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

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Overall summary

We carried out a comprehensive inspection of the NHS 111 service provided by South Western Ambulance Service NHS Foundation Trust (SWASFT) on 8, 9 and 12 March 2016.

Overall the Trust's NHS 111 service is rated as inadequate.

There were two call centres, one at the Headquarters based in Exeter (referred to in the report as Devon), the other in St Leonards (referred to in the report as Dorset). We visited both call centres and the SWASFT Headquarters. SWASFT NHS 111 provides a telephone service to a diverse population for Dorset, Devon and Cornwall.

NHS 111 is a telephone-based service where callers were 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, late opening pharmacy or home management.

The Care Quality Commission bought forward this comprehensive inspection due to intelligence we received; this included information received from former and current staff as well as patients raising concerns about the way the NHS 111 service was operated by SWASFT. The concerns included alleged ineffective use of systems and processes, staff levels and recruitment processes, lack of staff training and support, and the way complaints and significant events were managed.

Our key findings were as follows:

- The Trust had limited systems in place to mitigate safety risks across the NHS 111 service. When incidents and significant events were identified, investigated and reported, due to factors such as substantial staffing shortages and limited forward planning to meet expected demand on the service, these factors often prevented systems being followed and lessons being learnt.
- The NHS 111 service was monitored against the national Minimum Data Set for NHS 111 services and adapted National Quality Requirements. SWASFT were not consistently meeting these targets in most areas. Performance against some indicators such as calls being answered in 60 seconds were regularly at unacceptable levels. Necessary action to identify and improve callers' outcomes was not taken.
- There was also insufficient assurance to demonstrate callers received effective or responsive care and treatment. For example we saw evidence of urgent callers waiting for long periods to receive a call back from a clinical advisor. Despite being aware of issues, the Trust had not reviewed the calls in detail to identify the root cause.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example emergency and urgent callers were not being assessed in relation to their medical needs in a timely manner.
- SWASFT NHS 111 worked closely with all the Clinical Commissioning Groups who commissioned the service. NHS Dorset Clinical Commissioning Group, NHS Kernow Clinical Commissioning Group and NHS Northern, Eastern and Western Devon Clinical Commissioning Group.
- 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). However, once trained there were limited systems in place to monitor staff usage of NHS Pathways, for example inadequate levels of call audits were conducted by the Trust meaning that poor performance could not effectively be identified and managed in a timely way. Also, serious incidents and opportunities for learning could have been missed.
- The Trust did not develop staff knowledge, skills or experience to enable them to deliver good quality care and treatment. Staff did not always receive appraisals, supervision, support or sufficient training to perform their roles.

Summary of findings

- There were low levels of staff satisfaction and high levels of stress. There had been a high turnover of staff and significant sickness levels impacting on the service. Some staff were declined their annual leave requests as a result.
- Staff were supported to report issues and concerns but said often nothing was done by the Trust and no action was taken to change the factors that created the issues and concerns.
- Generic work station risk assessments were in place. However we saw examples of workstations (desks, computers and chairs) in both centres which were not appropriate for long periods of work or adjustable for individual members of staff. Staff told us safety in regard of workstations was not routinely monitored.
- The leadership within the organisation was variable and staff were confused on the leadership structure including who their line managers were. Staff told the inspection team the two call centres mostly worked separately to each other.
- There was eagerness by operational staff for continuous improvement and development of the service, but a lack of resources meant that improvements were not always implemented.
- We did not receive assurance from the leadership or governance processes in place that high quality care was being provided by the service. Senior staff did not demonstrate an extensive understanding of governance and its importance for the effective running of the service. This meant that they were unable to identify and mitigate risks effectively.
- During our inspection we found sections of staff, notably advisors and first line managers to be highly dedicated to and proud of the important work they were undertaking. However, they were also open and honest about the challenges they were facing on a daily basis. They were largely supportive of their immediate managers but found some senior managers and Board members to be remote and lacking an understanding of the issues they were experiencing.

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

The provider must:

- Continue to review staff numbers ensuring patients can access timely care and treatment when first accessing the service and when receiving a call back.
- Review the roles and responsibilities of Non Pathway Advisors ensuring callers consistently receive the correct level of advice when accessing the service.
- Ensure that the call queues, awaiting initial assessment and a clinical advisor call back are robustly monitored and managed by staff with clinical authority to intervene and allocate resources. This will ensure patients are being assessed and receive consultations within recommended timescales.
- Implement a consistent performance monitoring system for staff across both sites to identify and investigate poor performance.
- Identify individual and personal development needs of all staff including an appraisal programme.
- Increase the number of appropriate and effective call audits to ensure all staff are following the NHS Pathways system and local standard operating procedures (SOPs) allowing the service to identify areas of development and learning.
- Ensure all employees work at desks which have been suitably assessed for safety and ensure any work station risk assessments are followed up.
- Implement a clear leadership structure and staff made
- aware of their lines of management.

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?

Inadequate

The Trust's NHS 111 service is rated as inadequate for providing safe services and improvements must be made.

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, emergency and urgent callers were not being assessed in relation to their medical needs in a timely manner.
- There were not enough staff to keep patients safe. For example, a lack of staff often led to inappropriate triage of calls by transferring calls to the 999 emergency services or calls being placed into a queue without an appropriate triage. Call advisors told us there were often insufficient clinical staff available. Clinical staff confirmed this and we saw evidence of delayed call backs. Staff told us they worked long hours and many reported feeling high levels of stress and fatigue and subsequently made mistakes.
- There was a risk that staff may not recognise or respond appropriately to signs of deteriorating health and medical emergencies. For example, the service had introduced non-pathways advisors (NPA) who would take the patient details and warm transfer to a call advisor (a warm transfer is direct transfer with no delay). However, staff and managers stated that often these calls were placed into a call-back queue which could build to 50-60 patients waiting a Pathways assessment. Although this had a positive impact on performance against the call answering key performance indicators, the Pathways triage may not have started for several minutes.
- Monitoring of safety to drive improvements took place for significant concerns. Staff were informed of these changes and appropriate training and communication took place.
- However, we also saw examples where this process was not followed or managed as robustly for other more frequent events, notably, long delays in call backs. For example, if there was a long call back from a clinical advisor (we saw several examples including up to 22 hours), there was no investigation or analysis as to why there was a delay, if the delayed call back had been communicated with the caller or their symptoms checked to see if they had improved, deteriorated or new symptoms developed.

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- The Trust had clear agreements with other providers such as out of hours GP services and clinical commissioning groups for reporting adverse events.
- 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 call advisor handbooks in each section of the call centre.
- The Trust had a business continuity plan for each of its locations. Most call centre activities were understood and managed to assess foreseeable risk including seasonal and weather disruptions and loss of facilities or infrastructure. Staff understood their role in these incidents and they were involved in planning for such occurrences.

