from internal and external incidents were discussed to support improvement. Information about safety was valued and used to promote learning and improvement.
- Risk management was embedded and recognised as the responsibility of all staff.
- Staff took action to safeguard people and were aware of the process to make safeguarding referrals. All calls with safeguarding concerns were “warm transferred” (a direct call transfer where the caller was kept on the telephone) to a clinician to progress. In some circumstances this led to a verbal handover between health advisors and clinicians, and details of this were recorded.
- The service had long and short-term plans in place to ensure staffing levels were sufficient to meet anticipated demand for the service.
- Clinical advice and support was readily available to health advisors when needed.

Are services effective?

Good

The provider is rated as good for providing effective services.

- Daily, weekly and monthly monitoring and analysis of the service achievements was measured against key performance targets and shared with the lead clinical commissioning group (CCG) members. Account was also taken of the ranges in performance in any one time period.
- Appropriate action was undertaken where variations in performance were identified. Staff were trained and rigorously monitored to ensure safe and effective use of NHS Pathways.
- Staff received annual appraisals and personal development plans were in place; staff had the appropriate skills, knowledge and experience to perform their role.

Summary of findings

- Staff ensured consent, as required, was obtained from people using the service and appropriately recorded. There was an effective system to ensure timely sharing of patient information with the relevant support service identified for the patient and their GP.
- People's records were well managed, and, where different care records existed, information was coordinated.
- Staff used the Directory of Services and the appropriate services were selected.
- Capacity planning was a priority for the provider. The provider undertook detailed call level forecasting to enable them to ensure adequate staffing levels could be delivered.

Are services caring?

Good

The provider is rated as good for providing caring services.

- Friends and family survey data from December 2015 to August 2016 showed that between 74% and 81% of people would recommend the service to others.
- People using the service were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw staff treat people with kindness and respect, and maintained the caller's confidentiality.
- We heard staff listened carefully to information that was being told to them, confirmed the information they had was correct and supported and reassured callers when they were distressed.
- Staff obtained the patient's consent when it was necessary to share information or had their call listened to.

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services.

- There was a comprehensive complaints system and all complaints were risk assessed and investigated appropriately.
- Action was taken to improve service delivery where gaps were identified.
- Care and treatment was coordinated with other services or providers. There was collaboration with partners to improve urgent care pathways.
- Staff were alerted, through their computer system, to people with identified specific clinical needs and special notes or any safety issues relating to a patient.
- The service engaged with the lead clinical commissioning group to review performance, agree strategies to improve and

Summary of findings

work was undertaken to ensure the Directory of Services (DOS) was kept up to date. (The DOS is a central directory about services available to support a particular person's healthcare needs and this is local to their location).

Are services well-led?

Good

The provider is rated as good for being well-led.

- The provider had a clear vision and strategy to deliver a high quality service and promoted good outcomes for people using the service. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. Staff, including those who did not work conventional office hours, knew how to access senior leaders and managers if required.
- The provider's policies and procedures to govern activity were effective, appropriate and up to date. Regular governance meetings were held.
- There was an overarching governance framework which supported the delivery of the strategy and service quality. This included arrangements to monitor and improve quality and identify risk.
- The information used in reporting, performance management and delivering quality care and treatment was accurate, valid, reliable, timely and relevant.
- The provider was aware of and complied with the requirements of the duty of candour. The provider and managers encouraged a culture of openness and honesty. Systems were in place for notifiable safety incidents and key staff ensured this information was shared with staff to ensure appropriate action was taken. There was a strong focus on continuous learning and improvement at all levels.

Care UK – NHS 111 South West

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspection Manager. The team included two CQC inspectors, and a specialist advisor with experience of NHS 111 services and NHS Pathways training.

Background to Care UK – NHS 111 South West

Care UK, was founded in 1982, and the company is a large UK based independent provider of health and social care. Their services include treatment centres, GP practices, NHS walk-in centres, GP out-of-hours, prison health services and clinical assessment.

Care UK – NHS 111 South West was registered as a location in April 2014 and operates from:-

Nicholson House

Lime Kiln Close

Bristol BS34 8SR

The provider holds the contracts for 12 NHS 111 services across a range of geographical areas in England, including the south west and south east of England, London, and parts of the Midlands and the East of England. It is a telephone based service where people are assessed, given advice and directed to a local service that most appropriately meets their needs. People can call 24 hours a day, 365 days a year, and calls are free for landlines and mobile phones. The NHS 111 service is staffed by a team of trained health advisors, supported by clinical advisors who are experienced nurses and paramedics.

This is the first comprehensive inspection of the NHS 111 service provided by Care UK – NHS 111 South West.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Detailed findings

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

We carried out an announced inspection to Care UK – NHS 111 South West on 27 and 28 September 2016. We were unable to speak directly with people who used the service. However, with people's consent we listened to calls.

During our visit we:

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

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

Good

Are services safe?

Summary of findings

The provider is rated as good for providing safe services.

- Safety was seen as a priority.
- Service performance was continuously monitored and reviewed and improvements implemented.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- All opportunities for learning from internal and external incidents were discussed to support improvement. Information about safety was valued and used to promote learning and improvement.
- Risk management was embedded and recognised as the responsibility of all staff.
- Staff took action to safeguard people and were aware of the process to make safeguarding referrals. All calls with safeguarding concerns were "warm transferred" (a direct call transfer where the caller was kept on the telephone) to a clinician to progress. In some circumstances this led to a verbal handover between health advisors and clinicians, and details of this were recorded.
- The service had long and short-term plans in place to ensure staffing levels were sufficient to meet anticipated demand for the service.
- Clinical advice and support was readily available to health advisors when needed.

Our findings

Safe track record

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

- Significant events which met the threshold for a Serious Incident or Never Event were declared and investigated in accordance with the NHS England Serious Incident Framework 2015. The provider Care UK – NHS 111 South West shared information at provider and commissioner forums, and cooperated with investigations when required such as local authority safeguarding investigations.
- Learning from significant events was not confined to those that met NHS England's criteria for a Serious Incident (SI) or Never Event. The provider treated significant events including near misses as an opportunity for learning and risk reduction measures. We reviewed two investigations into SIs. The process of the investigations showed that audits of calls were made and outcomes reviewed. Any shortfalls identified assisted in determining possible root causes.
- Staff told us they would inform the team manager of any incidents and there was a recording form available on the provider's computer system for staff to record incidents. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that service/provider of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong, people were informed of the incident, received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.
- One incident related to a delay in diagnosis. Throughout the investigation, the patient concerned was kept informed of the process and was provided with a written outcome, with the offer of further discussion if needed for clarification. A shortfall identified related to how calls were handled and classified the delay as being due to human factors. As a result of the incident the provider had provided a training module on this area to improve

performance. A pilot study had been carried out with a local university to explore this issue further as one of the NHSE workforce pilots, the findings of which were about to be shared at a national event.

