Care UK - NHS 111 South West

Quality Report

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

Summary of findings

Ratings

Overall rating for this service	Outstanding
Are services safe?	Outstanding
Are services effective?	Outstanding
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Outstanding

Summary of findings

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Overall summary

This service is rated as Outstanding overall. (Previous inspection September 2016 – Good)

The key questions are rated as:

Are services safe? – Outstanding

Are services effective? – Outstanding

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Outstanding

We carried out an announced comprehensive inspection at Care UK – NHS 111 South West on 12 and 13 June 2019 as part of our inspection programme.

At this inspection we found:

- The service had good 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 able to access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation and the culture ensured all staff were engaged to deliver high quality person centred care.

We saw areas of outstanding practice:

- The implementation of a safeguarding hub, accessible 24 hours a day, to improve referrals for children and adults in need or at risk of abuse, had increased referrals, improved non-clinical and clinical handovers through implementation of handover tools, improved clinical availability during peak service demand and ensured follow-up for serious concerns to assure the service action had been taken.
- There was a well-embedded culture of high quality sustainable care such as the bridge team, an operational and clinical team which reviewed patients risks and the effectiveness and appropriateness of the care and performance across the region immediately, as it happened. This meant experienced staff, supported by comprehensive risk assessments, assessed and responded to patient risks quickly to ensure they received the most appropriate care and treatment.
- We saw a strong focus on continuous learning, quality improvement and risk management from complaints and incidents and performance management which included joint working and shared governance with partner organisations. The service demonstrated plans were consistently implemented, and had a positive impact on quality and sustainability of services. Improvement was evident as a result of shared learning and reviews with stakeholders. This included adapting auditing tools for quality assurance purposes to ensure learning was embedded and implementation of communication tools and apps. These processes were inclusive to agency staff.
- There was a strong focus on staff wellbeing. For example, implementation of resources to improve the working environment such as equipment, apps and the foundation bay. The implementation of the foundation bay for new health advisors had improved staff competencies and job retention.

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

- Respond to direct questions raised within formal complaints about the service.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Summary of findings

Good practice

We saw areas of outstanding practice:

- The implementation of a safeguarding hub, accessible 24 hours a day, to improve referrals for children and adults in need or at risk of abuse, had increased referrals, improved non-clinical and clinical handovers through implementation of handover tools, improved clinical availability during peak service demand and ensured follow-up for serious concerns to assure the service action had been taken.
- There was a well-embedded culture of high quality sustainable care such as the bridge team, an operational and clinical team which reviewed patients risks and the effectiveness and appropriateness of the care and performance across the region immediately, as it happened. This meant experienced staff, supported by comprehensive risk assessments, assessed and responded to patient risks quickly to ensure they received the most appropriate care and treatment.
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- There was a strong focus on staff wellbeing. For example, implementation of resources to improve the working environment such as equipment, apps and the foundation bay. The implementation of the foundation bay for new health advisors had improved staff competencies and job retention.

Care UK - NHS 111 South West

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a second CQC Inspector, an assistant inspector and an urgent care GP specialist adviser.

Background to Care UK - NHS 111 South West

Care UK was founded in 1982, and the company is a large UK based independent provider of health and social care. The service delivers more than 70 different NHS healthcare services including primary care consultation, GP Out of Hours, clinical assessment and treatment services, integrated urgent care services, prison health services and NHS 111.

Care UK provides contracts for 12 NHS 111 services across a range of geographical areas in England, including the South West and South East of England, London, parts of the Midlands and the East of England. (NHS 111 is 24 hours a day, telephone-based service where people are assessed, given advice or directed to a local service that most appropriately meets their needs. Calls are free for landlines and mobile phones).

For Somerset and Bristol, North Somerset, South Gloucestershire (BNSSG) NHS 111, the main contract holders are Devon Doctors and BrisDoc who hold overall accountability for the Integrated Urgent Care contract and sub-contract NHS 111 to Care UK. In Gloucestershire, Care UK is the main contract holder for NHS 111.

