South Western Ambulance Service NHS Foundation Trust (NHS 111 Service)

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	Requires improvement 
Are services safe?	**Good** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive to people's needs?	**Good** 
Are services well-led?	**Requires improvement** 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive follow up inspection of the NHS 111 service provided by South Western Ambulance Service NHS Foundation Trust (SWASFT) on 7, 8 and 20 December 2016. Overall following the December 2016 inspection, SWASFT NHS 111 service is rated as requires improvement.

The SWASFT NHS 111 service had previously been inspected in March 2016 and August 2016. The full reports for these inspections can be seen on our website www.cqc.org.uk

SWASFT NHS 111 service provides a telephone service to a diverse population for Dorset and Cornwall.

NHS 111 is a telephone-based service where callers are assessed, given advice and directed to a local service that most appropriately meets their needs. For example, this could be a GP service (in or out of hours), walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance, pharmacy or home management

At the March 2016 inspection, the service was rated as inadequate overall. The main issues identified at the inspection included insufficient numbers of staff and NHS 111 calls were not responded to in a timely and effective manner.

At the inspection in August 2016 we found that positive steps had been taken to address the identified issues. The key finding following the August 2016 inspection was a significant improvement in the approach of the Trust's the day to day and strategic running of the NHS 111 service that was not previously seen.

Our key findings were as follows:

- The Trust had significantly improved their systems in place to mitigate safety risks across the NHS 111 service and was now aligned to the SWASFT vision with safety and quality. We found that the Trust had recognised the need to improve the NHS 111 service. The NHS 111 service was monitored against the National Minimum Data Set for NHS 111 services and adapted National Quality Requirements. Performance against indicators was improving but still below national targets.
- Callers received a safer, more effective and responsive service than they had previously. However, patients were still at risk of potential harm as call answering performance and calls abandoned was still below national targets.
- Opportunities for learning from internal and external incidents were identified and discussed to support improvement. This included joint reviews with the NHS Pathways team for improvements in the assessment system.
- Staff took action to safeguard patients and were aware of the process to make safeguarding referrals. Safeguarding systems and processes were in place to safeguard both children and adults at risk of harm or abuse, including frequent callers to the service.
- Staff were trained to ensure they used the NHS Pathways safely and effectively. (NHS Pathways is a Department of Health approved computer based operating system that provides a suite of clinical assessments for triaging telephone calls from patients based on the symptoms they report when they call). Call audit activity had improved but still required further improvement to meet the NHS Pathways licence and to allow the service to identify areas of development and learning.
- The Trust developed the operational staff knowledge and skills and recognised the need to continue with the programme of staff support. The appraisal programme had been revised and delivered and operational staff received more frequent supervision, support and training to perform their roles.
- Staff commented that the service was safer and this had improved job satisfaction. There had been new staff recruitment at various levels although there was still a notable turnover of staff.
- Patients using the service were supported effectively during the telephone assessment process. Consent to the assessment was sought and their decisions were respected.

Summary of findings

- The Trust responded effectively to complaints and to patient and staff feedback. Although there was still a large number still being investigated.
- Senior staff demonstrated a much improved understanding of governance and how to effectively run an NHS 111 service. This included identification and management to safely mitigate risks.
- The Trust demonstrated positive development of leadership and management systems to deliver significant progress in improving the NHS 111 service.

However improvements are still required.

There were areas of practice where the provider MUST make improvements.

The provider must:

- Ensure systems are effective for patients to always access timely care and treatment.
- Ensure that all staff have the necessary skills and knowledge to undertake their roles.

The area where the provider should make improvements:

- Continue with the implementation of the staff recruitment to ensure the service is staffed to full capacity.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The Trust's NHS 111 service is rated as good for providing safe services

- Safety for callers was now seen as a priority.
- Action had been taken to increase the number of staff working on the NHS 111 service.
- Staff told us the service was now safer, with clinical advice and support readily available.
- Service performance was now monitored and reviewed with improvements implemented. This included safer clinical queue management and investigations into delayed call backs and lack of clinical advisors.
- Previous concerns regarding the risk that the role of Non-Pathways Advisors (NPA) may not recognise or respond appropriately to signs of deteriorating health and medical emergencies had been addressed.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Opportunities for learning from internal and external incidents were now discussed to support improvement. Information about safety was valued and used to promote learning and improvement. This included joint reviews, where needed, with the NHS Pathways team for improvements into the assessment system.
- Staff took action to safeguard patients and were aware of the process to make safeguarding referrals. This included a comprehensive triage ahead of referral.
- The working environment was now safer. We saw broken equipment was removed, chairs replaced and computer monitors were now ergonomic and adjustable.
- The Trust had a business continuity plan and the leadership team had a greater understanding of NHS 111 call centre activities.

Are services effective?

Requires improvement

The Trust's NHS 111 service is rated as requires improvement for providing effective services.

Summary of findings

- The service was monitored against National Minimum Data Set (MDS) and Key Performance Indicators (KPIs). The data provided information to the Trust and commissioners about the level of service being provided.
- The Trust identified areas of high risk and performance needed to improve. We saw an action plan to mitigate the risks was in place. The action plan was reviewed on a regular basis and remedial actions taken to improve the effectiveness of the plan.
- Performance had improved since the previous inspection (March 2016-September 2016), however more recent information to November 2016 showed the Trust had still not delivered the national call answering target.
- A single Trust wide quality assured call audit process had been established since our last inspection. The Trust ensured that each member of staff had at least one random call audit per month. The Clinical Commissioning Groups were aware of this level of frequency although this meant this remained below the NHS Pathways Licence recommendation.
- The audit activity did reduce in September 2016 and October 2016 whilst the Trust demobilised and changed the delivery of its NHS 111 services. More recent data for audit activity in November 2016 indicated a significant improvement in the levels of call audits to their revised target.
- A further improvement was that call advisors and clinicians received appraisals and face to face feedback when call audits had been carried out.
- The service met regularly with commissioners of the service, who were kept up to date about improvement plans, performance and subsequent actions being taken.
- Staff were trained and monitored to ensure safe and effective use of NHS Pathways and the Directory of Services (DOS) (DOS is a central electronic directory of local and national services which is integrated with NHS Pathways).
- Staff liaised with professionals and other agencies within multidisciplinary teams to meet the range and complexity of patients' needs.
- Staff ensured that consent to treatment was obtained from patients and appropriately recorded. The system to ensure timely sharing of patient information with the relevant service identified for the patient and their GP had improved since the March 2016 inspection.

Summary of findings

Are services caring?

Good

The Trust's NHS 111 service is rated as good for providing caring services.

The service continued to demonstrate a caring service.

- We observed patients who used the NHS 111 service being spoken with in a calm, patient and professional manner.
- Staff listened carefully to what was being said, checked information when necessary and were supportive and reassuring when responding to people calling in distress.
- The Trust submitted patient feedback that was recorded in monthly clinical governance reports. The feedback brought together patient feedback from multiple sources including patient opinion, results from the patient experience survey, and results from the NHS Family and Friends test.
- The most recent report showed that 93% of NHS Family and Friends test respondents would recommend the service. This was a 4% improvement since the March 2016 inspection.
- Patient consent was obtained to share information and to have their calls listened to and the patient's decision in relation to meeting their care needs was respected.

Are services responsive to people's needs?

Good

The Trust's NHS 111 service is rated as good for providing responsive services.

- Call back systems had improved and were now more responsive to callers' needs. For example, call answering performance and call abandonment performance had improved.
- The Trust understood the needs of the population it served and engaged with commissioners to try provide a service which was responsive to these needs.
- Staff had received training in equality and diversity, were aware of the language line phone facility (a translation/interpreter service) for patients who did not have English as their first language. We also saw a video relay service that allowed patients to make a video call to a British Sign Language (BSL) interpreter.
- Information about how to complain was available for patients. Information provided by the Trust reported patient complaints and healthcare professional feedback about the NHS 111 service had been reduced. Staff we spoke with commented incidents were now shared including clear actions points to address concerns.

Summary of findings

Are services well-led?

Requires improvement

The Trust's NHS 111 service is rated as requires improvement for being well-led.

- Staff were clear about the Trust's vision and their responsibilities in relation to it. Staff said improvement of the service specifically safety and quality was a top priority.
- Staff, including those who did not work conventional office hours, knew how to access senior leaders and managers if required.
- Staff informed us that they felt supported by the leadership team. Staff told us that although the past few months had been a time of change and uncertainty that they felt improvements had been made and there was good evidence of team working.
- Senior managers had a greater understanding of the governance processes affecting the NHS 111 service and the impact that risks carried to patient safety. Governance arrangements included improved processes for identifying, recording and managing risks, issues and implementing mitigating actions.
- The Trust had established a regulatory consolidated action plan and internal NHS 111 Improvement Team as a short term arrangement. This plan and team was an integral part of the Trust's strategy to improve. Senior staff we spoke with had identified further areas for improvement and had plans in place to continue with the changes in order to offer improved services to patients.
- The Trust recognised that their performance in achieving the expected standards for the NHS 111 service still required improvement despite improvements since our previous inspections in March 2016 and August 2016.