- The provider also conducted audits of the staff involved with the incident to ensure the level of assessment and care was appropriate in a range of other calls. We saw that the provider had shared the findings and any learning identified with staff and it was recorded as part of the quality assurance process. Examples of learning from significant events included 'hot topic' guidance which was cascaded to staff and updates in a safety bulletin. We saw a range of updates for staff including a sepsis awareness worksheet and 'hot topic' guidance for strokes and peritonitis (a severe infection of the abdomen which required hospitalisation).
- The provider had contributed information for serious case reviews. An example given to us related to case in which a patient had died. The provider openly and critically examined each aspect of their involvement in the case and had established whether there were lessons to be learnt from the circumstances of the case. This was one situation whereby the provider had shared areas of learning throughout the organisation where they considered could be improved when working with other professionals and agencies to safeguard adults and children at risk. The provider reviewed the effectiveness of their safeguarding policies and protocols using a safeguarding assurance framework; a safeguarding self-assessment and safeguarding audits. Audits were undertaken for 10% of all safeguarding referrals to other agencies, the audits covered the referral a process, record keeping, questioning and communication. We saw documentation which confirmed that pass rates of audits, including compliance with the safeguarding policy, were in line with the provider's standard operating procedure.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. For example, the medical lead had fed back suggestions for changes to NHS Pathways (the clinical decision support tool) based on incidents reviewed where potential risks relating to the algorithm (pathway) had been identified. The medical lead had made suggestions to improve safety to NHS Pathways, including changes to questions in respect of headaches in order to improve the identification of people with early signs of meningitis.
- We saw evidence that lessons were shared and action was taken to improve safety. Complaints, concerns, health care professional feedback, significant events and non-compliant call audits were reported on in a monthly clinical governance report. These were reviewed at the monthly NHS 111 and clinical commissioning group meetings, known as the 'Integrated quality and performance management board'. Following these, the provider was able to consider if there were any themes identified and then undertook any changes needed; for example, updating local operating policies.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff and clearly outlined who to contact for further guidance if staff had concerns about a person's welfare. The provider was aware of their responsibility in respect of 'working together to safeguard children' (2015). This is guidance on inter-agency working to safeguard and promote the welfare of children. For adults, this included the Care Act 2014, the Department of Health's guidance for professionals (March 2015) on Female Genital Mutilation and Safeguarding and the Prevent strategy. These had been incorporated with the provider's safeguarding assurance framework and staff training. In the area where calls were received there was a safeguarding noticeboard, containing .hot topic information such as signs of mental illness in patients of all ages. Information was available on staff work stations and detailed the different access pathways required for staff to use depending on the specific area that a patient lived in. Referrals were made by clinicians or team managers. Health advisors sought advice and support from a supervisor if they had a safeguarding concern identified during a call.

Good

Are services safe?

- All calls with a safeguarding concern were "warm transferred" (a direct call transfer where the caller was kept on the telephone) to a clinician to progress the issue; this meant some calls were, at times, ended by the health advisor and then a verbal "hand over" to the clinician made so they could then determine whether a safeguarding issue was relevant. In the 12 months prior to the inspection there had been 154 child safeguarding referrals and 284 adult safeguarding referrals made. Contributions were made to safeguarding meetings when required.
- Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. There was a lead member of staff for safeguarding; this was the director of nursing who had undertaken training to level five in safeguarding. There was also a clinical team leader trained to level four. Health advisors were trained to level two for safeguarding children, level three for clinical staff. We discussed examples of safeguarding concerns with three of health advisors and clinicians. Staff were able to demonstrate clearly how to identify and manage these cases. Other staff we spoke with during the inspection were aware of the safeguarding legislation which governed activity and gave examples such as 'working together to safeguard children' (2015).
- Staff had undertaken training in recognising concerning situations such as domestic violence or intoxication and followed guidance in how to respond, this included discussing real case scenarios during the induction period to give new staff a good awareness of potential areas for concern. Clinical advice and support was readily available to staff when needed. For example we saw a health advisor was able to pass a call which had concerned them to a clinician so as to ensure the patient received the most appropriate care. Clinical and non-clinical coaches (who provided support to health advisors) were present within the call room for staff to obtain advice if there were any concerns as to which pathway to use within the clinical decision support software. Staff told us the supervisors and coaches offered good support. Two examples we were given included clinical advisors supporting new health advisors after a difficult child safety call and a call involving an injury to an infant.
- Clinical staff had access to special patient notes and care plans, which included supporting information on people identified as frequent callers and those on end of life pathways. Staff were clear about the arrangements for recording patient information, maintaining records and making use of additional information. This made a difference to the management and support given to callers.
- As soon as a call was received by a health advisor, a patient record was established including name, age and address. We heard how staff checked information for accuracy whilst at the same time reassuring the caller. Information was recorded directly onto the computer system and all calls were recorded to enable information verification and quality management. Staff were clear about the arrangements for recording patient information and maintaining records.
- The provider used the Department of Health approved clinical decision support system NHS Pathways. (This is a set of clinical assessment questions to triage telephone calls from people and is based on the symptoms reported when they call. The tool enables a specially designed clinical assessment to be carried out by a trained member of staff who answers the call.) Once the clinical assessment was completed a disposition outcome and a defined timescale was identified to prioritise the patients' needs. Health advisors' and clinician advisors' call handling skills using the NHS Pathway systems were monitored regularly to ensure that dispositions reached at the end of the call were safe and appropriate. Two calls we listened to were referred on from the ambulance validation line which was a process whereby a clinician undertook a further assessment to see whether the dispatch of an ambulance was necessary. In both calls the ambulance disposition was reviewed by a clinician and an alternate pathway offered.
- Staff were able to access the advice of clinicians where the patient was not satisfied or did not accept NHS Pathway outcome or disposition. Should a clinician not be available for a direct call transfer (warm transfer) the patient could be placed in a 'call back' queue or health advisors could seek the advice of the clinical supervisor or team leader if they were uncertain of how to manage the call. We observed that the Care UK – NHS 111 South West service worked seamlessly with the other Care UK NHS 111 call centre locations in London and the South

East so if callers were experiencing any delays staff could support each other and provide calls back for people from a different location to reduce the delay to the patient's assessment. All the staff across the three locations had access to the NHS Pathways assessment that had been carried out and could access the Directory of Service to provide the correct ongoing health or care pathway, for the relevant geographical area.