Care UK – NHS 111 South West was registered as a location in April 2014 and operates from Nicholson House, Lime Kiln Close, Bristol BS34 8SR. The service is registered for the regulated activity: Transport services, triage and medical advice provided remotely. We visited this location as part of this inspection.

The South West registered location provides urgent health advice for Bristol, North Somerset, South Gloucestershire, Gloucestershire and Somerset with a population of approximately 2.2 million. Dental advice is provided for Gloucestershire. The service forms part of a network of five NHS 111 services.

The Care UK - NHS 111 South West service is staffed by a team of 230 staff, with 95% of staff such as trained health advisors (call advisors having undertaken intensive training to triage patients) and clinical advisors who are experienced nurses and paramedics having direct patient contact.

Why we carried out this inspection

We carried out an announced comprehensive inspection at Care UK - NHS 111 South West 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.

Outstanding ☆

Are services safe?

Summary of findings

We rated the service as outstanding for providing safe services because the processes and arrangements to safeguard and promote the welfare of people at risk and the culture of learning was consistently implemented and had a positive impact on quality and protection of those at risk.

Our findings

Safety systems and processes

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

- The provider conducted safety risk assessments. It 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 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, information and concern on modern slavery, identified by the service, was shared with the local Police constabulary. We observed staff taking steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. They followed appropriate policies and processes.
- All staff received up-to-date safeguarding and safety training appropriate to their role. This included level three safeguard training for children for health advisors. They knew how to identify and report concerns.
- Since December 2018, the local safeguarding lead had implemented a safeguarding hub initiative. This comprised of an administrative team which coordinated non-urgent adult and child safeguarding referrals and operated 24 hours per day, seven days per week. This ensured a fast response to all safeguarding concerns during times of high service demand. We saw positive evaluation of the service in terms of safeguarding patients which had resulted in a roll out across the provider's services.
- The safeguarding lead had implemented a document to help health advisors understand terminology and risks. We saw this has led to an increase in reporting due to improved understanding of risks associated with abuse.
- The safeguarding lead for the location undertook monthly reporting including analysis of trends and

themes such as gaps in service provision for vulnerable adults with suicidal thoughts. This led to work with local commissioners to pilot the use of mental health nurses within the service and a suicide prevention strategy.

- All possible safeguard concerns were passed to the clinical team for a call-back and where necessary other services were contacted. For example, when concerned for the welfare of a child the clinical team spoke to other services to ensure attendance and treatment had taken place. All handovers followed a pathway (CUPID) to ensure appropriate and accurate information was taken by the health advisor and passed to a clinician. This included: consent, urgency of response, patient is an adult / child in need, indication for referral, details of other information such as family members at risk. All referrals made to other agencies were added to the incident recording system and the safeguarding hub sought to follow these up for outcomes and further learning. The introduction of the safeguarding hub had reduced the amount of time clinicians were taken away from calls to complete safeguarding referrals and ensured timely referrals were made. Staff we spoke to were very positive about the introduction of the hub and the reduction on time spent away from patients, especially during busy periods.
- Safeguarding supervision was in place in addition to monthly one to one reviews. The supervision sessions were led by experienced clinicians with appropriate safeguarding training for the role.
- 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 undertaken where required. (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).
- 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 robust arrangements for planning and monitoring the number and mix of staff needed including workforce planning, call volume forecasting and a recruitment trajectory.
- There was an effective system in place for dealing with surges in demand. For example, the bridge clinical and operational team provided service resilience through management of the real time delivery of the service and ensured clinical safety. For example, by reprioritising patients waiting for clinical advice and acting as a central point for incidents that could affect business continuity.
- 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 changed or worsened.
- 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.

- Individual care records were written and managed in a way that kept patients safe. The care 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.
- Joint reviews of incidents were carried out with partner organisations, including the local A&E department, NHS ambulance Trust, GP Out of Hours services, and urgent care services.

