Staffordshire House

Quality Report

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

Ratings

Overall rating for this service	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

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of the Staffordshire Doctors Urgent Care NHS 111 service at Staffordshire House and Elizabeth House on 16 June 2016. NHS 111 is a telephone-based service where callers are assessed, given advice and directed to a local service that most appropriately meets 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 provider is rated as good.

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. Staff knew how to, and understood the need to raise concerns and report incidents and near misses. All events recorded were reviewed and categorised by the head of assurance.
- The provider was monitored against the Minimum Data Set (MDS) and Key Performance Indicators (KPIs). The data enabled the provider and commissioners to review the level of service being provided. Where variations in performance were identified, the reasons for this were reviewed and action plans implemented to improve the service.
- Staff were trained and monitored to ensure they used the NHS Pathways system safely and effectively.
- Information about services and how to complain was available and easy to understand. Complaints were fully investigated and when appropriate, patients were responded to with an apology and full explanation.
- There was clear leadership from a clinical and senior management perspective. Staff felt supported by senior management and a management rota was in place to ensure presence at busy times.
- There were safeguarding systems in place for both children and adults at risk of harm or abuse as well as frequent callers to the service. Safeguarding concerns were raised to the local safeguarding board but there was no evidence of any follow up from the provider.
- The provider was aware of and complied with the requirements of the Duty of Candour.

Summary of findings

- The provider had set clear priorities and strategies to achieve them. These included integration with the GP out of hours' service and innovation to improve patient care.

However there were areas of practice where the provider should make improvements:

- Review the safeguarding procedures to consider if a follow up to referrals and concerns should be implemented.
- Ensure that standard operating procedures (SOPs) are reviewed and updated where necessary in line with the review dates on the documents and that outdated SOPs are removed.

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.

- There was an effective system in place for reporting and recording significant events. Staff understood and fulfilled their responsibilities to raise concerns, and were encouraged to report incidents and near misses.
- Lessons were shared internally and with third parties to make sure action was taken to improve safety in the service.
- The service had clearly defined systems, processes and practices in place to keep patients safe and safeguarded from abuse. Staff understood their responsibilities and had received training relevant to their role. However there was no evidence of any follow up of safeguarding referrals and concerns.
- Risks to patients were assessed and well managed.
- The provider demonstrated a robust recruitment process. All staff were directly employed and relevant checks were seen to have been carried out on the staff whose files we checked. For example, professional registration where necessary, identification checks and Disclosure and Barring Service (DBS) checks.

Are services effective?

Good

The provider is rated as good for providing effective services.

- The service was monitored against the Minimum Data Set (MDS) and Key Performance Indicators (KPIs). The data provided information to the provider and commissioners about the level of service being provided. Where variations in performance were identified, the reasons for this were reviewed and action plans implemented to improve the service.
- The data highlighted that service levels were met on week days but not always at weekends. This problem had been identified by the provider and a realignment of rotas was to be implemented to increase the staffing levels at weekends.
- Staff were appropriately trained and monitored to ensure safe and effective use of the NHS Pathways system and the directory of services (DOS). There were enhanced training packages available to staff through distance learning courses at Keele University.

Summary of findings

- There was evidence of appraisals, performance monitoring processes and personal development plans were in place. Staff spoke positively about the scope for their own professional development.
- Information received from patients was recorded on the system and forwarded to both the service identified by the directory of services (DOS), (if the end disposition identified this) and to the patient's own GP.
- The provider had standard operating procedures available to all staff. However we saw that some review dates had lapsed and in one case an old version had not been removed from the file.
- There was an external directory of services (DOS) lead who was responsible for ensuring the information recorded in the directory was up to date and any problems were acted upon immediately.
- Call handlers and clinical advisors were provided with training on mental health awareness and the Mental Capacity Act 2005. Mental Capacity Act guidance was available on all work stations within the call centre. Staff had direct access to the mental health crisis team.
- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.

Are services caring?

Good

The provider is rated as good for providing caring services.

- Patient survey information for the period of January 2016 to April 2016 demonstrated that the NHS 111 service being provided by SDUC was comparable to the England average for the same period.
- We observed that call handlers spoke with patients respectfully and with care and compassion. Training on how to respond to callers who may be abusive had been provided to call handlers and staff felt supported by team leaders and colleagues.
- Feedback from patients about the services provided was positive although the amount of patient feedback was low.

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services.