- Health advisors and clinicians also had direct access to a supervisor for support or advice if needed during a call through their telephony system. For example we observed an advisor dealing with an emergency situation who was able to directly call a supervisor for support to ensure they were following the correct pathway. This allowed staff members who were having difficulty in managing a call to receive immediate assistance.
- There were clear processes in place to manage the transfer of calls, both internally within the service, and to external providers, to ensure a safe service. Standard operating procedures were available to all staff working for Care UK South West.
- Call response times, waiting times, abandoned call data were closely monitored throughout each shift and staff were deployed to manage demand at peak times. Clinical supervisors and team leaders had oversight of call types and these were triaged to ensure that those callers with more urgent needs were prioritised to ensure patient safety.
- Care UK – NHS 111 South West held staff records centrally and their human resource department managed recruitment. We saw the tracking document for each new recruit which indicated when key documents had been received. We tracked the recruitment and documentation for a new recruit who was attending for an interview. We found appropriate recruitment checks had been undertaken prior to interview. For example, proof of identification, 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. We also saw these records had been sought and obtained for all agency locum clinical staff who worked at the centre along with confirmation from the agency which provided staff. This allowed the service to closely monitor training and continuous professional registration of locum staff.
- Staff were provided with a safe environment in which to work, risk assessments and actions required had been taken to ensure the safety of the premises. Reasonable adjustments were undertaken to ensure work stations were appropriate for individual staff members. Height adjustable work stations, specialised chairs and IT equipment were available to staff where appropriate. The call centre was clean; desks were spaced appropriately to ensure that health advisors were not distracted by other calls.

Monitoring safety and responding to risk

- Risks to people using the service were assessed and well managed.
- Health advisors triaged patient calls by use of a clinical decision support system (NHS Pathways). This guided the health advisor to assess the patient based on the symptoms they reported when they called. Supporting this clinical decision tool was the directory of services (DoS) which identified appropriate services for the patient's care. Staff received comprehensive training and regular six monthly updates on the NHS Pathways; their competencies were assessed prior to handling patient telephone calls independently, and continuously through regular call audits for all members of staff.
- Shift rotas were planned and implemented using the workforce management tool and staff were scheduled to work against forecasted/anticipated levels of demand. Staff skill mix was monitored daily and any shortfalls highlighted and acted upon. Rotas were prepared in advance to ensure enough staff were on duty. Arrangements were in place to assist in managing staffing levels at times of high demand such as bank holidays.
- The management, resourcing and supervisor team maintained a continual oversight of staffing levels and call demand on the service. This was measured across previous known levels of demand on the service. The staffing levels were adjusted where possible to meet the demand, for example, the service increased the

numbers of staff available at weekends. Shift start times and lengths could be adjusted and breaks were planned to times of predicted lower demand within health and safety guidance on safe working.

- The service maintained a constant surveillance over the levels of demand on the service and monitored the numbers and conditions of the people waiting for clinical advisor call them back. Where possible calls taken by health advisors requiring further advice were warm transferred to a clinician but where this was not possible, the call was put into a call back queue which was monitored. This queue was assessed and some calls were prioritised to receive a clinical advisor call back within ten minutes; others to receive a call back within two hours depending on the presenting clinical need.

Arrangements to deal with emergencies and major incidents

- The service had adequate arrangements in place to respond to emergencies and major incidents.
- The provider had a comprehensive business continuity plan in place to deal with emergencies that might interrupt the smooth running of the service. This included loss of mains power, loss of utilities, loss of staffing, evacuation of the building and loss of the Directory of Services. The plan included emergency contact numbers for staff. The service could operate if required from any of the three locations providing call handling services. This provided increased resilience and mitigated the risk of any potential loss of service.
- The provider had engaged with other services and commissioners in the development of its business continuity plan.
- We were given an example by Care UK of emergency plans in action when they notified us of an incident related to a hoax bomb threat. The call centre was evacuated as a result of a call threatening to “blow it up”. Calls were rerouted to call centres in London and Ipswich as part of the provider’s normal contingency.

Good

Are services effective?

(for example, treatment is effective)

Summary of findings

The provider is rated as good for providing effective services.

- Daily, weekly and monthly monitoring and analysis of the service achievements was measured against key performance targets and shared with the lead clinical commissioning group (CCG) members. Account was also taken of the ranges in performance in any one time period.
- Appropriate action was undertaken where variations in performance were identified. Staff were trained and rigorously monitored to ensure safe and effective use of NHS Pathways.
- Staff received annual appraisals and personal development plans were in place; staff had the appropriate skills, knowledge and experience to perform their role.
- Staff ensured consent, as required, was obtained from people using the service and appropriately recorded. There was an effective system to ensure timely sharing of patient information with the relevant support service identified for the patient and their GP.
- People's records were well managed, and, where different care records existed, information was coordinated.
- Staff used the Directory of Services and the appropriate services were selected.
- Capacity planning was a priority for the provider. The provider undertook detailed call level forecasting to enable them to ensure adequate staffing levels could be delivered.

Our findings

Effective needs assessment

Care UK – NHS 111 South West assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- We saw that the service had systems in place to ensure all staff were kept up to date. Staff had access to guidelines from NICE and NHS Pathways, and used this information to deliver care and treatment that met people's needs. We saw the provider used varied means of communicating these guidelines to staff which included through team meetings, workshops, printed information on workstations and information boards in the rest area. The provider monitored that these guidelines were followed, if the guidelines were not followed, staff would receive feedback or training with action plans if needed. The service used NHS Pathways version 11 at the time of our inspection.
- All health advisors and clinicians completed a mandatory training programme to become licensed in using the NHS Pathways software. Once training had been completed both health advisors and clinicians were subject to a structured quality assurance programme. We saw the provider had experienced health advisors to undertake call auditing, who had received training to do this. Calls managed by both health and clinical advisors were regularly audited using the NHS 111 standard audit tool. The minimum standard was that 1% of calls per call handler were audited. Internal audits were carried out by NHS pathways trained health and clinical advisors working to the work to the NHS 111 commissioning standards. Any audit which scored below 86% was considered a fail and was reviewed by a pathways trainer or a supervisor. Each occurrence was then discussed with the health or clinical advisor who handled the call. The provider also sent recordings of calls which formed part of complicated complaints or significant incidents to NHS Pathways for review; internal auditors attended NHS Pathways Audit levelling sessions. Care UK also conducted network wide audit levelling sessions in which peer review took place.

Good

Are services effective?

