Osprey House

Inspection report

Osprey House
Osprey Road, Sowton Industrial Estate
Exeter
Devon
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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?		**Good**	●

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Osprey House on 4 February 2019 as part of our inspection programme.

At this inspection we found:

- The service had systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.

- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were mostly able to access advice care and treatment from the service within an appropriate timescale for their needs. At times when service demand was high regional escalation plans were implemented and external organisations keep abreast of performance and risk.
- There was a focus on continuous learning and improvement at all levels of the organisation.

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. The team included a CQC Inspector and a GP specialist adviser.

Background to Osprey House

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Osprey House is part of Vocare Limited. This service provides a NHS 111 service for a population of approximately 786,000 patients in Devon. Since October 2016, the provider, Vocare, is sub-contracted to deliver the service as part of an Integrated Urgent Care service. They are accountable to the main contract holder Devon Doctors. Vocare deliver GP Out of Hours and urgent care services to more than 9.2 million patients nationally. (NHS 111 is a telephone based service where people are assessed, given advice and directed to a local service that most appropriately meets their needs).

We visited Osprey House as part of our inspection. It operates between 7am and 11pm 365 days a year (with access to NHS 111 outside of these hours provided by another Vocare location). Osprey House operates from:

Osprey Road, Sowton Industrial Estate, Exeter EX2 7WN. The location is registered with the Care Quality Commission under the Health and Social Care Act 2008 to provide the following regulated activity: Transport services, triage and medical advice provided remotely.

Approximately 70% of public contact to this service is handled by Vocare House, Balliol Business Park, Newcastle Upon Tyne NE12 8EW. This location is registered separately with the Care Quality Commission. We did not visit this as part of this inspection.

Are services safe?

Good 🟢

We rated the service as good for providing safe services.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments where necessary. It had safety policies, including Health & Safety, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse. For example: sharing concerns of risk with GP practices and actively following up referrals made through local safeguarding processes. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were mandatory within the provider's policy. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. The clinical service manager provided staff with regular updates such as best practice assessments and accessing safeguarding phone apps. We saw key national safeguarding weeks were highlighted with additional advice for staff such as domestic violence and abuse week.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was a system in place for dealing with surges in demand.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Systems were in place to manage people who experienced long waits.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The NHS Pathways system records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Track record on safety

The service had a good safety record.

- There were risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts. We saw actions taken to disseminate National Patient Safety Alerts to staff to ensure they understood possible complications from medicines.
- Joint reviews of incidents were carried out with partner organisations, including the local ambulance and Integrated Urgent Care services.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

Are services safe?

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service was in the process of training additional staff in the skills required to investigate incidents.
- The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, the service held a monthly look back and learn incident review involving staff who managed the patient contact for each incident. A webinar encouraged staff to look at solutions. As a result of one review, a presentation on end of life care was produced by a clinician and shared across the region.

- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and remote staff.
- The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service. For example, reviews of the outcomes reached during call advisor triage such as an emergency ambulance pathway for individual patients when the attending paramedics reduce the urgency for treatment following clinical assessment. (NHS 111 dispositions is a term used for the outcome of care needed and range from advice on self-care through to an emergency ambulance).

Are services effective?

We rated the service as good for providing effective services.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- Telephone assessments were carried out using NHS Pathways, a national operating model. Staff had received specific training in line with national guidelines for this clinical tool, used for assessing, triaging and directing contact from the public to other services such as urgent and emergency care services and GP services in and out of hours. NHS Pathways provided regular 'hot topic' updates such as treatment of sepsis to ensure staff maintained their awareness and were familiar with the process.
- Other operating processes were in place such as clinical validation and at peak times a clinician was made available to specifically manage these. (Clinical validation is the review of a call handler assessment and functions to review the assessment and where necessary improve treatment responses without reducing quality and safety).
- Patient needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients need could not be met by the service, staff redirected them to the appropriate service such as the local Integrated Urgent Care Clinical Assessment Service (CAS). (CAS comprises of a range of clinicians offering different clinical skills, including GPs who are able to close calls through clinical telephone consultation. This impacted by decreasing the need for face to face assessments and providing faster access for patients).
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example, a standard operating procedure was in place for children aged under one and adults aged over 80 to be transferred directly to the CAS.
- We saw no evidence of discrimination when providing care and treatment advice.
- Arrangements were in place to deal with repeat patients. There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans/guidance/protocols were in place to provide the appropriate support.
- 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 clear explanation was given to the patient or person calling on their behalf.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care and treatment advice provided such as emergency dispositions and the need for clinical validation of ambulance dispositions.

