Mallard House Call Centre

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

NHS 111 is a telephone based service where patients are assessed, given advice and directed straightaway to a local service that most appropriately meets their needs. For example that could be an out-of-hours GP service, walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance or late opening chemist.

The Leicester, Leicestershire and Rutland NHS 111 service, provided by Derbyshire Health United (DHU) was inspected on Tuesday 17 March 2015 between 10.30 am and 9pm. The service had not been subject to any previous CQC inspection.

We carried out the inspection as part of our new inspection programme to test our approach going forward and therefore we did not provide a rating for the service.

Summary of findings

The inspection took place at the provider's primary call centre situated at Mallard House, Stanier Way, Wyvern Business Park, Chaddesden, Derby. Two other call centres used by the provider in delivering this service were not inspected.

Our key findings were:

- Derbyshire Health United provided a safe, effective, caring , responsive and well-led service.
- There were systems in place to help ensure patient safety through learning from incidents and complaints about the service.
- The provider had taken steps to ensure that all staff underwent a thorough recruitment and induction process to help ensure their suitability to work in this type of healthcare environment.
- Patients experienced a service that was delivered by dedicated, knowledgeable and caring staff.
- Staff were supported in the effective use of NHS Pathways. (NHS Pathways is computer software that provides clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call. NHS Pathways operates on diagnosis of exclusion, excluding conditions based on a set of triage questions).
- We found that the service was well-led and managed by an effective senior management team and board of directors, and their values and behaviours were shared by staff.
- Members of the staff team we spoke with all held very positive views of the management and leadership and felt well supported in their roles.

There were areas where the provider could make improvements and should:

- Ensure that staff receive an annual appraisal.

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?

There were clear procedures and policies that staff were aware of to enable them to recognise and act upon any serious events or incidents and any learning was shared with staff.

We found that the provider had systems in place to ensure that people seeking to work at DHU were appropriately recruited to ensure their eligibility and suitability to work in a healthcare environment.

All staff, both permanent and temporary underwent a thorough induction process upon starting work at DHU.

The provider had good systems in place to identify and safeguard patients at risk of harm.

There were robust systems in place designed to allow continuity of service in the event of power or telephone systems failures or other circumstances that might affect the delivery of the service.

Are services effective?

We found that the service was effective in responding to calls and directing patients to the appropriate healthcare service that best met their needs.

Clinicians were subject to continuing clinical supervision and case review to ensure their effectiveness in delivering the appropriate assessment for patients. All call taking staff were regularly monitored to ensure the effective and safe use of NHS Pathways.

The provider undertook hourly, daily, weekly and monthly measurement of the service effectiveness and achievement to continually assess and improve the service to patients.

There was an effective system in place to ensure information about patients coming into contact with the NHS 111 service was shared at the earliest opportunity.

There was good collaborative working between the provider and other healthcare and social care agencies to help ensure patients received the best outcomes in the shortest possible time.

Call advisors and nurse advisors sought consent from patients during telephone conversations.

Are services caring?

Patient experience surveys conducted by the provider showed a high degree of satisfaction with the service provided and the attitude of staff towards patients.

Summary of findings

There was a process in place to ensure patients whose first language was not English were able to access the service through interpreter services. The provider was taking positive steps to engage with and involve hard to reach groups of patients.

We heard patients and their carers being spoken with professionally, courteously and empathically.

Are services responsive to people's needs?

There was a complaints system and we saw that any learning from those complaints was shared with staff.

The provider undertook continuing engagement with patients to gather feedback on the quality of the service provided.

The provider undertook hourly assessments of the efficacy of the service to ensure that patients' needs were met.

There were systems in place to ensure that during anticipated high levels of demand sufficient staff were available to maintain a high standard of service.

Are services well-led?

Members of staff we talked with commented positively about the management of the service and said there was a desire from above for staff to continually learn and improve.

There was a strong and stable management structure; the Chief Executive Officer, the nominated individual, registered manager and other senior staff were very knowledgeable and were an integral part of the staff team. Both the board of directors and the executive displayed high values aimed at improving the service and patient experience and took positive steps to remind and re-enforce those values with all staff.