(for example, treatment is effective)

We were shown evidence that call audits for staff had been completed. For example:

- From June 2016 to August 2016 there had been a total of 1071 audits for non-clinical staff. Staff were audited pro-rata according to the hours they worked. In June 2016 the audit team completed all of the 99 required audits for the non-clinical staff, all 111 required for July 2016 and 99 of the 104 required for August 2016. The percentage of calls which did not meet the required standard over the three months was 13%. We looked through audits and action plans to ensure the correct feedback and actions were in place. For example, we saw one health advisor had failed four out of five audits in June 2016 and had received feedback. Subsequently they then passed five out of five audits in July and August 2016.
- From June 2016 to August 2016 there had been a total of 389 audits for the clinical staff. In June, July and August 2016 all the expected number of audits had been completed. The percentage of calls which did not meet the required standard from June 2016 to August 2016 was 3.6%. We looked through audits and action plans to ensure the correct feedback and actions were in place.
- Where any gaps had been identified from the audit process, or any learning identified from an incident or investigation, discussions were had with staff at a one to one meeting. When necessary the staff member received either additional coaching or formal training, an action plan was devised to manage the process. During this time the staff member may work in other areas and not take calls until the issue was resolved, this was determined for each individual case. Following this process, staff would undergo an increased level of auditing, supervision and support each month until managers had been satisfied that the required standard had now been reached. Staff we spoke with commented on the positive way feedback was given about their performance even when the process identified areas for improvement.
- Real time performance was monitored and action taken to ensure where performance of the service was at risk of performing below the expected standard; for example, delay in answering calls within agreed timescales. Actions taken included changes in break times, contacting off duty staff members to rearrange their upcoming shift and offering overtime to staff to work on from their present shift finish time.
- When staff were not able to make a direct appointment on behalf of the patient, clear referral processes were in place and seen by the inspectors. These were agreed with senior staff and a clear explanation was given to the patient or person calling on their behalf.
- Staff told us they had easy online access to policies, procedures, e-learning and supporting information such as Toxbase (a primary clinical toxicology database of the National Poisons Information Service) and hot topics (NHS Pathways updates).
- Discrimination was avoided when speaking to people who called the Care UK- South West NHS111 service. For example health advisors had access to Language Line for people who did not have English as their first language.

Management, monitoring and improving outcomes for people

The service monitored its performance through the use of the national Minimum Data Set, as well as compliance with the NHS 111 Commissioning Standards. In addition the provider had established performance monitoring arrangements and reviewed its performance for each 15 minute interval against the forecasted call volume.

The provider was issued with a Contract Performance Notice by the lead clinical commissioning group in May 2016 because of the provider's failure to achieve the required percentage of calls answered within the 60 second KPI (key performance indicator) from 26 February 2016. However, the provider demonstrated that there had been progress in meeting the two KPIs relating to responsiveness of the service for calls answered within 60 seconds and percentage of calls abandoned after 30 seconds.

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

For Bath and North East Somerset and Wiltshire:

- April 2016, 85.2% of calls answered within 60 seconds, which was lower than the England average of 87.1%
- May 2016, 91.2% of calls answered within 60 seconds, which was better than the England average of 88.2%

Good

Are services effective?

(for example, treatment is effective)

- June 2016, 93.4% of calls answered within 60 seconds, which was better than the England average of 90.6%,

For Bristol, North Somerset and South Gloucestershire:

- April 2016, 84.9% of calls answered within 60 seconds, which was lower than the England average of 87.1%.
- May 2016, 91.5 % of calls answered within 60 seconds, which was better than the England average of 88.2%.
- June 2016, 93.9% of calls answered within 60 seconds, which was better than the England average of 90.6%.

For Gloucester and Swindon:

- April 2016, 88.6% of calls answered within 60 seconds, which was similar to the England average of 87.1%.
- May 2016, 92.2% of calls answered within 60 seconds, which was better than the England average of 88.2%.
- June 2016, 93.5% of calls answered within 60 seconds, which was better than the England average of 90.1%.

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

For Bath and North East Somerset and Wiltshire:

- April 2016, 2.7% which was similar to the England Average of 2.8%
- May 2016, 1.6% which was better than the England average of 2.5%
- June 2016, 1.1% which was better than the England average of 1.8%

For Bristol, North Somerset and South Gloucestershire:

- April 2016, 3% which was above the England Average of 2.8%
- May 2016, 1.5% which was better than the England average of 2.5%
- June 2016, 1.2% which was better than the England average of 1.8%

For Gloucester and Swindon:

- April 2016, 3.2 % which was above the England Average of 2.8%
- May 2016, 1.5% which was better than the England average of 2.5%
- June 2016, 1.2% which was better than the England average of 1.8%

Data for calls back by a clinical advisor within 10 minutes (higher numbers are better) showed:

For Bath and North East Somerset and Wiltshire:

- April 2016, 45.5% which was higher than the England average of 39.1%
- May 2016, 53.1% which was higher than the England average of 40.6%
- June 2016, 53.8% which was higher than the England average of 39.9%

For Bristol, North Somerset and South Gloucestershire:

- April 2016, 42.9%, which was higher than the England average of 39.1%
- May 2016, 50.5%, which was higher than the England average of 40.6%
- June 2016, 39.9%, which was the same as the England average of 39.9%

For Gloucester and Swindon:

- April 2016, 45.5%, which was higher than the England average of 39.1%
- May 2016, 52.5%, which was higher than the England average of 40.6%
- June 2016, 53.2%, which was higher than the England average of 39.9%

The NHS 111 services are measured against patient outcomes in comparison to the national average for the numbers of people sent to an accident and emergency department (A&E), or referred for an ambulance disposition or referred for a primary care pathway.

Data from July 2016 showed that Care UK – NHS 111 South West was performing in line with national averages, for example:

For Bath and North East Somerset and Wiltshire:

- 11% of patients were referred to an ambulance disposition, compared to the national average of 13%.
- 7% of patients were referred to A&E compared to the national average of 9%.

Good

Are services effective?

(for example, treatment is effective)

- 59% of patients were referred to a primary care pathway compared to the national average of 60%.

For Bristol, North Somerset and South Gloucestershire:

- 10% of patients were referred to an ambulance disposition, compared to the national average of 13%.
- 7% of patients were referred to A&E compared to the national average of 9%.
- 56% of patients were referred to a primary care pathway compared to the national average of 60%.

For Gloucester and Swindon:

- 10% of patients were referred to an ambulance disposition, compared to the national average of 13%.
- 7% of patients were referred to A&E compared to the national average of 9%.
- 54% of patients were referred to a primary care pathway compared to the national average of 60%.

