West Midlands Integrated Urgent Care - Navigation Point

Inspection report

Waterfront Business Park
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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 location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

Overall summary

Letter from the Chief Inspector of General Practice:

We carried out an announced comprehensive inspection at West Midlands Integrated Urgent Care, Navigation Point, Waterfront Business Park, Dudley Road, Brierley Hill, DY51LX on 23 and 24 January 2019. The provider is a division of Care UK and they provide the NHS111 service element of the West Midlands Integrated Urgent Care model from a single site supported by other Care UK Health Care sites based nationally. Care UK is an independent organisation that deliver more than 70 dedicated services throughout health care in the UK including out-of-hours services, NHS 111 service and hospitals. The West Midlands Integrated Urgent Care model is an innovation designed with an overarching alliance agreement that unites all providers who deliver urgent care services for the region.

We rated the provider as good overall and outstanding for providing well-led services.

Our key findings were as follows:

- There was an open and transparent approach to safety and an effective system in place to report and record significant events and serious incidents. Staff knew how to raise concerns and understood the need to report incidents. Staff considered the organisation as having a supportive culture and learning was shared locally and nationally within the organisation as well as with external stakeholders.
- Staff took action to safeguard patients and were aware of the process to make safeguarding referrals. Safeguarding systems and processes were in place to safeguard both children and adults at risk of harm and abuse, including calls from children and frequent callers to the service.
- The provider had comprehensive systems and procedures to ensure a safe working environment, maintained a risk register and held regular internal and external governance meetings where safety was a standing agenda item. The safety team had engaged with NHS England to advise on best working practice for NHS111 providers.
- The service was monitored against a National Minimum Data Set (MDS) and Key Performance Indicators (KPIs). The data provided information to the provider and commissioners about the level of service provided.
- Staff had been trained and were monitored to ensure they used NHS Pathways safely and effectively (NHS Pathways is a licensed computer-based operating system that provides a suite of clinical assessments for triaging telephone calls from patients based on the symptoms they report when they call).
- Patients who used the service were supported effectively during the telephone triage process and consent was sought. We observed staff treated patients with compassion and respect.
- The provider was responsive and acted on patients' complaints effectively and feedback was welcomed by the provider and used to improve the service.
- There was a clear management structure and visible leadership at all times. Staff told us that they were approachable and supportive.
- The provider was aware of, and complied with the duty of candour. Staff told us there was a culture of openness and transparency.
- The provider was actively engaged with innovations to improve and streamline the provision of care to improve the patient experience. Examples included a project to establish an electronic link between providers within the urgent care alliance.

We saw several areas of outstanding practice including:

- The provider consistently demonstrated a proactive approach to risk management for both clinical risk and environmental risk. Some of these had been recognised nationally and had been shared with other providers as examples of best practice.
- The provider demonstrated a strong culture of using innovation to improve the experience of both patients and staff. For example, the establishment of a 'foundation bay' to support new and existing staff.

Overall summary

Whilst we found no breaches of the regulations, the provider should:

- Continue to explore ways in which to increase the percentage of calls answered within 60 seconds.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Our inspection team

Our inspection team was led by a CQC lead inspector and the team included two CQC inspectors, a GP specialist advisor and a nurse specialist advisor with experience in urgent care and out of hours care.

Background to West Midlands Integrated Urgent Care - Navigation Point

A new integrated urgent care service model has been implemented for the first time in the West Midlands, hosted by NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG) on a collaborative commissioning agreement between 16 CCGs. The arrangement sees the providers collaborate with various CCGs and in an alliance of five urgent care providers working with a joined-up approach.

The contract holder for the NHS111 service provided in the West Midlands is West Midlands Integrated Urgent Care (WMIUC). This service is part of Care UK, a company founded in 1982 which is now a large independent provider of health and social care services. Their services include treatment centres, GP practices, NHS walk-in centres, GP out-of-hours, prison health services and clinical assessment. Care UK provide a total of five NHS111 contracts in England.The service covers the West Midlands and includes the areas of Birmingham, Coventry, Warwickshire, Herefordshire, Shropshire and the Black Country. The geographic area covers 4,000 square miles, and a population of 4.65 million people. The service answered approximately 1.2 million calls in 2018. The staffing consisted of 255 full time equivalent (FTE) non-clinical staff (health advisors, service advisors and team managers). The clinical team consisted of 49 FTE clinical advisors and six point five FTE clinical supervisors. The clinical assessment service (CAS) was staffed with 24 FTE clinicians (GPs, advanced nurse practitioners, dental nurses, mental health nurses and pharmacists).