South Western Ambulance Service NHS Foundation Trust (NHS 111 Service)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission inspection manager. The team included two additional inspection managers, an inspector and two NHS 111 specialist advisors, both with knowledge and experience of the NHS 111 service.

Background to South Western Ambulance Service NHS Foundation Trust (NHS 111 Service)

South Western Ambulance Service NHS Foundation Trust (SWASFT) was the first ambulance service to be authorised as an NHS Foundation Trust on 1 March 2011. In February 2013, it acquired neighboring Great Western Ambulance Service NHS Trust.

The Trust's core operations include the following service lines:

- Emergency ambulance 999 services
- Urgent Care Services – GP out-of-hours medical care (Dorset and Gloucestershire) and Urgent Care Centre (Tiverton)
- Patient Transport Services – non-emergency transport for eligible patients with a medical need for transport (Bristol, North Somerset and South Gloucestershire)
- NHS 111 services for Cornwall & Isles of Scilly and Dorset.

This report relates to the inspection of the NHS 111 services only.

The Trust operates NHS 111 services from one main call centre location:

- East Division Headquarters Acorn Building, Ringwood Road, St Leonards, Hampshire, BH24 2RR.

Further clinician support is available from a hub base:

- Trust Headquarters, Abbey Court, Eagle Way, Sowton Industrial Estate, Exeter, Devon, EX2 7HY

The provision of the NHS 111 service covers the counties of Dorset, Cornwall and the Isles of Scilly. The area covered has a geographic area of 2,400 square miles, a population of 1.3 million and a high influx of visitors per year. There are two clinical commissioning groups (CCGs) who have contracts with the Trust for NHS 111 service.

- NHS Dorset CCG
- NHS Kernow CCG

Previously, the Trust provided NHS 111 services for two additional areas. The contract for the delivery of the NHS 111 services in these areas (Northern, Eastern and Western Devon CCG and Torbay CCG) ceased on 30 September 2016.

Detailed findings

SWASFT NHS 111 service operates 24 hours a day 365 days of the year. It is a telephone based service where patients are assessed, given advice and directed to a local service that most appropriately meets their needs. For example, this could be a GP service (in or out of hours), walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance, pharmacy or home management.

Why we carried out this inspection

We undertook a comprehensive inspection of South Western Ambulance Service NHS Foundation Trust (SWASFT) NHS 111 service in March 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The service was rated as inadequate for providing safe, effective, responsive and well-led services. The service was rated as good for providing caring services.

We issued a warning notice to the provider in respect of two legal requirements that were not being met, relating to 'Safe care and Treatment' (Regulation 12) and 'Staffing' (Regulation 18).

We undertook a focussed inspection on 17, 18 and 19 August 2016. The inspection was undertaken to look at requirements of the warning notices associated with the Health and Social Care Act 2008 issued at the March 2016 inspection.

Both inspection reports can be found by selecting the 'all reports' link for South Western Ambulance Service NHS Foundation Trust on our website at www.cqc.org.uk.

We undertook an announced comprehensive inspection on 7 and 8 December 2016 to the East Division Headquarters (St Leonards, Hampshire) and an unannounced visit to the hub site in Exeter on 20 December 2016. This inspection was carried out to ensure improvements had been made.

How we carried out this inspection

To get to the heart of people's experiences of care, we always ask the following five questions of every service and provider:

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

Before visiting the NHS 111 service, we reviewed a range of information that we held about the service provider, South Western Ambulance Service NHS Foundation Trust (SWASFT) and asked other organisations to share what they knew about the Trusts provision of the NHS 111 service. This included information from the local clinical commissioning groups (CCGs) and NHS England.

We carried out an announced comprehensive inspection to the SWASFT NHS 111 service on 7, 8 and 20 December 2016.

During our inspection we:

- Spoke with a range of staff including directors for the service, Board members, senior managers, clinical managers, call advisors and clinical advisors.
- Observed the call centre environment over three weekdays and two weekday evenings when GP practices were closed.
- Observed staff completing their role and supported callers who were contacting the NHS 111 service.
- Looked at a range of records including audits, staff personnel records, staff training, patient feedback and complaints.
- Reviewed the previous Care Quality Commission (CQC) inspection reports and the action plans submitted by SWASFT outlining how they would make the necessary improvements to comply with the regulations.
- Did not speak directly with patients who used the service. However, we observed staff in the call centre speaking with patients who telephoned the service.

Good

Are services safe?

Summary of findings

The Trust's NHS 111 service is rated as good for providing safe services

- Safety for callers was now seen as a priority.
- Action had been taken to increase the number of staff working on the NHS 111 service.
- Staff told us the service was now safer, with clinical advice and support readily available.
- Service performance was now monitored and reviewed with improvements implemented. This included safer clinical queue management and investigations into delayed call backs and lack of clinical advisors.
- Previous concerns regarding the risk that the role of Non-Pathways Advisors (NPA) may not recognise or respond appropriately to signs of deteriorating health and medical emergencies had been addressed.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Opportunities for learning from internal and external incidents were now discussed to support improvement. Information about safety was valued and used to promote learning and improvement. This included joint reviews, where needed, with the NHS Pathways team for improvements into the assessment system.
- Staff took action to safeguard patients and were aware of the process to make safeguarding referrals. This included a comprehensive triage ahead of referral.
- The working environment was now safer. We saw broken equipment was removed, chairs replaced and computer monitors were now ergonomic and adjustable.
- The Trust had a business continuity plan and the leadership team had a greater understanding of NHS 111 call centre activities.

Our findings

At our previous comprehensive inspection in March 2016, the NHS 111 service delivered by the Trust was rated as inadequate for providing safe services.

- Patients were at risk of harm because systems and processes were not in place to keep them safe. Furthermore, there were not enough staff to keep patients safe and there was a risk that staff may not recognise or respond appropriately to signs of deteriorating health and medical emergencies.

At our comprehensive inspection in December 2016 we found the following:

Safe track record and learning

Investigation of significant events was not confined to those that met NHS England's criteria for a Serious Incident. Previously the Trust did not record or report of all incidents within the Trusts provision of the NHS 111 service, for example long call backs and minimal numbers of clinicians. At the December 2016 inspection we saw there was a more thorough system and process in place and the Trust now treated all NHS 111 incidents including significant events (including near misses) and actions following previous Care Quality Commission inspections, as an opportunity for learning and implementing risk reduction measures.

- Staff told us they would inform their manager of any incidents and also demonstrated they knew how to report incidents officially through a web-based incident reporting and risk management system. We saw a reminder on how to report incidents was published in weekly staff bulletins.
- The Trust had agreements with other providers such as out of hours GP services and clinical commissioning groups for reporting adverse events.

During discussions with senior staff at the December 2016 inspection we were presented with a comprehensive analysis of the Trusts NHS 111 performance. This included comparisons to other NHS 111 services within the south region and national NHS 111 services. We also saw senior staff had engaged with other NHS 111 services as part of the Trusts improvement plan.

Good

Are services safe?

The Trust and Urgent Care Service (UCS) within the Trust carried out an analysis of identified serious significant events. We saw examples where learning from serious incidents was actioned. For example:

- Following a serious incident there was a joint review with the NHS Pathways team. This review included a recommendation and assessed the safety benefits of splitting a NHS Pathways question into three separate questions to ensure callers safely understood each component of the question.
- Staff we spoke with explained there had been training sessions and communications about this incident and the importance of addressing each component within the question. Staff also described other recent updates including sepsis awareness update training. Sepsis is a rare but serious complication of an infection.
- This incident also include a review by the Trust's Urgent Care Service team (NHS 111, GP Out of Hours Service and Urgent Care Centre) to conduct an analysis on a specific pathway used when assessing children presenting with one symptom.
- The Duty of Candour is a regulation in the Health and Social Care Act 2008 Regulations 2014 which describes what providers must do to make sure they are open and honest with patients and their families when something goes wrong with their care and treatment. We saw examples of when things went wrong with care and treatment patients received reasonable support, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We saw evidence including safety records, incident reports, patient safety alerts and minutes of meetings that lessons were shared and action was taken to improve safety. Complaints, concerns, health care professional feedback, significant events and non-compliant call audits were reported on in a monthly clinical governance report. These were reviewed at the monthly NHS 111 and clinical commissioning group meetings and documented within the monthly 'integrated corporate performance report'.
- Whilst all serious incidents were investigated by the management team of the NHS 111 service, these findings may have had the potential to act as a learning point for other parts of the organisation, for example their emergency operations centre. This meant that as a whole organisation, serious events could have re-occurred in other parts of SWASFT. Following the review the managers were able to consider if there were any themes identified and then undertake any changes needed, for example up dating local operating policies.