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 including safeguarding referrals. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. For example, monthly audits and reports including safeguarding assurance and overdue investigation completions. The medical director and clinical lead discussed all new significant events.
- The service learned and shared lessons, identified themes and took action to improve safety in the service. They demonstrated how learning was incorporated into day to day practice. For example, lessons were shared across the network within clinical and staff newsletters, and monthly supervision and processes were embedded to ensure the learning was incorporated into daily practice.
- Clinical training sessions such as the summer clinical events programme, where learning was delivered as part of clinical updates, included clinical knowledge and development around treatment of illness relating to learning from incidents . We saw a session on insect bites was within the programme of learning following an incident.
- We reviewed four root cause analysis (RCA) processes for significant events and found these were appropriate and detailed. Summaries of the RCA were disseminated to all staff for learning. There was an audit tool via the eLearning system to track that staff had read the recommendations. We saw actions from each review were checked for implementation. For example, through call audits.
- 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 quarterly end to end reviews with other organisations. Learning was used to make improvements to the service and we saw examples of joint governance and integration with other providers as a result. As an outcome of one review, additional training was undertaken on the importance of staff speaking directly to patients. A handover tool for telephone handovers between clinical and non-clinical staff was implemented called DCRASH which was a six questions prompt based on clinical reasoning and criteria that highlights urgency. Call audits now included the handover call as part of the competency measures.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Summary of findings

We rated the service as outstanding for providing effective services because the service was proactive in the implementation of innovative approaches to support and develop staff to provide effective care and treatment.

Our findings

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 with a set of clinical assessment questions based on the symptoms reported when patients called. The tool enabled a specifically designed clinical assessment to be carried out by a trained member of staff who answered the call.
- 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.
- Health advisors' and clinical advisors' call handling skills using the NHS Pathway systems were monitored regularly to ensure that decisions reached at the end of the call were safe and appropriate. We saw call auditing was at a minimum in line with national guidance and NHS contracts.
- Staff were able to access the advice of clinicians where the patient was not satisfied or did not accept the NHS Pathway outcome or decision. Should a clinician not be available for a direct call transfer (warm transfer) the patient could be placed in a 'call back' queue or health advisors could seek the advice of the clinical supervisor or team leader if they were uncertain of how to manage the call.
- We observed that the Care UK – NHS 111 South West service worked seamlessly through their 'bridge' team with the other Care UK NHS 111 call centre locations.

- If patients were experiencing any delays staff could support each other and provide call back for people from a different location to reduce the delay to the patient's assessment. All the staff across the locations had access to the NHS Pathways assessment that had been carried out and could access the Directory of Service to provide the correct ongoing health or care pathway, for the relevant geographical area.
- Since implementation, the bridge clinical team had demonstrated a positive reduction in patients referred to an emergency department or ambulance through active prioritisation of the clinical call queue and proactive response through risk based assessments for those patients requiring clinical support and most at risk from serious harm. Patients were assessed and directed more appropriately, and audits of the clinical bridge team demonstrated faster responses to assess patients and direct them to the most appropriate service .
- Structured assessment and handover tools such as DCRASH (used to ensure effective telephone handovers from non-clinical to clinical staff) were in place to ensure handovers from health advisors to clinicians incorporated the necessary information to make a judgement on urgency and need. The service evidenced updates within the tool based on learning from serious incidents and complaints.
- 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). Where any weakness in the system was identified, measures were put in place such as extra clinical training on 999 validations and serious illness (sepsis and measles); 'back to basics' health advisors supported to improve the competency of new staff and worked with ambulance colleagues to improve their understanding of systems and processes.
- Patients' 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 specific commissioned contracts, so children and adults with specific age ranges would be transferred directly to the CAS. For Bristol this was children aged under two and adults aged over 85.
- 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. A frequency caller lead was in place who liaised with GPs, other services such as commissioners and ambulance services and had direct contact with the caller outside of them calling for advice and support. 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.
- Technology and equipment were used to improve treatment and to support patients' independence. For example, PUFFIN, a live service update tool allowed for coordination of communication across the network of NHS 111 services and up to date information about service availability across the commissioned services. For example, access to a local CAS (Clinical assessment service) and urgent care treatment centres. The tool included availability of skilled clinicians at the CAS such as those clinicians with mental health expertise. This meant staff could direct patients through to the service that could most appropriately manage their illness.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, monthly audits of health advisor and clinical calls

Outstanding ☆

Are services effective?

