Care UK – East of England

Quality Report

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

Ratings

Overall rating for this service	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?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of the Care UK East of England NHS 111 service for Suffolk, Lincolnshire and Milton Keynes on 20 and 21 July 2016. The service operates from a single call centre in Ipswich but can also be operated from two other Care UK call centres at Southall (London) and Bristol.

NHS 111 is a telephone-based service where callers were assessed, given advice and directed to a local service that most appropriately met their needs. For example, this could be a GP service (in or out of hours), walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance, late opening pharmacy or home management.

Overall the service is rated as 'Good'.

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.
- 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.
- Staff were trained to use the NHS Pathways clinical triage system effectively and safely and there were effective systems in place to monitor staff usage of the system. There were high levels of call audit that was in excess of the minimum requirement. This helped to enable the timely and effective management of poor or potentially risky performance.
- Patients experienced a service that was delivered by dedicated, knowledgeable and caring staff.
- Patients using the service were supported effectively during the telephone triage process. Consent to triage was sought and their decisions were respected. We saw that staff treated patients 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.
- All opportunities for learning from internal incidents and complaints were used to promote learning and improvement.
- There was an overarching governance framework across the NHS 111 service, which supported the delivery of the strategy and good quality care. This included arrangements to monitor quality and identify risk.

Summary of findings

- 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. The provider had systems in place for notifiable safety incidents and 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.

The areas where the provider should make improvement are:

The provider should ensure that all complaints are dealt with in a consistent way, ensuring all dates were recorded.

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 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 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 using the service and were aware of the process to make safeguarding referrals
- Clinical advice and support was readily available to health advisors when needed.
- Capacity planning was a priority for the provider and there were sufficient numbers of trained, skilled and knowledgeable staff available at all times; even at times of fluctuating demand.

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, and had the appropriate skills, knowledge and experience.
- There was an effective system to ensure timely sharing of patient information with the relevant support service identified for the patient and their GP.
- Staff used the directory of services and the appropriate services were selected.

Are services caring?

Good

The provider is rated as good for providing caring services.

Summary of findings

- Patient survey data from December 2015 to June 2016 showed that patients were satisfied with the level of service they received.
- People using the service were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Staff maintained people's confidentiality.
- We heard staff that listened carefully to information that was being told to them, confirmed that 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 have their call listened to

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services.

- The service had long and short-term plans in place to ensure staffing levels were sufficient to meet anticipated demand for the service.
- There was a comprehensive complaints system and all complaints were risk assessed and investigated appropriately. However we found that there was some inconsistency in the way that relevant dates were recorded.
- Action was taken to improve service delivery where gaps were identified.
- Care and treatment was coordinated with other services and other services or provider. There was collaboration with partners to improve urgent care pathways.
- Staff were alerted, through their computer system, to people with identified specific clinical needs, care plans and any safety issues relating to a patient.
- The service engaged with the lead clinical commissioning group (CCG) to review performance, agree improvement strategies 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.)

Are services well-led?

Outstanding

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

- The provider had a clear vision and strategy to deliver a high quality service and promote good outcomes for people using the service. Staff were clear about the vision and their responsibilities in relation to it.

Summary of findings

- 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.
- The provider had an emphasis on developing staff and helping them to progress through a portfolio based approach that enabled them to gain experience in other healthcare activities provided by Care UK Ltd.
- 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 a good quality service. 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. The provider had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The provider proactively sought feedback from staff and people using the service, which it acted on.

There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- The provider should ensure that all complaints are dealt with in a consistent way, ensuring all dates are recorded.

Care UK – East of England

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector; the team included a further CQC inspector, an NHS 111 specialist advisor, a GP specialist advisor and a manager specialist advisor.

Background to Care UK – East of England

Care UK East of England is part of Care UK (Urgent Care) Ltd.

It operates a single call centre in Ipswich where it provides NHS111 services under separate contracts for Lincolnshire, Suffolk and Milton Keynes. Patient demographics vary across the three contracts, with there being a higher proportion of elderly people living in rural communities in Suffolk and Lincolnshire compared to Milton Keynes' higher percentage of younger people living in an urban environment.

In total the service covers a population of approximately 2.25 million and in the last 12 months received in excess of 408,000 calls.

NHS 111 is a 24 hours a day, 365 days a year service. It is a telephone based service which can be accessed free of charge from any telephone. It enables people to be assessed, given advice or directed to a local service that most appropriately meets their healthcare needs.