There was a clear leadership and management structure and staff we spoke with were clear as to whom they could approach with any concerns they might have. We saw that staff took part in reflective supervision to enable them, amongst other things, to reflect upon their own performance with the aim of learning and improving the service. However the numbers of staff who had received an appraisal in the previous year was low.

The provider supported both clinical and non-clinical staff by providing a range of training opportunities all aimed at delivering high quality, safe care and treatment to patients.

Staff told us that they worked for a supportive and progressive organisation.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Ensure that staff receive an annual appraisal.

Mallard House Call Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and the team included two further CQC inspectors, a GP, a paramedic and specialist advisor with experience of NHS 111 services.

Background to Mallard House Call Centre

Derbyshire Health United is a social enterprise that holds the contract for the provision of the NHS 111 contract for Leicester, Leicestershire and Rutland. The service is commissioned on behalf of the three clinical commissioning groups, namely Leicester City, Leicestershire West and Leicestershire East and Rutland by the Leicestershire West clinical commissioning group.

The service provides for a population of approximately 996,000 people living in Leicester City, Leicestershire and Rutland. 95.1% of the population are registered with a GP and 8.6% of the population are from ethnic minorities. .

The provider has three call centres that people calling 111 may be connected to. These are located at Mallard House, Derby; Ashgate Manor, Chesterfield and Fosse House, Leicester. The primary call centre is Mallard House that handles approximately 70% of all calls. Calls are automatically directed to any of the three call centres based upon the availability of call takers. Mallard House was the only one of the three call centres visited during the course of the inspection.

Three other NHS 111 contracts are also held by DHU and are operated from the same locations. Call takers and nurse advisors are not allocated to one particular NHS 111 service and take calls from patients of all four contract areas.

Derbyshire Health United employs 223 call advisors (154 whole time equivalent-WTE) and 66 nurse advisors (38 WTE). The equivalent of 21% of the staff at work at the time of our inspection were engaged on the Leicester, Leicestershire and Rutland NHS 111 contract.

From April 2014 to February 2015 the service had received in excess of 185,000 calls from patients and others seeking assistance.

Why we carried out this inspection

We carried out this inspection as part of the development of our approach to inspecting NHS 111 services. Therefore we have not rated the service.

The service had not been subject to any previous CQC inspection.

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 this NHS 111 service and asked other organisations to share what they knew about the service. We also reviewed information that we had requested from the provider and other information that was available in the public domain.

We carried out an announced visit to Mallard House on 17 March 2015. During our visit we spoke with18 members of staff that included the Chief Executive Officer, Director of Human Resources, the NHS 111 and Operations Director, Head of Clinical Governance and the Clinical Director and Deputy Clinical Director. We met and spoke with nurses advisors and call advisors.

With the consent of those involved we listened to call advisors and nurse advisors talking with callers to the service.

We also reviewed a range of records including audits, training records and information regarding complaints and incidents.

Are services safe?

Our findings

Safe track record

Derbyshire Health United was able to demonstrate a good track record in keeping people safe.

Staff we spoke with confirmed they had access to a wide range of procedures, policies and protocols that were available on the providers computer system that all relevant staff had access to. These covered a range of subjects including everyday activity and service delivery aimed at ensuring the best outcomes for patients. We saw they had been regularly reviewed and updated where necessary.

Staff were clear about their line of management and told us they would have no concerns about reporting any safety incidents and near misses.

Learning and improvements from safety incidents

The provider had a system in place for the reporting, recording and monitoring of significant events and complaints. The provider had a nominated member of staff who dealt with complaints about the service. There were 47 complaints in 2014. The complaints officer had good communications and working relationship with their opposite number in the out-of-hours service for Leicestershire and they conducted joint call reviews where required. We saw evidence that any learning from complaints was cascaded to staff.

We saw an example of learning from an incident which had resulted in a call advisor being required to complete a NHS Pathways 'hot topic', supported by a clinical trainer and was then subject to three successful clinical audits.