Are services effective?

Inadequate

The Trust's NHS 111 service is rated as inadequate for providing effective services and improvements must be made.

- 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.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the Trust was comparing its performance to others, either locally or nationally. For example, in relation to call advisor audits, in the three month period between November 2015 and January 2016 only 725 of the 2207 call advisor audits required were carried out (33.4%). In the three month period between 1 November 2015 and 31 January 2016 there were 186,625 calls.
- There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required.
- There was no system of performance review for call advisors and clinical advisors.
- The Trust had a high turnover of staff and a challenging sickness rate which supported concerns raised by whistle-blowers. For example, recent turnover data between November 2015 and 7 February 2016 showed that turnover within the Non Pathways Advisors group was 71.7%, call advisor group was 15% and clinical advisors was 44.7%.

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Are services caring?

Good

The Trust's NHS 111 service is 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.
- The 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.

Are services responsive to people's needs?

Inadequate

The Trust's NHS 111 service is rated as inadequate for providing responsive services and improvements must be made.

- Call back systems were not effective or responsive to callers' needs which meant they did not receive timely care when they needed it. During our inspection we noted that in the preceding seven days, the longest wait for a call back from a clinical advisor was over 17 hours.
- The service had a high rate of calls abandoned. This included calls being placed in queues or on hold prior to the patient being spoken to which delayed the patient assessment. For example, we witnessed calls being answered by call advisors and then being placed on hold, meaning that initial 60 second call-answering target was met but patients would not be spoken with immediately to assess their clinical needs.
- 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.

Are services well-led?

Inadequate

The Trust's NHS 111 service is rated as inadequate for being well-led and improvements must be made.

- The Trust had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it.
- There was a documented leadership structure but staff were unaware of this. Staff told us they were supported by local

Summary of findings

operational management but added that senior managers were not visible and at times they were not sure who to approach with issues. For example, training needs and annual leave requests.

- NHS 111 call centre staff interacted with other services in the Trust. However, they only felt part of the call centre where they worked and did not feel part of the wider organisation.
- All staff had received inductions but not all staff had received regular performance reviews. Some staff had attended staff meetings and events. 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. The only assurance we were informed of was a monthly report to the clinical commissioning group. Actions taken included offering current staff overtime, review of rota patterns, facilitating conversations between the senior management team and service lines, and changes to the audit tool. These actions and assurances were not proportionate to the level of risk identified by staff and inspectors.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Continue to review staff numbers ensuring patients can access timely care and treatment when first accessing the service and when receiving a call back.
- Review the roles and responsibilities of Non Pathway Advisors ensuring callers consistently receive the correct level of advice when accessing the service.
- Ensure that the call queues, awaiting initial assessment and a clinical advisor call back are robustly monitored and managed by staff with clinical authority to intervene and allocate resources. This will ensure patients are being assessed and receive consultations within recommended timescales.
- Implement a consistent performance monitoring system for staff across both sites to identify and investigate poor performance.
- Identify individual and personal development needs of all staff including an appraisal programme.
- Increase the number of appropriate and effective call audits to ensure all staff are following the NHS Pathways system and local standard operating procedures (SOPs) allowing the service to identify areas of development and learning.
- Ensure all employees work at desks which have been suitably assessed for safety and ensure any work station risk assessments are followed up.
- Implement a clear leadership structure and staff made aware of their lines of management.

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

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection teams were led by a Care Quality Commission inspection manager. There were three teams with a total of 13 members including inspection managers, hospital and primary care inspectors and NHS 111 specialist advisors.

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)
- 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 Devon, 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 two call centre locations:

- Trust Headquarters, Abbey Court, Eagle Way, Sowton Industrial Estate, Exeter, Devon, EX2 7HY
- East Division Headquarters, Acorn Building, Ringwood Road, St Leonards, Hampshire, BH24 2RR

The provision of the service covers the counties of Dorset, Devon, Cornwall and the Isles of Scilly. The area covered has a geographic area of 5,000 square miles, a population of 2.5 million and 17.5 million visitors per year. There are three Clinical Commissioning Groups who have contracts with the Trust for NHS 111 service.

- NHS Dorset Clinical Commissioning Group
- NHS Kernow Clinical Commissioning Group
- NHS Northern, Eastern and Western Devon Clinical Commissioning Group. This contract arrangement is due to end during October 2016.

The South Western Ambulance Service Foundation Trust 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, late opening pharmacy or home management.

The Trust employed 210.44 whole time equivalent (wte) staff within the NHS 111 service.

- 6.91 wte of these were non pathway advisors,
- 134.73 wte of these were call advisors.
- 20.63 wte of these were senior call advisors.

The advisors were supported by 37.17 wte clinicians and 11 wte administrators and managers.

Why we carried out this inspection

The Care Quality Commission bought forward this comprehensive inspection due to intelligence we received. This included information received from former and current staff as well as patients raising concerns about the way the NHS 111 service was operated by SWASFT and increased media interest. There were four whistleblowers who approached CQC with their concerns. The concerns included alleged ineffective use of systems and processes, staff levels and recruitment processes, lack of staff training and support, and the way complaints and significant events were managed.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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, and reviewed the information on their website. We asked other organisations such as commissioners and Healthwatch to share what they knew about the performance of the NHS 111 service.

We carried out an announced inspection on 8 and 9 March 2016 and an unannounced inspection on 12 March 2016.

During our visit, we spoke with a range of staff including directors for the service, Board members, senior managers, clinical managers, call advisors, clinical advisors, a NHS Pathway trainer and the lead for information technology.

We were unable to speak with patients who used the service. However, we listened to calls, with patient consent, and observed how clinical advisors and call advisors spoke with and supported patients who used the service. We looked at a range of records including audits, staff training, patient feedback and complaints.

Inadequate

Are services safe?

Summary of findings

The Trust's NHS 111 service is rated as inadequate for providing safe services and improvements must be made.