Effective staffing

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

- The provider had an induction programme for all newly appointed staff. This covered such topics as information governance, health and safety, NHS Pathways training, safeguarding, call control, mental health awareness, basic life support, performance and quality assurance processes, communication requirements and specific procedures relating to their place of work. We saw evidence that all staff also completed mandatory training e-learning modules such as equality and diversity, and work station health and safety awareness, before they started operationally within their new role. All other modules had to be completed within three months of starting employment. The provider was able to offer full time and part time induction courses in order to accommodate employees with caring responsibilities.
- The provider could demonstrate how they ensured role-specific training and updating for relevant staff. For example safeguarding training to the appropriate levels. The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had individual personal development plans and access to appropriate training to meet their learning needs and to cover the scope of their work. This included on-going support during sessions, one-to-one meetings, appraisals, clinical supervision and facilitation and support. All staff had had an appraisal within the last 12 months, other than in exceptional circumstances (such as long-term sick leave), which were clearly documented.
- We saw evidence which was confirmed by staff that they had received training that included: use of the clinical pathway tools, how to respond to specific patient groups, the Mental Health Act 1983, the Mental Capacity Act 2005, safeguarding for adults and children, fire procedures, and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training and there was a record of what had been done and what training was due. The provider supplemented this training with a series of workshops which staff attended when there was an identified training need or by choice. We were also told that the provider received feedback from the health advisors about the areas where additional training was needed, for example, additional training had been arranged for responding to callers with a mental health condition. The staff also spoke about the usefulness of using scenarios as a learning tool which linked to the human factor awareness when handling calls. We observed that staff had completed workbooks on the recent NICE guidance related to sepsis. This demonstrated the on-going training and updating for staff to keep their knowledge current with the NHS England 'hot topic'. Staff were able to complete training during quieter shifts or had protected time allocated.
- The provider had recognised the stress that working in the NHS 111 environment created for staff and had provided access to counselling for all staff. The staff could access this service without a referral from a supervisor or manager.

Working with colleagues and other services

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

- The provider was aware of the times of peak demand and had communicated these to the ambulance service. This included the arrangements to alert the ambulance service when demand was greater than expected. It was recognised that the clinical decision

support tool used in NHS 111 produced high rates of ambulance dispositions that may not always be necessary. Care UK – NHS 111 South West had an ambulance validation line that operated from 7am until midnight. We reviewed the standard operating procedure in place which indicated that a clinician was available to validate green (lower priority) ambulance dispositions and refer on those that may benefit from further clinical assessment with a nurse or a paramedic.

- During the month of August 2016 Care UK – NHS 111 South West validated 62% of 3,912 ambulance dispositions and 38% of ambulance dispositions were directed to a more suitable pathway. The data for the provider indicated that in August 2016 10% of assessments ended with an ambulance disposition whilst for the week ending 28 August 2016; the England average was 12%. This initiative provided the service with reassurance that requests for ambulances were appropriate.
- There were arrangements in place to work with social care services including information sharing arrangements. Evidence was seen that information was easily available to ensure that safeguarding concerns followed the correct referral pathway for each of contracted local authority areas.
- Staff knew how to access and use patient records for information and when patient or health professional directives may impact on another service; for example, advanced care directives or do not attempt resuscitation orders.
- The provider had systems in place to identify 'frequent callers' and staff were aware of any specific response requirements. The provider had a clear operating procedure to deal with these and when required had met with these individuals to explain the purpose of the NHS 111 service. They encouraged the individuals to contact other services which they could access, which could be more appropriate for their needs. They also explained the impact their frequent calls may have on other people trying to contact the service. We also saw that when frequent callers were experiencing on-going mental health concerns, with their consent, the provider contacted the person's GP to arrange for an appointment when the GP practice was open.
- Information about previous calls made by people was available so staff could access this information and discuss any relevant issues with people and assist them in the decision making for that specific call.

Consent

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, Deprivation of Liberty Safeguards 2007 and Gillick competency for children and adolescents. Staff had received training in these areas as part of their induction and as part of their on-going development
  The process for seeking consent was monitored through audits.
- Access to patient medical information was in line with the patient's consent. We listened to calls to the service in the centre. Throughout the telephone clinical triage assessment process the health advisors checked the patient's understanding of what was being asked. People were also involved in the final disposition (outcome) identified by the NHS Pathways and their wishes were respected. Should a patient decline the final disposition their call was transferred to a clinician for further assessment.
- Staff were also aware of when they may need to share information against the patient's wishes, such as in cases where people were suicidal and threatening to harm themselves, or where others may be at risk. Staff were also aware of patient confidentiality when information related to a third party. We heard a caller request information about their relative. The caller lived a long distance away and their relative was frail and the caller wanted to obtain information about the advice given by the service. The health advisor checked the patient's situation and with their permission arranged for a clinical advisor to ring the caller back.

Good

Are services caring?

Summary of findings

The provider is rated as good for providing caring services.

- Friends and family survey data from December 2015 to August 2016 showed that between 74% and 81% of people would recommend the service to others.
- People using the service were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw staff treat people with kindness and respect, and maintained the caller's confidentiality.
- We heard staff listened carefully to information that was being told to them, confirmed the information they had was correct and supported and reassured callers when they were distressed.
- Staff obtained the patient's consent when it was necessary to share information or had their call listened to.

Our findings

Kindness, dignity, respect and compassion

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

- Staff were provided with training in how to respond to a range of callers, including those who may be abusive. All the caller interactions we heard were non-judgmental and treated each patient as an individual whatever their circumstances. We spoke with health advisors about the frequent callers and they explained that they responded to them in the same way as all other callers.

  We observed that staff handled calls sensitively and with compassion. In particular we observed how a call handler dealt with a call from a family member who was concerned about their vulnerable relative. We saw that call was dealt with effectively and efficiently, with due compassion, patience and respect for both parties involved.

- The Care UK NHS 111 South West service was part of the NHS England- GP Patient Survey published in July 2016 for out of hours services, including NHS 111. This contained aggregated data collected from July-September 2015 and January-March 2016.

  Bath and North East Somerset Clinical Commissioning Group area 89% of patients had confidence and trust in the NHS service staff compared to the England average of 86%.

  Bristol Clinical Commissioning Group area 87% of patients had confidence and trust in the NHS service staff compared to the England average of 86%.

  Gloucestershire Clinical Commissioning Group area 88% of patients had confidence and trust in the NHS service staff compared to the England average of 86%.

  Wiltshire Clinical Commissioning Group area 92% of patients had confidence and trust in the NHS service staff compared to the England average of 86%.

  North Somerset Clinical Commissioning Group area 89% of patients had confidence and trust in the NHS service staff compared to the England average of 86%.

Good

Are services caring?

Swindon Clinical Commissioning Group area 87% of patients had confidence and trust in the NHS service staff compared to the England average of 86%.

- The provider informed us that they undertook the NHS Friends and Family test and reported this monthly. Patient feedback had been sought using text messaging. We saw that for the period 01/12/2015 to 01/03/2016 the responses indicated 86% would recommend the service. However, they had identified that the response rate for those people aged over 65 was lower than anticipated and had reverted to sending out printed surveys to obtain feedback in addition to text messaging. The provider representatives told us of their plans to engage with other organisations such as Healthwatch in order to obtain public and patient feedback.
- We were provided with a copy of the patient and public involvement toolkit for Care UK – NHS 111 South West staff members. This document was issued in October 2012 and its contents had been reviewed in January 2016. The provider had set up a South West Urgent Care Patient and Carers Experience Forum. We saw that roles had been created, but not yet recruited to, for a Head of Patient and Stakeholder Engagement and local Patient and Stakeholder Engagement to further engage with external agencies and people to obtain feedback about the service being provided.