(for example, treatment is effective)

including agency staff. Where appropriate clinicians took part in local and national improvement initiatives. For example, a recent project to review category three and four ambulance outcomes.

- 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 saw the most recent results for the service (March – April 2019) and reviewed data for the past year (where relevant) which showed the provider was meeting the national performance indicators or in line with national averages:
- NHS 111 are required to answer calls to the service within 60 seconds. The three commissioned services (Gloucester, Somerset and BNSSG (Bristol, North Somerset and South Gloucestershire)) services had slight differences within the contracts. For example, in Somerset callers aged five or under and aged over 75 were automatically re-routed through the clinical assessment service (CAS).
- In April 2019 Gloucester achieved an overall call answered in 60 seconds of 93% with 16 out of 30 days in April exceeded 95% call answering. For Gloucestershire, call answering within 60 seconds varied between 70% and 86% for the period December 2018 to March 2019 which was in line with average national performance (74%).
- In April 2019, Somerset achieved 95% and BNSSG 91% of 60 second call answering with an abandonment rate of under 1%. Average call abandonment rates are approximately 3.8% and the national target is set at 5% of call volume. Call abandonment rates for Gloucestershire were also below 1% meaning all contracts were better than England averages. (Call abandonment records callers to the service who terminate the call after 30 seconds. This can indicate risk to patients with a serious illness being unable to access timely treatment).
- National data for England NHS 111 providers showed in April 2019, 12.7% of calls led to referral to the Ambulance Service and 8.6% of calls resulted in a recommendation to attend accident and emergency (A&E). Care UK NHS 111 South West data indicates they are below national averages for referrals to A&E with an average of 7%.
- NHS England sets key performance indicators for 999 emergency ambulances. This is 10% of call volume. Although data collected shows amounts of outcomes for 999 responses it does not indicate how many were either declined by patients or a clinician changed the outcome following a reassessment of patient conditions. Data for Care UK – NHS 111 South West was on average slightly above national targets.
- We spoke to the service regarding 999 outcomes and saw they had an effective clinical validation system in place which was coordinated through the operation bridge team. For the NHS 111 locations within the Care UK network. (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). We reviewed 999 validation data and saw on average 85% of all calls requiring clinical validation took place.
- The clinical validation system included reviews of other ambulance pathways such as a category three and four ambulance disposition. (These are national standards of responses to certain conditions). We saw the service had a coordinated response within their network to clinical validation and were working towards improving patient outcomes. A clinical risk assessment tool was undertaken by the clinical bridge team meaning all ambulance calls were overseen by experienced clinicians and where necessary patient call-backs were expedited. For example, in Gloucestershire (April 2019), 59% of Category three & four ambulance dispositions were clinically assessed and of these 61% were re-directed to a more appropriate service. Overall, the service was above national averages for clinical contact with patients.
- Due to fluctuations in service demand, there were some areas on some occasions where the service was outside of the target range for an indicator. However, the data we reviewed showed at these times the service was in line with national averages. The provider was aware of these areas and we saw evidence that attempts were being made to address them through the workforce planning team, short and long term action plans and recruitment plans.
- Prior to inspection we spoke to the clinical commissioning groups who commissioned the service. We were advised Care UK – NHS 111 South West were generally meeting its locally agreed targets as set by its commissioner.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- APE, a performance measuring tool was used for real-time data on staff performance such as the amount of calls taken by clinical staff per hour and site performance. The tool gave clear data on how staff members were performing, as well as allowing the bridge team to react to service demand. For example, if service level was low, staff could be given opportunities to undertake training or be utilised to support other services. This was used in conjunction with an audit tool and reviewed during monthly reviews.
- Where the service was not meeting the target, the provider had put actions in place to improve performance in this area. For example, a trajectory improvement plan for clinical advisor calls undertaken per hour showed month on month improvement. The plan generated monthly actions for example, identification of locum staff who were outliers and performance reviewed monthly.
- The service made improvements through the use of completed audits. Audits had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. For example, weekly clinical and operational analysis reports to review performance, highlight issues and inform future planning were undertaken. Audits around management of clinical validation through the bridge team from February to May 2019 showed improved clinical validation of calls within 60 minutes.
- A process was in place to contact accident and emergency to follow-up on any child referred to the service. Relevant action was taken such as calling parents when children failed to attend and reporting to relevant organisations.