The provider employs 98 (whole time equivalent - WTE: 61) health advisors and six operations supervisors, 38 (WTE 24) clinical advisors and three clinical supervisors at the call centre. Health advisors are non-clinical staff who are the first point of contact when a caller is connected to NHS111. A clinical advisor is a clinically trained member of staff, typically a nurse or paramedic.

They are supported by a team that includes administration staff, managers, an audit lead and a training co-ordinator.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. 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 this NHS 111 service and asked other organisations, including commissioning CCGs 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 on 20 and 21 July 2016.

During our visit we spoke with members of staff. They included the National Operations Manager, Director of Nursing and Safeguarding, Deputy Service Director for NHS 111, Network Manager, the NHS111 National Operations Manager and the Clinical Lead. We met and spoke with clinical advisors and health advisors, call centre managers and shift managers as well as range of administrative staff.

We listened to health advisors and clinical advisors talking with callers to the service. We did not listen to the caller element of the telephone conversation.

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

Good

Are services safe?

Our findings

Safe track record

Staff we spoke with confirmed they had access to a wide range of procedures, policies and protocols that were available to all relevant staff on the provider's computer system. These covered a range of subjects including a personally adaptable dashboard (with topics of interest to individual roles), everyday activity and service delivery aimed at ensuring the best outcomes for patients.

The provider had a system in place for the reporting, recording and monitoring of complaints.

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

- Significant events that that met the threshold for a serious incident or 'never event' were declared and investigated in accordance with the NHS England Serious Incident Framework 2015.
- Investigation of significant events was not confined to those that met NHS England's criteria for a serious incident or 'never event'.The provider treated significant events including near misses as an opportunity for learning and risk reduction measures.
- Staff told us they would inform the provider/manager of any incidents and there was a recording form available on the service's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that service/provider of services must follow when things go wrong with care and treatment).
- There was good evidence of learning from experience, both good and bad, and a clear culture of openness and honesty.
- 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.
- The provider carried out a thorough analysis of complaints, serious incidents and significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety. For example, in a case where a delay in access to translation services, caused by the provider of interpreter services not being able to find a Somali interpreter quickly enough, had led to an adverse impact on patient care. Action had been taken and a service level agreement put in place to help ensure speedy access to interpreter services.

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. The policies clearly outlined who to contact for further guidance if staff had concerns about a person's welfare. We spoke with the lead member of staff for safeguarding. Contributions were made to safeguarding meetings when required and reports prepared and shared with parties having responsibility for ongoing patient care. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. Health advisors were trained to level two and clinical advisors to level three.
- Staff had received training in recognising concerning situations and followed guidance in how to respond. Clinical advice and support was readily available to staff when needed.
- There were clear processes in place to manage the transfer of calls, both internally within the service, and to external services/providers, to ensure a safe service. We saw that the time taken for clinicians to call back patients within 10 minutes was much better than the national average. The monthly averages for Lincolnshire, Milton Keynes and Suffolk respectively were 45.8%,44.5% and 45.3% as compared to the national average of 40.7%
- There were systems in place to monitor call handling and response times to ensure a safe service. For

example for answering calls within 60 seconds the monthly averages for Lincolnshire, Milton Keynes and Suffolk respectively were 92.6%, 93.1% and 91.5% as compared to the national average of 87.7%.

- We reviewed eight personnel files of health advisors and clinical advisors and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- 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. All staff had undergone work station posture training and there were posters around to serve as reminders. Monitors were height adjustable and there was evidence of some staff being given higher grade orthopaedic chairs following assessments from occupational health.