We looked at three serious incidents that had occurred in 2014. Two related to information technology issues. We saw that they had been correctly recorded and a full root cause analysis undertaken. Steps to prevent any re-occurrence were clearly documented and had been actioned. Investigation and root cause analysis of the other incident resulted in a call advisor undertaking a period of self-directed learning and reflective support. The advisor was also provided with some additional guidance with regard to mental health calls.

Reliable safety systems and processes and practices

Derbyshire Health United had in place effective systems to ensure the service provided was safe and used NHS Pathways to deliver that service. NHS Pathways is computer software that provides clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call. NHS Pathways operates on diagnosis of exclusion, excluding conditions based on a set of triage questions. It contains an integrated directory of services,(DOS) which best identifies the appropriate healthcare service to meet a patient's needs. After the disposition (the plan for continuing health care of a patient following discharge from the NHS 111 service) is reached the DOS is launched which lists in ranking order all the services which match the required skill set and are geographically appropriate for the patient. If the call is complex, beyond the scope of the call advisor or the patient refuses the NHS Pathways disposition instruction, the call advisor can warm transfer this call to a nurse advisor (a warm transfer is a term used to describe the process whereby a caller is held on the line and transferred directly to another service or advisor without the need for a call back).

All of the staff we spoke with were able to demonstrate a good working knowledge of what may constitute a safeguarding concern and how they would raise a concern. Training records we looked at showed that all staff received training in safeguarding vulnerable adults and children as part of their mandatory training. We talked with the named nurse for safeguarding children who explained and showed us the safeguarding process the provider had in place to help protect vulnerable adults and children and the interaction with other agencies. In 2014, the last period for which full figures were available, DHU raised 414 safeguarding concerns that were passed on to the relevant agencies for further investigation. The nurse told us how they sometimes got involved in serious case reviews but were not involved in any aftercare or actions plans resulting for the review, unless there was an impact or a matter that the provider needed to address. We saw that it was recorded on NHS Pathways where a safeguarding referral was made and this included a free text field for more detailed information. Staff who raised safeguarding concerns were sent an email thanking them for making the referral and where possible given feedback.

We saw that the lead nurse was instrumental in publishing a quarterly newsletter regarding safeguarding. We saw the latest newsletter and noted that it contained information

Are services safe?

for staff regarding female genital mutilation. The Christmas newsletter had contained reminders about the potential for an increase in domestic violence and need for extra vigilance.

We also saw that the provider was holding evening learning sessions to inform and make staff aware of domestic violence and its effects on both adults and children.

Monitoring safety and responding to risk

We saw that there were sufficient staff to meet demand and that as the day progressed into the time when GP surgeries closed additional staff came on duty to meet the expected increased demand on the NHS 111 service. Waiting times for calls to be answered were clearly displayed and were constantly monitored. In times of exceptional or unexpected demand the provider had a system that sent an alert to the mobile telephones of staff at work, though not working at that time as a call handler or nurse advisor, but who were licensed to use NHS Pathways, which enabled them to respond and be utilised to handle calls.

We saw that the provider used detailed forecasting and analysis to predict demand at peak times, for example bank holiday weekends. We looked at the historic forecasted demand and compared it with the actual demand and found the forecasting to be very accurate. This enabled the provider to ensure that correct number of staff were available.

The ratio of call advisors to nurse advisors was 4:1. We looked at the ratios over time and saw that this ratio was consistently maintained.

The provider was aware of the constant need to recruit and train new staff. Turnover of call advisors stood at 20% per annum which meant that 100 hours of call advisor time needed to be recruited monthly. The target was met but we were told that it was challenging, given the lead in time from recruitment to a call advisor being fully trained and licensed to use NHS Pathways.

We noted that prior to September 2014 there had been no use of agency nurse advisors but from then there had been a steady increase in their use. It was explained that the service had undergone some re-structuring which had resulted in the re-grading of nurse advisors. This has caused some staff to leave their posts and the shortfall had been made up with agency staff in the short term. As more nurses were recruited and trained in the use of NHS Pathways the use of agency nurse advisors was predicted to decrease.