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example, emergency and urgent callers were not being assessed in relation to their medical needs in a timely manner.
- There were not enough staff to keep patients safe. For example, a lack of staff often led to inappropriate triage of calls by transferring calls to the 999 emergency services or calls being placed into a queue without an appropriate triage. Call advisors told us there were often insufficient clinical staff available. Clinical staff confirmed this and we saw evidence of delayed call backs. Staff told us they worked long hours and many reported feeling high levels of stress and fatigue and subsequently made mistakes.
- There was a risk that staff may not recognise or respond appropriately to signs of deteriorating health and medical emergencies. For example, the service had introduced non-pathways advisors (NPA) who would take the patient details and warm transfer to a call advisor (a warm transfer is direct transfer with no delay). However, staff and managers stated that often these calls were placed into a call-back queue which could build to 50-60 patients waiting a Pathways assessment. Although this had a positive impact on performance against the call answering key performance indicators, the Pathways triage may not have started for several minutes.
- Monitoring of safety to drive improvements took place for significant concerns. Staff were informed of these changes and appropriate training and communication took place.
- However, we also saw examples where this process was not followed or managed as robustly for other more frequent events, notably, long delays in call backs. For example, if there was a long call back from a clinical advisor (we saw several examples including up to 22 hours), there was no investigation or analysis as to why there was a delay, if the delayed call back had been communicated with the caller or their symptoms checked to see if they had improved, deteriorated or new symptoms developed.
- The Trust had clear agreements with other providers such as out of hours GP services and clinical commissioning groups for reporting adverse events.
- 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 call advisor handbooks in each section of the call centre.
- The Trust had a business continuity plan for each of its locations. Most call centre activities were understood and managed to assess foreseeable risk including seasonal and weather disruptions and loss of facilities or infrastructure. Staff understood their role in these incidents and they were involved in planning for such occurrences.

Inadequate

Are services safe?

Our findings

Safe track record

Although there was a system in place for reporting and recording significant events they were not robust systems for reporting of other events.

- Staff told us they would inform their manager of any incidents and there was a recording form available on the computer system.
- The Trust had agreements with other providers such as out of hours GP services and clinical commissioning groups for reporting adverse events.
- For the financial year 2015-16 the Trust reported no serious incidents to the Dorset Clinical Commissioning Group (CCG) until January 2016, but had since reported three serious incidents in a six week period. At the time of our inspection all were still under investigation. Themes from incidents reported to one of the CCGs included training, incorrect disposition (disposition means the outcome of each call assessment), high demand on service and gaps in provision.
- Senior staff told us that they benchmarked against local call centre services but could not describe their safety or performance record compared with other NHS 111 services.

Learning and improvements

The service carried out an analysis of identified serious significant events. We saw examples where learning from serious incidents were actioned for example; following a serious incident there was a review of persons with sepsis (sepsis is also referred to as blood poisoning or septicaemia and is a potentially life-threatening condition, triggered by an infection or injury). Action taken included a Trust wide approach to ensure all relevant staff knew how to respond in the event of suspecting a patient had sepsis. Staff explained there had been training sessions and communications about this event.

However, we also saw examples where this process was not followed or managed as robustly for other more frequent events, notably, long delays in call backs. The Trust also failed to use internal processes or opportunities to identify events or issues to effectively respond. For example, if there was a long call back from a clinical advisor (we saw a number of examples including up to 22 hours), there was no investigation or analysis as to why there was a delay, if the delayed call back had been communicated with the caller or their symptoms checked to see if they had improved, deteriorated or new symptoms developed.

There was a Trust wide regular publication called 'Reflect'. We saw examples from July 2015, November 2015 and January 2016. The aim of the publication was to share learning from investigations such as those arising from serious, moderate, adverse incidents, complaints claims and inquests from across the Trust. Topics included a variety of clinical updates as well as the responsibilities of the Duty of Candour. We spoke to staff who confirmed they had received the publication, however they commented it contained limited information on the NHS 111 service and due to work pressures they often did not have time to read this.

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.

When we spoke with senior staff about the management and learning from incidents we were told that there were very few incidents for the Trust's NHS 111 service and that many came from other providers.

Reliable safety systems and processes and practices

The Trust did not have robust enough systems, processes and practices in to ensure the safety of patients.

- 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 call advisor 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. There was a lead member of staff for safeguarding and information of contacts with other local authorities were available.

Inadequate

Are services safe?

- Information shared from the Trust's September 2015 Board report showed between April 2014 and March 2015, the Trust had made 7,769 safeguarding referrals with 34% (2,641 referrals) relating to NHS 111 services. Since February 2015, the Trust had made (via the NHS 111 service) 3517 safeguarding referrals, although they had limited involvement in the follow up.
- 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 triage 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 (DoS), to locate an appropriate service in the patient's local area.
- We saw many examples of the use of the Pathways system and DoS to provide effective outcomes for patients. The senior call advisors and clinical advisors monitored the Pathways system and the call advisors, to ensure patient safety. However, with limited numbers of clinical advisors there was a risk the call advisors would not be monitored by a clinician. Staff we spoke with commented that clinical support was limited and there was often a delay in receiving clinical support.
- When calls were received which required clinical advice, staff were expected to refer the callers to the clinician or clinical floorwalker. Call advisors told us there were often insufficient clinical staff available and clinical staff confirmed this. Performance data also demonstrated delayed call backs. An example of a delay in receiving clinical support was provided by the CCG following a call review in February 2016. A call advisor who was assessing a child with a fever (a fever is a raised temperature, caused by infections or other illness) requested clinical support to undertake assessment of the child's symptoms. The call advisor waited for three minutes until a clinical advisor responded. This placed the patient at potential risk and the Trust's standard operating procedures (SOPs) stated staff should wait no longer than 30 seconds for a clinical advisor, then return to the call and offer a disposition.
- As soon as a call was received by a call advisor or Non-Pathways Advisor (NPAs), a patient record was established including name, age and address. Call details were also collected prior to staff commencing standard NHS Pathways questions. We heard how staff double checked information for accuracy whilst at the same time reassuring the caller. Information was recorded directly onto the computer system and all calls were recorded to enable information verification and quality management.
- Call volumes and low numbers of clinical staff resulted in delays in some patients receiving clinical input into their condition potentially affecting their safety. This included calls answered by NPAs where the patients had not completed a Pathways assessment.
- Advice about how to self-medicate was occasionally provided. Where concerns were simple the caller was referred to their local pharmacist for advice or a referral was made to another service for this advice (i.e. an out of hours GP service).
- Internal call centre calls made by call advisers or NPAs to clinicians in Dorset were not recorded. This meant that it was not possible to evidence what advice was given to staff from clinicians. In the event of a significant event needing a thorough investigation access to the voice recordings would not be possible.
- Call advisors and other 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.
- Staff had access to and demonstrated compliance with key policies such as hand hygiene, and demonstrated an awareness of infection prevention and control issues when giving advice to callers; for example, where open wounds were discussed.

Inadequate

Are services safe?