Summary of findings

- The provider understood the needs of the population it served and engaged with the local Clinical Commissioning Groups to provide services that were responsive to the needs of the population.
- The service had access to a translation service for callers who required the service and did not speak, or had limited use of English. The service also used Typetalk, a telephone relay service which supports deaf, deafblind, deafened, hard of hearing and speech impaired people to communicate with others via telephone.
- Staff were able to directly book appointments with the GP Out-of-Hours service for patients who lived in Staffordshire.
- Call handlers were supported by nurses to provide clinical support in decision making. Staff could carry out warm transfers of calls (a warm transfer allows staff to speak with the person they intend transferring the call to prior to handing over the call).
- Information about how to complain was available and easy to understand. Evidence seen showed that the service responded quickly and sensitively to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The service was responsive to feedback and used performance information proactively to drive service improvements. SDUC acknowledged that they had not responded in a timely manner to a recent dip in performance but had put plans into place to rectify this and we saw evidence of early signs of improvement.
- SDUC monitored its performance against the Minimum Data Set (MDS) and Key Performance Indicators (KPIs). Performance was discussed with the Clinical Commissioning Group at monthly clinical quality review meetings. Where variations in performance were identified, the reasons had been reviewed and action plans implemented to improve the service.
- The views of patients were taken into account and each caller was invited to respond to the friends and family test.
- The provider held monthly governance meetings with the Staffordshire CCG representatives who led on the commissioning of the urgent care and the 111 service for all clinical commissioning groups of the county.

Summary of findings

- There was an overarching governance and performance management framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The senior management team encouraged a culture of openness and honesty. The service had systems in place for knowing about 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, staff were encouraged to continually learn and develop their skills.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Review the safeguarding procedures to consider if a follow up to referrals and concerns should be implemented.
- Ensure that standard operating procedures (SOPs) are reviewed and updated where necessary in line with the review dates on the documents and that outdated SOPs are removed.

Staffordshire House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, a NHS111 specialist advisor, a second CQC inspector and a CQC inspection manager.

Background to Staffordshire House

Staffordshire Doctors Urgent Care Limited (SDUC) is a private limited company commissioned to provide the NHS 111 service to the population of Staffordshire. In North Staffordshire, SDUC also provides the GP out-of-hours service but the service contracts are not integrated. We will report on the GP out-of-hours service separately. The NHS 111 service covers a population of approximately 857,000 people living in Staffordshire. SDUC is part of the Vocare Group, a provider of urgent care services across the UK that includes GP out of hours services, urgent care centres and the NHS 111 service. Vocare formed SDUC as a subsidiary of the Vocare Group to provide out of hours services and the NHS 111 service in Staffordshire.

SDUC started providing the 111 service in September 2014 on a short term contract. In October 2015, they were awarded a four year contract. SDUC operates two NHS 111 call centres in Staffordshire under a hub and spoke model. Staffordshire House in Stoke on Trent is the hub and Arun House in Stafford is the spoke site. These call centres are registered as locations with the CQC. Calls may be answered at either of the call centres, based on the availability of call advisors. We visited Staffordshire House during the course of the inspection. We did not visit Arun House as part of the inspection as all governance arrangements are at Stafford House and the data is integrated. From April 2015 to March 2016 the service had received a daily average of 561 calls from patients and other seeking assistance. The daily call volumes averaged 458 on weekdays and 900 per day at weekends. The volume was projected to increase by 5% during 2016/17.

The workforce consists of four full time equivalent (FTE) management staff, seven FTE team leaders, two FTE governance staff, 62 FTE call advisors and 31 FTE clinical advisors. The senior management team consists of a Head of Region who reports into the Vocare Group Operations Director.

Patients ring the NHS 111 service where their medical need is assessed by a call handler or a clinical advisor based on the symptoms they report when they call. If a patient needs to speak to a doctor, the request is transferred to another service, for example, to the patient's GP surgery, to the GP Out-of-Hours service or to the accident and emergency (A&E) department.

Why we carried out this inspection

We inspected this service as part of our new 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the 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. During our inspection we:

- Visited Staffordshire Doctors Urgent Care NHS 111 service at Stafford House on 16 June 2016.
- Observed call handlers and clinical advisors carrying out their role.
- Spoke with a range of clinical and non-clinical staff (including, nurses, shift and team leaders, call handlers, senior managers and directors).
- Reviewed documentation made available to us.