The management team had responded to the potential risks created by insufficient numbers of staff and ensured risks were now monitored and managed by staff with clinical authority to intervene and allocate resources whilst gaining a better understanding of the risks relating to long call backs on NHS 111 calls. For example:

- The Trust had implemented a revised procedure for the management of long calls on the clinical call back queue. This specifically included the arrangements and triggers for 'comfort calling' patients. 'Comfort calling' is a procedure whereby a clinician monitors the clinical call back queue. The clinician assessed and arranged a call advisor or senior call advisor to re-assess the patients, determining whether a caller's symptoms had changed and where appropriate taking action to ensure risks are appropriately managed. The Trust told us that the improved 'comfort calling' process also ensured patients experiencing a long call back received regular and planned communication from the NHS 111 service.
- The Trust had agreed with the commissioners a monthly review of a sample of calls which experienced a long call backs. We were presented with the findings of the first review, the date range of this sample was between 12 May 2016 and 13 June 2016 (19,046 calls within this period, of which a total of 62.5% of clinician call backs were made within 30 minutes and 86.9% within 120 minutes). The review had focussed on the longest waiting 20 calls. Each call was reviewed by a Specialist Senior Paramedic. The outcome was that the review demonstrated that all of the 20 calls reviewed were considered low risk with the vast majority ending with a 'home management advice' endpoint.
- A further review of calls of long call back, with a much larger sample size (378 calls), was completed in August 2016. This review was supported by two clinical commissioning groups (CCG) GPs for additional assurance.

Overview of safety systems and processes

The Trust had embedded systems, processes and practices in to the Trust's provision of the NHS 111 service to ensure the safety of patients.

Good

Are services safe?

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation. Local requirements and policies were accessible to all staff in the handbooks in each section of the call centre. The safeguarding policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The Trust had a safeguarding lead with overall responsibility for providing support, training and advice to staff. The lead was responsible for the relationships with the 30 safeguarding adults and safeguarding children's boards that exist within the Trust's area. There were named professional leads for safeguarding in each of the trust's divisions and these were the people who attended their local safeguarding boards. The Trust always attended child death review panels and participated as required in serious case reviews. The three named professionals and the head of safeguarding attended 136 multi-agency meetings between November 2015 and October 2016 (not limited to NHS 111 referrals).
- All safeguarding training was delivered face to face within the Trust. All advisors were trained to level two for safeguarding children. We discussed examples of safeguarding concerns with advisors and they were able to demonstrate clearly how to identify and manage these cases. Safeguarding referrals were triaged ahead of referral. We saw information of a recent audit of adult and child safeguarding referrals had been undertaken which confirmed that the vast majority of the referrals were appropriate.
- Between November 2015 and October 2016, the Trust's NHS 111 service made 4,379 safeguarding referrals with an average of 364.9 per month.
- We saw staff had a clear awareness of how to identify concerning situations and respond appropriately. For example, terminated calls or background noise. We observed staff making safeguarding referrals and following calls which raised concerns about safety. We saw that these situations were managed sensitively.
- The Trust used the Department of Health approved NHS Pathways system (a set of clinical assessment questions to manage telephone calls from patients). This was based on the symptoms they reported when they called. The tool enabled a specially designed clinical assessment to be carried out by a trained member of staff who answered the call. Once the clinical assessment was completed, a disposition outcome and a defined timescale were identified to prioritise the patient's needs. At the end of the assessment if an emergency ambulance was not required, an automatic search was carried out on the integrated Directory of Services, to locate an appropriate service in the patient's local area.
- Previously, there was limited clinical oversight of the call advisors use of the NHS Pathways system and the calls awaiting call backs from clinical advisors. At the previous inspection, staff we spoke with commented that clinical support was limited and there was often a delay in receiving clinical support. Call advisors told us there were often insufficient clinical staff available and clinical staff confirmed this.
- Throughout the December 2016 inspection we saw how the Trust now effectively managed the clinical queue. We saw how the levels of demand on the service were monitored, including the numbers and reasons of the people waiting for clinical advisor call them back. Where possible calls received by call advisors which required further advice were warm transferred to a clinician but where this was not possible, the call was put into a call back queue which was monitored. This queue was assessed and some calls were prioritised to receive a prioritised clinical advisor call back.
- We spoke to different members of staff throughout the December 2016 inspection, staff spoke highly of the new process in how the call backs were managed and believed the service was now significantly safer. For example, call advisors advised clinical support was now readily available including support at times of high demand for example at evenings, weekends and bank holidays. Clinical advisors advised the new process also allowed specific calls to be allocated to individual users with a specialist background into the reason why the caller was using the service and as a result callers received safer advice. For example, a clinical advisor with a specialist interest and additional qualifications in substance misuse could be allocated specific calls within this specialism.
- Staff had access to patient 'special notes' via the Adastra system to alert them to patients with, for example, pre-existing conditions or safety risks where the GP practice had submitted these notes on behalf of their patients.

Good

Are services safe?

- Staff had access to and demonstrated compliance with key policies and demonstrated an awareness of infection prevention and control issues when giving advice to callers; for example, where open wounds were discussed.
- All call advisors received NHS Pathways training which lasted three weeks. This was followed by two weeks preceptorship with an experienced call advisor to ensure that staff were appropriately trained. The training included how to provide a safe service to children of all ages and included safeguarding children. During the training course the staff learnt that if the NHS Pathway responses did not seem representative of the information being provided they should seek clinical advice and refer to SOPs (standard operating procedures) for the concerns being presented. We observed how staff employed this learning and how they requested clinical advice and referred to the SOPs.
- Risk assessments and actions required had been taken to ensure the safety of the premises.
- We reviewed personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS).
- During the December 2016 inspection we saw the concerns about the working environment had been addressed by the management team, specifically by the Trust's Health and Safety Committee. During the inspection we witnessed that the environment had improved as broken equipment was removed, chairs replaced and computer monitors were now ergonomic and adjustable. We also saw evidence of completed site specific display screen equipment risk assessments for individual users.

Monitoring safety and responding to risk

Risks to patients were assessed and actions taken to ensure risks were well managed.

- As part of the operating model for the delivery of NHS 111 services it is imperative that the Trust complies with the clinician level requirements of the NHS Pathways system at all times. The NHS Pathways End User License Agreement stipulates that there must be at least one accredited clinician physically present in each room for each shift of non-clinical advisors.
- We saw the Trust implemented an updated SOP in June 2016 which states that any incident where the Trust does not meet the required levels of clinical cover will be subject to a significant incident being raised. Information in relation to the number of incidents identified and the length of time where clinical cover was below the required levels will therefore be reported in future monthly governance reports on a monthly basis.
- There have been no incidents regarding lack of clinicians reported in September 2016, October 2016 or November 2016.
- Since our last inspection the Trust had recognised staffing levels had been below those needed and had engaged with commissioners to agree the levels required. The Trust had taken a number of actions to increase the number of staff working on the NHS 111 service to ensure callers were assessed in a timely manner. Actions included informal consultations with clinicians to review existing working arrangements, retention bonuses, overtime incentives and an accelerated recruitment programme.
- At the March 2016 inspection there was a risk that the role of Non-Pathways Advisors (NPA) may not recognise or respond appropriately to signs of deteriorating health and medical emergencies. Following the March 2016 inspection, the Trust had reviewed and subsequently de-established the role of NPAs in July 2016.
- Staff said the de-establishment of the NPAs and other improvements resulted in a much improved and safer service due to the endeavours of the Trust, which in turn had a positive effect on the waiting times, patient outcomes and staff morale.

Arrangements to deal with emergencies and major incidents

The Trust had arrangements in place to respond to emergencies and major incidents. These arrangements also included activities undertaken which were understood and managed to consider foreseeable risk.

Good

Are services safe?

