Unit 4

Inspection report

Unit 4
Greenways Business Park, Bellinger Close
Chippenham
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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 Unit 4 on 21 January 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.
- The management and administrative system for recording the provider's mandatory training was not up to date and indicated gaps in training completion. The service was unable to fully evidence training completion.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access 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.
- Views and experiences of people who used the service was limited. This meant they had limited opportunity to actively engage in shaping the service.
- There was a focus on continuous learning and improvement at all levels of the organisation. However, we found limited evidence to support testing of new learning was embedded.

The areas where the provider **should** make improvements are:

- Consider a formal system to demonstrate evidence of how learning from incidents and quality improvement work has been embedded and improved quality of care delivery.
- Continue to develop the programme of completed audits to identify impact on patient care.
- Systems to demonstrate completion of one to one monthly reviews and training records should be maintained for all staffing groups to enable oversight from the leadership team.
- Continue to improve opportunities to engage the views and experiences of service users including carers and people in a range of equality groups.

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 two CQC Inspectors and a GP specialist adviser.

Background to Unit 4

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.

Unit 4 is part of Vocare Limited. This service provides a NHS 111 service for a population of approximately 900,000 patients in the Bath and North-East Somerset, Swindon and Wiltshire region. Since May 2018, 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 Medvivo. 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 Unit 4 as part of our inspection. It operates 24 hours, 365 days a year from Greenways Business Park, Bellinger Close, Chippenham SN15 1BN. 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.

Good

Are services safe?

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 had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction. 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 such as sharing concerns of risk with GP practices and 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 for all staff under 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).
- We were advised all staff received up-to-date safeguarding and safety training appropriate to their role. However, the provider's overarching training record showed gaps in recording for clinicians safeguarding adults level two training. Following inspection, the service provided written confirmation of up to date safeguarding training which we were unable to verify.
- Staff we spoke to knew how to identify and report concerns.
- There was an effective system to manage infection prevention and control.
- 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 comprehensive 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 service and urgent care services.

Good

Are services safe?

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- 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 learned and shared lessons, identified themes and took action to improve safety in the service. For example, following an IT event which identified significant concerns with the IT monitoring system, regular checks were undertaken to ensure it was working appropriately.
- 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 agency 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 dispositions reached during call advisor triage such as an emergency ambulance pathway for individual patients when the attending paramedics attend and reduce the disposition following clinical assessment.

Good

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 defined 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.
- 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 improve further 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 by clinical telephone consultation, decreasing 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 five and adults aged over 80 to be transferred directly to the CAS. There was a specific procedure whereby patients receiving end of life care were early exited from NHS Pathways and transferred to the CAS.
- Arrangements were in place to deal with repeat patients. For example, quarterly clinical meetings and local high impact meetings with external partners such as ambulance and mental health services took place to identify the needs of frequent callers.
- We saw no evidence of discrimination when making care and treatment decisions.
- 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 provided such as emergency dispositions and 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. For example, contract renegotiations. The service commenced in May 2018 and contracts were based on predictive contacts to the service but evidence showed these predictions were significantly below contacts actually being made.
- In December 2018 the service had an abandonment rate above the required 5% on 10 out of 31 days. The service could demonstrate a variance in call demand against

forecast and adequate shift fill such as 22 December 2018 where abandonment rate was 8%, the variance in call demand was 56% and both call advisor and clinical shift fill at 100%.

- On 2 December 2018 the abandonment rate was 23% with a call variance of 66% with 95% call advisor and 114% clinical advisor shift fill in place. The days where the service was in line with national targets showed averages of abandoned calls between 0.2% and 4.7%.
- Where the service was not meeting the target, the provider had processes in place to improve performance in this area. For example, warm call transfers to clinicians, clinical 'floor walkers' at one call centre and forecasting data to increase staff availability where peaks in demand were expected.
- The service used information about care and treatment to make improvements such as updated national sepsis guidance.
- Where data showed the service was outside of the national performance indicator such as patients awaiting call back from a clinician for more than one hour they were able to demonstrate action taken. For example, a monthly review was undertaken to analyse clinical safety and any potential harm and clinical calls reviewed to ensure clinicians appropriately managed case types.
- In October 2018 36 calls (0.2% of all calls received) did not receive a call back from a clinician within the hour timeframe.
- In December 2018 56 calls breached the one-hour call back. No harm was identified. We saw evidence learning was shared with clinical leads to increase focus of completion of calls during shifts.
- The service made improvements through the use of audits and an annual quality improvement plan which monitored clinical effectiveness. The positive impact of clinical audit on quality of care and outcomes for patients was limited as the service had been commissioned for eight months at the time of inspection. 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 was in place to assist in reducing the number of low priority ambulances dispatched where a more suitable but still safe alternative may be available).
- The service was actively involved in quality improvement activity. For example, call audits for clinicians and call handlers were regularly audited to identify areas for improvement. For example, during October 2018, 21 clinicians were eligible for audit and all of these were compliant. Out of 45 emergency calls, 44 were assessed to be appropriate. For the one felt to be inappropriate the clinician received detailed feedback. Audits were also undertaken for specific clinical areas, for example, dental cases analysis audit, between May and December 2018.

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. Up to date records of skills and qualifications were maintained.
- The provider had a management and administration system for statutory and mandatory training however gaps within the training record was evident such as safeguarding adults level 2 training and basic life support training for clinicians which indicated a 63% completion. We were told individual certificates of completion were maintained at the two call centres and team leaders had responsibility to maintain their own records to further assurance and discrepancies. We were unable to evidence completion of training at the Newcastle call centre. However, post inspection we received evidence that demonstrated that this had been undertaken.
- The provider provided staff with ongoing support. This included one-to-one meetings, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate a plan for all annual appraisals to be undertaken by the end of the first year of business.
- 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.