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 which included part-time NHS Pathways training to accommodate staff with personal responsibilities. Health advisors within the network entered a foundation bay for six weeks, once they completed the core module one training. The foundation bay aimed to support new health advisors was designed to 'bridge the gap' between modules one and two of NHS Pathways. It is run by operational supervisors with support of the audit and training team.
- The introduction of this additional support ensures a named support, weekly meetings and regular feedback, additional audits to ensure staff met expectations, and a dedicated 'helpline' number to a supervisor. Since its introduction the service has benefitted from improved staff retention and improved audit pass marks. Staff we spoke to told us the process improved their competence and confidence.
- 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, qualifications and training were maintained. Staff were encouraged and given opportunities to develop such as advanced clinical qualifications, clinical modules to improve skills and an apprentice scheme for administrative staff.
- 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.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. The service was in the process of implementing a back to basics programme to support health advisors with skills such as typing, improved English language and positive behaviour. These aligned with the NHS national Integrated Urgent Care aims.
- Clinical staff were recruited across the network of five of the providers NHS 111 services. Looking at vacancies across the network ensured staff could be recruited into each location to meet shift vacancies such as during peak call times.
- The location made use of clinical agency staff to cover vacancies or during times of high call forecasting. We saw agency staff were subject to the same auditing, training and performance management processes as employed staff.

Coordinating care and treatment

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Staff worked together, and worked well 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. For example, to build a better working relationship (in terms of understanding of each other's services) reciprocal shadow shifts had taken place with the local ambulance Trust. This had helped staff and both organisations understand the patient's journey and resulted in a decrease in total negative health professional feedback received from paramedics over the past 6 months.
- 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 with other services. For example, the mental health nurse pilot to improve access to care for those patients experiencing mental illness. Staff communicated with patient's registered GP's 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. There were established 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 NHS 111 service with specific referral protocols for patients referred to the service. An electronic record of all consultations was sent to patients' own GPs.
- There were clear and effective arrangements for booking appointments, transfers to other services, and requesting ambulances for people that required them. Staff were empowered to make direct referrals and/or appointments for patients with other services where possible.
- Issues with the Directory of Services (DoS) were resolved in a timely manner. For example, real time changes to services such as an unexpected closure of a service, were communicated through the PUFFIN system, a live system to manage urgent communications, until the DoS could be changed.

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 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. A quiz on mental capacity had identified good understanding from all staff.
- 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 including consent to refer through safeguarding processes.

Good

Are services caring?

Summary of findings

We rated the service as good for caring.

Our findings

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. For example, staff had received awareness training on mental health management.
- The patient survey for April 2019 asked patients if they felt they were treated with respect. Of the 313 responses 88% felt they were treated with respect. Previous surveys had a similar response.

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 had access to patient care plans if required and those patients that had special notes detailing their needs or treatment requirements. Health advisors could early exit from NHS Pathways and pass the call to the clinical team.
- Staff communicated with people in a way that they could understand, for example, communication aids, telephone text services and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services.

Privacy and dignity

Good

Are services caring?

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

We rated the service as good for providing responsive services.

Our findings

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 improved services where possible in response to unmet needs such as providing mental health awareness training to staff to improve knowledge and skills.
- The service had a system in place that alerted staff to any specific safety or clinical need of a person using the service. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, 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. For example, the NHS 111 textphone service.
- The service was responsive to the needs of people in vulnerable circumstances. They worked with the commissioner and main contract holder to improve services. For example, different contracts allowed for an early exit from the NHS 111 Pathway and immediate transfer to the clinical assessment service (CAS) for different population groups. In Somerset, this was people aged under five or aged over 75 and in Bristol people aged under two or aged over 85.
- The NHS 111 survey in April 2019 showed 85% of the 313 patients who responded said the call advisor listened carefully to them. Previous surveys had a similar response.