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. It had an integrated directory of services (DoS) which identified appropriate services for the patient's care. Staff received comprehensive training and regular updates on NHS Pathways and their competencies were assessed prior to handling patient telephone calls independently, and continuously through regular call audits for both health advisors and clinical advisors.
- Procedures to raise concerns about staffing and patient caller demand could be escalated by use of the escalation plan when appropriate. Clinicians were available throughout every shift to provide support to patients through the clinical decision support system and to provide real time support to health advisors. However there were occasions when access to a clinician was not immediate, which meant patients were held in a queue or received a call back from a clinician. This was normal industry practice and was carefully monitored. The provider was consistently better than the national average for call backs within 10 minutes.
- We saw that there were sufficient staff to meet demand and that as the day progressed into the out-of-hours' period additional staff came on duty to meet the expected increased demand on the NHS111 service. Waiting times for calls to be answered and the number of calls queued were clearly displayed and were constantly monitored. Staff at the call centre were seated in separate sections of health and clinical advisors, each with supervisors. The supervisors were centrally placed to ensure they had a good overview of the call centre and could monitor calls where necessary. Call taking staff could summon for advice and assistance by the raising of a coloured card for instance when a caller was conducting basic life support..
- We saw that the provider used detailed forecasting and analysis to predict demand at peak times, for example public holidays, national and international events and extreme weather periods.
- We looked at the historic forecasted demand and compared it with the actual demand and found the forecasting to be accurate. This enabled the provider to ensure that correct number of staff were available.
- The ratio of health advisors to clinical advisors was better than the 6:1 required under the Pathways licence. For example, at the time of our inspection, and data we reviewed indicated the Ipswich call centre was operating at ratios varying from 5:1 to 2:1. We looked at the ratios over time and saw that the ratio was consistently maintained at 6:1 or better.

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 for major incidents such as power failure or building damage, as well as those that may impact on staff such as a flu pandemic. The plan included emergency contact numbers for staff. The plan also addressed fluctuations in demand for the service and staff shortages.

The provider had engaged with other services and commissioners in the development of its business continuity plan for example their response to a major public health situation.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The provider had processes in place to ensure that clinicians assessed needs and delivered care in line with current evidence based best practice guidelines.

- The provider had systems in place to ensure all staff were kept up to date. Clinical staff had access to guidelines from NICE and reported that they used this information to help ensure that people's needs were met.
- Staff had access to patient demographics and special patient notes, where they were in place, via the NHS Spine using their smart cards.
- Assessments were carried out using approved clinical assessment tools, or locally agreed standard operating procedures. The number of calls and outcomes were monitored, and action taken where needed. For example, we saw the provider had recently introduced a project to assist, support and educate health advisors with handling call types that were destined to require an ambulance response or referral to accident and emergency. The project was aimed at reducing the number of calls directed for an ambulance or emergency department response. We saw this project was piloted prior to our inspection with one member of staff, and had resulted in a significant drop in aforementioned referrals, namely from 24% to 4% over the trial period. Based on this outcome the project was extended to a further eight members of staff at the time of our inspection, of which the outcome was not yet known but appeared to be on track to achieve a reduction in referrals. The project was overseen by the clinical lead.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place and a clear explanation was given to the patient or person calling on their behalf.

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 Commissioning Standards. In addition the provider had established its performance monitoring arrangements and reviewed its performance daily.

The service was a consistently high achiever across all measures, as indicated below, which provides a monthly breakdown of the key performance indicators averages for the provider compared to the England average.

Lincolnshire

Calls offered 15,156

abandoned after 30 seconds 1.4% (national average 3.0%)

answered in 60 seconds 92.6% (national average 87.8%)

of calls triaged 85.5% (national average 86.7%)

of calls transferred to clinical advisor 20.6% (national average 22.1%)

of calls passed for call back 12% (national average 12.7%)

of call backs within 10 minutes 45.8% (national average 40.7%)

Milton Keynes

Calls offered 5,137

abandoned after 30 seconds 1.3% (national average 3.0%)

answered within 60 seconds 93.1% (national average 87.8%)

calls triaged 84.4% (national average 86.7%)

calls transferred to clinical advisor 21.1% (national average 22.1%)

calls passed for call back 12.3% (national average 12.7%)

call backs within 10 minutes 44.4% (national average 40.7%)

Suffolk

Calls offered 14,048

Good

Are services effective?

(for example, treatment is effective)

abandoned after 30 seconds	1.4% (national average 3.0%)
answered within 60 seconds	91.5% (national average 87.8%)
calls triaged	86.4% (national average 86.7%)
calls transferred to clinical advisor	20.9% (national average 22.1%)
calls passed for call back	12.0% (national average 12.7%)
call backs within 10 minutes	45.3% (national average 40.7%)

Effective staffing

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

- The provider had a comprehensive induction programme for all newly appointed staff. This covered such topics as fire safety, data protection and social media policy.
- 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 and each staff member's training requirements and due date of refresher training were carefully recorded and monitored. Staff had 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, coaching and mentoring, clinical supervision and facilitation and support . The current rate of training compliance exceeded 97%.
- All staff had an appraisal within the last 12 months, other than in exceptional circumstances (such as long-term sick leave), which were clearly documented.
- Staff received training that included: use of the clinical pathway tools, how to respond to specific patient groups, Mental Health Act, Mental Capacity Act 2005, safeguarding, fire procedures and information governance awareness. Staff had access to, and made use of, e-learning training modules and in-house training.