Arrangements to deal with emergencies and major incidents

We reviewed the comprehensive business continuity plan, available electronically and in hard copy format, that was in place to inform staff in the event that the normal operation of the service was interrupted by such things as failure of power, telephony, staffing issues or forced evacuation of a call centre. For example we saw how calls could be routed to the providers other two call centres in the event that one was not functioning.

We looked at a serious incident that had necessitated the implementation of part of the plan following information technology failure. We also saw the escalation and plans that were available to cover staff shortages.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Call handlers and nurse advisors had all undertaken and successfully completed the necessary training before being licensed to use NHS Pathways. Their performance and adherence to the methodology was regularly monitored and assessed by means of monthly auditing of a sample of the calls they had dealt with. Any identified failings or sub-standard performance was immediately addressed and support provided to enable the individual to improve.

Call handlers and nurse advisors were regularly assessed and a sample of their calls reviewed every month to ensure their competency and safety in using NHS Pathways. There was use of agency nurse advisors and we saw that there was a process in place to ensure their effective and safe use of NHS Pathways which entailed live call audits with special attention to clinical content. We were told that seven agency nurse advisors had been stood down as a result of this rigorous auditing since October 2014.

We looked at records of the auditing of calls and saw the actions the provider had taken, which had included advice, mentoring and suspension from taking calls.

Management, monitoring and improving outcomes for people

DHU used some National Quality Requirements, (predominantly used by GP out -of-hours providers) as a means of assessing the effectiveness of the service in meeting patients' needs. These covered quality indicators such as the percentage of calls answered, those answered within 60 seconds and the percentage of calls abandoned by the caller.

For example we saw that in February 2015, 97.1% of calls had been answered, compared with a national average of 93.3%. Of those calls 89.2% were answered within 60 seconds.

The provider had no means of monitoring the outcomes for patients once they had been referred on to another healthcare provider, but did have processes in place to identify repeat callers and frequent callers.

Effective staffing

We looked at the personnel files of nine members of staff, both call advisors and nurse advisors. Records showed that they had the correct skills and qualifications to carry out their duties. Nurse advisors had their professional registrations recorded. We saw evidence of the thorough induction process that all staff undertook, including nurse advisors hired through an agency.

We saw evidence that staff had taken part in a wide range of training including information governance, records management, patient confidentiality, child and vulnerable adult safeguarding and equality and diversity. Staff we spoke with confirmed that in the main training met their needs and that there was time allowed to complete the training. However we noted that one member of staff said it was difficult to assess mental capacity on the phone, particularly with someone who may have dementia.

The provider had recently recruited a team of dental nurses to give advice to callers, predominantly with regard to pain relief. This was a new initiative funded by NHS England. The dental nurses were all to be trained and licensed in the use of NHS Pathways and those that had already completed the training were actively working in the service.

We reviewed the process the provider had in place for assessing the competence of call advisors and nurse advisors through monthly review of a sample of their calls. We looked at the records of some of these routine audits as well as some that had been triggered as a result of a Datix report from other healthcare professionals. (Datix is web-based patient safety software for healthcare risk management applications.)

Working with colleagues and other services

DHU held regular meetings with the commissioning clinical commissioning group (CCG) of the service and other healthcare providers involved in urgent care, for example the out-of-hours GP provider and the ambulance service.

Maintaining the directory of services was the responsibility of the commissioning CCG but DHU had staff whose responsibility was to liaise with the CCG to help ensure that it met the needs of patients.

Adastra was used to record every contact between callers and NHS 111. The information was passed to the service identified through the directory of services as best meeting the patients' healthcare needs and to the patients' own GP where they so consented.

Information sharing

Are services effective?

(for example, treatment is effective)

The provider worked in collaboration with other healthcare providers such as GPs in providing the best outcomes for patients. Where GPs had signed up to the medical interoperability gateway it was used to share patient information.

When referring patients to the out-of-hours service the provider used the interoperability toolkit to send an electronic message which was despatched within three minutes of the termination of the call with the patient. It was then the responsibility of the out-of-hours provider to contact the patient or carer to make the necessary arrangements for a consultation.