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us that they reported significant events, including concerns regarding patient safety or any other incidents, via an electronic 'Datix' reporting system.
- Serious adverse events (SAEs) were escalated for review by the Head of Assurance for the Vocare Group. Significant incidents (SIs) were reviewed by the SDUC clinical directors. All significant incidents and events were reviewed at the monthly clinical quality meeting held with representatives from the clinical commissioning groups (CCGs) within Staffordshire (including an Urgent Care lead appointed to represent all Staffordshire CCGs). Incidents were categorised and escalated to the Head of Assurance when viewed as in need of further investigation due to the severity. These were then referred to as serious adverse events. All incidents and events were submitted to and reviewed with the CCG representatives.
- The provider carried out an analysis of the significant events and incidents reported via 'Datix'.
- There had been 394 incidents recorded in the period April 2015 to November 2015. An audit trail was viewed to evidence that each event had been reviewed and actioned. Three of these incidents had been categorised as serious incidents requiring investigation (SIRI). We reviewed one of these incidents in detail and saw evidence that staff, partner organisations and people who use the services were involved in the investigation.
- Staff spoken with told us that they received feedback on significant incident reports and they were able to give examples of shared learning. A monthly newsletter for staff included shared learning from incidents and complaints. For example, in the June 2016 newsletter, the shared learning was for the diagnosis and treatment of sepsis following an incident when symptoms had not been recognised immediately by the call handler.
- Urgent communication with clinicians was facilitated via alerts on the computer desktop. The computer system provided an audit trail that could be used to show who sent the alert and who received it.

Overview of safety systems and processes

The provider had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. Clear information was available outlining who to contact for further guidance if staff had concerns about a patient's welfare. Information was available to guide staff when making a referral and contact numbers were easily accessible. The provider told us that there had been 155 safeguarding referrals made in the preceding 12 months, 87 related to children and 68 related to adults. Staff had received training relevant to their role (clinical advisors to safeguarding level three and call handlers to safeguarding level two) and were supported by named safeguarding leads for children and adults. They understood their responsibilities and demonstrated they knew who the safeguarding leads were. Although safeguarding concerns were recorded and communicated to the local safeguarding team or the police, there was no process in place to review each safeguarding referral made.
- The NHS 111 service used NHS Pathways, a licenced computer based operating system. NHS Pathways is a suite of clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call. It has an integrated directory of services, which identifies appropriate services for the patient's care if an ambulance is not required. Staff received comprehensive training on NHS Pathways and their competency assessed prior to handling telephone calls independently. In accordance with the NHS Pathways licensing agreement, call advisors and clinical advisors had a minimum of three calls audited each month to monitor their competency using the NHS Pathways triage systems correctly.
- Special notes provided by GPs were used to identify specific conditions or needs, for example, if children who were on child protection plans, or were vulnerable adults, for example residing in a care home or patients with a learning disability. Systems were also in place to

report concerns for further assessment. Special notes are used to share patient specific details between healthcare providers and could be added to a patient's records by the SDUC governance team.

- New employees received a corporate induction. We reviewed personnel files that showed call advisors received an initial training programme on NHS Pathways before being assigned to a graduation bay with a coach for further call handler training. Calls were monitored to ensure pathways were followed before training was completed.
- Recruitment checks were carried out and the six files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identity, references, qualifications, registration with appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were procedures in place for monitoring and managing risks to patient and staff safety. The provider had up to date fire risk assessments. We saw that the provider had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella. All electrical equipment was checked to ensure the equipment was safe to use. The working environment was seen to be safe and assessment done included the use of visual display units (VDUs) by staff.
- Due to difficulties in retaining and training call advisors, SDUC had implemented an integrated voice recording (IVR) system. An IVR is an automated option system for callers to select from). SDUC had employed support advisors who were able to handle non clinical calls such as appointment follow up, and this freed up capacity for trained call handlers and clinical advisors.
- A standard operating procedure (SOP) had been implemented for which required all children up to six months old to receive a clinical assessment when a call was received with concerns over their health and wellbeing.

Monitoring risks to patients

Risks to patients were normally assessed and well managed.

- A rota management team was responsible for planning and monitoring the number of staff needed to meet patients' needs including call handlers and clinical advisors. The team used a model to forecast activity per hour across each shift and this translated into predicted staff required. A buffer of 28% staffing was added to allow for sickness, holidays and short notice problems. This was in line with the industry standard for call centres.

A member of the senior management team was responsible for managing an electronic system which managed current staffing levels. This included the number of staff hours lost due to maternity leave and sickness and other absence. The system also forecast the number of hours which would become available when new employees began their employment within the call centre and how many hours were invested in staff training. This system was used to enable the rota management team to plan cover effectively. However planned levels were not always achieved due to staff absenteeism. Attrition rates had increased up to 27% prior to Christmas which is above national average of 22% for call centres. Sickness absence levels for call advisors ranged from 8.0% to 12.2% between September 2015 and April 2016.

Sickness levels for clinical advisors has ranged from 1.5% to 5.6% between September 2015 and April 2016. Following a successful bid to NHSE NHS 111 workforce development funds SDUC were awarded £34,745 to address sickness absence and attrition rates. The outcome of the pilot for the duration of a period of three months (January 1st 2016 to March 31st 2016) was under review although premium rates of pay had been introduced for weekend shifts.