Working with colleagues and other services

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

- We knew that the provider was to lose the contract for the provision of NHS111 services to one of the areas in October 2016. Nevertheless we saw evidence that the provider was working in close collaboration with the commissioning CCG's in the development of an integrated clinical hub that was to be operated by a the incoming NHS111. We spoke with the commissioning CCG who confirmed this to be the case.
- 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 or lower than expected.
- Staff knew how to access and use patient records for information and when 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. There were also systems in place to respond to calls from children and young people.
- Information about previous calls made by patients was available and protocols were in place to inform staff of how they should deal with frequent and repeat callers, for example nursing and care homes.

Consent

Staff sought patients' consent in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and Gillick competency for children.
  We listened to both health advisors and clinical advisors talking with callers. We did not listen to the caller side of the conversation. We heard the advisors ask the caller for consent to share their personal data, for example

Good

Are services effective?

(for example, treatment is effective)

with the out-of-hours service. Until the call taker had acknowledged consent on their records they could not proceed with questioning the caller; this ensured consent was taken.

- Health advisor staff we spoke with were able to demonstrate a working knowledge of the Mental Capacity Act 2005 and we saw that staff received training in this area. They told us that if they had any concerns they would seek advice from a clinical advisor or supervisor.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We listened to both health advisors and clinical advisors talking with callers. We did not listen to the caller side of the conversation. We heard staff speak to callers in a professional and caring manner. Good clear health care instructions were given together with an explanation for the disposition reached.

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. Our observations were that staff handled calls sensitively and with compassion.

We reviewed the providers 'Equality, Dignity and Respect' policy and found it to be well written and fully encapsulated the seven core principles of maintain people's dignity and included giving health advisors a simple to use flowchart on how to use both translation services and services for those with a hearing impediment. The policy also ensured that patients from travelling communities, homeless communities, the disabled and all other aspects of equality were not discriminated against in any way.

Results from the surveys conducted by Care UK showed people felt they were treated with compassion, dignity and respect.

- For example we looked at the data for the period December 2015 to June 2016 and found that 94% patients in Ipswich and East Suffolk and 100% of patients in West Suffolk strongly agreed or agreed that they were treated with respect during their contact with the service.
- In December 2015 the provider had received 118 survey returns with 79.7% of patients recommending the service.
- In February 2016 the provider had received 127 survey returns with 87.4% of patients recommending the service.
- In May 2016 the provider had received 141 survey returns with 81.6% of patients recommending the service.
- The provider kept historic data of patient surveys and was able to compare the responses over time. For example, for Suffolk, in the period October 2015 to March 2016 328 patients had responded to the survey compared to the period October 2013 to March 2014 when 459 patients had responded. This survey explored questions around satisfaction, whether patients complied with the advice given and what alternative care they would have sought without the NHS111 service.

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.

Patient/carer support to cope emotionally with care and treatment

- Staff were trained to respond to callers whomay be distressed, anxious or confused. Staff were able to describe to us how they would respond and we saw evidence of this during our visit.
- There were established pathways for staff to follow to ensure callers were referred to other services for support as required, although the provider did express concerns that there was little support available for patients with mental health needs as there was no mental health crisis team in Suffolk and the only pathway open to patients was through GP services. The provider had voiced their concerns to local healthcare commissioners.
- There was a system in place to identify frequent callers and protocols were in place to provide the appropriate support through referral to the appropriate service to meet their needs as directed by the directory of services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 these were identified.