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 per day, seven days per week.
- Patients mostly had timely access to initial assessment and treatment. We saw the most recent results for the service (October 2018 – May 2019) which showed the provider was in line with national averages:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Monthly performance data for calls answered within 60 seconds in May 2019 (for which the target was 95%) was 84% for Bristol, North Somerset and South Gloucestershire and 82% for Gloucestershire. These figures indicated the service was below national targets however, they were in line with national averages. The service was able to explain changes to their workforce plan and overtime to mitigate results for this month.
- Monthly performance data for the number of calls abandoned (the national target is less than 5%) showed the service was meeting national target. In May 2019 the data was 2% and 3% respectively. (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).
- 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. For example, changes to recruitment and retention of staff, call forecasting and workforce improvement plans.

- The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services.
- Patients with the most urgent needs had their care and treatment prioritised.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Referrals and transfers to other services were undertaken in a timely way. For example, people aged under five and aged over 75 were exited from the NHS Pathways triage service and transferred to the Somerset CAS.
- The service prioritised people with the most urgent needs at times of high demand. Care UK – NHS 111 South West developed a system to ensure that all the calls waiting for a clinical advisor to call back were managed and reviewed within the network by the bridge team. A senior clinician had responsibility for overseeing any calls waiting in their queues and identifying the priority of calls for clinical advice. This involved identifying those which needed a call back immediately and/ or escalating to the 999 service if required.
- The Care UK – NHS 111 South West centre had access through the bridge to clinical advisors at the other locations within the network so if a call needed urgent intervention and a clinical advisor was not free in the South West the call could be seamlessly transferred to a clinical advisor at other locations. During the inspection we observed that the Care UK – NHS 111 South West service could take calls from any of the calls centres so patient delays to accessing care were minimised, and this was continually adjusted according to demand.
- The bridge team coordinated comfort calls to ensure patients received a timely call back from a clinician. All calls awaiting call back were reviewed by the clinical bridge team and where necessary escalated.

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. We saw a low level of complaints based on call volumes up to 65,000 per month.

- 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. We reviewed 60 of the 142 complaints received in the last year and found clearly documented actions and lessons learnt. Of these 60, two complaints were reviewed in detail. We found these were satisfactorily handled in a timely way. However, a direct question from the complainer had not been addressed in both complaints.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. For example, patients calling NHS 111 may then be directed through to the clinical assessment service. This meant the main contract holder for the Integrated Urgent Care service coordinated the investigation and response.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, complaints about staff attitude resulted in additional call auditing and complaints about wrong advice given to attend NHS organisations for further care resulted in updates where necessary to the directory of services.

Are services well-led?

Outstanding ☆

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

Summary of findings

We rated the service as outstanding for well-led services because the culture of the service encouraged continuous improvement and innovation to drive and improve the delivery of high-quality person centred care.

Our findings

We rated the service as outstanding for well-led services because the culture of the service encouraged continuous improvement and innovation to drive and improve the delivery of high-quality person centred care.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. We saw the national leadership team involved local leadership teams in bi-monthly service reviews including risk and performance.
- Local staff in lead roles were encouraged to identify areas for improvement and implement changes to improve the effectiveness and quality of care. For example, the safeguarding lead had implemented new structures and processes such as the safeguarding hub, additional resources for health advisors, a handover tool and clinical safeguarding supervision to improve staff knowledge and support and, improvement in the management of safeguarding concerns and responsiveness to concerns. Implementation of new processes had demonstrated improvements in the quality of and care patients received and influenced the wider organisation.
- Leaders at all levels were visible and approachable. They worked closely and collaboratively with staff and others to make sure they prioritised compassionate and inclusive leadership. Leaders had an inspired shared purpose and strived to deliver and motivate staff to succeed.
- 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, capabilities and skills, including planning for the future leadership of the service. An in-house leaders and managers training programme

Are services well-led?

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and development structure was in place which was interfaced with the NHS Leadership Academy training courses. This helped managers to focus on understanding how leadership behaviours affected the culture and climate, and how staff affected the experiences of people who used the service and the quality of care provided.

- Senior regional leaders had regular meetings with the local leadership team and through the local network of leaders. They encouraged local leaders to work within the network to enable effective and responsive performance management across the network.
- Leaders encouraged annual away days for clinical supervisors and the bridge team. The most recent away day focus was leadership.