- Managers we spoke with provided a comprehensive understanding of their role in major incidents and they were involved in planning for such occurrences. The duty manager took on the role of co-ordinating the services responses and liaised with other services through their Bronze and Silver command structures (a gold/silver/bronze command structure is used by emergency services to establish a hierarchical framework for the command and control of major incidents and disasters).
- The Trust had a business continuity plan in place. This detailed the arrangements that were in place in the event of equipment failure for example the telephone or computer systems and issues in relation to the building and staffing.
- If the Trusts main call centre (East Division Headquarters) was unable to take calls, the national contingency service would be requested for two hours until the call centre at Trust Headquarters in Exeter was scaled up and call advisors mobilised to work from the new location.

Requires improvement

Are services effective?

(for example, treatment is effective)

Summary of findings

The Trust's NHS 111 service is rated as requires improvement for providing effective services.

- The service was monitored against National Minimum Data Set (MDS) and Key Performance Indicators (KPIs). The data provided information to the Trust and commissioners about the level of service being provided.
- The Trust identified areas of high risk and performance needed to improve. We saw an action plan to mitigate the risks was in place. The action plan was reviewed on a regular basis and remedial actions taken to improve the effectiveness of the plan.
- Performance had improved since the previous inspection (March 2016-September 2016), however more recent information to November 2016 showed the Trust had still not delivered the national call answering target.
- A single Trust wide quality assured call audit process had been established since our last inspection. The Trust ensured that each member of staff had at least one random call audit per month. The Clinical Commissioning Groups were aware of this level of frequency although this meant this remained below the NHS Pathways Licence recommendation.
- The audit activity did reduce in September 2016 and October 2016 whilst the Trust demobilised and changed the delivery of its NHS 111 services. More recent data for audit activity in November 2016 indicated a significant improvement in the levels of call audits to their revised target.
- A further improvement was that call advisors and clinicians received appraisals and face to face feedback when call audits had been carried out.
- The service met regularly with commissioners of the service, who were kept up to date about improvement plans, performance and subsequent actions being taken.
- Staff were trained and monitored to ensure safe and effective use of NHS Pathways and the Directory of Services (DOS) (DOS is a central electronic directory of local and national services which is integrated with NHS Pathways).
- Staff liaised with professionals and other agencies within multidisciplinary teams to meet the range and complexity of patients' needs.
- Staff ensured that consent to treatment was obtained from patients and appropriately recorded. The system to ensure timely sharing of patient information with the relevant service identified for the patient and their GP had improved since the March 2016 inspection.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous comprehensive inspection in March 2016, the NHS 111 service delivered by the Trust was rated as inadequate for providing effective services.

- Patient outcomes were hard to identify as little or no reference was made to quality. Data showed that care and treatment was not delivered in line with recognised professional standards and guidelines. For example, the service was not meeting the National Minimum Data Set for NHS 111 services and adapted National Quality Requirements. Some indicators such as calls being answered in 60 seconds were regularly at unacceptable levels. Necessary action to improve callers' outcomes was not taken.

At our comprehensive inspection in December 2016 we found the following:

Effective needs assessment

The Trust assessed caller's needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. We saw the Trust had systems in place to ensure all staff were kept up to date. Clinical staff, notably clinical advisors had access to guidelines from NICE and used this information to help ensure that people's needs were met. We saw the Trust monitored that these guidelines were followed.

The Trust used the Department of Health approved NHS Pathways system (a set of clinical assessment questions to manage telephone calls from patients). The tool enabled a specially designed clinical assessment to be carried out by a trained member of staff who recorded the patients' symptoms during the call. When a clinical assessment had been completed, a disposition outcome (i.e. what the patient needed next for the care of their condition) and a defined timescale was identified to prioritise the patients' needs.

We saw evidence that all call advisors had completed a mandatory training programme to become licensed users of the NHS Pathways programme. Once training was completed, call advisors became subject to call quality monitoring against a set of criteria such as active listening, effective communication and skilled use of the NHS Pathways functionality.

It is a condition of the NHS Pathways user licence and a National Quality Requirement for NHS 111 services that providers must regularly audit a random sample of patient contacts. The sample must include enough data to review the performance of all staff that provides care.

Following the March 2016 inspection the Trust had established a regulatory consolidated action plan and internal NHS 111 Improvement Team. This team had reviewed the risk of low levels of call audits and implemented six measurable actions to be completed with the objective to increase call audit activity and call monitoring. For example:

- The Trust had contacted commissioners and the NHS Pathways license team to ascertain and fully understand national monitoring compliance.
- The Trust had set a target that all staff should have at least one call audited per month; a timeframe and tracker was introduced to enable a proactive approach and strategy to increase and monitor call audit activity. The Clinical Commissioning Groups were aware of this level of frequency although this meant the Trust performance remained below the NHS Pathways Licence recommendation.

We noted that the audit activity did reduce in September 2016 and October 2016 whilst the Trust demobilised and changed the delivery of its NHS 111 services. The decline in the performance correlated with the Exeter call centre demobilising and the associated staff leaving their existing positions. There were significant changes into operations of the NHS 111 contracts in September 2016/October 2016. For example:

- In August 2016, 386 call advisor call audits were required – 210 had been completed. This was 54% of the audit target.
- In August 2016, 38 clinical advisor call audits were required – 32 had been completed. This was 84% of the audit target.
- In September 2016, 438 call advisor call audits were required – 179 had been completed. This was 41% of the audit target.
- In September 2016, 42 clinical advisor call audits were required – 34 had been completed. This was 81% of the audit target.

Requires improvement

Are services effective?

(for example, treatment is effective)

- In October 2016, 383 call advisor call audits were required – 141 had been completed. This was 37% of the audit target.
- In October 2016, 52 clinical advisor call audits were required – 26 had been completed. This was 50% of the audit target.

Further performance and monitoring tools were introduced to ensure the increased activity of audits was managed effectively. Trained call auditors were approached and offered overtime to complete call audits and call levelling exercises were completed. Call levelling is a process when a random selection of calls are listened to by small groups and audited together. After each call, there was a discussion of the scores for the criteria monitored and where there was a wide variation.

At the August 2016 inspection, we reported that the Trust advised of significant improvement in the levels of call audit and the establishment of a single Trust wide quality assured audit process. Monitoring tools used to manage call audit activity indicated significant improvement across both call centres. The plan was to deliver a 5% increase on the previous months audit levels; the actual increase was 30.7%.

In order to increase audit activity, the Trust had introduced a 'live' audit tracker to enable a proactive approach and strategy to increase and monitor call audit activity. Further actions included training additional call auditors and the existing trained auditors had been approached and offered overtime to complete call audits.

The Trust supplied data for audit activity in November 2016 which indicated a significant improvement in the levels of call audits. For example:

- 366 call advisor call audits were required – 369 had been completed.
- 97 clinical advisor call audits were required – 97 had been completed.

Where any gaps had been identified from the audit process, or any learning identified from an incident or investigation, discussions were had with staff at a one to one meeting. This was a new process and had been introduced since the March 2016 inspection. When necessary the staff member received either additional coaching or formal training, an action plan was devised to manage the process.

We reviewed individual coaching and performance improvement plans for two members of staff. Staff we spoke with commented on the positive way feedback was now provided even when the process identified areas for improvement.

Staff we spoke with during the December 2016 inspection who completed audits described a more thorough process in escalating concerns identified during the call audits. They also spoke highly of the increased focus on call audits including the benefits of the 'live' audit tracker. The call audit tracker also identified an increase in the overall quality of calls. For example:

- In October 2016, 91% of call advisor calls had been scored as quality compliant (85% and above). This was a 9% improvement on March 2016 figures as 82% of call advisor calls had been scored as quality compliant (85% and above).
- In October 2016, 96% of clinical advisor calls had been scored as quality compliant (85% and above). This was a 23% improvement on March 2016 figures as 73% of clinical advisor calls had been scored as quality compliant (85% and above).

The Trust used the Directory of Services which provided staff with real-time information about services available to support a particular patient. The commissioners of the NHS 111 service were responsible for ensuring these resources were available and were correctly updated.

Management, monitoring and improving outcomes for people

The Trust monitored the performance of NHS 111 against the national Minimum Data Set (MDS) and adapted National Quality Requirements (NQRs).

The Trust had contracts to deliver NHS 111 services for Dorset and Cornwall. The contract for the delivery of the NHS 111 services for the Northern, Eastern and Western Devon and South Devon and Torbay CCG areas ceased on 30 September 2016. The contract was retendered and the services were transferred to a new provider on 1 October 2016.

Although the Trust's performance had improved since the previous inspection (March 2016-September 2016), more recent information supplied by the Trust indicated that since the change in contracts the Trust had not delivered

the national call answering target in October 2016 or November 2016. Specifically, the percentage of calls answered within 60 seconds was below (worse than) the national target of 95%.

For the two contracts delivered in October 2016 data showed:

- 78.4% of Dorset calls and 76.4% of Cornwall calls were answered within 60 seconds. The national average for October 2016 was 88.5%.