- The service offered a 24 hours a day, 365 days a week service.
- There was a 10am daily telephone conference between all Care UK NHS111 call centres to discuss performance, demand and staffing.
- The service continually analysed the demand on services and adjusted the levels of staffing according to predicted demand. For example cover was increased on known busy periods such as weekends, bank holidays and during major sporting events. Industry software was utilised as a workforce management tool for forecasting, scheduling and intraday management to predict demand and the required cover. Examples of flexibility had been built into the system for example flexible start times, and a range of different shift lengths. These were monitored and adjusted as required.
- Care UK had responded to the challenge of linking multiple call centres to provide a resilient national service, through an initiative called 'The Bridge'. It was a virtual team made up of both clinical and operational managers that provided network oversight to the business on a 24/7 basis. It enabled more effective management of key performance indicators as well as assuring the clinical safety of the patient's journey through the service during times of pressure or high demand. During live service delivery, the networked call-centres received resource direction instructions from the bridge team who monitored real-time demand. We observed the process in operation and saw that it was effective in the management of resources to best meet caller demand.
- Care pathways were appropriate for patients with specific needs, for example those at the end of their life, and babies and young children.
- There were translation services available in real time and covering a wide range of languages.
- The service had in place arrangements to support people who could not hear or communicate verbally through text based telephone systems.

Tackling inequity and promoting equality

- Reasonable adjustments had been made so that disabled people could access and use services on an equal basis to others,for example through the use of non-verbal telecommunications systems for those experiencing hearing impairment.
- The service engaged with people who were in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services, for example during the induction training staff had training on awareness of a range of factors which can affect access, including scenarios to increase skills in assisting patients with communication difficulties or memory impairments. The staff undertook training to increase recognition and awareness in dementia and other areas which can impact on care, for example domestic violence .
- 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

- People had timely access to advice, including from a health advisor or clinical advisor when appropriate.
- The telephone system was easy to use and supported people to access advice.
- Data showed that the service had performed consistently well. For example, we saw that the percentage of calls answered within 60 seconds for the Care UK East of England service in the period June 2015 to June 2016 was above average in all months but one (September 2015). For the same period, call backs within ten minutes were below average in June and July 2015 but had remained above average from August 2015 to June 2016.
- The service had worked hard to anticipate and respond to increased levels of demand on the service that was illustrated by the performance over the December period of 2015 with the percentage of calls answered

Good

Are services responsive to people's needs?

(for example, to feedback?)

within 60 seconds at 94.7% compared to the national average of 86.1% and the percentage of call backs within ten minutes at 59.7% compared to the national average of 41.8%.

- Referrals to 999 during December 2015 were 11.2% (national average 11.8%) and referrals to accident and emergency were 7.6% (national average 7.5%).

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.
- Care UK had a designated member of staff to deal with complaints at each of the three call centres. These members of staff could deal with complaints originating from any of the three contracts and recorded information centrally. The provider had received a total of 18 complaints regarding the NHS 111 service in the period June 2015 to June 2016. These consisted of nine for Suffolk, one for Milton Keynes and eight for Lincolnshire.
- We looked at the records of the complaints and saw they had been effectively investigated and responded to and were escalated to serious incidents if deemed required. We could not be assured that all complaints had been dealt with in a timely way as the recordings of complaints' time frames proved to be inconsistent. The provider acknowledged that more cohesion between the different sites was required and informed us on the day of inspection that they would ensure a uniform approach was put in place ensuring all time and date details are recorded.
- A review of the complaints had been completed but this did not show that any themes were recurring.
- Learning from complaints was evident and shared with staff if appropriate through learning or forums. Individual staff involved in the complaint were informed of any concerns or outcomes. Where necessary action was taken to prevent any re-occurrence by means of additional support, training, supervision or reflection.
- Records clearly showed that the provider fulfilled its duty of candour and people were told when they were affected by something that went wrong. We saw that letters of apology had been sent where it was appropriate.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care.

The provider had a clear vision to deliver a high quality service and promote good outcomes for people using the service.

- The service had a robust strategy and supporting business plans that reflected the vision and values and were regularly monitored.
- Staff with whom we spoke were aware of the vision and values of the service.
- Staff referred to a culture that was patient focused and committed to improving service delivery and patient outcomes.

Governance arrangements

Governance and performance management arrangements were proactively reviewed and reflected best practice. The provider had an overarching governance framework which supported the delivery of the strategy and a good quality service. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Locally, day to day management of the service rested with the clinical lead, quality governance manager and call centre manager together with the medical lead. This team reported directly to the national governance structure including board level on matters such as patient safety, performance, safeguarding that provided operational infrastructure and diverse functional expertise.
- The provider was ISO 27001 (information governance) and ISO 9001(quality management)accredited.
- Service specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the service was maintained at all levels in the organisation through monthly quality assurance meetings at local and national level.
- Performance was continually monitored in real time and best use of resources utilised though 'The Bridge'. The Bridge was Care UK's response to the challenge of linking multiple call centres to provide a resilient national service. The Bridge was a virtual team made up of both clinical and operational managers that provided network oversight to the business on a 24/7 basis. It enabled Care UK to more effectively manage KPI's as well as assuring the clinical safety of patients during times of pressure or high demand. During live service delivery, the networked call-centres received resource-direction instructions from the bridge team who monitored real-time demand.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- Clinical quality meetings were held by the NHS111 Clinical Governance and Call Review Group which we saw discussed a wide range of topics including performance, safeguarding, recruitment , training, serious incidents and complaints.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership, openness and transparency