Care planning and involvement in decisions about care and treatment

- Care plans, where in place, informed the service's response to people's needs, though staff also understood that people might have needs not anticipated by the care plan.
- We saw that staff took time to ensure people understood the advice they had been given, and the referral process to other services where this was needed. This included where an appointment had been made by the NHS 111 service with another service.
- We heard people's preferences being accounted for during calls and we observed health advisors checking that people had understood what had been said to them, and that they understood the next steps for their treatment. People were offered information about the healthcare services which were local to them to access.
- We found the service could access special notes or care plans, where the patient's usual GP shared information about their patients who might need to access the local GP out-of-hours service, such as those nearing end of life or those with complex care needs. The use of care plans supported person centred care sharing an individual's wishes in relation to care and treatment.

Patient/carer support to cope emotionally with care and treatment

- We listened to how people, or their carers, were informed of the final outcome of the NHS Pathways assessment. We observed health advisors and clinicians speaking calmly and reassuringly to people. We also saw that the advisors repeatedly checked that the patient understood what was being asked of them and that they understood the final disposition (outcome) following the clinical assessment.
- There were arrangements in place to respond to those with specific health care needs such as end of life care and those who had mental health needs. Agreed care plans were available to staff to access for specific patients to ensure that the correct care was delivered to the patient.
- Health advisors and clinical advisors were clear on the standard operating procedures in place which detailed the actions they would take in the event that a patient declined the final disposition.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The provider is rated as good for providing responsive services.

- There was a comprehensive complaints system and all complaints were risk assessed and investigated appropriately.
- Action was taken to improve service delivery where gaps were identified.
- Care and treatment was coordinated with other services or providers. There was collaboration with partners to improve urgent care pathways.
- Staff were alerted, through their computer system, to people with identified specific clinical needs and special notes or any safety issues relating to a patient.
- The service engaged with the lead clinical commissioning group to review performance, agree strategies to improve and work was undertaken to ensure the Directory of Services (DOS) was kept up to date. (The DOS is a central directory about services available to support a particular person's healthcare needs and this is local to their location).

Our findings

Responding to and meeting people's needs

- The service engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where a need for these was identified.
- The service was provided 24 hours a day, 365 days a week.
- The service continually analysed the demand on services and adjusted the levels of staffing according to predicted demand. For example, staff numbers were increased during known busy periods such as weekends, bank holidays and during major sporting events. Staffing requirements of the service were broken down into 15 minute intervals to allow in depth analysis, and a range of rota options were in place to ensure staff could be deployed to provide the best possible cover. Flexibility had been built into the system, for example flexible start times, and a various shift lengths. These were monitored and adjusted as required.
- The provider described the steps they took to ensure that care pathways were appropriate for people with specific needs. The service had a system in place that alerted staff to any specific safety or clinical needs of a patient, this included special patient notes and patient specific care plans. The staff we observed had a good understanding of the care plans.
- There were translation services available and all staff we spoke with were confident in accessing this service for callers who did not have English as their first language.
- The service used text talk for people with a hearing impairment.

Tackling inequity and promoting equality

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- New staff received training in equality and diversity during their induction and this training was updated for all staff on an annual basis.

Access to the service

- The telephone system was easy to use and supported people to access advice.
- Action was taken by Care UK – NHS 111 South West reduce the length of time people had to wait for subsequent care or advice where possible; for example, the estimated demand was measured against staff resourcing in 15 minute intervals to try to provide the correct staffing levels. We looked at how the estimates compared with actual the demand over the August 2016 Bank Holiday weekend for the Care UK – NHS 111 South West service. The planned staffing levels had matched the predicted demand.
- People had timely access to advice, including from a health advisor or clinical advisor when appropriate. Over the three bank holidays in August 2016 the average number of calls answered in 60 seconds was 93% compared to the England average of 93% (the performance target was above 95%). The call abandonment rates also demonstrated that callers were able to access the service for help and advice; for example, over the three bank holiday days the Care UK – NHS 111 South West average call abandonment rate was 0.4% (the target is below 5%).
- The service prioritised people with the most urgent needs at times of high demand. Care UK – NHS 111 South West developed a system to ensure that all the calls waiting for a clinical advisor to call back were checked (The Bridge). A senior clinician had responsibility for overseeing any calls waiting in their queues and identifying the priority of calls for clinical advice. This involved identifying those which needed a call back immediately and/ or escalating to the 999 service if required. The Care UK – NHS 111 South West centre had access to the clinical advisors at the other two locations (Ipswich and London) so if a call needed urgent intervention and a clinical advisor was not free in South West the call could be seamlessly transferred to a clinical advisor at other locations. The senior clinician could adjust the clinicians work stream according to the calls waiting; for example, increase the number of clinical advisors completing call backs and adjust the number of clinical advisors available for warm transfers. During the inspection we observed that the Care UK – NHS 111 South West service could take calls from any of the calls centres so patient delays to accessing care were minimised, and this was continually adjusted according to demand.
- Referrals and transfers to other services were undertaken in a timely way. We saw examples of referrals sent automatically through secure information systems and examples of timely referrals to different health and social care providers.

Listening and learning from concerns and complaints

- The provider had an effective system in place for handling complaints and concerns. Information about how to complain was available and easy to understand and evidence showed the provider responded quickly to issues raised.
- Data since July 2015 provided by Care UK – NHS 111 South West indicated there were 133 complaints and they had received feedback from 38 health care professionals. The South West call centre received 609,000 calls per annum. We saw communication and staff attitude were the commonest concern raised. We found appropriateness of referral was the commonest reason for health professional's feedback to the organisation and was related to the triage outcome using the NHS Pathway. Complaints were included in the Care UK – NHS 111 South West Performance and Quality Report July 2016, which included lessons learnt. The clinical governance team reviewed the complaints received to see if there were any themes that could be identified and any areas of learning which were shared within the staff team and commissioning organisations. They reported learning and themes via the internal quality assurance meetings and their internal National Quality Assurance Group. They also displayed complaint learning on the staff electronic display board in the break area. The Head of Governance also shared learning internally via emailed bulletins which went to all staff. Externally they reported any complaint learning and themes monthly to the Integrated Quality and Performance Management Board which consisted of Commissioners, contract managers and patient safety leads from each of the CCG's. There was also a Quality Sub-Group quarterly with the Associate Director of urgent care for the CSU, contact managers and patient

Good

Are services responsive to people's needs?

(for example, to feedback?)

safety and quality representatives from each of the CCG's. Reports were provided for each of these groups and Care UK took questions should they arise in these forums. They monitored trends and themes monthly and monitored the effectiveness of our learning communication by ensuring that there was no increase in complaints or incidents where a learning element was involved. If necessary they placed particular themes on their risk register.