For the two contracts delivered in November 2016 data showed:

- 76.6% of Dorset calls and 75.7% of Cornwall calls were answered within 60 seconds. The national average for November 2016 was 88.2%.

This was a slight improvement on call answering aggregated data made available at our inspection in March 2016. Information provided by the Trust for that inspection highlighted performance between 1 November 2015 and 6 March 2016 averaged 73.2% of calls being answered within 60 seconds.

During the December 2016 inspection, we saw recruitment to fill outstanding vacancies was not expected to be completed until the end of quarter three (March 2017). The Trust planned to be broadly at establishment from January 2017, with call answering performance expecting to improve. The performance improvement trajectories had been shared with the commissioners.

Alongside recruitment, the Trust had taken several additional actions to address call answering performance concerns. For example:

- In November 2016, work schedules had been reviewed and revised work patterns planned with a view to increase availability in times of high demand. This was due to commence in January 2017.
- We saw evidence and staff spoke of a new focus on clinical queue management including frequent callers, clinical call backs and complex call handling. This focus commenced with a 'warm transfer week' which started in November 2016. Un-validated data supplied at the December 2016 inspection showed initial improved performance and we witnessed more effective management of clinical queues that was not seen on previous inspections.

Since the previous inspection in August 2016, further evidence of improvement was shown by a reduction in the percentage of calls abandoned. Calls abandoned is a marker of patient experience, a high call abandoned rate is considered not to be safe and may reflect a high level of clinical risk for patients. The national target for calls abandoned (after 30 seconds) was below 5%.

For the two contracts delivered in October 2016 data showed:

- 5% of Dorset calls and 6% of Cornwall calls were abandoned (after waiting 30 seconds). The national average was 2%.

For the two contracts delivered in November 2016 data showed:

- 6% of Dorset calls and 6% of Cornwall calls were abandoned (after waiting 30 seconds). The national average was 3%.

This was an improvement since the March 2016 inspection as information provided by the Trust highlighted that between 1 November 2015 and 6 March 2016, 8% (aggregated data) of calls were abandoned (after waiting 30 seconds).

However, we saw that in both October 2016 and November 2016, there were several occasions, mainly at weekends where the level of calls abandoned was not safe. For example, one Sunday in October 2016, 26% of calls (299 calls) were abandoned after 30 seconds. The Trust advised this was an unusual series of events including an increased number of calls and unexpected short term staff absence. The Trust provided evidence that supported this as the abandonment rate for the other Sundays within October 2016 were 8.1%, 2.1%, 4.6% and 5.7%.

Further performance data using the national Minimum Data Set (MDS) and adapted National Quality Requirements (NQRs) shows performance was improving but was still below national targets and national averages. For example:

Percentage of calls needing a call back by a clinical advisor which had a call back within 10 minutes (national average 38%):

- October 2016: Dorset – 24% Cornwall 26%
- November 2016: Dorset – 22% Cornwall 23%

Requires improvement

Are services effective?

(for example, treatment is effective)

Call data provided to the inspection team during the December 2016 inspection, indicated improvement and a reduction in the longest wait for a call back. However, callers were still experiencing delays in calls on some occasions; for example:

- In October 2016, the longest call back aggregated for the Cornwall service and Dorset service was 16 hours

The Trust was expecting further improvement with the addition of further call advisors in December 2016, January 2017 and February 2017.

The majority of call outcomes from November 2016 were in line with national averages, for example:

- In November 2016, the average episode length (combined call advisor and clinical advisor) for Dorset calls was 19 minutes, 40 seconds and Cornwall calls was 21 minutes, 38 seconds which was longer when compared to the national average (16 minutes, 30 seconds).
- In November 2016, 15% of Dorset calls and 17% of Cornwall calls received an ambulance disposition. This was in line with the national average of 14%.
- In November 2016, 7% of Dorset calls and 6% of Cornwall calls were recommended to attend the nearest emergency department, compared with the national average of 7%.

We discussed the areas where the NHS 111 service was not meeting the MDS and NQR targets with the management team and what, if any measures the service had put in place. We saw the Trust was significantly more active in trying to manage this risk including regular discussions with members of the senior management team and members of the Board. They were aware of lower performance levels and were continuing with a number of actions to improve performance; including staff recruitment and training.

Effective staffing

We saw the Trust's provision of the NHS 111 service had experienced a number of challenges to the delivery of its service which included staff recruitment and retention. This had been reflected on the risk register and discussed in the monthly integrated corporate performance reports, NHS 111 governance reports, and Trust board meetings.

- At the time of the December 2016 inspection the Trust employed 118.80 whole time equivalent (wte) staff within the NHS 111 service. This included 71.20 wte (head count 118) as call advisors, 10.56 wte (head count 13) as senior call advisors and 27.04 wte (head count 42) as clinical advisors. The operational team were supported by 10 wte (head count 10) administrators and managers.
- The Trust informed us they had experienced a high turnover rate, with turnover at the end of November 2016 approaching 50% over the past 12 months. This rate of turnover was for a variety of reasons but more recently included the planned closure of Exeter call centre as a main location.
- We saw the Trust was undertaking regular training courses for new call advisors in an attempt to meet the funded establishment levels. There was one live training course at the time of the December 2016 inspection and further courses planned for January 2017 and February 2017.
- We saw dashboards which highlighted times when the service was most busy and we saw staffing levels increased during this time. The Trust's own planning tool supplied by the Resource Operation Centre showed that where the trajectory of activity went up, so did the staffing levels but not necessarily relative to the number of call advisors or clinicians required in order to answer the volume of calls being received.
- At the time of the December 2016 inspection the Trust's NHS 111 service still had insufficient numbers of staff to meet the performance expectations of the service at all times.
- The Trust had responded to our concerns about managing staff performance and in December 2016 we saw the Trust was embedding a new 'intelligent data tool' to enable the Trust to create reports to provide an overview of performance at individual staff level. Staff were involved and consulted in the process of embedding this tool into the service. We also saw the Trust had considered how to motivate and support staff through this significant change in effective performance management.
- In December 2016 we saw the Trust's management of sickness related absence had improved and included additional support measures for employees. The Trust provided data which indicates sickness levels had reduced which had a positive direct impact on the patients and the remaining staff on duty. For example,

total sickness (combined short term and long term) for Trust's NHS 111 service in April 2016 was 10%. Most recent data for November 2016 showed a reduction in sickness (combined short term and long term) was 7.8%.

- Once employed, staff underwent a range of induction training which included effective use of the NHS Pathway system, safeguarding vulnerable adults and children and health and safety awareness. The NHS Pathways training included tests to ensure an appropriate level of competency. Staff that did not pass these tests were not employed in the call centres. This was followed by two weeks preceptorship with an experienced call advisor to ensure that staff felt supported in their initial practice and received feedback about call handling.
- There had been planned changes to the management structure with some staff being promoted. Some of the staff spoken with were enthusiastic about their new opportunities for development.
- The learning needs of staff were identified through a system of appraisals, one-to-one meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, mentoring, supervision and facilitation and support. Staff told us they were given protected time to undertake mandatory training and paid overtime if training was not delivered during their shift. Staff told the inspection team this was one of the areas that had significantly improved since our previous visits.
- At the December 2016 inspection, improvement had been made to staff appraisals and we saw a new focus in identification of individual development needs via an effective appraisal system. The Trust set an internal target to achieve 85% of appraisals completed by 1 September 2016 with account taken for staff absent from work on long term sickness or maternity leave.
- Supervisors and managers on the NHS 111 service had training on how to complete an effective and productive appraisal, the Trust set up an appraisal tracker and implemented monthly reporting for completed appraisals. We viewed the appraisal tracker which clearly highlighted those members of staff with the longest gap since there previous recorded appraisal. Although the Trust missed its internal target to achieve 85% compliance by 1 September 2016, this target was met by 5 December 2016. We were told appraisals for those returning from maternity leave would be undertaken upon their return depending on the length of their maternity leave.
- To further increase the level of performance monitoring, the urgent care services (NHS 111, GP Out of Hours and Urgent Care Centre) leadership team were reviewing the potential of introducing 360 appraisals for NHS 111 staff. The 360 appraisal system is a process in which employees receive confidential, anonymous feedback from the people who work around them.
- Staff received training that included the use of the clinical pathway tools, how to respond to specific patient groups, Mental Capacity Act 2005, safeguarding, fire procedures and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. For example, duty of candour, equality and inclusion, fire safety and evacuation, infection prevention and control, information governance, manual handling, safeguarding.
- The service could demonstrate how they ensured role-specific training and updating for relevant staff was managed through the use of a training matrix and a Trust wide mandatory training workbook which the provider shared with us.
- Staff we spoke with during the December 2016 inspection said the annual leave process had significantly improved. We saw improved rates of annual leave take up, staff had been involved in the revised annual leave process and staff satisfaction regarding annual leave had improved.
- The Trust had previously recognised the stress that working in the NHS 111 environment created and had provided access to counselling for all staff for more than a year. This was called 'the staying well service' and provided immediate access to sources of support in either a phone call or email. This service triaged calls and provided direct support and/or signposting to the most appropriate services for additional help and assistance. Staff could access this service without a referral from a supervisor or manager. Two members of staff we spoke who had recently used the 'staying well service' praised the benefits of this service.