- There was a memorandum of understanding (MOU) to transfer calls to the out of hours GP service at pre-determined peak times on Friday evenings 6pm to 11pm as well as Saturdays, Sundays and Bank holidays during the hours of 8am to 11pm. The MOU helped manage call waiting times however, staff told us calls for clinical advice still built up for some callers with non-urgent needs waiting approximately six hours for a clinician to call them back with advice.
- All call advisors received NHS Pathways training which lasted three weeks. This was followed by two weeks shadowing 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 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.
- All electrical equipment in the call centres was checked to ensure the equipment was safe to use. The service had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). These were recorded in a health and safety risk assessment provided to us.
- There was limited action taken to improve the working environment of staff. Whilst a generic work station risk assessment was in place, we saw at least 10 workstations in Dorset, where computer monitors were propped up by telephones and cardboard boxes. This meant they could not be adjusted for individual users. We saw at least six chairs in the Dorset call centre which were not adjustable and a limited number of ergonomic height adjustable desks. Staff explained that these faults and requirements had been reported but nothing had been done and added that staff safety in regard of workstations was not routinely monitored. We were told that staff often changed where they sat at each shift. We observed limited space in the Devon call centre where a number of desks for call advisors were surrounded by box files and there was limited room for personal belongings. These matters had not been addressed by the management team.

Monitoring safety and responding to risk

Risks to patients were assessed but not always well managed.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. However, the number of staff available was often below those identified as being needed to manage patients' calls. This particularly impacted on clinical staff where, at certain times, there was just one clinician on duty during busy periods. For example, only one clinician was available at each location on Saturday 12 March 2016 between 8.30pm and 9.30pm. This was confirmed with information made available to us by the Trust.
- Staff we spoke with felt that the Trust's NHS 111 service was not safe due to insufficient call advisors and clinicians at the busiest times. This had an adverse effect on the waiting times which hampered safe care. Staff raised these concerns and felt listened too but said they had not noticed any tangible difference.

Overall call advisor staffing levels were below those required at several points during our inspection which impacted on patient care, for example:

- Information for Dorset on Wednesday 9 March 2016 at 6.30pm showed there were 34 patients waiting in the queue to speak with a clinical advisor. We noted the longest call currently waiting was six and a half hours for advice regarding home management.
- Information for Devon on Saturday 12 March 2016 showed there were two staff fewer than identified numbers required during our period of observation. We noted calls waiting for responses increased during this period from 64 calls to 87 calls. The longest call currently waiting to be answered was approximately 10 minutes, with the longest waiting time for the day being 16 minutes.
- Information for Dorset on Saturday 12 March 2016 Saturday showed there were five staff fewer than

identified numbers required during our period of observation. We noted the longest call currently waiting to be answered was 3.5 minutes, with the longest waiting time for the day being 7.5 minutes.

A staffing system was in place which allocated resources based on anticipated service demand and fluctuation. Copies of information provided to us and the observations we made showed resources varied across the day and night. Staff levels varied from around four call advisors between 2am and 6am increasing to 32 at busy weekend morning periods around 9am and 10am. Clinical staff would arrive on duty to a back log of call backs that those on duty could not address due to high volumes for the staff level provided.

The Trust had recognised staffing levels were below those needed and had engaged with commissioners to agree the levels required. They had begun recruiting in line with the trajectory set by commissioners. Retention of staff had also improved between September 2015 and the end of January 2016 which the Trust told us resulted in an 8% reduction in turnover figures.

We received staff feedback from Dorset and Devon through a CQC staff feedback email inbox specific to this inspection, comment cards and information from whistle-blowers. These raised concerns that there were insufficient numbers of staff on duty. Comments were specific in relation to delays in receiving clinical advice and support. This feedback was reiterated by most staff we spoke with who gave us examples where they had felt unsupported, or had transferred calls to the 999 possibly unnecessarily. Staff had a standard operating procedure to follow to ensure life threatening calls were transferred to 999 services in a set time. Staff explained that other calls were left for significant amounts of time without clinical intervention, with potential incorrect dispositions. Staff also added that the unavailability of clinicians often meant that non–clinicians were making clinical decisions.

Arrangements to deal with emergencies and major incidents

The Trust had a business continuity plan for each of its locations and call centre activities were understood and managed to consider foreseeable risk including:

- Seasonal or weather
- Loss of facilities or infrastructure

Call centre staff understood 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).

We heard how they had responded to a local incident during the observation on Saturday 12 March 2016 at Trust Headquarters in Devon. Staff liaised with the command centre and the ambulance service to plan for additional resources if they were required.

However, we did not see reassurance that the Trust's NHS 111 service was proactive in managing all changes in demand. For example, during our inspection on 9 March 2016, there was a national Junior Doctors' strike. This was likely to increase the call activity to NHS 111 services. We saw the Trust had not scheduled additional staff to manage any increase in call volumes.

Inadequate

Are services effective?

(for example, treatment is effective)

Summary of findings

The Trust's NHS 111 service is rated as inadequate for providing effective services and improvements must be made.

- 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.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the Trust was comparing its performance to others, either locally or nationally. For example, in relation to call advisor audits, in the three month period between November 2015 and January 2016 only 725 of the 2207 call advisor audits required were carried out (33.4%). In the three month period between 1 November 2015 and 31 January 2016 there were 186,625 calls.
- There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required.
- There was no system of performance review for call advisors and clinical advisors.
- The Trust had a high turnover of staff and a challenging sickness rate which supported concerns raised by whistle-blowers. For example, recent turnover data between November 2015 and 7 February 2016 showed that turnover within the Non Pathways Advisors group was 71.7%, call advisor group was 15% and clinical advisors was 44.7%.

Our findings

Effective needs assessment

The Trust had submitted the results of an internal audit that they carried out reviewing NHS 111 operations. There were a number of recommendations as a result of the audit including:

- A recommendation stated that, within the current costs constraints of the NHS 111 contract, the Trust should review the number of clinicians on rotas at peak times. This was to see if it was possible to increase availability to enable call advisors to obtain clinical advice without delay. This was due by March 2016. During the inspection no evidence was provided that this action would be completed within the timescale.
- A recommendation, stated call advisors should be reminded of the policies relating to how many times they should attempt to speak with clinicians during each call and what action to take if they were unable to get hold of a clinician. The Trust stated this was on-going.
- A recommendation stated the Trust should ensure that the NHS 111 call advisors/clinicians audit and coaching process was reviewed and approved. This was due by March 2016. However, during our inspection in the second week of March 2016, we saw no evidence to demonstrate significant progress on this.

All call advisors and clinical advisors had been through a mandatory training programme to become a licensed user of the NHS Pathways. Once trained and licensed to use NHS Pathways, call advisors and clinical advisors should have had their performance regularly monitored. The Trust had identified performance monitoring through the call audits was poor and a top priority for improvement. The current levels of staff limited the number of audits being completed and effective performance management.