- Advanced nurse practitioners' (ANP) and nurses' telephone lines ensured that call advisors received clinical support to aid decision making if required. Call handlers we spoke with during the inspection said that clinicians were normally readily available for advice or for call transfer on weekdays but not always at weekends. On the day of the inspection there were six call handlers and nine clinicians working at the centre. The provider was participating in a pilot project for ANPs to have direct access to the mental health crisis team.
- We spoke with a member of the senior management team who showed us how their business continuity plan worked in conjunction with their daily situational reports. These reports monitored their key performance indicators (KPIs) which included a KPI to answer all calls within 60 seconds against a target of 95%. The

situational report was sent to commissioners on a daily and weekly basis. A manager was responsible for monitoring these reports on a daily basis to ensure targets were achieved, and they liaised with the rota team to ensure staffing levels were sufficient. When call demand increased, elements of the business continuity plan were followed to ensure staffing levels were increased to meet demand. Calls could be rerouted to other centres locally and nationally to deal with a system failure. The plans in place were robust but the commissioners had noted that performance at the centre had been impacted by the volumes of calls coming in from out of area.

Arrangements to deal with emergencies and major incidents

The service had adequate arrangements in place to respond to emergencies and major incidents.

- All staff received annual basic life support training; staff we spoke with confirmed this and certificates were seen in the staff files.
- The provider had a comprehensive business continuity plan that was available to staff electronically via the intranet, a hard copy was located in the call centre and each shift manager held a copy. This document contained detailed escalation information on the actions to be taken in specific situations, such as whole system failure of electronic systems for both NHS111 and Out-of-Hours services, excess incoming call demand and directory of services failure. The plan contained emergency contact numbers for staff. During our inspection we viewed a copy which was available within the call centre. The plan included how a surge in demand could be managed by rerouting calls to other 111 centres in the country run by the Vocare Group.
- The working environment consisted of an open plan area with an adjoining staff room and a meeting room. Areas were seen to be tidy and well maintained and there were no safety hazards seen. The layout included partitions between desks to reduce sound interference.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All call handlers and clinical advisors were required to complete a comprehensive mandatory training programme to become a licensed user of NHS Pathways (a pre-agreed pathway of care that encompasses current evidence based national guidelines). Once trained and licensed to use NHS Pathways, call handlers and clinical advisors were required to have their performance monitored on a monthly basis. Routine audits were carried out by NHS Pathways trained coaches. A minimum of three calls per month were audited against a set criteria such as active listening, effective communication and skilled use of the NHS Pathways functionality.

We spoke with call handlers and nurse advisors during the inspection who told us that they had received a minimum of three call review audits per month, feedback was delivered on the outcome of the call reviews by team leaders who had all been trained as Pathways coaches. We saw evidence of review audits for staff showing all results were between 95% and 100%. We spoke with a range of staff who told us that that they participated in regular training sessions including specialist topics such as dementia, recognising and managing frequent callers, and mental health. Staff spoke positively of the support from colleagues and management, and the audits and feedback were seen as a positive learning experience.

Call review and NHS Pathway review meetings took place with other health care professionals such as the ambulance services and mental health services. Team managers met monthly to review and audit individual calls and pathways, any issues arising were addressed and an action plan implemented based on the outcome of the review. Where call handlers had failed an audit for two or more calls in a month, they were taken off line and a comprehensive consolidation pack had been developed and staff were supported in meeting the required standards.

During our inspection we saw various notice boards providing information on subjects referred to as 'hot topics'. These were also sent to call centre staff by email which had to be signed to provide an audit trail that they had been read. For example, we saw during the inspection that sepsis was the monthly focus. The notice boards contained photographs and probing questions to help call handlers deal with this condition. Sepsis is a serious illness which happens when the body has an overwhelming immune response to a bacterial infection.

Staff confirmed they had easy access to comprehensive policies and protocols electronically. During our inspection we saw evidence of policies which was available to all staff on an intranet. We saw that each desk had a red book containing all standard operating procedures (SOPs). Of the three SOPs we reviewed, two had review dates that had lapsed. For instance, the SOP covering managing calls about children had a review date of October 2014.

Management, monitoring and improving outcomes for people

The provider monitored the performance of NHS 111 against the Minimum Data Set (MDS) KPIs, some of which were locally agreed with the commissioners. This was discussed with the lead for the CCG and SDUC managers during monthly contract monitoring meetings. Where variations in performance were identified, the reasons for this were reviewed and action plans implemented to improve the service. We saw examples of when the commissioners had performed unannounced visits at weekends. Their findings were formulated into service improvement plans, which indicated where improvements had been made. There was a recovery plan in place to address areas where data indicated a downturn in performance.

All calls were recorded and the provider carried out regular call audits, for example, call handlers received a minimum of three audits per month. Audit results for April 2016 showed that all eligible clinicians had been reviewed, 94.6% attained full achievement and 5.4% partial achievement. All call handlers had been reviewed, 88% attained full achievement and 12% partial achievement (partial achievement meant the indicator was adequately demonstrated and that any issues identified in relation to this did not affect the overall safety or quality of the call).