Consent to care and treatment

We saw that staff sought consent from patients to share information of the call with other Healthcare Providers. Where consent was declined then their wishes were respected although there was an expectation that in a medical emergency situation, and there being no alternative, then staff would access the record. DHU employed a privacy officer who had oversight of these incidents and ensured that they were accessed correctly.

In those cases where consent to share information was declined, call handlers routinely referred the calls to a nurse advisor for an assessment of the patient's mental capacity to be considered. We found that some nurse advisors had received specific training in assessing mental capacity but others had only received more general training as part of the mandatory vulnerable adults training. During the time we listened to call advisors and nurse advisors dealing with callers we noted advisors tried to ensure that the callers understood what was being said to them.

Staff we spoke with were aware of obtaining consent from patients and had a knowledge of the Gillick competency test which is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. There was an accessible policy concerning consent available on the computer system. All patients were asked if they consented to the record of their contact with NHS 111 being shared with their GP.

Are services caring?

Our findings

Dignity, respect and compassion

In all we listened to 14 telephone conversations between call advisors and nurse advisors and patients and carers we found that that they were treated with respect and compassion. In particular we noted how a very elderly patient was advised and re-assured by a nurse advisor.They were given appropriate advice for dealing with their health issue at home without the need for a disposition to another healthcare provider.

We looked at the results of the latest NHS 111 Service satisfaction report which had been conducted on behalf of the provider by an independent survey company. The survey had taken place between April and September 2014. 625 questionnaires had been sent out to patients who had used the service and 215 had been returned, a response rate of 32%. 191 of respondents had stated they would be either extremely likely or likely to recommend the service to friends and family.

Involvement in decisions about care and treatment

Owing to the nature of the service we were unable to speak directly with patients who telephoned NHS 111 although we did take the opportunity for those members of our inspection team with clinical expertise to listen in to the calls. In total we listened to 14 calls. In all calls we listened to we heard that the call advisor or nurse advisor fully involved the caller in the triage process and kept them fully informed as to their options. Advisors carefully followed the NHS Pathways methodology and used the directory of services to signpost callers to the nearest healthcare option that best met their needs.

Patient/carer support to cope emotionally with care and treatment

We heard call advisors offer empathetic and compassionate support to callers and ensured that callers understood the final outcome, where referral to another healthcare provider was suggested. Where callers did not accept the final disposition the call was 'warm transferred' to a nurse advisor to enable them to speak to the caller.

A call handler provided us with a document that was available to call and nurse advisors titled 'Dealing with emotion'. It was well considered and informative guidance to staff to help them develop the skills needed to defuse emotion and show compassion in a professional manner whilst maintaining focus.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

DHU continually monitored its performance using daily situation reports and weekly and monthly reports to ensure it met the needs of patients. The provider had been successful in predicting and meeting demand for its services but was concerned that funding may not be available to meet the predicted increased demand going forward of 8.5% over and above the contract volume for 2015/16. We were informed that the provider was in talks with the commissioners of the service regarding this matter.

During the course of our visit we saw how the management were putting in place extra staff for the upcoming bank holiday weekend to meet predicted increased demands on the service.

Tackling inequity and promoting equality

We found no evidence that patients were treated any differently based on their personal religious or cultural beliefs. Dispositions to healthcare services that best met the needs of patients was based on assessment alone.

Staff training in equality and diversity was provided. Translation services were available to those callers whose first language was not English.

Access to the service

NHS 111 is a toll free telephone service. Callers are not charged whether they call from a landline or a mobile telephone. There is no restriction of who can use the service and it is open to all, whether or not they are registered with a GP.

One of the outcomes used to measure performance was the number of calls that were answered within 60 seconds. We saw that there had been a notable dip in performance in December 2014 due to unprecedented demand on the service that had been reflected in similar services.

89% of the respondents to the service satisfaction survey had reported that they had got through to the service on their first call. 92% of respondents were either very or fairly satisfied with their 111 experience.

Listening and learning from concerns and complaints

Derbyshire Health United had received 47 complaints regarding the NHS 111 service in 2014. This represented 0.02% of the 193,860 calls received..