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, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated when necessary with other services such as community nursing.
- Patient's registered GP received an electronic summary of care and treatment so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary.
- 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 referral protocols for patients referred to the service such as people over the aged of 80 years who would have an early exit from the NHS Pathways system and were reviewed by a clinician. This was a new approach to managing an integrated care system and at the time of inspection an audit to review effectiveness had not taken place.
- 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 patients need 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.

Good

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 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. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Staff communicated with people in a way that they could understand, for example, communication aids such as a video relay service that allowed access to a British Sign Language (BSL) interpreter via 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.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- 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.

Good

Are services responsive to people's needs?

We rated the service as good / outstanding 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 provided services in response to those needs. The provider engaged with the main contract holder who held accountability for the contract and had the 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 decision 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 a video relay service and NHS 111 textphone service.
- The service was responsive to the needs of people in vulnerable circumstances. There was a system in place to identify frequent vulnerable callers via monthly high caller reports. The provider had worked with the main contract holder as part of their integrated urgent care service delivery, to support these patients and reduce the number of calls received. By working collaboratively with the local hospitals, the ambulance service, mental health teams and the patient's own GP, high intensity user plans were implemented where appropriate. There was evidence that these had made a positive impact. For example, In December 2018, 30 calls a day were being received from one patient. A high intensity user plan was implemented and by the third week of January only five calls had been received from this patient and none had been received in the two days prior to the inspection.

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 70% and 90%. Available data for December 2018 and January 2019 showed improvement with the mean average of 85% 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 in line or below 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 to rota's 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, we saw that this was being monitored by the main contract holder and subject to contract review by the clinical commissioning groups who commissioned the service.

Good

Are services responsive to people's needs?

- 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 appropriately to improve the quality of care.

- 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 procedure were in line with recognised guidance. Since the service started in May 2018 there had been 47 complaints. We reviewed five 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. The main contract holder had oversight, monitored all complaints and where necessary took the lead on investigations. For example, following validation, a case had been downgraded from an ambulance disposition to a home visit, the patient was not informed and they did not receive a visit. Unit 4 reported to the main contract holder, whose clinical director spoke with the family, acknowledged the errors that had taken place and assured them that steps had been taken that would reduce the risk of this happening in the future.
- The service learned lessons from concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, the ambulance service had fed back that a number of category one calls were not appropriate. Call recordings were analysed and feedback to individual call handlers given. Learning was shared via newsletters and meetings. Staff were required to sign to acknowledge that they had been read. However, we saw that only seven out of 38 staff had signed to say they had read the November newsletter. This meant that the management team could not assure themselves that learning was being embedded.

Good

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). People were in post who 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 clinical validation. (Clinical validation is the review of a call handler assessment and functions to improve further treatment responses without reducing quality and safety).
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders who were based at Unit 4 were visible and approachable and worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. However, senior leaders were not present on a daily basis. 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 national 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.

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 to Medvivo, the main contract holder. These were discussed and actions determined and reviewed at the weekly risk meeting which were attended by both Unit 4 and Medvivo. 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. For example, call handling staff had attended courses which developed probing skills to facilitate improved patient assessment. 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.

Good

Are services well-led?

- 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.
- 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. However, the overarching training record we saw during the inspection had 290 gaps. It did not accurately record completion of the statutory and mandatory training from the training e-learning system. This led to a reliance on staff to manage a third system of paper documentation which was specific to each site meaning the leadership team did not have oversight of training records. Post inspection we were sent information that demonstrated that training had been completed by staff.
- In addition, although compliance for completion of one to one staff reviews was audited regularly the formal system to document these was not completed for clinical staff.
- 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.
- The provider had established 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 identify days when additional staff may be required. The provider had processes to manage current and future performance of the service. 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 audits had been undertaken within the region to identify areas for for improvement. 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. However, because the contract had only been in place for seven months, follow up audits that may demonstrate a positive impact on quality of care had not been undertaken.

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 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 service was not always able to demonstrate how the embedding of learning locally was audited to demonstrate new learning changed practice which could result in similar events occurring in future. The shortness of time since the contract commenced was a limitation however the service could demonstrate lessons had been learnt through a reduction of similar incidents occurring.

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.

Good

Are services well-led?

The main contract holder undertook quarterly quality visits. As part of this inspection we reviewed the most recent quality visit report, Vocare responses and assurances around any identified risks and the regional risk register where risk and actions were recorded.

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 availability 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.
- 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 accurate and useful. There were plans to address any identified weaknesses.
- 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 a 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. For example, a text messaging feedback survey was planned for implementation. The main contract holder gathered patient views including their experience of NHS 111 through patient feedback cards at face to face appointments.
- The service had carried out a patient survey however only 25 views had been recorded which was below the contract agreement of 25% of patients who contacted the 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 during 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 contract holder had recently undertaken a staff survey and had included the Unit 4 location staff.
- The service worked with stakeholders around performance. For example, there was evidence that the service met with ambulance and urgent care providers regularly to monitor the high ambulance and emergency department dispositions.
- 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, the dissemination of learning from incidents and complaints was shared in newsletters, staff performance reviews and presentations. The provider was working towards alignment with the NHS Workforce Blueprint.
- Staff knew about improvement methods and had the skills to use them.
- Learning was shared within the region however there was no formal system to understand the impact of the learning on quality improvement.
- There were local and national systems to support improvement and innovation work.