We looked at key performance indicators data which showed that the provider had made improvements in 2016 against the national target of 95% of calls answered within 60 seconds:

- Between June 2015 and May 2016, the average performance was over 91%. However, monthly data showed a downward trend in performance to a low

Good

Are services effective?

(for example, treatment is effective)

point of 71% in March 2016. In April 2016 this trend in performance had been reversed and 87% of calls had been answered within 60 seconds. The provider attributed the drop in performance to a delayed response to increased call volumes and improvement was as a result of improved management of the shift pattern and increased engagement with staff.

- Data for April 2016 evidenced the average time to answer a call was 27 seconds. For April 2016 the warm transfer from a call handler to a clinician was 30%, this was higher than the national average of 22% and meant a higher than average clinical interaction with the patients at the inception. From these transfers 73% were transferred directly to a clinician with the patient still on the line, 27% were called back from the group of calls. When reviewed against the full call volume into the 111 service this meant that 8% of callers received a call back. Data provided showed that between April 2015 and March 2016 call backs made within ten minutes ranged between 25.1% and 38.3% (the national average is 41%).

The provider spoke of the call abandonment rate as being their acid test of performance. The data for calls abandoned after at least 30 seconds between June 2015 and May 2016 was 2.2%. The target set in the contract was less than 5% and this was bettered each month during the period.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The rate of attrition (staff turnover) was higher the national averages (27% compared to the national average of 22%) for call centres, however a three month project on staff retention had been completed in 2016 and actions taken included premium pay rates for weekend work and rota realignment to distribute the workload more evenly between staff.

- The provider had a corporate induction programme for newly appointed members of staff that covered such topics as integrated clinical governance, information governance, fire safety, health and safety, equality and diversity. Staff then completed an induction, robust training programme and probationary period appropriate to their job role. Staff were also allocated a 'buddy' to support them in their role upon completion of their initial induction and training period.
- The provider had a mandatory training programme that covered topics such as basic life support, safeguarding adults and children and infection prevention and control and Mental Capacity Act (MCA) training. The check of staff files evidenced completion of this training and staff that we spoke with demonstrated an understanding of the MCA.
- Evidence was available which showed that SDUC NHS 111 strictly followed the licencing requirements of NHS Pathways training. Staff were provided with training on any updates relating to NHS Pathways.
- During our inspection we observed call handlers when in conversation with service users. We saw that questions were often rephrased to assist the understanding of callers. The call handlers asked probing questions and demonstrated a good understanding of the pathways. Call handlers that we observed were well supported when required by team leaders and clinical advisors. Staff confirmed that this was typical of their experience but some expressed that weekends were more challenging when clinical advisors were not always readily available and team managers worked under more time pressure.
- The learning needs of staff were identified through ongoing assessments and meetings and a system of appraisals was in place. Staff received individual reflective feedback based on their performance. Personal objectives and training and development plans were developed and reviewed annually or more frequently if required. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included distance learning from Stoke on Trent College for mandatory training that included mental health and dementia. Keele University provided free online distance training for staff to all staff to help with their continued professional development. Courses included cardiac awareness and sensitive communication. All advisors had received appraisals in the preceding 12 months. Clinicians were supported with revalidation through reflection sessions and the clinical management team had supported three clinicians through revalidation since April 2016.

Good

Are services effective?

(for example, treatment is effective)

- During our inspection we saw evidence of clinical updates which included updates for staff such as sepsis (a potentially life threatening condition also known as blood poisoning) and Toxbase (the online database of the National Poisons Information Service).
- The sample of staff files we looked at contained completed performance appraisal and development reviews. The staff we spoke with told us they had received an appraisal. The annual appraisals focussed on staff performance and development needs.