Providers of NHS 111 services are required to submit call data every month to NHS England by way of the Minimum Data Set (MDS). The MDS is used to show the efficiency and effectiveness of NHS 111 providers. We reviewed results from October 2018 through to January 2019 which showed the provider was mostly in line with national averages for national performance indicators.

- There were areas where the service was outside of the target range for an indicator. However, the provider was aware of these areas and we saw evidence that attempts were being made to address them. Data between October and December 2018 showed monthly improvements in performance. Days when performance achieved was under a set benchmark for the service resulted in external reporting and where necessary incident investigation to analyse clinical safety. This provided quality assurance to the main contract holder and enabled any impact or potential harm to be identified and acted on.

Are services effective?

- In November 2018 the service had an abandonment rate better than the required national 5% target on 6 out of 30 days.
- Average abandonments rates for October 2018 (3%), November 2018 (4%) and December 2018 (2%).
- Local key performance indicators (KPI) were in place to assure the clinical commissioning group and Integrated Urgent Care service the provider was performing effectively and to drive improvements in performance locally, ensuring patients receive the best possible clinical outcomes. For example, local KPIs included:

- The percentage of frequent callers (using NHS 111 more than 10 times per month) whose frequency of use is immediately highlighted to their own GP.

- The percentage of searches undertaken to establish and check patient demographics with the Personal Demographics Service (PDS). (PDS is the national electronic database of NHS patient identifiable details such as date of birth and NHS Number which helps healthcare professionals identify patients and match them to their health records).

- Where the service was not meeting the target for clinical call backs the provider had processes in place to improve performance in this area. For example, direct transfers to clinicians, clinical 'floor walkers' at one call centre and forecasting data to increase staff availability where peaks in demand were anticipated.

- The service used information about care and treatment to make improvements such as updated national sepsis guidance.

- The service made improvements through the use of completed audits and an annual quality improvement plan which monitored clinical effectiveness. There was clear evidence of action to resolve concerns and improve quality such as a regional review of ambulance dispositions resulting in further training for staff and updated processes with regards to the validation process. (Clinical validation is in place to assist in reducing the number of low priority ambulances dispatched where a more suitable but still safe alternative may be available).

- A comfort call audit in January 2019 highlighted the processes in place required updating to reflect the new clinical assessment service model. We saw briefings had taken place to relevant staff for awareness of the cases and associated updated processes. (Comfort call processes were in place to ensure at times of high demand, those patients waiting for a clinical call back from the service or the Integrated Urgent Care service received a non-clinical comfort call to assess they had not deteriorated to a point where emergency intervention was necessary).

- The service was actively involved in quality improvement activity such as monthly reviews of 50 patient contacts. The service reviewed call recordings against criteria such as the NHS Pathways tool and the directory of services (DOS). In December 2018 the review showed 94% (47) of calls outcomes were appropriate (an increase from November 2018 (86%) and October 2018 (76%)) and staff received recommendations when calls did not meet the benchmark. For example, staff were reminded to ask patients to take part in the monthly patient survey and DOS champions were being developed through a web based project management system.

- They had an in-depth quality improvement plan which included areas where CQC had identified the need for improvement at the provider's other services.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered such topics as in-depth NHS Pathways training on the use of the clinical triage system.

- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.