Monitoring performance was varied and limited. However, the inspection team saw when gaps in the call advisor or clinical advisors performance had been identified (through significant event investigation and occasional call audits), this was then discussed with the staff member and an agreed plan of support implemented. We saw an example for a call advisor who received additional support,

Inadequate

Are services effective?

(for example, treatment is effective)

including one to one meetings and on the job coaching to address performance issues. However, we were informed by staff that monitoring of poor performance of clinical staff in Dorset was not always carried out.

Calls were triaged through NHS Pathways (which is a software system of clinical assessment for triaging telephone calls from the public based on the symptoms they report when they call). Staff told us the NHS Pathways system was updated regularly and changes communicated to staff through training sessions and formal communication.

The information submitted by the Trust indicated that limited audits had taken place on calls in the last 12 months.

The inspection team were given audit information for NHS 111 call advisors and clinical advisors between 1 November 2015 and 31 January 2016. This showed the number of calls being audited against targets and the compliance of the audits being completed. Of the calls audited compliance was poor and the Trust was aware of a requirement to improve levels of audit, for example:

- In the three month period between 1 November 2015 and 31 January 2016 there were 186,625 calls.
- In relation to call advisor audits, out of a total of 2207 audits which should have been completed only 725 were done equating to 33.4% of the expected amount. In November 2015, only 37.1% of calls which should have been audited were audited. In December 2015, only 30.9% of calls which should have been audited were audited. In January 2016, only 32.3% of calls which should have been audited were audited.
- In relation to clinician audits, in the three month period between 1 November 2015 and 31 January 2016 out of a total of 260 calls which should have been audited only 38 were completed (15.7%). Monthly performance was 7.3% for November 2015, 23.7% for December 2015 and 16.2% for January 2016. One clinician told the inspection team that after they had completed their NHS 111 induction training they were not aware of any of their calls being audited in the last six months.
- Of those audits completed, 75.2% of call advisor audits were compliant (545 out of 725) and 81% of clinician audits were compliant (93 out of 244).

As a result of low levels of audits the service had not rigorously monitored performance on NHS Pathways and had not identified where specific staff had gaps in skills and knowledge. Callers may therefore receive incorrect or inappropriate advice from an advisor whose performance and calls had not been monitored. Furthermore, information which could have been gained was not used for continuous improvement and would not identify key areas where either additional training or modifications to existing training was required.

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). Information from January 2015 to December 2015 demonstrated some examples performance across the call centres:

- The average episode length (combined call advisor and clinical advisor) was 19 minutes, 11 seconds which was longer when compared to the national average (15 minutes, 25 seconds).
- 85.9% of calls were answered which was less than the national average of 94.6%.
- 11.7% of calls received had an ambulance disposition. This was in line with the national average of 11%.
- 5.7% of calls received were recommended to attend the nearest emergency department, compared with the national average of 8.2%.
- 28.5% of calls received a call back from a clinical advisor in 10 minutes. This was a significantly slower response when compared to the national average of 43.5%; resulting in potential delays for patients in receiving relevant clinical advice or access to appropriate treatment.
- 8% of calls were abandoned (after waiting 30 seconds) which was significantly more than the national average at 1.8%. (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 Trust had taken steps to reduce this by employing Non Pathways Advisors (NPAs). More recent data indicates the Trusts' response and recruitment of

Inadequate

Are services effective?

(for example, treatment is effective)

Non Pathways Advisors had reduced the average percentage of calls abandoned. For example, between 1 November 2015 and 31 January 2016, 3.5% of calls were abandoned.

The role of Non Pathways Advisors (NPAs) had been a national development for non-urgent, health information calls. For example, by providing information on the location of the nearest pharmacy. The employment of NPAs released Pathways trained call advisers to act on calls requiring triage. Information provided to us showed NPAs worked at the weekend which was the period of highest demand and took calls from the standard call list within the call centre. NPAs recorded the demographics (name, date of birth and current location) of the caller then if the caller needed triage they were put on a call back list after life threatening conditions were excluded. The call back list was supervised by a clinician who assessed the clinical urgency of the situation.

However, this meant that the caller's problem was not identified in the first call and resulted in waiting for a call back, which could lead to a variable delay.

Effective staffing

At the time of the inspection the Trust employed 210.44 whole time equivalent (wte) staff within the NHS 111 service. This included 6.91 wte as non pathway advisors, 134.73 wte as call advisors and 20.63 wte as senior call advisors. The advisor team were supported by 37.17 wte clinicians and 11 wte administrators and managers. The managers worked across two call centres.

The Trust had a level of oversight about the capacity and demand of the service and could manage individual performance if standards in terms of timely calls were falling in Devon but not in Dorset where there was no individual performance data for staff. In Devon, senior call advisors also known as supervisors, were informed who the staff were to be supported and helped them to improve.

The activity through the call centres could be observed by the information management team.

Inspectors were shown dashboards which highlighted times where the centres were most busy and could inform us that staffing levels were increased during this time.

Tables 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.

As part of the planned inspection, the Trust was asked to respond to CQC with the current numbers (March 2016) of whole time equivalent staff, turnover of staff and sickness absence rate:

- Staff comments during the inspection and data received from 1 February 2015 to 31 January 2016 indicated the Trust had a high turnover of staff and a challenging sickness rate that impacted on the service. Staff we spoke with during the inspection suggested organisational problems and a lack of staff support, which supported concerns raised to CQC by whistle-blowers was one of the reasons for high sickness levels. Turnover between 1 November 2015 to 7 February 2016 within the Non Pathways Advisors (NPA) group was 71.7%, call advisor group was 15% and clinical advisor was 44.7%.It was noted that the NPA staff group are small compared to other staff groups and since March 2015 17 NPAs have left the Trust and a further five had been successful in their applications to become call advisors and are now working within the Trust.
- Sickness levels had a direct impact on the patients and the remaining staff on duty, specifically in the Devon call centre. Combined (Devon and Dorset) data from 1 February 2015 to 31 January 2016 indicated sickness levels were 3.4% for Non-Pathways Advisors, 8.9% of call advisors and 12.2% for clinicians. More recently, information from a Quality Group meeting in January 2016, attended by the Trust and Clinical Commissioning Groups reported the sickness absence rate within SWASFT NHS 111 clinical team was 33% and for the whole month of January was 29.3%. It was noted that sickness levels in Dorset were better than in Devon.
- Between 1 February 2015 and 31 January 2016, the Trust had used 22 agency call advisors (13 in Devon and nine in Dorset). The 22 agency call advisors worked an average of 13.7 hours a week and were with the Trust for an average of 300 days each. The Trust advised that their NHS 111 service did not currently use any agency staff.