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 service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with patients, staff and external partners.
- 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. Leaders encouraged and motivated staff to actively engage in shaping and improving the service and culture.

- 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. 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. They told us they felt listened to and their views were taken into account.
- There were processes for providing all staff with the development they need. For example, in the past year the provider had funded staff members to gain further clinical qualifications such as acute care practitioner and non-medical prescriber. The service understood how increasing staff expertise above role requirements could improve patient care and treatment and balanced the risk of upskilling staff against staff retention. They provided an apprenticeship scheme for management courses.
- All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. For example, following losses of new staff due to the pressure of the environment (from call volumes and in-experience of dealing with traumatic health events) the service listened to staff feedback and implemented a foundation bay to support new health advisors. The foundation bay allowed staff to gain experience and competencies within the role within a supported area of the service with direct and instant access to supervisors and experienced staff without the pressures of managing call volumes. This meant if a traumatic call such as a patient requiring cardiopulmonary resuscitation was received, experienced staff allocated for supervision and mentoring were always available to assist new staff. We saw positive examples of leaders listening to staff and taking action to support and empower staff with caring responsibilities to succeed. By adapting organisational expectations and offering flexible working staff told us leaders improved work life balance and wellbeing, and allowed scope for them to be innovative with managing daily work.

Are services well-led?

Outstanding ☆

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- The service had a system to ensure feedback (SHEEP) provided to staff was done in a positive way to enable staff understanding and reflection of events. This supported behaviour change and reinforced a positive workplace. (SHEEP is an acronym for System, Human interaction, Environment, Equipment, Personality).
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. For example, a hearing loop system for staff was provided to enable staff with a hearing disability to meet expected call competencies and improve communication with patients. Medical emergency risk assessments and procedures were in place for individual staff with a chronic illness. Their colleagues were aware of steps they should take during an emergency.
- Staff had received equality and diversity training. Staff felt they were treated equally and encouraged to succeed. Staff had undertaken wellness bias training. A training that helped staff to understand how automatic judgements can impact patient outcomes .
- There were positive relationships between staff and teams. A staff counsel was in place to provide an appropriate arena for staff to raise concerns. Leaders actively reviewed suggestions and concerns and encouraged staff to take action to implement improvements. For example, monthly nomination awards for staff were in place and all staff had the opportunity to nominate colleagues. Other activities such as quizzes with prizes based on new and updated governance processes was in place.
- Mental health first aiders were available during shifts to support staff following difficult or upsetting patient interactions. Staff had received specific training to provide this role.

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.
- Clinical leads across the network met monthly and undertook regular telephone meetings to review governance. This included a policies and procedures operating group where clinical leads reviewed all policies, clinical staffing meetings to review workforce and resourcing, and an audit review meeting.

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. Local risks were managed within the local area of concern.
- The provider had processes to manage current and future performance of the service. Performance of employed and agency clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Agency staff underwent the same performance management audits as employed staff.
- Leaders had oversight of MHRA alerts, 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 the local commissioners as part of contract monitoring arrangements.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The providers had plans in place and had trained staff for major incidents. Since 2018, NHS 111 providers had become part of the NHS strategic national framework containing principles for health emergency preparedness, resilience and response (EPRR) for the NHS in England. We reviewed the providers emergency planning and business continuity including local

Are services well-led?

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processes which enable to service to maintain critical services during an EPRR event. We saw a progressive response to planning resilience and supporting further development against NHS EPRR Core Standards.