We looked at a report of all 47 complaints and saw they had been correctly recorded, investigated and responded to. The investigations included reviews of the calls and where appropriate an apology to the complainant. Learning from the complaints was evident and individual call advisors and nurse advisors involved in the complaint were involved. Where necessary action was taken to prevent any re-occurrence by means of additional support, training, supervision or reflection.

Analysis of the complaints had been completed but this did not show that any one theme was significantly higher than others, the predominant issues being assessment outcome, assessment process, staff attitude and incorrect process. The provider was taking steps to address the issues identified.

Are services well-led?

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

Our findings

Vision and strategy

Derbyshire Health United had a goal to deliver a high quality, safe and effective service. There was clear and unambiguous evidence that this was cascaded to staff through various media including its training program, known as DHU UXL and various newsletters including the monthly board brief, all of which were freely and easily accessible to staff. The senior management had recognised the challenges of competitive bidding to secure the future of the 111 service and had identified four initial key performance indicators (KPIs) to measure performance. We saw that the provider was working with all staff to achieve the targets which included coaching support for call and nurse advisors, workshops and inclusive communication. This was to be supplemented by performance lists and individual statistics around the KPIs. The provider had stressed to staff that the goal could only be achieved through working together and this was not meant as a threat to them. The management had acknowledged and congratulated advisors on doing a difficult job.

DHU had recently introduced a staff reward scheme that recognised individuals as having made an exceptional contribution to the service. Known as 'Limelight' recipients were recognised in internal newsletters and received a small gratuity.

Governance arrangements

A new governance model had been introduced with clear lines of responsibility and accountability across all areas of the service. We reviewed the minutes of various meetings for example a meeting of the board to approve the corporate risk register based on the reviews that were undertaken at the various governance committees. Each key risk was the responsibility of designated members of the Executive team, and formed part of the key objectives of each Executive to provide further assurance.

Leadership, openness and transparency

DHU had recently undergone some changes at board level. A new chair and four new non-executive directors had been appointed during February 2015. We saw that they had a wide range of skills and expertise which covered NHS and private healthcare, local government and industry. We met with the Chief Executive and other senior managers who demonstrated a desire and passion to deliver high quality, safe services. There was good evidence of their aims and values being cascaded to staff at all levels within the organisation.

There were good systems for reporting performance and concerns through to board level and we reviewed minutes of meetings that reflected this.

A human resources update, which detailed such things as new starters, leavers and sickness levels were made available to all staff through the monthly newsletter thus helping to promote a climate of openness and transparency.

Staff told us that they felt empowered to approach management with any issues they had and had clear and defined lines of upward supervision. Call and nurse advisors were accepting of the need to regularly audit and quality control their work and told us that they found it useful.

Public and staff engagement

Staff we spoke with told us that they felt involved and engaged in the delivery of the service and that their views were listened to. Staff said they thought the management and supervision structure was open and transparent and said they regularly saw senior management in the call centre and its environs. They told us they were approachable and listened to what they had to say. DHU had introduced a Communication and Engagement Forum to enable staff to become involved. All staff had been given 15 minutes of working time to partake in the staff survey.

DHU commissioned and independent company to carry out satisfaction surveys with people who had called the 111 service, with 32% of the number of questionnaires being returned. This was considered to be a good response rate.

Feedback from health care professionals working in other healthcare settings were taken seriously as were complaints and compliments about the service and its staff. We saw that DHU taken the positive step of reproducing the compliments, including naming the members of staff involved in the monthly Board Brief.

Continuous improvement

We looked at the training that was provided to staff and saw that it was appropriate and fitting to their role, helping

Are services well-led?

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

them to maintain and improve the patient experience. This included mandatory training such as safeguarding children and vulnerable adults and basic life support, information governance, health and safety and diversity. In addition training on integrated clinical governance was given at induction.

Licensed users of NHS Pathways received the training and updates as required under the licensing agreement.

Staff received regular meetings with their line manager and appraisal every 12 months. We saw that the level of appraisal was low, but we were satisfied that this was as a result of the high number that had been carried out in the previous January and now fell outside of reporting parameters. There were also a large number of new staff who were not due an appraisal as they were included in probationary review figures.