NHS 111 service operates 24 hours a day, 365 days a year. It is a telephone based service where people are assessed, given advice and directed to a local service that most appropriately meets their needs.

This inspection was the first since WMIUC were awarded the contract in November 2016.

Good

Are services safe?

Safe track record

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

- Significant events that met the threshold for a serious incident or serious 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 serious event. The provider treated significant events including near misses as an opportunity for learning and risk reduction measures.
- There was a computerised system known as 'Datix' that supported staff with the reporting, recording and management of incidents. The incident recording system supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that provider of services must follow when things go wrong with care and treatment).
- Joint reviews of incidents were carried out with partner organisations. For example, the near miss report contained an example of the provider working with secondary care providers to investigate an unexpected death.
- 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 monitored safety and carried out a thorough analysis of the serious incidents, significant events and near misses. There had been nine near misses recorded in the last 12 months.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetingswhere these were discussed. We saw evidence that lessons were shared and action was taken to improve safety. For example, we reviewed a serious event from 2018 where the correct pathway had been followed but instructions on the pathway not been followed correctly resulted in delayed treatment. Following an internal review of a case, the pathway instructions were reviewed to reduce the complexity for health advisors, the handover process between health advisors and clinicians was reviewed and staff reminded of the steps to take. Clinicians were reminded to review each call when multiple contacts have been made relating to the same symptoms (to look specifically at signs of the patient's condition worsening). A policy decision was made to direct any situation to a clinician (for fuller assessment) when the advice given directly contradicts the pathway's answer.

Overview of safety systems and processes

The provider 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. There was a lead member of staff for safeguarding. Contributions were made to safeguarding meetings when required. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- Clinical staff and appropriate administrative staff had access to people's medical or care records. Staff were clear on the arrangements for recording patient information and maintaining records. Special notes were used appropriately for people with specific conditions or needs and this made a difference to those people.
- Staff had had training in recognising concerning situations and followed guidance in how to respond. Clinical advice and support was readily available to staff when needed. Health advisors could refer cases to the Clinical Assessment Service (CAS) where all 'speak to' dispositions were transferred.
- There were clear processes in place to manage the transfer of calls, both internally within the service, and to external providers, to ensure a safe service; for example, to the out-of-hours service.
- There were systems in place to monitor call handling and response times to ensure a safe service. The call abandonment rate was consistently below the national target 5% (call abandonment rates are monitored to ensure that that patients are able to get through to the service rather than hanging up if their call isn't answered in a timely fashion).

Good

Are services safe?

- We reviewed five personnel files 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.

Monitoring safety and responding to risk

Risks to people using the service were assessed and well managed.

- Staff were able to identify potentially life-threatening situations. For example, staff had been trained on how to identify the signs of potential sepsis.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet people's needs. The rota system in place for all the different staffing groups ensured the service fully understood how many staff were required to meet the demand. There was forecasted and live data to provide leaders with visibility on performance. In peak times, the provider could re-direct or have calls re-directed from other NHS111 centres in England run by Care UK.

Arrangements to deal with emergencies and major incidents

The service had comprehensive and detailed 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.
- Simulation was used extensively to test resilience and response to major incidents. For example, the provider participated in table top simulation events with NHS England teams annually where a major disaster scenario (such as a major road traffic accident or terrorist attack) was used to test resilience.
- The provider had engaged with other services and commissioners in the development of its business continuity plan.

Good

Are services effective?