- We looked at five complaints received in the last 12 months and found these were dealt with in a timely way, with openness and transparency. We saw examples of the communication throughout the complaint process to involve and update the complainant about any action being undertaken. For example, on one occasion the provider wrote to the complainant noting that further investigations were needed and informing them of progress made to date. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of the service, for example, we tracked one complaint about staff attitude and noted the clear process of investigation. There was a clear outcome and response to the complainant. Where action such as further training and monitoring was indicated we saw this had been recorded on the individual staff record.
- The Care UK – NHS 111 South West clinical governance team also had access to any themes identified across the wider organisation. They valued the opportunity to look at any areas for improvement. They completed trend analysis and reviewed themes of what presenting symptoms or conditions were leading to inappropriate dispositions or early call exits to identify appropriate learning packages. These were shared using the quality monitoring recording and reporting processes internally through the quality assurance meetings and externally through the Integrated Quality and Performance Management Board.
- Care UK – NHS 111 South West demonstrated how they shared information with other agencies and cooperated with investigations when required. The medical lead had fed back suggestions for change directly to NHS pathways (the clinical decision support tool) based on incidents reviewed where potential risks relating to the pathways had been identified. The medical lead had made suggestions to improve safety, including suggestions to improve the identification of early sepsis. NHS Pathways had acted on some of these suggestions.

Are services well-led?

Good

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

Summary of findings

The provider is rated as good for being well-led.

- The provider had a clear vision and strategy to deliver a high quality service and promoted good outcomes for people using the service. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. Staff, including those who did not work conventional office hours, knew how to access senior leaders and managers if required.
- The provider's policies and procedures to govern activity were effective, appropriate and up to date. Regular governance meetings were held.
- There was an overarching governance framework which supported the delivery of the strategy and service quality. This included arrangements to monitor and improve quality and identify risk.
- The information used in reporting, performance management and delivering quality care and treatment was accurate, valid, reliable, timely and relevant.
- The provider was aware of and complied with the requirements of the duty of candour. The provider and managers encouraged a culture of openness and honesty. Systems were in place for notifiable safety incidents and key staff ensured this information was shared with staff to ensure appropriate action was taken. There was a strong focus on continuous learning and improvement at all levels.

Our findings

Vision and strategy

- The provider had a clear vision to provide a service which was making a difference to people and deliver a high quality service. The Care UK – NHS 111 South West leadership team recognised the NHS 111 service had undergone considerable change and development since its inception in 2013. The leadership team embraced the challenges this had given their service and utilised opportunities to continually review the systems and processes they used to provide care and assessments for people. They had reviewed their values and vision, these recognised the need to monitor performance targets and to meet required standards; provide the best possible care and outcomes for people; ensure the best experience for people; and also highlighted the importance of the people involved in the organisation; and the need for the staff to feel valued and receive appropriate support and development to carry out their role.
- The service had a strategy and supporting business plans which reflected the vision and values and these were regularly monitored. The Care UK – NHS 111 South West leadership team supported staff innovation and quality improvement; for example, the Medical Director had undertaken research into how human factors such as attitude and unconscious bias could influence and impact on the patient's experience and outcomes. The research had involved analysis into a large number of calls received by the service, root cause analysis of any issues, national patient safety investigations, reviewing professional responsibilities and any system factors which impacted on the patient experience. The research identified themes and areas for improvement and ways the service could mitigate any risks. This learning was shared with NHS Pathways, the local clinical commissioning group, NHS England, the wider Care UK organisation and a training package was shared across all the Care UK – NHS 111 South West staff.
- The service was looking for opportunities to develop pathways and worked with other agencies to ensure work was not duplicated and shared ideas and best practice.

Are services well-led?

Good

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

Views of staff were sought through a range of methods such as supervision meetings, team meetings and staff forum meetings, and included both clinical and non-clinical staff. The staff we spoke with were clear on their role and responsibilities and their contribution to the vision of the NHS 111 service to deliver high quality care and promote good outcomes for people. In the latest staff survey the results indicated that respondents felt they were treated with fairness and respect by the management.

Governance arrangements

Care UK – NHS 111 South West was a location of Care UK (Urgent Care) Limited which was a large national organisation, with strategic and operational policies and procedures in place. These were supported and monitored by governance structures and arrangements. The service had an overarching governance framework which supported the delivery of care. The organisation had developed a governance structure for the NHS 111 service with clear arrangements for monitoring all aspects of the service provided. Locally clinical governance procedures and reporting pathways were established and regular clinical governance meetings were undertaken by the senior management team, commissioners and national leads. This had been audited over the three years since it had been developed to ensure the care was safe and effective.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Staff had developed productive working relationships. Local operating procedures had been agreed which ensured that staff were working in line with standard operating procedures and protocols.
- An understanding of the performance of the service was maintained. The leadership team had developed a continuous quality improvement model of audit management for the service, which monitored all aspects of the service. This, along with the integrated clinical governance framework provided an overview with direct links into action plans with risk ratings for several areas such as audit, clinical governance, human resources, health and safety, local operating procedures, operational processes, performance, planning and training. The progress of the action plans were reviewed regularly and reported on to the integrated quality and performance management board.
- Clinical governance procedures and reporting pathways were well established and regular clinical governance meetings were undertaken at provider, service, commissioner and national level. A monthly clinical governance report was produced to summarise the on-going work across the region and included statistical data relating to call activities, audits and trends. This information was shared with staff through a number of internal communications such as e-bulletins. This gave an overview and assurance of the service for members of the commissioning CCGs. Actions to address any performance issues were highlighted and monitored through the contract meetings with commissioners of the service.
- A programme of continuous clinical and internal audit, including regular call audits, was used to monitor quality and to make improvements. The Care UK – NHS 111 South West team had developed the auditing tool to include a system to help identify any themes and trends. From this the staff had identified the need for a number of development workshops for staff, recent topics had included awareness of stroke symptoms, chest pain and workshops to improve probing question skills.
- The Care UK – NHS 111 South West management team had developed a supporting risk assessment governance structure for the NHS 111 service, The Bridge model, to provide a clear structure to the clinical decision making involved in the prioritisation of managing the calls awaiting a clinician call back.
- Care UK – NHS 111 South West senior managers were clear learning was an on-going process for everyone within the organisation and that learning was shared. We saw board minutes, lessons learnt and governance bulletins which supported this.

Leadership, openness and transparency

The leadership team demonstrated they were committed to promoting a culture of working together and openness. Staff we spoke with in a variety of different roles knew who their team members were and there were effective systems of communication and supportive working implemented. We spoke with staff who had lead roles for example, in staff development, managing complaints and safeguarding referrals. All confirmed that there were positive working relationships between the different teams.

Are services well-led?