- 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. For example, the safeguarding hub who provided support to clinical advisors and streamlined safeguarding processes. Since December 2018 the safeguarding hub had seen an increase in safeguarding referrals for the South West location and a reduction in clinical time taken away from clinical calls.
- Within the Care UK – NHS 111 South West network, a supporting risk assessment governance structure 'the bridge' was implemented to provide a clear structure to the operational management of resources, pressures within the system, key performance indictors (KPIs) and clinical safety. This was in additional to local leadership within the location and ensured the location functioned effectively as part of the providers regional NHS 111 network. The operational team managed services within the network using real time data and forecasting which meant they are able to improve patient flow during times of high demand. The clinical bridge comprised of experienced clinicians using a risk assessment model to clinically assess and prioritise each patient case that required call-back or validation. This ensured fast, appropriate responses based on clinical need were undertaken and effectively reduced initial national standard pathways indicating an emergency response.
- Performance management tools such as Ape (an agent performance tool for each clinician); an internal innovation tool (PUFFIN) to help the bridge staff manage communications on a large scale. This reduced multiple emails through the network and enabled staff to have instant live updates regarding key messages such as service status and access to clinical assessment centres (CAS).

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. For example, workforce forecasting, daily reviews of service levels and planning and live performance management through the bridge team. 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. For example, call audits and performance management tools.
- 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. For example, DCRASH a handover tool that is used to ensure effective telephone handovers from non-clinical to clinical staff encouraged improved communication. The tool had been improved based on the recommendations from both serious incidents and complaints the service has received.
- 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.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- At the time of inspection, patient feedback had not been undertaken for two months due to work being undertaken to ensure compliance with consent for feedback was in line with GDPR (General Data Protection Regulation). We reviewed feedback between October 2018 and April 2019 which indicated between 81% and 87% of patients would recommend the service to family and friends. Between 9% and 12% would not recommend the service. Response rates varied between

Are services well-led?

Outstanding ☆

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243 and 395 patients completing the survey. During our visit we reviewed progress of work being undertaken to ensure requests for patients experience feedback met GDPR policy.

- In April 2019, 85% of 255 patients (excluding Somerset) said they were satisfied with the NHS 111 service.
- Staff were able to describe to us the systems in place to give feedback. For example, monthly performance reviews and safeguarding supervision. Staff who worked remotely were engaged and able to provide feedback through the same mechanisms. We saw evidence of a staff survey and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.
- Health professional feedback received from other health services were reviewed by clinical supervisors and fed back to staff.

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 which influenced processes and policy and focused on incorporating and testing learning in daily practice. For example, a monthly newsletter for clinical staff which had an in-depth clinical learning focus on relevant topics as well as information on key performance indicators, and a Care UK's internal journal which highlighted incidents and topics seen in national Primary Care services such as sepsis included expected actions staff were required to take to make improvements to care quality. In addition the clinical bridge team produced learning documents related to trends in calls. For example, an increase in childhood rashes led to presentation, treatment and advice updates for management of common and infectious rashes. Bespoke training sessions were available to clinicians around seasonal illness and learning from incidents such as managing insect bites. Implementation of learning and improved staff understanding of disease management was tested regularly through structured assessment tools. For example, the call auditing system and monthly review meetings.
- The service made use of internal and external reviews of incidents and complaints. They demonstrated joint working and shared governance with partner organisations / stakeholders around significant risks such as serious incidents and implemented changes to improve the quality of care and patient experience such as DCRASH (a communication handover tool). We saw the focus on continuous improvement influenced the wider organisation.
- There was a culture of undertaking national pilot schemes to optimise appropriate care and treatment such as a category two ambulance pilot to reduce inappropriate category two ambulance requests. (Category two ambulances are those categorised for an emergency and serious life threatening condition).
- Staff knew about improvement methods and had the skills to use them.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There was a strong culture of innovation evidenced by the systems in place to support improvement and innovation work. For example, the service used innovative ways to improve care where possible for example, the clinical bridge model supported by a risk stratification tool and an audit process, and the development of tools to improve quality of care provided. For example, an audit tool to identify themes of caller requests, and a performance measuring tool.
- The learning and development of staff was recognised as important for the NHS 111 service, for delivery of best practice care, for staff to feel valued and to support staff retention. We found supporting continuous professional development (CPD) was a priority. Care UK – NHS 111 South West supported the delivery of CPD in the context of meeting performance targets. This was done by using its forecasting scheduling tool which enabled them to predict periods where protected time could be planned without compromising responsiveness to patient demand. Care UK – NHS 111 South West also brought in staff for overtime in order to support the delivery of CPD.
- The introduction of a mobile phone app for staff to allow access to management of annual leave and booking of shifts.