Effective needs assessment

The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The provider had systems in place to ensure all staff were kept up to date. Clinical staff had access to guidelines from NICE and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed as part of regular call audits.
- Telephone assessments were carried out using a defined operating model. Staff were aware of the operating model which included transfer of calls from a health advisor to a dental nurse or a mental health nurse. Health advisors were trained to take callers through a pathway assessment based on their symptoms. West Midlands Integrated Urgent Care (WMIUC) used the Department of Health approved NHS Pathways system (a set of clinical assessment questions to triage telephone calls from patients).
- 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, calls could be re-directed to other NHS111 centres run by Care UK when target call response times were not being met.
- Real time performance was monitored and action taken to ensure where performance was at risk of reducing. Clinical navigators monitored the queue of calls for clinicians and reprioritised based on clinical risk. Health advisors could transfer calls to the clinical assessment service (CAS)
- When staff were not able to make a direct appointment on behalf of the patient, clear referral processes were in place. These were agreed with senior staff and a clear explanation was given to the patient or person calling on their behalf.

Management, monitoring and improving outcomes for people

The provider monitored its performance through the use of the National Quality Requirements and 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 monthly.

- Abandonment rates were consistently below the national target 5%. For example, in November 2018 it was 1.6%. The worst day of the month was 4.4%.
- In November 2018 the percentage of calls triaged was 85%. The national average was 80-85%.
- In November 2018 the percentage of calls where the disposition required a warm transfer to a clinician was 25%. A warm transfer is where a call is transferred while the patient remained on the line.
- In November 2018 the percentage of calls that had clinical contact was 57%. The national average was 53%. The combined clinical response for all contacts (calls warm transferred to a clinician and a call back in ten minutes) was 63.4%. The national average was 57.4%.
- In November 2018 the percentage of call backs by a clinician made within 10 minutes was 48.6%. The national average was 38.4%.
- In November 2018, 79.2% of the highest priority call backs (P1s) were made within 10 minutes. Although there was a fall in December 2018 in the percentage of high priority calls (P1) being called back within 10 minutes, performance remained above the national average of 57%, achieving 79.2% in November 2018 and 61% in December 2018. The provider had identified the reasons behind the drop and was taking proactive action together with commissioners to address these issues. Patient safety calling took place when a backlog occurred. These are comfort calls from a health advisor with a standard operating procedure.
- In November 2018, the percentage of calls answered within 60 seconds was 87%. The national average was 81%. In December the percentage was 78% against the national average of 81%. The provider had identified the reasons for this deterioration which resulted from having a large cohort of new starters that extended the handling times as new members of staff were supported. In addition the forecast volume of 100,000 for December 2018 was exceeded with 131,000 calls being received. By January 2019 this had improved with a running average for the month was 81%. The calls

abandoned running average was at 2.4%. The provider had submitted a plan of action to the commissioners that included a recruitment plan to increase the number of health advisors.

The performance was reported to the commissioners monthly. There had been three contract performance notices (CPNs) issued by the co-ordinating commissioner (Sandwell and West Birmingham Clinical Commissioning Group) in December 2018. WMIUC had responded to each with an action plan, and at the time of the inspection, the actions plans were with the commissioners for approval. One of the CPNs was issued for failure to meet the 95% target of for calls to be answered within 60 seconds. WMIUC had started initiatives to improve performance; for example, to increase staff retention, the provider had introduced a 'foundation bay' that assisted new starters to adapt to the job role and environment.

There was evidence of improvements through the use of completed audits:

- Clinicians were regularly audited by a minimum of three cases reviewed. The frequency increased if there were concerns with performance.
- Feedback from audits was monitored and team managers and coaches aimed to provide feedback on the same day as the audit.

Effective staffing

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

- The provider had an induction programme for all newly appointed staff. This covered such topics as equality and diversity, safeguarding and health and safety.
- The provider could demonstrate how they ensured role-specific training and updating for relevant staff. For example, safeguarding training to the appropriate levels. For example, for those reviewing patients with long-term conditions.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support. 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, 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 service providers to ensure people received co-ordinated care.

- The provider was aware of the times of peak demand and had communicated these to the ambulance service. This included the arrangements to alert the ambulance service when demand was greater or lower than expected.
- There were arrangements in place to work with social care services including information sharing arrangements. The 'frequent caller management' process was to have a local multidisciplinary approach to managing patients identified by local health and social care providers and commissioners.
- 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/young people.