Coordinating patient care and information sharing

- All information received was recorded on the system, consent was sought from the patient when personal details were shared with healthcare service providers, this information was forwarded to both the service when identified by the directory of services (DOS) and to the patient's own GP.
- Relevant information about patients was available electronically for call handlers and clinical advisors in a timely and accessible way through the summary care records, special patient notes (created by the patient's own GP and shared with the out of hours provider) and the Adastra advanced care planning system (used to support patients who have complex medical needs and to avoid unnecessary hospital admissions).
- There was an external Pathways facilitator who attended the centre weekly and held workshops with staff. For example, in June, 10 staff had attended a probing workshop with the DOS facilitator.
- The provider shared relevant information with other services in a timely and effective way and worked with other health and social care services. For example there were established links with the ambulance service, GPs, the local accident and emergency department, mental health team and the Bipolar Association.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Staff we spoke with told us they had completed Mental Capacity Act training and Deprivation of Liberty Safeguards training. This training formed part of the service's mandatory training requirements.
- We observed a number of call handlers and clinical advisors when speaking with patients (we did not listen in to the patient side of the call). Throughout the clinical triage assessment process, the call handlers and clinical advisors checked the patients understanding of what was being asked of them. Patients were asked to consent to their information being shared with both their GP and the service identified by the NHS Pathways and Directory of Services.
- The process for seeking consent was monitored through regular call review audits and feedback was delivered to staff during a monthly one to one meeting regarding their performance.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We reviewed the most recent survey results (October 2014 to September 2015) available from NHS England on patient satisfaction for people who had used the Staffordshire Doctors Urgent Care (SDUC) 111 service during this period. The results showed that the service performance was comparable with or above the England average:

- 93% of respondents stated they were 'very or fairly satisfied' with their NHS 111 experience and 5% were 'dissatisfied'.
- 94% of respondents stated they complied or partially complied with the advice given and 4% stated that they did not comply with the advice given.
- 86% of respondents stated their problem had been resolved or improved and 13% stated there was no change to their problem or it had worsened.

Benchmarking nationally can only be done for satisfaction scores. The England averages were 88% and 6% respectively (respondents are given four options to choose from for satisfaction scores from very satisfied to dissatisfied).

The provider monitored patient satisfaction through the friends and family test. Results between January 2016 and May 2016 showed that between 70% and 88% of respondents were likely or extremely likely to recommend the service and between 3% and 11% were unlikely or extremely unlikely to recommend the service. Each caller was invited to complete the survey at the end of the call. The number of respondents was low for the numbers of callers, for example, in May 2016, 15 out of 26,872 (0.06%) callers had completed the survey.

New employees received training in equality and diversity as part of their corporate induction training. Staff we spoke to were aware of the Language Line facility to assist patients to communicate better, and commented that it was used on a regular basis. In addition, systems were in place to identify frequent users of the NHS 111 service or frequent callers and staff used the 'special notes' facility to log information. A safeguarding lead attended multi-disciplinary meetings and also vulnerable adult risk meetings across all CCGs. A policy was in place for all calls that related to a child aged less than six months to ensure they were transferred to a clinician for assessment. Systems and procedures were in place to identify and manage frequent callers, for example staff liaised with the local mental health team when appropriate. Call handlers and clinical advisors spoken with said they felt supported by their shift managers and team managers and appreciated them being there at weekends.

Care planning and involvement in decisions about care and treatment

We observed call handlers and clinical advisors speaking with patients (we did not listen in to the patient side of the call). We observed that call handlers and clinical advisors spoke with patients in a respectful manner with care and compassion, they were confident in the use of the NHS Pathways programme and the patient was involved and supported to answer questions thoroughly. The final outcome of the NHS Pathways clinical assessment was explained to the patient and in all cases patients were given advice about what to do should their condition worsen. Staff used, when required, the directory of services (DOS) to identify available support services close to the patient's home.

Patient and carer support to cope emotionally with care and treatment

We observed call handlers speaking in a calm and reassuring manner to patients whilst also following the NHS Pathways. Call handlers were positive about clinical support provided. For example, a call handler spoke of having received a difficult call on behalf of a patient with serious breathing difficulties. The nurse on duty had taken the call immediately, provided support and CPR advice, and then supported the call advisor after the patient had been dealt with.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The provider worked with the local Clinical Commissioning Groups (CCGs) to plan services and to improve outcomes for patients in the area. SDUC monitored its performance daily against the Minimum Data Set (MDS) and Key Performance Indicators (KPIs), some of which were locally agreed, and this was discussed with the lead for the CCG at monthly contract monitoring meetings. Where variations in performance were identified, the reasons for this were reviewed and action plans implemented to improve the service. Services were planned and delivered to take into account the needs of different patient groups to help provide flexibility, choice and continuity of care. For example:

- Systems were in place to electronically record additional information for patients with complex health and social care needs or may be at risk to themselves or others; or cannot manage their healthcare themselves. Special notes were used to record relevant information for patients such as frequent callers, children subject to child protection plans, patients who were known to be violent or the location of medicines in a patient's home.
- The service took account of differing levels in demand in planning its service; peak demand plans covered local planned events, national celebrations and national holidays. The practice performance data showed that service levels dropped below the agreed levels at weekends. In response, the provider had realigned future rotas.
- Additional training was available for call handlers to assist them to identify and support confused or vulnerable callers. These calls could be transferred to a clinical advisor for further assessment. Staff received equality and diversity training as part of their induction and mandatory annual training updates.
- Staff we spoke with were aware of the Language Line facility to assist patients whose first language was not English to communicate better, and commented that it was used on a regular basis. The service also utilised Typetalk, a telephone relay service which supports deaf, deafblind, deafened, hard of hearing and speech impaired people to communicate with others via telephone.
- The service was able to book appointments directly with the GP Out-of-Hours service for patients who lived in Staffordshire. Appointments could be booked at the urgent care centre, walk-in centre, certain GP practices and extended hours GP hubs. The service was able to carry out warm transfers (internal immediate transfer of the telephone call from a call handler to a clinical advisor). The warm transfers were audited monthly. The results for April 2016 showed a higher percentage of warm transfer of calls when compared with the national average warm transfer rate (the number of calls transferred for clinical input). The percentage of warm transfers was 30% compared with the national average of 22%.
- The provider was aware of the needs of the local population and developed the services it provided to account for these. For example, Staffordshire had been identified as an area with above average numbers of patients who experienced mental health problems and the provider had established direct links with the mental health crisis team.

Access to the service

SDUC provided the NHS 111 services for the whole of Staffordshire. The NHS 111 service was available 24 hours a day, 365 days of the year. Patients accessed the service by dialling 111. Calls were answered at either of the two call centres based in Stoke on Trent and Stafford. The provider was part of a corporate group that operated NHS 111 call centres in other parts of the country. Calls could be routed between centres to manage peaks in call volumes or manage any system failure.

Calls to the service were answered by a call handler who established the patient's name, date of birth, registered home address and contact telephone number so they could contact the patient should the call become disconnected. Call handlers used NHS Pathways to triage telephone calls from patients and direct them towards the most appropriate service.

Listening and learning from concerns and complaints

The provider had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for NHS 111 services in England.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients who made a complaint were sent a copy of a complaints leaflet, which detailed how to make a complaint and offered contact details for telephone, email and post. In addition there was information about an online platform which could be used to make any comments including complaints. Details were provided of the Patient Advice and Liaison Service (PALS) and the Parliamentary and Health Service Ombudsman.

Complaints were recorded on the clinical operating system (Datix) and acknowledgements were seen to have been sent within three working days. Complaints were dealt with by designated individuals dependent on the nature of the complaint, for example, team leaders and clinical staff. As part of the complaint investigation, calls were listened to and information recorded on a review document. When a complaint involved multiple services we saw that a joint investigation took place.

The service had received 61 complaints in the preceding 12 months, which equated to 0.03% of patient contacts with the service. A number of complaints had been made in relation to breaches of confidentiality, for example, when a caller abandoned the call and the call handler made a referral to the safeguarding board or police and in doing so, the patient details were disclosed. The provider was aware of this and the safeguarding policy stated that these referrals were made as part of a duty of care and only to organisations that were aware of and protected patient confidentiality.

We looked at the summary of complaints received in the preceding 12 months. We found that these had been satisfactorily handled and dealt with in a timely manner. We looked at three complaints in detail. We saw that the complaints had been investigated and a response sent to the complainant, which included an apology where appropriate. We also noted that internal learning outcomes, for example training, had been completed or planned in response to the learning for the organisation. A culture to encourage duty of candour was evident through the complaints process. Duty of Candour is a legislative requirement for providers of health and social care services to set out some specific requirements that must be followed when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Complaints were reviewed at team leader meetings held fortnightly. Information on complaints was fed back to all staff via a monthly newsletter. Information on complaints was compiled into a quarterly report and reviewed as a standing agenda item at the monthly clinical quality review meeting (CQRM) held with the commissioners.

Are services well-led?

Good

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

Our findings

Vision and strategy

The provider had a corporate mission statement to innovative, high quality healthcare services patients and commissioners delivered through effective partnerships. The provider was monitored by its commissioners through a set of key performance indicators. There had been a drop in performance levels over the past six months but prior to this; the centre had been one of the highest performing centres within the Vocare Group. There was a short term performance recovery plan in place that detailed an improvement strategy. The management team had identified a higher volume of calls being received at weekends and had realigned the staff rotas to increase the number of staff at peak times. There was a plan to integrate the NHS 111 service with the out of hours service also provided by the Vocare Group.

Governance arrangements

The provider had an overarching governance framework, both as a corporate group and as a localised provider which supported the delivery of the strategy and good quality care.