Inadequate

Are services effective?

(for example, treatment is effective)

- Several staff we spoke with described systemic problems when trying to book their annual leave. We heard many examples of staff endeavouring to book annual leave which was turned down, despite giving over nine months' notice. Staff told the inspection team that as the majority of annual leave requests are declined, staff therefore had at times reported as sick and did not attend their scheduled shift.
- In conjunction with a recruitment organisation a new and improved recruitment campaign had been designed. This had attracted a large number of potential candidates. In addition, open evenings were held where between 60 and 130 potential employees attended each evening. During recruitment an experiential learning process to 'test' candidate's aptitude for taking NHS 111 calls was used and interviews were held at busy times so candidates could understand the look and feel of the service at its busiest. Clinical staff recruitment had not identified the correct calibre or volume of candidates that were required. For example, the last recruitment period resulted in one successful candidate. In addition six Clinical Supervisors were on long and short term sickness absence. The local team in Dorset had acknowledged the risks associated with this and were seeking ways in which to support the clinical staff currently working within the service. A recruitment report provided to the CQC inspection team confirmed the actions being taken. This included establishing a clinical working group to review and oversee clinical actions and ensuring fortnightly progress meetings were planned.
- 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 who 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.

Good

Are services caring?

Summary of findings

The Trust's NHS 111 service is 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.
- The 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.

Our findings

Dignity, respect and compassion

We reviewed the most recent survey result data (April 2015 to September 2015) available from NHS England on patient satisfaction for people who had used the South Western Ambulance Service NHS Trust 111 service during this period.

The results indicate that caller satisfaction was comparable to the England average for Cornwall and Dorset. However, a higher proportion were dissatisfied with the service in Devon. For example:

- 90.6% of respondents from Cornwall stated they were 'very or fairly satisfied' with their NHS 111 experience and 3.5% were 'dissatisfied'.
- 89.1% of respondents from Dorset stated they were 'very or fairly satisfied' with their NHS 111 experience and 6.5% were 'dissatisfied'.
- 87.3% of respondents from Devon stated they were 'very or fairly satisfied' with their NHS 111 experience and 9.2% were 'dissatisfied'.
- The England average responses were 88.3% and 5.2% respectively.

Further data from October 2015 NHS 111 Patient Experience Survey indicates further caller satisfaction. For example:

- 77% 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. 4% of respondents felt the questioning was not right.
- 81% of survey respondents felt that the call advisor listened to what they had to say and 93% of respondents felt that they were treated with dignity and respect at all times.

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.

Good

Are services caring?

The February 2016 report showed that 89% of NHS Family and Friends test respondents would recommend the service, though 7% would not.

There were 16 positive comments and 15 negative comments received during January 2016. Positive comments related to patients feeling grateful for the service. Respondents cited how impressed with the service they were and how each person they spoke to was helpful and kind. Negative comments included comments about long waits for clinicians to call back and concerns around triage length and the detail of questions.

We received feedback from the local Healthwatch organisations. The Dorset Healthwatch had received 38 comments with 22 positive reviews related to the staff with praise for their attitude and the advice that they provided.

Details of the five positive reviews from Plymouth Healthwatch indicated that service users were happy their disposition (two reviews), they thought the service was efficient (two reviews) and there was praise for staff (one review).

Torbay Healthwatch reported in March 2016 to CQC that they had received 10 online reviews plus two complaints in the past 12 months. Most comments were positive about the service. Negative comments were about the operator putting people on hold and promises to call backs not being kept, waiting for call backs, slow processes and messages not being passed through to other services such as community nurses and out of hours services.

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 59 reviews on the Trust's NHS 111 profile on the Patient Opinion website. We saw all of the reviews had been responded to by the Trust. Positive aspects that people had highlighted included the care they received whilst negative aspects that people had highlighted included waiting times.

New staff 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 service) to assist patients to communicate better. We saw language line contact details were available on each work station area in the call advisors handbook and were told it was rarely needed.

All the caller interactions we heard were non-judgmental and treated each patient as an individual whatever their circumstances were.

In addition systems were in place to identify high intensity users or repeat callers and staff used the 'special notes' facility to log information. Special notes were a way in which the patient's usual GP can raise awareness about their patients who might need to access the out-of-hours service, such as those nearing end of life or those with complex care needs and their wishes in relation to care and treatment.

Involvement in decisions about care and treatment

We did listen to calls with the patient's consent. These were calls received by call advisors and clinical advisors. Throughout the telephone clinical triage assessment process the call handlers and clinical advisors checked the patients understanding of what was being asked of them. Patients were also involved in the final outcome (disposition) identified by the NHS Pathways and their wishes respected.

We observed and heard advisors 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.

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 as 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.

Staff used, when required, the Directory of Services to identify available support services close to the patient's home. For example, we heard a patient being advised of their local urgent care centre including confirmation of the opening hours.

Staff confirmed that they received training on the Mental Capacity Act 2005 as part of their induction training.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

We listened to how patients and their carers were informed of the final outcome of the NHS Pathways assessment. We observed call advisors speaking calmly and professionally to patients. For example, one person experiencing poor mental health rang and was clearly anxious. The call advisor was calm, reassured the patient and spoke in a clear and composed manner to fully understand the reason for the call.

Throughout the conversation, the call advisor adapted their questions to enable the patient to understand what information they were being asked for. We observed that the patient's decision to accept the final outcome was respected. For example, one patient's final disposition (outcome) identified that an ambulance should be dispatched. The patient refused and the call advisor attempted to transfer the call immediately to a clinical advisor. The transfer was not successful but we saw a clinical advisor had immediately called the patient back and on subsequent review the patient agreed with the clinical advisor and an ambulance had been arranged.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The Trust's NHS 111 service is rated as inadequate for providing responsive services and improvements must be made.

- Call back systems were not effective or responsive to callers' needs which meant they did not receive timely care when they needed it. During our inspection we noted that in the preceding seven days, the longest wait for a call back from a clinical advisor was over 17 hours.
- The service had a high rate of calls abandoned. This included calls being placed in queues or on hold prior to the patient being spoken to which delayed the patient assessment. For example, we witnessed calls being answered by call advisors and then being placed on hold, meaning that initial 60 second call-answering target was met but patients would not be spoken with immediately to assess their clinical needs.
- 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.