- The provider understood the learning needs of staff and provided protected time and training to meet them. For example, 'spotlight' training was held to highlight effective needs assessment for difficult calls such as depression in children and young people.

- Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

- The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making.

Are services effective?

- There was a clear approach for supporting and managing staff when their performance was poor or variable. For example, call auditing and reviews of care and treatment given to patients. When there were concerns or areas for improvement they implemented coaching development plans to support staff. This had led to positive staff feedback around support and mentoring provided by the team leaders and the organisation.

Coordinating care and treatment

Staff worked together, and worked with other organisations to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, and services were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services or when they were referred. Care and treatment for patients in vulnerable circumstances was coordinated when necessary with other services with other services such as community nursing.
- Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. There were established NHS Pathways for staff to follow to ensure callers were referred to other services for support as required.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service had formalised systems with the Integrated Urgent Care provider with specific management protocols for patients referred to the service. For example, people over the aged of 80 years who would have an early exit from the NHS Pathways system and were then reviewed by a clinician.

- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs. Staff had recently received additional NHS Pathways approved training updates on the management of depression.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language.

- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids such as a video relay service that allows access to a British Sign Language (BSL) interpreter through a video call and the NHS 111 textphone service for people with difficulties communicating or hearing.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Are services responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of its population and tailored services in response to those needs. The provider engaged with the main contract holder who held accountability for the contract and had responsibility to work with commissioners to secure improvements to services where these were identified.
- The provider improved services where possible in response to unmet needs. For example, following a review of the management of callers to the region reporting a death, staff were provided with learning on processes such as advanced decisions for cardio pulmonary resuscitation (DNACPR), verification and certification of death. This meant all callers to the NHS 111 service within the region received accurate and appropriate care and advice.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service such as those patients receiving end of life care or those with specific treatment plans. Care pathways were appropriate for patients with specific needs, for example those aged 80 years of age and older, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service such as the NHS 111 textphone service.
- The service was responsive to the needs of people in vulnerable circumstances as they worked within the main contractors standard operating procedures for population groups which improved access to care and treatment. For example, children under one and adults over 80 years had specific processes where the NHS Pathways system could be exited early and the call transferred to a clinical assessment service for rapid advice and treatment.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients were able to access care and treatment at a time to suit them. The service operated 24 hours a day, seven days a week.
- Patients mostly had timely access to initial assessment and treatment. We saw the most recent results for the service (October 2018 – January 2019) which showed the provider was in line with national averages:
  - Weekly performance data for calls answered within 60 seconds (for which the target is 95%) varied between 68% and 88%. Available data for December 2018 showed improvement in data with the mean average of 80% of calls answered within 60 seconds which was in line with national averages.
  - Weekly performance data for the number of calls abandoned (the national target is less than 5%) showed the service was mainly meeting national target. (Abandonment rates indicate the number of service users who abandoned the call. This can indicate risk to patients with a serious illness being unable to access timely treatment).
- The service forecasted times when demand and access to the service may increase. At times where, high abandonment rates had been recorded we saw these mainly correlated with local forecasting for increased service demand.
- Where people were waiting a long time for an assessment or treatment there were arrangements in place to manage the queue system. We reviewed episodes of higher than average abandonment rates and saw where possible additional staff had been allocated and calls routed to staff across other regional call centres.
- Areas where the provider was outside of the target range for an indicator such as answering a call within 60 seconds was monitored by the main contract holder and subject to contract review by the clinical commissioning group who commissioned the service.
- Where the service was not meeting the target, the provider was aware of these areas and we saw evidence that attempts were being made to address them such as the escalation processes and reviews of breaches. Safety netting advice was provided through the automated call wait system.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them to improve the quality of care.

Are services responsive to people's needs?

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Since January 2018 47 complaints had been received. We reviewed the six in progress complaints and three completed complaints and found that they were satisfactorily handled in a timely way.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. For example, the main contract holder had oversight, monitored complaints, requested case reviews and where necessary took the lead on investigations.