- There was a clear management structure in place, senior staff were very knowledgeable and an integral part of the team. The senior management were experienced and had diverse professional backgrounds and knowledge. They aimed to improve the service and patient experience and regularly monitored performance in conjunction with the commissioners.
- There was a clear staffing structure in place and staff were aware of their own roles and responsibilities. Staff were encouraged to continually develop their skills and knowledge.
- Provider specific policies were implemented and were available to all staff electronically across all locations. Staff were regularly updated of any updated they were required to be aware of.
- Staff had been invited to attend regular team meetings but uptake was low and the meetings had ceased. However, staff we spoke with stated that team leaders and managers were supportive and visible at busy times. There was an open plan office environment that supported this. Communication from team leaders was made via email and a monthly newsletter.
- Calls received by the NHS 111 were monitored daily in line with the NHS 111 Minimum Data Set (MDS) and Key Performance Indicators (KPIs). Daily and weekly situational reports were produced and monitored on a daily basis. Monthly contract monitoring meetings were held with appointed leads and representatives of Staffordshire Clinical Commission Groups.
- A comprehensive understanding of the performance of the provider was maintained and reviewed in a monthly meeting with the commissioners. The commissioners had undertaken two visits in 2016, one announced and one unannounced, to inspect the service. An action plan produced following these inspections included rota realignment to optimise the staff available at the busiest times.
- A programme of continuous clinical and internal audit was in place which was used to monitor quality and to make improvements, including continual auditing of call advisors telephone calls and monitoring individual use of the NHS Pathways.
- A programme of continual appraisal, clinical supervision and performance management was in place to ensure a high level of patient care was delivered.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Incidents and events were recorded by staff at the centre and reviewed with the commissioners at regular meetings. Serious adverse events were escalated to the Head of Assurance for the Vocare Group.

Leadership and culture

There was a clear leadership and management structure in place. The management team was supported by the board of Vocare Group who were experienced and had diverse professional backgrounds and knowledge. Both displayed high values aimed at improving the service and patient experience and were taking positive steps to address the recent drop in performance.

Throughout the inspection we found the service encouraged a culture of openness and honesty and were

Are services well-led?

Good

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

prepared to learn from incidents, complaints and near misses, we found all staff welcoming during our inspection. The leadership of the service was visible and staff we spoke with told us they felt supported by the senior management team.

The provider was committed to developing the workforce and there was evidence that staff were encouraged and supported to attend training appropriate to their roles. There were robust training programmes in place for all members of staff and protected time was provided for training to be completed. A training programme had been introduced to monitor and improve individual and collective performance of call handlers and clinical advisors against clinical and operational targets. This programme involved one to one coaching from experienced trainers both clinical and non-clinical and also involved regular call reviews. A minimum of three calls per month were reviewed for all call advisors, and audits of clinical pathways were carried out.

The provider ensured that the nurse advisors were supported to revalidate their professional registration. All members of staff participated in appraisal schemes and continuing professional development. All clinical staff received a high level of continual clinical supervision and audit of their competencies. It was evidenced that staff had learnt from incidents, staff received reflective feedback on their performance and were given additional support if needed.

The provider had a corporate leadership course that was aimed at identifying and nurturing talented individuals within the workplace. Staff we spoke with commented positively on the course and the commitment from the employer to develop individuals.

Grant monies had been secured through national funding for workforce investment. This money had been used to review staff attrition and retention (staff attrition is the turnover of staff that in 2015 was 27% compared to the national average of 22%). The project had been completed over a three month period and had commenced and concluded with staff being invited to complete an anonymous questionnaire. Resilience leadership and wellbeing training sessions had been laid on for all staff and incentive schemes such as employer of the month and attendance awards had been offered for the three months. Staff were positive about the project, specifically the training provided, but performance data reviewed before and after highlighted a reduction in staff satisfaction. However, staff viewed an enhanced payment for working unsocial hours as a positive outcome from the project and the management of the centre stated that the results represented an increased awareness among staff of the issues addressed but the results were still under review.

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

The provider encouraged feedback from patients, the public and staff. Staff engagement was more informal but staff we spoke with stated that morale was good and that their feedback was listened to and valued. We invited members of staff to complete comment cards prior to the inspection and ten were received. The comments were overall positive but highlighted concerns of clinical cover at weekends and a number of negative comments were made about the terms and conditions of employment.

- The provider had patient representatives at the monthly call review meetings.
- The provider used the friends and family test to monitor feedback from service users. An option to complete the survey was given at the start of each call.
- SDUC had presented the service to local patient and public involvement groups and liaised with Staffordshire Health Watch. We were told that discussions with the CCG were being held to establish the most appropriate meetings for a patient participation group (PPG) to attend.

Continuous improvement

There were a number of examples seen during the inspection of where SDUC had taken steps to improve the safety and effectiveness of the NHS 111 service provided:

- Due to difficulties in retaining and training call advisors, SDUC had implemented an integrated voice recording (IVR) system. An IVR is an automated option system for callers to select from).
- A standard operating procedure (SOP) had been implemented for which required all children up to six months old to receive a clinical assessment when a call was received with concerns over their health and wellbeing.
- SDUC was piloting a project for advanced nurse practitioners (ANPs) to work autonomously in the out of hours provider in South Staffordshire.