A systematic approach was taken to working with other organisations to improve care

outcomes, tackle health inequalities and obtain best value for money.

There were clear lines of accountability within the service. The senior management team had been engaged in projects to ensure a focus on high quality and performance. They were proactive in ensuring effective working relationships with other stakeholders and 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 ensure services were accountable and supported by strong governance processes. For example the work they had done with a commissioning CCG in preparation for a new NHS111 provider taking over their contract demonstrated an emphasis on high quality patient care and continuity of service was paramount.

Are services well-led?

Outstanding ☆

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

Operational staff had access to managerial guidance and support. They were clear about their line management arrangements as well as the clinical governance arrangements in place. All those we spoke with were able to tell us who their immediate line manager was and expressed confidence in their management arrangements.

There were arrangements to support joint working by staff, for example through team meetings. Staff who did not work office hours (e.g. night shift workers) were supported in joint working and engaging with members of their team, even if their working hours did not allow them to attend team meetings.

Data was used to improve performance and there were systems in place to ensure data was accurate and timely. Real time information on performance was available, ensuring that senior managers could respond immediately to any unusual increase in call volumes and provide further support to team managers in ensuring timely access was available to the service for callers through 'The Bridge'.

Staff attrition for both clinical and health advisors was in line with best practice in similar services.

Public and staff engagement

Qualitative information from patient complaints and compliments was used alongside the findings from surveys to improve performance.

There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive staff engagement. Staff at all levels were actively encouraged to raise concerns.

Staff were able to describe to us the systems in place to give feedback. These included clinical advisors meetings and webinars, and a company newsletter. In addition staff produced their own newsletter.

A staff forum was held monthly which was chaired by the call centre manager. A wide range of subjects relating to patient safety and performance were discussed. We saw evidence that the provider was responsive to the suggestions put forward, for example how the colour scheme in the call centre had been changed .

The Chief Executive Officer held a monthly webinar that was open to all staff. The latest one had an emphasis on 'Brexit' and the possible effects on non UK citizens employed by Care UK.

We saw evidence of the most recent staff survey and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.

Care UK commissioned an external company to carry out satisfaction surveys with people who had called the NHS111 service.

- Surveys were undertaken using a text messaging system, this had commenced in December 2015 and was sent to every caller using a mobile number. The provider was also developing a more in-depth patient feedback tool to be able to assess satisfaction for specific patient groups, but this was not yet operational at the time of inspection.
- The provider had also attended local public events (for example The Suffolk Show and GP practices) to inform the public of the services provided and how best to use them.

The provider had a whistleblowing policy and staff we spoke with were aware how and where to access it.

Continuous improvement

A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.

- The leadership drove continuous improvement and staff were accountable for delivering

  change. Safe innovation was celebrated. There was a clear proactive approach to seeking

  out and embedding new ways of providing care and treatment.
- There was a focus on continuous learning and improvement at all levels within the service and had placed an emphasis on developing staff to meet their potential and helping them to progress through a portfolio based approach that enabled them to gain experience in other healthcare activities provided by Care UK Ltd if they wished to do so.

Are services well-led?

Outstanding ☆

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

- The provider had a 'Learning and Management System' that was available to all employees and gave access to on-line training and learning, including identified learning from significant events.
- Validated training for nurse clinican advisors was automatically appended to their re-validation process.
- The provider had developed an 'App' for mobile telephones and tablets called 'My Care UK' which enabled staff to access Care UK news, internal job opportunities, senior manager blogs and e-learning through the Care UK Academy of Excellence.
- The provider operated a reward scheme for employees who were nominated as 'The Local Health Care Hero' by their peers in recognition of good work. Recipients received a small monetary token of appreciation.

The thorough investigation of complaints and incidents, and the cascading of the findings to staff at all levels demonstrated a desire for continuous learning and development of individuals and the service