Our findings

Responding to and meeting people's needs

We found the service was not always responsive to callers' needs. The Trust's NHS 111 service had limited systems in place to maintain the levels of responsiveness required for their NHS 111 service and the systems that were in place were not utilised effectively. For example, call waiting queues were not routinely monitored to escalate concerns about ongoing delays and calls abandoned were not monitored for impact on other services. Abandoned calls could result in patients seeking medical advice elsewhere for example at local emergency departments.

Identified patient needs were not being met in a timely manner. For example, a national key performance indicator (KPI) stated that 95% of calls should be answered within 60 seconds. The actual performance between 1 November 2015 and 6 March 2016 averaged 73.2% of calls being answered within 60 seconds which did not meet the indicator.

We witnessed calls being answered by call advisors and then being placed on hold, meaning that initial 60 second targets would be met but patients would not be spoken with immediately to identify their clinical needs.

The service had introduced Non-Pathways Advisors who would take the patient details and should warm transfer (internal immediate transfer) to a call advisor, however, staff and managers stated that often these calls where then placed into a queue which could build to 50-60 patients waiting a Pathways assessment. This impacted the Trust's call answering KPIs, as it was recorded that the call may be answered in the 60 seconds, even though the triage may not have started for several minutes.

The Trust Board of directors meeting on 25 February 2016 included data to suggest it was not meeting other NHS 111 Service Quality Requirements. For example,

- 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%. Findings were lowest for Devon at 84%.
- Providers must regularly audit approximately patients' experiences of the service. Findings were lowest at

Dorset 0.52%. Whilst the actual number of audits depends on the number of staff, their experience and working hours, the expectation equates to approximately 1% of call volumes.

- Providers must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service. Findings were non-compliant, the expectation is compliant.
- No more than 5% of calls should be abandoned before being answered. The Trust's combined abandonment rate for this period averaged 6.4% (range of 3.7% to 9.1%)
- 100% of immediately life threatening conditions to be passed to the ambulance service within three minutes. The Trust achieved 94.3%.

Feedback in March 2016 from one of the Healthwatch groups, corroborated our findings, specifically about the service not being responsive to caller's needs, showed that in the past 12 months they had received 10 online reviews of the service and two complaints. The comments made were centred around issues such as:

- Operators putting people on hold for too long
- Promises of call backs not being kept
- Waiting times for call backs
- Slow processes and answering time
- Operators not passing messages through to other services (e.g. community nurses / out of hours Doctors service).

Access to the service

South Western Ambulance Service NHS Foundation Trust NHS 111 service operated 24 hours a day 365 days of the year. The NHS 111 telephone number is a free telephone number to anyone living in England. Call handlers and clinical advisors had access to a translation service, known as 'Language line', for callers who required the service and did not speak or had limited use of English. Staff told us the translation service was rarely used.

Nationally recognised times of increased activity to the NHS 111 service include weekday mornings between 8am and 10am, weekday evenings between 6pm and 7.30pm and the 24 hour periods on Saturdays, Sundays and Bank Holidays. These increased activity times occurred at both locations we inspected.

Information we were provided with showed that performance was generally below either the internal targets or national KPIs for service access. Information provided to us and the observations we made showed patients were not receiving support in a timely way. However data available in the Devon location showed call handling was improving. For example, a month on month performance chart showed that, in August 2015, call answering performance (calls answered in 60 seconds) was 73.7% and by February 2016 it had improved to 87.5%. The national target was 95%.

The Trust monitored its daily performance against the Minimum Data Set and we observed morning performance calls between operational managers discussing variations in performance. These calls identified the reasons for low performance. One reoccurring reason for low performance was insufficient numbers of call advisors and clinical advisors. During the performance calls we heard action plans were being implemented to improve the service. For example, implementing the memorandum of understanding with Devon Doctors, the local out of hours GP service, to forward calls directly to them for clinical advice.

We reviewed performance reports before, during and after the inspection, this included corporate performance reports. The reports identified the Trust was continually reporting problems accessing the service, specifically call answering (calls answered within 60 seconds, national target 95%) and abandonment rates (national target under 5%). In quarterly reports to the Board, although improving call answering performance in the NHS 111 service was noted as one of the Trust's biggest risks on the corporate risk register. Performance from the Minimum Data Set was reported as follows:

- April 2015, call answering performance was 56.7%; call abandonment rate was 11.3%.
- July 2015, call answering performance was 60.5%; call abandonment rate was 8.9%.
- September 2015, call answering performance 70.7%, call abandonment rates was 4.7%.

- November 2015, call answering performance 80.7%, call abandonment rates was 2%.

Between 1 November 2015 and 6 March 2016 the average percentage of calls meeting the 60 second KPI was 81.5% against a national target of 95%. Performance was affected due to staffing levels and lack of resources.

Information from the Trust Board of Directors report 25 February 2016 showed all calls which were referred to a clinician should be warm transferred (immediate internal transfer) or receive a call back within 10 minutes of being referred. In the three month period between 1 November 2015 and 31 January 2016 an average of 45.5% in Devon received a call back within 10 minutes of being referred. Information provided by the Trust informs us that there is a local agreement for the call backs to be achieved in 20 minutes.

In this three month period (1 November 2015 and 31 January 2016) we saw examples of delayed call backs, for example: the longest wait for a call back in Devon was over 21 hours (with an average of over 11 hours over the period).

During the inspection we saw the longest wait for a call back for the week prior to the inspection (week commencing 29 February 2016) was almost 18 hours (17 hours, 55 minutes). We discussed the long call backs with the operational managers during the inspection and asked if investigations were undertaken to investigate what had happened to the patients and an analysis into why there was a long call back. The managers we spoke with were unaware of such investigations taking place but commented it would be useful to investigate each case.

Since the introduction of the Non Pathways Advisors (NPAs) the Trust was performing better than the national KPI for the percentage of calls abandoned (calls abandoned is a marker of patient experience, a high call abandoned rate is not safe and may reflect a high level of clinical risk for patients). The KPI indicates less than 5% of calls should be abandoned. The average percentage of calls abandoned between 1 November 2015 and 31 January 2016 was 3.5%. However, data provided by the Trust showed that this performance was inconsistent and had fluctuated between 1% and 25%.

Recently, the Trust had introduced clinical floorwalkers. During our inspection we observed one floorwalker to be competent in the use of the NHS Pathways system and they used the system to inform their decision making. However, staff informed us that not all clinical floorwalkers had been trained in the use of the NHS Pathways system. Therefore whilst they were able to provide clinical advice to call advisors, their advice may not be recorded and they would have limited knowledge on how the staff would navigate through the Pathways process. Following the inspection the Trust advised where the floorwalker is not NHS Pathways trained their scope is to assist in clinical questions and not those relating to specific NHS Pathways queries. Should the query from the call advisor require NHS Pathways process input, the Senior Call Advisors assists with this.