Consent

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and Gillick competency for children.
- At the end of each call the patient was asked to consent to the information being transferred to their own GP.
- Access to patient medical information was in line with the patient's consent.

Good

Are services effective?

- Staff we spoke with could give examples of when they might override patient's wishes, for example, when there was a significant risk of harm to the patient if no action was taken.

Good

Are services caring?

Kindness, dignity, respect and compassion

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

Staff were provided with training in how to respond to a range of callers, including those who may be abusive. Our observations were that staff handled calls sensitively and with compassion.

Results from the surveys, feedback and NHS Choices showed people felt they were treated with compassion, dignity and respect. The provider used monthly feedback from patients via text messaging service. We noted from these results that:

- For January 2019, 82% of patients said they would recommend the service to friends and family if they needed similar care or treatment. This was based on 795 patient responses.
- The trend in patient feedback over a 12-month period was consistent. In 2018 the lowest month was 79% and the highest 84% of patients who said they would recommend the service to friends and family if they needed similar care or treatment.

Care planning and involvement in decisions about care and treatment

- Care plans, where in place, informed the service's response to people's needs, though staff also understood that people might have needs not anticipated by the care plan.
- We saw that staff took time to ensure people understood the advice they had been given, and the referral process to other services where this was needed. This included where an appointment had been made by the NHS 111 service or where a request was to be made for a future appointment.
- Staff used a 'Directory of Services' (DoS) to identify available support close to the patient's geographical location.
- Health advisors were clear on the local operating procedures in place which detailed the actions they would take in the event that a patient declined the final disposition (outcome).

Patient/carer support to cope emotionally with care and treatment

Staff were trained to respond to callers who may 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. For example, call handlers repeatedly checked that the patient understood what was being asked of them and they understood the final disposition following the clinical assessment.

There were arrangements in place to respond to those with specific health care needs such as end of life care and those who had mental health needs. There were established pathways for staff to follow to ensure callers were referred to other services for support as required.

There was a system in place to identify frequent callers and care plans/guidance/protocols were in place to provide the appropriate support.

Good

Are services responsive to people's needs?

Responding to and meeting people's needs

The service engaged with the NHS England Area Team and lead Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, action plans were agreed with the CCG when performance was below contractual targets.

- The service was provided 24 hours a day, 365 days a week.
- The provider took account of differing levels in demand in planning its service. For example, the forecasting of resource required accounted for any large public events that had been laid on in the surrounding area.
- Care pathways were appropriate for patients with specific needs, for example those at the end of their life, and babies and young children.
- The provider had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. This included patient notes and care plans.
- The provider used all available data to ensure it was responsive to people's needs. These included response times, prioritising calls, monitoring of calls and call abandonment.
- There were translation services available.

Tackling inequity and promoting equality

- Reasonable adjustments had been made so that people could access and use services on an equal basis to others. For example, translation services were available. There were specialist advisors available, for example; specialists in mental health, safeguarding and sexual health.
- The provider had in place arrangements to support people who could not hear or communicate verbally. The service offered 'Typetalk' so patients could communicate in writing when using a telephone.
- The provider 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, the provider identified and tracked callers who may be vulnerable and informed a multi-agency team regarding alternative support.

Access to the service

The service was monitored against a data set that was made of contractual targets set by the lead Clinical Commissioning Group (CCG). The provider monitored their performance against the contractual targets and, where data was available, against national average performance for NHS111 service providers.

- In November 2018 the percentage of call backs by a clinician made within 10 minutes was 48.6%. The national average was 38.4%.
- Technology was used to support improvement to the patient experience. For example, the provider planned to implement the 'Electronic Prescription Service' (EPS) that allowed a prescribing clinician to electronically transfer a prescription to the pharmacy of the patient's choice.
- Action was taken to reduce the length of time people had to wait for subsequent care or advice.
- Action was taken to minimise the number of calls that were abandoned by the caller. The forecasted demand was measured against staff resourcing using live data that was updated every three seconds. During peak periods, the centre could divert to or have calls diverted from the other four NHS111 centres in England run by Care UK.
- The provider identified and prioritised people with the most urgent needs, even at times of high demand. For example, a senior clinician had responsibility for overseeing any waiting calls and identifying the call priority for clinical advice or escalating to the 999 service if required.
- Referrals and transfers to other services were undertaken in a timely way.
- The percentage of calls transferred for clinical advice was in line with the national average.