Working with colleagues and other services

Requires improvement

Are services effective?

(for example, treatment is effective)

Improvements had been made and we saw staff worked with other providers to ensure patients received co-ordinated care.

- Following the March 2016 inspection, we saw evidence that the Trust and the NHS 111 leadership team met regularly with the CCGs for the contracts where all aspects of improvement, performance and future development were discussed.
- At the December 2016 inspection, we saw the Trust's NHS 111 team now worked closely with the Trust's 999 service and other urgent care services provided by the Trust (GP Out of Hours and Urgent Care Centre) to ensure a safe and effective service was provided. Work had commenced to review a number of services provided by the Trust to develop an integrated urgent care service clinical hub.
- The Trust had greater awareness of the times of peak demand and had communicated these to the 999 service. This included the arrangements in place when demand was outside of the expected pattern.
- Staff knew how to access and use patient records for information and when directives may impact on another service for example advanced care directives or do not attempt resuscitation orders.
- The Trust had systems in place to identify 'frequent callers' and high intensity users of the service. This information had been shared with the 999 service and if required the GP Out of Hours and patients' In Hours GP were contacted and advised of the frequent contact made by these patients.
- Information about previous calls made by patients was available; staff could use this information where relevant to support the clinical decision process.

Consent to care and treatment

We saw staff sought patients' consent to care and treatment in line with legislation and guidance.

- Both call advisors and clinical advisors understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Access to patient medical information was in line with patient's consent.
- Although no calls were listened to during our inspection, we heard staff checked the patient understanding of what was being asked of them. Patients were also involved in the final disposition (outcome) identified by the NHS Pathways and their wishes were respected.
- At the end of each call, callers were asked to consent to their information being transferred to their GP.
- Staff we spoke with also gave examples of when they might override a patient's wishes, for example when they believed there was a significant risk of harm to the patient if no action was taken. We saw a protocol was in place to support staff to take action when they believed the patient was at significant risk of harm.

Good

Are services caring?

Summary of findings

The Trust's NHS 111 service is rated as good for providing caring services.

The service continued to demonstrate a caring service.

- We observed patients who used the NHS 111 service being spoken with in a calm, patient and professional manner.
- Staff listened carefully to what was being said, checked information when necessary and were supportive and reassuring when responding to people calling in distress.
- The Trust submitted patient feedback that was recorded in monthly clinical governance reports. The feedback brought together patient feedback from multiple sources including patient opinion, results from the patient experience survey, and results from the NHS Family and Friends test.
- The most recent report showed that 93% of NHS Family and Friends test respondents would recommend the service. This was a 4% improvement since the March 2016 inspection.
- Patient consent was obtained to share information and to have their calls listened to and the patient's decision in relation to meeting their care needs was respected.

Our findings

At our previous comprehensive inspection in March 2016, the NHS 111 service delivered by the Trust was rated as good for providing caring services.

- We observed patients who used the NHS 111 service being spoken with in a calm, patient and professional manner.
- Staff listened carefully to what was being said, checked information when necessary and were supportive and reassuring when responding to people calling in distress.
- Patient consent was obtained to share information and to have their calls listened to and the patient's decision in relation to meeting their care needs was respected.

At our comprehensive inspection in December 2016 we found the following:

Dignity, respect and compassion

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

- Staff were provided with training in how to respond to a range of callers, including those who may be abusive. All the caller interactions we heard were non-judgmental and treated each patient as an individual whatever their circumstances. We spoke with call advisors about frequent callers and they explained that they responded to them in the same way as all other callers.
- We observed that staff handled calls sensitively and with compassion. Staff listened carefully to what was being said, checked information when necessary and were supportive and reassuring when responding to people calling in distress. For example, we observed how a call advisor dealt with a call from a patient. We saw that following the initial assessment the call was efficient and immediately transferred to a clinical advisor. On review, the clinical advisor advised this patient to make contact with their GP within six hours. During the March 2016 inspection, call advisors said immediate transfers through to clinical advisors were rare due to low levels of staff and calls were either inappropriately transferred to the ambulance service or unsafely placed on a queue for a call back. All staff we spoke with at the December

Good

Are services caring?

2016 inspection said this had greatly improved and there was always a clinical advisor available for clinical support and the availability of clinical advisors for an immediate transfer had greatly improved.

The Trust submitted patient feedback that was recorded in monthly clinical governance reports. The feedback brought together patient feedback from multiple sources including patient opinion, results from the patient experience survey, and results from the NHS Family and Friends test.

We reviewed the most recent GP Patient Survey data published in July 2016 for out of hours services, including NHS 111. The results are provided at clinical commissioning group (CCG) level and contained aggregated data collected from July 2015 - September 2015 and January 2016 -March 2016 from people who had used the South Western Ambulance Service NHS Trust 111 service during this period.

- Dorset CCG - 91% of patients had confidence and trust in the NHS 111 service member of staff.
- Kernow CCG – 89% of patients had confidence and trust in the NHS 111 service member of staff.
- These were both similar when compared to the England average of 90%.

During the inspection we reviewed information and patient feedback about the service collated via the NHS Friends and Family Test. This national test was created to help service providers and commissioners understand whether their patients were happy with the service provided, or where improvements were needed.

- The most recent report showed that 93% of NHS Family and Friends test respondents would recommend the service. This was a 4% improvement since the March 2016 inspection.

The Trust monitored patient feedback and the quality of services and treatment received from the NHS 111 service.

The most recent findings indicated further caller satisfaction and an improvement on previous feedback. For example:

- 80% of survey respondents confirmed that call takers had introduced themselves at the start of the call and that they were asked an appropriate amount of questions. This was an increase of 3% from the previous survey.
- 85% of survey respondents felt that the call advisor listened to what they had to say. This was an increase of 4% from the previous survey.
- 93% of respondents felt that they were treated with dignity and respect at all times. This was the same as the previous survey.

Patient Opinion is an independent non-profit feedback platform for health services, which aims to facilitate honest and meaningful conversations between patients and providers. There were 65 reviews, 12 of which had been fully completed, on the Trust's NHS 111 profile on the Patient Opinion website. We saw all of the reviews had been reviewed by the Trust. All of the respondents (12 out of 12) advised they would recommend the NHS 111 service provided by the Trust.

Involvement in decisions about care and treatment

- We observed and heard staff spoke with patients respectfully, with care and compassion. Call advisors and clinical advisors were confident in navigating through the NHS Pathways programme and the patient was involved and supported to answer questions thoroughly. The final outcome of the NHS Pathways clinical assessment was explained to the patient and in all cases patients were given advice about what to do should their condition worsen.
- We heard people's preferences being accounted for during calls and at the end of each call, the patient was asked to consent to their information being transferred to their GP. Staff also gave examples when they would override patients' wishes or did not receive consent, for example where they believed there was significant risk of harm of the patient if no action was taken.
- The final disposition (outcome) of the clinical assessment was explained to the patient and agreement sought that this was appropriate. In all cases patients were given advice about what to do should their condition change or deteriorate.

Patient/carer support to cope emotionally with care and treatment

During the inspection, we observed how staff spoke with and supported patients who used the service.

- Throughout conversations, we heard staff adapt questions to enable the patient to understand what information they were being asked for.

Good

Are services caring?

- We heard how patients and/or their carers were informed the final outcome of the NHS Pathways assessment. Similar to our previous inspections in March 2016 and August 2016 we heard staff speaking calmly and reassuringly to patients. We also saw that the staff repeatedly checked that the patient understood what was being asked of them and that they understood the final disposition (outcome) following the clinical assessment. We observed that the patient's decision to accept the final disposition was respected and staff taking time to answer patients' questions thus ensuring they understood the information they were being provided with.
- Staff were provided with training in how to respond to a range of callers, including those who may be abusive. Our observations at the December inspection, aligned with findings at the previous inspections showed that staff handled calls sensitively and with empathy and compassion.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The Trust's NHS 111 service is rated as good for providing responsive services.