- The service learned lessons from individual concerns and complaints and from analysis of trends. As a result, it acted to improve the quality of care. For example, advising staff when there are pathways to follow for medical conditions which they were not aware of and discussing appropriate behaviour when speaking to patients.

Are services well-led?

We rated the service as good for leadership.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The provider had completed a consultation to restructure management and regional leadership with a triumvirate directorial model (a regional medical director, clinical director and director supported by an associated local team). This allowed an overview of quality and safety across the region and ensured any lessons learnt were embedded across sites. People we spoke to were able to provide evidence the structure was embedded.
- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it. For example, the leadership team demonstrated autonomy and ability to drive change locally such as the introduction of a clinical lead within the staffing model. At one of the call centres a clinician acted as a 'floor walker' during peaks in service demand. This enabled them to support staff in real-time and improve outcomes for patients through clinical assessment or advice at the time of the patient's call.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The provider monitored progress against delivery of the strategy. The service had a realistic strategy and supporting business plans to achieve priorities.
- The South West regional leadership team had developed local vision, values and strategy jointly with staff to support delivery of high quality care and promote good outcomes for patients. This complemented the national organisational vision and set of values.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. All complaints and incidents were reported monthly to the main contract holder. These were discussed and actions determined and reviewed at risk meetings. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received an annual appraisal in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was an emphasis on the safety and well-being of all staff. For example, the service had provided staff with a mental health coping strategies seminar.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Are services well-led?

- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, predictions on call forecasting were in place to highlights days when additional staff may be required. A daily call took place to ensure staff were aware of risks such as service performance, complaints or incidents of concern.

The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of incidents and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and stakeholders as part of contract monitoring arrangements.

We found learning from audits within the region had been acted on resulting in a positive impact on quality of care and outcomes for patients. For example, the national minimum data set in one NHS 111 service identified a higher than average ambulance disposition. The provider had reviewed and taken action to resolve the issue with the introduction of clinical 'floor walkers' across the region who had received additional senior clinician training.

There was a comprehensive process of continuous clinical and non-clinical call auditing used to monitor quality and performance of employed staff. We saw where performance fell below the required standard that staff had coaching plans, which included staff development to support them.

Staff we spoke with were able to discuss how policies or practice had been changed as a result of learning from incidents. For example, when the contract commenced there were a number of incidents raised for incorrect referrals to district nursing teams. Staff received updated information and the directory of services (DoS) updated.

The providers had plans in place and had trained staff for major incidents.

The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Local escalation plans were in place to deal effectively with fluctuations in demand and capacity and enabling the regional leadership to manage and mitigate associated clinical risk. In addition, the regional leadership team had a 'touchpoint management' system in place to ensure regional senior manager presence during weekends and evenings to risk assess current performance.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was useful. There were plans to address any identified weaknesses.

Are services well-led?

- The service used information technology systems to monitor and improve the quality of care.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service had a patient engagement strategy which included a plan to gather a full and diverse range of patient views and concerns they could act on to shape services and culture.
- The service had carried out a patient survey of patients who contacted the service. Patient uptake was poor however a text messaging feedback survey was planned for implementation. Patient and health care professional compliments were recorded including those patients that provided feedback through the Integrated Urgent Care service.
- Staff were able to describe to us the systems in place to give feedback such as a suggestion box and staff engagement, open forum sessions to discuss issues.
- Staff who worked remotely had a contract with the local service and were engaged and able to provide feedback such as through supervision. The provider had recently

undertaken a national staff survey and although not specific to the location, the findings were fed back to staff. We saw evidence of the most recent staff survey and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service worked with stakeholders around performance.
- Engagement with external partners was firmly embedded such as the local NHS England forum

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the service. For example, there was evidence that the service met with ambulance and urgent care providers regularly to monitor ambulance and emergency department dispositions.
- Staff knew about improvement methods and had the skills to use them.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared within the region however a formal system to understand the impact of the learning on quality improvement had recently been introduced so evidence to demonstrate effectiveness was limited.
- There were local and national systems to support improvement and innovation work.