Listening and learning from concerns and complaints

The provider had an effective system in place for handling complaints and concerns. A system of categorising complaints had been piloted in 2018. Patients who had made a complaint were contacted, dependent on the issues raised, to determine whether they would be satisfied for the complaint to be reviewed informally or be converted to a 'concern'. In 2018, 32 complaints had been converted into a 'concern'. This meant that the complainant would receive a written response that detailed the findings and outcome following an investigation into the complaint. The total number of complaints received in 2018 was 286 (0.02% of contacts).

Good

Are services responsive to people's needs?

Information was shared with the staff member involved. Any learning points were shared with the wider team by email. All complaints were entered onto an electronic system (Datix) by a team manager. This system allowed data, including learning outcomes, to be shared internally and externally when deemed appropriate.

Patients who wished to make a complaint were transferred to a manager. Details of who to complain to were given over the telephone, emailed or sent by post to the complainant. An initial acknowledgement letter included information on the advocacy service. The final response letter included details of the escalation process; for example, the details for the Parliamentary and Health Service Ombudsman.

We looked at two complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, with openness and transparency in dealing with the complaint. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of the service. For example, we reviewed one complaint that related to inappropriate use of questioning in a pathway. We saw that this had been discussed with the member of staff involved and an identified need for the staff member to ensure that the outcome of each call and action taken to obtain advice was accurately and fully recorded.

The provider shared learning from complaints with other services and there was evidence of change as a result. For example, a complaint that related to delayed treatment for a palliative patient transferred to the out-of-hours service resulted in the patient experience lead reporting and investigating the issue with providers within the alliance of urgent care providers. This resulted in a review of how urgent calls were managed between the NHS111 and out-of-hours services.

Outstanding ☆

Are services well-led?

The provider is rated as outstanding for being well-led. This was because:

- The provider had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- A systematic approach was taken to working with other organisations to improve care and treatment outcomes, tackle inequalities and obtain best value for money.
- There was a high level of constructive engagement with staff, including staff who did not work conventional office hours (e.g. night shift workers). There was mental health support for staff and a proactive approach to recognising the potentially distressing nature of some calls.
- The leadership had focused on innovative ways to improve service to patients and to retain and motivate staff.
- The provider was continually researching and implementing new approaches to collaborative working with other health and social providers.
- 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

Vision and strategy

Care UK had a shared vision and set of aims that applied to all services within the group including West Midlands Integrated Urgent Care (WMIUC). These were:

- 'To be the UK's leading independent provider of health care services principally to the NHS, supporting people to live independent and fulfilling lives.'
- 'To be the partner of choice in the public sector and the provider of choice for our customers, trusted to deliver the right care, in the right place, at the right time.'
- 'To differentiate ourselves by the quality of our services, ensuring we are innovative and customer focused.'

There was a set of values in the form of strap lines. These included:

- 'Customers are at the heart of everything we do.'
- 'Every one of us makes a difference.'

There was a written set of values based on three 'Ps': patients, people and performance. This encompassed putting safety and effectiveness at the heart of the service. The vision and strategy was developed by staff who worked for WMIUC.

The provider 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 spoke positively about the culture of leadership and support and recognised the improvements that had been achieved since WMIUC were commissioned to provide the service.