- Call back systems had improved and were now more responsive to callers' needs. For example, call answering performance and call abandonment performance had improved.
- The Trust understood the needs of the population it served and engaged with commissioners to try provide a service which was responsive to these needs.
- Staff had received training in equality and diversity, were aware of the language line phone facility (a translation/interpreter service) for patients who did not have English as their first language. We also saw a video relay service that allowed patients to make a video call to a British Sign Language (BSL) interpreter.
- Information about how to complain was available for patients. Information provided by the Trust reported patient complaints and healthcare professional feedback about the NHS 111 service had been reduced. Staff we spoke with commented incidents were now shared including clear actions points to address concerns.

Our findings

At our previous comprehensive inspection in March 2016, the NHS 111 service delivered by the Trust was rated as inadequate for providing responsive services.

- Call back systems were not effective or responsive to callers' needs which meant they did not receive timely care when they needed it. The service had a high rate of calls abandoned. Information about how to complain was available for patients. Staff told us there was a pattern of complaints but no action was taken to prevent reoccurrence. Organisational learning did not take place despite patient complaints relating to the same issues.

At our comprehensive inspection in December 2016 we found the following:

Responding to and meeting people's needs

The Trust had a collaborative working relationship with the CCGs and provided them with monthly reports, which covered operational and clinical performance activity, serious incidents, complaints, outcome of investigations, and patient feedback. These reports also contained information regarding improvements the Trust was making following previous Care Quality Commission inspections. The Trust also met on a regular basis with the CCGs where performance, demand and feedback data was discussed.

Systems had been implemented and the Trust had made improvements for call answering performance. For example, call answering performance had improved, call abandonment had reduced and the length of call backs had reduced. These different elements resulted in an improvement in how the Trust responded to patient needs in a timely manner.

The Trust also provided evidence of further improvement including how the Trust was now meeting NHS 111 Service Quality Requirements. For example:

- NHS 111 providers must send details of all consultations (including appropriate clinical information) to the patient's GP practice by 8am the next working day. The target for this is 95%. In March 2016 we saw findings were as low as 84%. Recent data shows in October 2016, 97.5% of Dorset calls and 97.4% of Cornwall calls were

Good

Are services responsive to people's needs?

(for example, to feedback?)

sent to the patient's GP practice by 8am the next working day. In November 2016, 97.5% of Dorset calls and 98.2% of Cornwall calls were sent to the patient's GP practice by 8am the next working day.

Access to the service

The NHS 111 service operated 24 hours a day, 365 days of the year.

- Nationally recognised times of increased activity to the NHS 111 service include weekday mornings between 7am and 8am, weekday evenings between 6pm and 9.30pm and the 24 hour periods on Saturdays, Sundays and Bank Holidays.
- The telephone system was easy to use and supported people to access advice.
- Referrals and transfers to other services were undertaken in a timely way. We saw examples of referrals sent automatically through secure information systems and examples of timely referrals to different health and social care providers.
- New staff had received training in equality and diversity during their induction and this training was updated for all staff on an annual basis.
- Staff we spoke with were aware of the language line phone facility (a translation/interpreter service) for patients who did not have English as their first language. We saw Language Line contact details were available on each work station. Staff told us this service was rarely used.
- There was a facility to provide text relay phone service for patients with difficulties communicating or hearing.
- The Trust offered a video relay service that allowed patients to make a video call to a British Sign Language (BSL) interpreter. The BSL interpreter would call an NHS 111 call handler or clinical advisor on behalf of the patient so they were able to have a real-time conversation with the NHS 111 adviser via an interpreter.

During the December 2016 inspection, we saw the Trust was now monitoring and endeavouring to improve patient's access to the service and the Trust's performance against the Minimum Data Set (MDS) and Key Performance Indicators (KPIs). We saw performance was now comprehensively discussed and variations in performance closely monitored. The Trust now had a greater understanding of the levels of responsiveness required for their NHS 111 service and systems were in place and were utilised effectively. This was an improvement in both call answering and call abandonment performance since the March 2016 inspection.

In addition, the Trust now ensured the call back queues were monitored and managed by staff with clinical authority to intervene and allocate resources. Further actions were implemented in an attempt to gain a better understanding of the risks relating to long call backs on NHS 111 calls. For example, the Trust had implemented a revised procedure for the management of long calls on the clinical call back queue. This specifically included the arrangements and triggers for 'comfort calling' patients.

During the December 2016 inspection, staff told the inspection team, although there was a delay in call backs for some callers usually at weekends, the new comfort call process was working effectively and if there was ever a concern about a delay in a call back there was now clinical support available to ensure these concerns were addressed with a prioritised call back.

Listening and learning from concerns and complaints

In the 12 months prior to the December 2016 inspection (November 2015 and 31 October 2016) the Trust had received fewer concerns and complaints, specifically 790 cases of feedback related to their NHS 111 services.

- 204 of these were from the public and 586 from healthcare professionals. Feedback themes related to access, communication, and disposition (outcome) issues.

Recent information provided by the Trust reported 13 patient complaints about the NHS 111 service had been received in the two month period, September 2016 and October 2016. This was a reduction by 46% using the same two month period for the previous year (September 2015 and October 2015) when 24 patient complaints had been received.

The Trust told us the reduction in healthcare professional feedback may have been a result of detailed engagement including sharing details of the NHS Pathway assessment system with external providers (health care professionals) via the CCGs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

During the March 2016 inspection we saw 360 incidents remained open and they had been open on average 168 days with 261 incidents open for more than 71 days. To reduce the backlog of incidents the Trust had responded to concerns and reviewed the requirement for administrative support to join the team Urgent Care Service (UCS) team investigating incidents and complaints. The Trust had monthly milestones to ensure concerns and complaints were monitored and investigated in a timely manner. The UCS Line responsible for the investigation of incidents had investigated and closed nearly 1,500 incidents since April 2016.

During discussions with the UCS Governance Manager we saw the Trust now had an effective system in place for handling complaints and concerns. This included an overall analysis of all complaints received for the last 12 months had been carried out. This analysis had been introduced as a result of the NHS 111 Regulatory Consolidated Action Plan. This included the alignment of coding for serious, moderate or adverse incidents and complaints. We saw this provided an overview of the types of incidents and complaints received and identified themes or trends so that planned action could be taken to improve safety and or satisfaction with service delivery. This analysis was also included in the monthly Patent Safety and Experience Report.

Previously, staff we spoke with said they didn't always know who to report a complaint to, that communication of concerns and complaints was limited and although trends and themes had been identified little action had been taken to improve services.

Staff we spoke with during the December 2016 inspection said would raise any complaints with their line managers and commented incidents were now shared including clear actions points to address concerns. A call advisor told us of one recent complaint occurred when advisors had incorrectly logged out of the telephone system for a break or at the end of a shift. This resulted in several callers accessing the service, the call being answered but no advisor available to commence the call. We saw the Trust had reviewed this and actioned a change in process to ensure staff correctly logged out of the telephone system to prevent this happening again.

We saw operating procedures to guide staff and managers through the process of dealing with complaints. Information about how to complain was available on the provider website.

Are services well-led?

Requires improvement

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

Summary of findings

The Trust's NHS 111 service is rated as requires improvement for being well-led.

- Staff were clear about the Trust's vision and their responsibilities in relation to it. Staff said improvement of the service specifically safety and quality was a top priority.
- Staff, including those who did not work conventional office hours, knew how to access senior leaders and managers if required.
- Staff informed us that they felt supported by the leadership team. Staff told us that although the past few months had been a time of change and uncertainty that they felt improvements had been made and there was good evidence of team working.
- Senior managers had a greater understanding of the governance processes affecting the NHS 111 service and the impact that risks carried to patient safety. Governance arrangements included improved processes for identifying, recording and managing risks, issues and implementing mitigating actions.
- The Trust had established a regulatory consolidated action plan and internal NHS 111 Improvement Team as a short term arrangement. This plan and team was an integral part of the Trust's strategy to improve. Senior staff we spoke with had identified further areas for improvement and had plans in place to continue with the changes in order to offer improved services to patients.
- The Trust recognised that their performance in achieving the expected standards for the NHS 111 service still required improvement despite improvements since our previous inspections in March 2016 and August 2016.

Our findings

At our previous comprehensive inspection in March 2016, the NHS 111 service delivered by the Trust was rated as inadequate for providing well-led services.

- There was a documented leadership structure but staff were unaware of this. Many staff told us they had frequent line manager changes and so did not get time to form a good working relationship. Failure to meet call audit compliance was rated as high risk. However, there was limited monitoring and review of this risk.