Good

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

The Care UK – NHS 111 South West leadership team told us about their development over the last three years since the NHS 111 contract had begun. They demonstrated continuous improvement through staff surveys, learning and development, and staff progression through the organisation. For example, they had recently developed a "3 P" strategy – people, patient and performance, with the focus on developing staff so they were confident and competent, and had a better understanding of the work processes. The staff we spoke to during our inspection told us they were proud of the progression they had made individually and as an organisation for people. We saw many examples of staff development for example; training on health topics for new staff, development into coaching and auditing roles, management training for new team leader and supervisors.

- Care UK – NHS 111 South West team had established a staff forum with representatives from different staff groups to discuss issues and concerns that affected them. Staff spoke positively about this and felt it was an effective way to share their views and to get answers to their questions.
- There were clear lines of accountability within the service. Staff understood the structure and had access to their team managers and senior managers. They were proactive in ensuring effective working relationships with other stakeholders. They regularly met with the commissioning groups and other health and social care providers to try to ensure they were working together to respond to local health inequalities and ensured services were accountable and supported by strong governance processes.
- Operational staff were clear who to go to for guidance and support. They understood the line management arrangements as well as the clinical governance arrangements which were in place. They described to us how the current management team was working effectively. Staff told us the leadership team had an open door policy, were good communicators and were supportive.
- There were arrangements in place to provide support to staff in the event of any traumatic event or serious incident. For example, during staff induction examples of potentially difficult calls or situations were discussed. Staff were advised how to gain support from their line managers. Team leaders were visible and responsive to call handlers. We saw, when needed, staff received immediate assistance and support with calls that were traumatic or if further support was needed. Notices in the communal staff areas highlighted the importance of seeking support and help if they had experienced any difficult or traumatic calls. Staff we spoke with were aware of the counselling and well-being support available.
- There were arrangements to support joint working by staff for example, through team meetings. Staff who did not work office hours (for example night shift workers) were supported in joint working and engaging with members of their team.

Public and staff engagement

The service engaged with the public through a number of methods including patient satisfaction surveys, and a range of options to give feedback or raise complaints of concerns through their website. The service had recognised the importance of links with local Healthwatch groups to gain patient feedback.

- The service carried our regular surveys of people who used the service via the NHS Friends and Family test survey; this showed the patient satisfaction with the service. We found that for the previous nine months (December 2015 – August 2016) that the number of people who would recommend the service was between 74% and 81% with those who would not recommend the service at between 11% and 18%.The patient response during this period was between 234 and 324 responses. The results from September 2016 were that 80% would recommend the service whilst 13% would not recommend the service with a sample size of 278 responses.
- The Care UK – NHS 111 South West team was proactive in engaging with their staff teams. Staff were provided with opportunities to feedback formally through one to one meetings, staff surveys, staff forum meetings and yearly appraisals where staff were asked to provide feedback on the working conditions, training and development, management and support and their overall job satisfaction. The sample of staff appraisals we reviewed showed that staff had scored the service highly on all these areas. Staff told us that this was a

Are services well-led?

Good

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

good place to work; the provider had sought ways to incentivise staff. These were not only financial but staff recognition and funding for social events for both staff and their family members.

- There was a new starter booklet that outlined Care UK's values. There was also a 'health advisor of the month' scheme, in which staff members could nominate an individual who would be awarded a gift voucher.
- The recent staff survey (2016) had gained feedback on morale, key dislikes and key likes for staff as well as the chance to give feedback on other issues. We saw evidence of staff feedback following the survey and actions taken as a result. The survey had highlighted that staff reported that colleagues were supportive, there was a team spirit and it was a friendly and enjoyable place to work. Staff considered they helped people, made a difference to people and did a worthwhile job. We observed there was high morale and a supportive culture evident in the call centre and across administrative, managerial and frontline staff. Compliments received about service were shared with staff.
- We saw other examples of proactive engagement with staff groups; for example, a consultation over pay and conditions. Care UK – NHS 111 South West were flexible with rotas and staff were able to alter individual shifts or apply for a permanent change of their hours within a six month notice period.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. The service maintained a risk register in order to identify and take preventative action and promote service resilience. We saw the following examples of continuous improvement and innovation within the service:

- We saw Care UK – NHS 111 South West was seeking to improve recruitment processes and improving retention rates during first six months of employment for health advisors and clinical advisors. They had started running open days which offered the opportunity for those recently recruited to the service, to come and learn more about what the job involved and better understand expectations of role. These open days also offered an opportunity to learn more about the organisation before embarking on the training. We observed one of the opening evenings taking place for newly recruited staff. A total of 12 people attended where the values and mission statement for Care UK – NHS 111 South West were shared. During the open evening the new recruits also had the opportunity to listen to calls to get a better feel of what the job entailed. There was a new starter booklet that outlined Care UK – NHS 111 South West values which had photos of all the team, shared information about the staff representatives, 'Free Fruit Friday', charity and upcoming events including the Christmas party.
- Care UK – NHS 111 South West had introduced incentive payments to encourage staff retention and promoted personal development plans as a way to access additional training and personal development.
- The learning and development of staff was recognised as important for the NHS 111 service, for delivery of best practice care, for staff to feel valued and to support staff retention. We found supporting continuous professional development (CPD) was a priority. Care UK – NHS 111 South West supported the delivery of CPD in the context of meeting performance targets. This was done by using its forecasting scheduling tool which enabled them to predict periods where protected time could be planned without compromising responsiveness to patient demand. Care UK – NHS 111 South West also brought in staff for overtime in order to support the delivery of CPD. We saw that six clinicians had recently undertaken a university module with a local university in remote clinical decision making. The service arranged a number of guest speakers to provide updates and awareness of the wider health services; for example, one of the local Out of Hours providers had recently given a training session.
- The senior management team had developed a number of methods to support the staff leaning and development, including a team manager development structure which was interfaced with the NHS Leadership model for any new team managers which was also being rolled out for all the established team managers. This helped managers to focus on understanding how leadership behaviours affected the culture and climate and how staff affected the experiences of people who used the service and the quality of care provided.

Are services well-led?

Good

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

- The service had shared the learning from the human factors research across all the staff and the wider organisation, NHS pathways and with NHS England.
- The service used innovative ways to improve care where possible for example, the Bridge model supported by a risk stratification tool and an audit process and the development of the audit tool to improve identification of themes of caller requests.
- The service was 'winner of the Care UK Health Care Awards' for 'Innovation 'in 2015 and had been shortlisted for the National Health Service Journal Awards 'For use of information technology to improve clinical safety' in 2016.
- The Care UK – NHS 111 South West team were working with a university to provide a pilot service for people who had diabetes who needed daily support and advice to help them manage their condition in their home environment, reducing the need to visit their GP or local hospital and reduce the risks and complications of diabetes. The pilot project involved providing the patients with the training and technology to undertake healthcare monitoring at home. They provided the supporting software and training for the Care UK – NHS 111 South West clinicians to deliver coaching and support for up to 1,000 patients. The aim of the project was to provide evidence for this type of support and technology and to promote self-care and awareness.