Governance arrangements

WMIUC was part of a large national organisation with strategic and operational policies and procedures in place supported by their own governance structures and arrangements. Senior managers reported to and attended governance meetings in line with their organisational governance structures. The provider had an overarching governance framework for the NHS111 service 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. Staff had developed working relationships with colleagues at other NHS111 call centres run by Care UK and shared best practice and learning.
- 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.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. A database had been developed to monitor all aspects of the service. This database provided an overview with direct links into action plans with risk ratings for areas such as audit, performance, clinical governance and training.
- The provider had a virtual team made up of both clinical and operational managers that provided oversight at all times across the multiple call centres. This team was known as 'The Bridge'. This team was responsible for real-time service delivery and to provide clinical safety on the patient journey through the system. There had

been national recognition for the innovation of this service; for example, in 2016, it had been nominated for a nationally recognised award for the use of information technology to improve clinical safety. This was not only driving change within their own organisation but nationally.
- A comprehensive programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- Medical directors arranged virtual sessions where staff could dial in to discuss shared learning.

Leadership, openness and transparency

There were clear lines of accountability within the service.

- The structure of the contact centre was divided into a clinical management team, an operational management team, a clinical assessment service (CAS) management team and a patient and stakeholder engagement team.
- Staff were clear who to go to for guidance and support. They were clear about their line management arrangements as well as the clinical governance arrangements in place. They spoke positively about the availability and visibility of the senior management team who worked on a rotational basis to have a regular presence at the centre that included time at weekends.
- Drop-in sessions were laid on for staff. These were available as a group or one-to-one. Staff were encouraged to raise any concerns and put forward any ideas that could improve the working environment.

There were arrangements to support joint working by staff, for example through team meetings. Staff who did not work office hours (for example, night shift workers) were supported in joint working and engaging with members of their team, even if their working hours did not allow them to attend team meetings. The team at the centre were supported by a national manager for the Care UK NHS111 services. Staff told us that this management team regularly visited the centre and were contactable when not on site.

Data was used to improve performance and there were systems in place to ensure data was accurate and timely. For example, wall boards provided staff with live information that updated every three seconds. Staff could see the performance from other regional NHS111 centres run by Care UK and would use this information to provide resilience during peak times.

There were arrangements in place to provide support to staff in the event of a death or serious incident. For example, complex calls could be referred to the CAS and call handlers could alert team leaders to request support during a call.

Public and staff engagement

The provider carried out regular monthly surveys of patients who used the service. They did this by inviting feedback at the end of each call.

Staff were able to describe to us the systems in place to give feedback. These included a staff council where representatives from across the workforce attended monthly meetings with the management team. There were drop-in sessions laid on for staff and these took place on different days and times to allow all staff the opportunity to attend. A monthly newsletter was emailed out to all staff and gave information on the service; for example, on complaints, service performance and new staff members. Care UK offered an 'employee assist programme' where staff could access confidential support on work-related or personal challenges.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the service. The provider committed significant investment into renovation and refurbishment of the building to increase capacity, bring the centre up to current health and safety and environmental standards, and to improve the working conditions for staff. The renovation and refurbishment work included:

- All new LED lighting
- new office furniture throughout that included accessible desks and seating
- repairs to all window locking mechanisms and door closing systems
- a new building management system (BMS, a system that controls and monitors the building's mechanical and electrical equipment such as ventilation, heating and lighting)
- installation of a new glazed atrium which could be opened in the event of a fire.

We saw the following examples of continuous improvement and innovation within the service:

Outstanding ☆

Are services well-led?

- The establishment of a foundation bay to assist staff retention with a proactive approach to supporting new starters and those staff whose performance required improvement.
- The introduction of 'free fruit Fridays' and a tea lady.
- Improved paramedic and healthcare professional access through dedicated lines that could be automatically selected by the caller.
- A 'mental health first aid' standard operating procedure was introduced to support a timely intervention from a specialist in mental health in one of the multiple NHS111 centres. The process worked by informing a specialist advisor as soon as any concern was identified so a suitable time could be agreed to facilitate an intervention.
- An 'alliance provider passback project'. This project investigated when cases had been re-directed between providers within the alliance. As a result of the project, a technical link was established that allowed cases to be seamlessly re-directed electronically between urgent care providers.
- The implementation of an integrated safeguarding hub to provide 24 hour safeguarding and referral services to the centre.

We also saw examples of how the provider had driven improvement and innovations nationally:

- The resilience planning had disaster recovery plans had been adopted by NHS England to be used as best practice for other NHS111 providers.