At our comprehensive inspection in December 2016 we found the following:

Vision and strategy

The Trust had a mission, vision, values and a strategy. The vision included a commitment to deliver high-quality services to patients in the right place at the right time. All staff we spoke with during the December 2016 inspection were aware of this and their responsibilities in relation to it.

The Trust provided information of the four agreed corporate objectives for 2017. These objectives focused on supporting staff, delivering performance and clinical quality.

- We saw improvement of safety and service quality was a top priority and the service fully embraced the need to change and improve.
- Previously, staff told us they were supported by local management but at times they were not sure who to approach with issues. During discussions with staff at the December 2016 inspection, staff told us the Trust had shared clear information on how, when and who to escalate issues to.
- The staff we spoke with had a clearer understanding on their role and responsibilities. They understood their contribution to the vision of the NHS 111 service to deliver high quality care and promote good outcomes for patients.
- Senior members of staff told the inspection team, the previous months had been difficult and challenging, including the change in the NHS 111 contracts the Trust delivered, the de-mobilisation of the Exeter NHS 111 call centre and the adverse media attention.

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- Following the first inspection in March 2016, the Trust had established a regulatory consolidated action plan (known as RCAP1) which was updated and enhanced following each subsequent visit (August 2016 and December 2016). This work was managed by an internal NHS 111 Improvement Team. Following changes introduced as a result of the first plan, the second plan added new actions to help embed and sustain the improvements made. Senior staff we spoke with had identified further areas for improvement and we saw these fed into further iterations of RCAP, which remained in place for further improvements.

Governance arrangements

The Trust had made significant improvements to their governance framework to support the strategy to deliver high quality and compassionate care to patients in the most clinically appropriate, safe and effective way. However, some of the new improvements and the effectiveness were difficult to evidence due to the short time since implementation. The governance framework outlined the structures and procedures in place however, improvements were still required.

- Senior managers had a greater understanding of the governance processes affecting the NHS 111 service and the impact that risks carried to patient safety. Governance arrangements included improved processes for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw improved clinical governance procedures and reporting pathways for the Trusts provision of the NHS 111 service had been established. We saw more frequent clinical governance meetings were undertaken by the senior NHS 111 management team, commissioners and national leads.
- Monthly clinical governance reports and integrated corporate performance reports were produced at the inspections. We saw these reports summarised the performance of the Trust's services including NHS 111 service and included statistical data relating to call activities, audits and trends. Actions to address any performance issues were highlighted and monitored through the contract meetings with commissioners of the service. The Trust states these reports were an integral part of the Trust's performance management assurance to commissioners.
- Senior managers understood more clearly the impact that poor performance had on safety. Patient safety and running a safe effective service was central in all discussions during the inspection in December 2016.
- Learning from concerns, complaints and incidents and any emerging patterns and trends were now monitored and learning shared ensuing appropriate actions was taken.
- Systems had been implemented and the Trust had made improvements. For example, call answering performance had improved, call abandonment had reduced and the length of call backs had reduced.
- Risks posed by poor performance in access and call timeliness had been reviewed and continued to be recognised by the Trust. An action was taken for example, the Trust had dis-established the Non-Pathways Advisor role and formalised the 'comfort calling' process. More staff had been recruited
- We saw evidence to show the Trust had started to introduce systems to ensure associated risks were mitigated for the safety of patient's health and welfare. The Trust was aware that it was too early to see all systems fully embedded and to demonstrate that the new systems and processes were effective.

Although governance arrangements had improved and systems implemented to minimise risks occurring, potential risks to patients remained, for example:

- Callers were still not being assessed in relation to their medical needs in a timely manner as according to best practice guidelines.
- Systems to proactively monitor calls via call audits were not at the recommended level to identify risks and poor practice.
- Call back systems were not always sufficient to meet the needs of patients in a timely way.

Leadership, openness and transparency

The leadership team had been through several changes following our inspection in March 2016. Since October 2016, the provider had appointed two new operation managers and the deputy head of urgent care services was due to

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become the head of urgent care services imminently, which would maintain continuity in the management team. We saw the leadership team had worked together to identify the areas where further improvements was required.

- The Trust had reorganised the service at one location whilst allowing some clinicians to be based at the Exeter call centre. The Trust had new management structure with staff newly promoted who would need adequate training and support for their roles.
- The Trust introduced a NHS 111 Improvement Team on temporary basis to lead the changes most urgently needed. This was due to cease and the responsibilities would transfer to the new management team to see through the improvements still required.
- Previously, staff we spoke with described that their morale was low. Staff we spoke with also told us that they felt, that the NHS 111 service was a different, less satisfied team than that of their colleagues in the rest of the Trust. Staff told us in December 2016 that since our previous inspections and the change of contracts in October 2016; staff morale had improved, job satisfaction had increased, they were proud to wear the Trust uniform and there was now a sense of 'one team'.
- Furthermore, staff informed us that since the last inspection, they had been involved in discussions about how to run and develop the service and the senior management encouraged members of staff to identify opportunities to improve the service delivered by the Trust. Staff informed us that they felt supported by the leadership team following the March 2016 and August 2016 inspection. Staff told us that although the past few months had been a time of change and uncertainty that they felt vast improvements had been made.
- During the December 2016 inspection, we saw supervisors and managers were much more visible in the call centre. All staff we spoke with knew who their immediate manager was. Staff told us due to the different working patterns, team meetings were not possible but all supervisors and managers were approachable.
- The leadership team ensured that there were policies and process in place so that when members of their teams dealt with distressing incidents they were supported. Staff confirmed they were supported in their role and they were confident that if they required immediate assistance it would be provided. The staff were positive about the counselling services available including the 'Staying Well Service'.
- The Trust was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

Public and staff engagement

The Trust engaged with the public through a number of methods including patient satisfaction surveys, and a range of options to give feedback or raise complaints of concerns through their website. The service had recognised the importance of links with local Healthwatch groups, social media and Patient Opinion to gain patient feedback.

- The Trust carried out regular surveys of people who used the service via the NHS Friends and Family test survey; this showed the patient satisfaction with the service. The most recent data shows, 90% of respondents were satisfied with the NHS 111 service (Dorset contract) and 92% were satisfied with the NHS 111 service (Cornwall contract).
- The management team for the NHS 111 service were open to receiving complaints and provided information to patients so that complaints or compliments could be made on line, in writing or verbally on the telephone.
- Systems were in place to acknowledge and risk assess all feedback received from health professionals. Feedback was now reviewed to identify overall themes and trends. An overview of the issues identified was shared at the monthly regional clinical commissioning group meetings. Health professional feedback was reviewed and investigated in accordance with the risk identified. Areas identified for improvement were responded to and issues with the NHS Pathways triage were reported appropriately to NHS Pathways. Areas identified for learning were also shared with the other services provided by the Trust.
- Staff told us the managers within the NHS 111 service were now proactive in engaging with their staff. Staff told us senior managers were more visible including

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regular 'walk arounds' they were provided with opportunities to feedback formally through one to one meetings, staff surveys, a suggestion box and the appraisal programme had recently re-started.

- Staff had access to the Trust intranet where they could access policies, procedures, learning and development such as NHS Pathways and updates.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. For example:

- All aspects of the delivery of the NHS 111 service had been reviewed following our previous inspections and were being regularly monitored. We saw the Trust was actively implementing plans to improve the service delivery.
- To improve their performance the Trust advised that opportunities for call streaming were being explored with Cornwall out of hours GP service. The proposals would be similar to the previous memorandum of understanding that the Trust had with a different local out of hours GP service, to forward calls directly to them for clinical advice and reduce the number of calls requiring a call back within 10 minutes. Furthermore, the Trust had agreed a local variation to this metric for contractual purposes. This variation amended the target to be 75% of calls having a call back within 20 minutes.
- Following a serious significant event, there was a joint review with the NHS Pathways team. This review included a recommendation and assessed the safety benefits of splitting a NHS Pathways question into three separate questions to ensure callers safely understood each component of the question.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The Trust systems were not always effective to assess, monitor and improve the quality and safety of the NHS 111 service. Specifically this relates to: Callers were still not being assessed in relation to their medical needs in a timely manner as according to best practice guidelines. Call back systems were not always sufficient to meet the needs of patients in a timely way. This was in breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The Trust did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons employed on the NHS 111 service. Specifically: Call answering performance was below required targets and patients could not access timely care and treatment. This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Trust did not have sufficient systems to proactively provide staff with appropriate support or supervision to enable them to carry out the duties they are employed to perform.

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Requirement notices

The Trust could not demonstrate through volume of call audits or other systems the assurance that all staff had the necessary skills and knowledge to undertake their roles.

This was in breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.