Listening and learning from concerns and complaints

Four whistleblowing complaints had been received by Care Quality Commission regarding the NHS 111 services provided by the Trust. The whistle-blower complaints were all similar in nature and indicated issues with the operation of the service. These included that concerns raised had not been acted upon, the service not being resourced appropriately, and staff were not being supported in their roles. The actions taken in response to these complaints were limited with most of the action being individual feedback and learning. Given the number of patient complaints regarding the same issues and the frequency of the complaints, there did not appear to be organisational learning taking place at the service. Additionally there were a high number of patient complaints that were closed without any action being taken, which supported claims from whistle-blowers that the service ignored issues raised.

The Trust had received 986 feedback about incidents and complaints regarding NHS 111 services since 1 February 2015:

- 231 of these were from the public and 755 from healthcare professionals. The majority of complaints from both sources related to a lack of responsiveness.
- Almost half of the 231 service user complaints related to delays (115 complaints), either due to having to wait to access the service or having to wait for call backs. Complainants reported having to wait up to 40 minutes on first dialling NHS 111 before speaking to anyone. Some complainants reported waiting up to 20 hours for a call back, though others complained that they never received their call back.
- No action was taken in response to 50.2% of the closed complaints, including in instances where the complaints

were upheld. At the time of inspection (March 2016) 30 complaints remained open. Where action was taken in response to the complaints, it was focused on individual feedback and learning. On limited occasions the action stated that further audits would take place or that information would be re-issued to all staff, however, there is no reference to processes being reviewed or new policies being implemented. Which suggested that there is limited systematic learning taking place at the service from the complaints.

- On average it took the Trust 49 days to close 201 complaints. 10 complaints were closed on the same day as they were received.
- One of the 30 complaints that was open during the inspection in March 2016 was received in June 2015 and it was not clear what action was being taken to address the complaint. On average the open complaints had been open for 52 days. The longest complaint was open for 271 days.
- Of the 755 incidents received from healthcare professionals, the majority (96%) related to 'infrastructure or resources – other'.
- From the incidents categorised as 'Infrastructure or resources – other' most of the incidents related to a process issue (381 incidents), e.g. callers being directed to services that were not operational, calls not being answered, significant delays to calls being answered and call advisors dictating course of action for other services. We saw information relating to one incident, a safeguarding issue, when a nurse was sent on a home visit even though a note on the computer system explicitly stated that this should not take place.
- Of the 755 incidents, 395 were closed. No action was taken in response to 42% of the closed incidents. Where action was taken in response to the incidents, it was typically feedback to the relevant individual and given the number of incidents and their frequency, there was no clear evidence that wider learning was taking place.
- Of the 395 closed incidents the Trust took an average of 71 days to close the incidents.
- Of the 360 incidents that remain open, they had been open on average 168 days with 261 incidents open for more than 71 days.
- An overall analysis of all complaints received for the last 12 months had been carried out. This provided an overview of the types of complaints received and potentially identified themes or trends so that planned action could be taken to improve satisfaction with service delivery.

Staff we spoke with said that that although trends and themes had been identified little action had been taken to improve services. One member of staff commented that they found it frustrating to be receiving the same type of complaints all of the time, indicating that service learning was not taking place.

Are services well-led?

Inadequate

(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 inadequate for being well-led and improvements must be made.

- The Trust had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it.
- There was a documented leadership structure but staff were unaware of this. Staff told us they were supported by local operational management but added that senior managers were not visible and at times they were not sure who to approach with issues. For example, training needs and annual leave requests.
- NHS 111 call centre staff interacted with other services in the Trust. However, they only felt part of the call centre where they worked and did not feel part of the wider organisation.
- All staff had received inductions but not all staff had received regular performance reviews. Some staff had attended staff meetings and events. 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. The only assurance we were informed of was a monthly report to the clinical commissioning group. Actions taken included offering current staff overtime, review of rota patterns, facilitating conversations between the senior management team and service lines, and changes to the audit tool. These actions and assurances were not proportionate to the level of risk identified by staff and inspectors.

Our findings

Vision and strategy

The Trust had a mission, vision, values and a strategy. The vision included 'To be an organisation that is committed to delivering high-quality services to patients and continue to develop ways of working to ensure patients receive the right care, in the right place at the right time'. Staff within the Devon call centre had access to this but staff within Dorset told us they were not aware of the vision statements and their responsibilities in relation to it.

- There was a documented leadership structure but staff were unaware of this. Staff told us they were supported by local management but at times they were not sure who to approach with issues.
- Prior to the inspection the senior management team had announced that they were not going to continue with the re-procurement of the Devon contract for NHS 111. This decision was made by the chief executive and the Executive Directors Groupwhich was later discussed and approved at the Trust Board. We were told that this decision was influenced by an increase in adverse media attention and the impact this was having on the organisation's reputation. Staff at the Devon call centre told us they had received letters from the Trust and felt unsettled regarding their future employment.
- Senior staff discussed with inspectors the difficulties they were facing in the current financial climate and said that they struggled to provide high quality care on the funding they received. Senior management level staff discussed with inspectors the difficulties they were facing in providing appropriate care within the terms of the contract they agreed with Commissioners.

Governance arrangements

The governance arrangements in place did not align with the Trust's strategy to deliver high quality and compassionate care to patients in the most clinically appropriate, safe and effective way.

- Senior managers had a limited understanding of the governance processes affecting the NHS 111 service and the impact that risks carried to patient safety. One

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senior manager interviewed could not describe how information about staff performance was disseminated to their staff and could not give the inspection team assurance that this was being well managed.

- Local managers had a good understanding of the governance processes and were keen to implement these. However, they did not have the capacity to fully utilise this knowledge. For example, one manager we spoke with spent most of their time managing incidents and complaints rather than their main governance role due to the numbers of complaints needing to be managed.
- Three senior managers could not describe to inspectors the impact that poor performance had on safety. One of these managers said that there was no safety impact and that the only implication was financial. Another said that the impact to patient care was incredibly small. When we asked another senior manager what the biggest risk was they described the financial challenges rather than the impact on quality and safety.
- Inspectors were provided with examples of monthly clinical governance reports. There was evidence of learning from serious complaints and incidents where changes in practice were as a result of this. However learning from patterns and trends from minor, low risk complaints was not subsequently monitored which meant that learning did not always take place and appropriate actions were not taken.
- Where shortfalls had been identified in the performance report around staff auditing, there were no mitigating actions identified.
- The highest risk on the NHS 111 risk register was the service not meeting its Key Performance Indicator for calls answered in less than 60 seconds. This was risk assessed as a high risk (risk level 20). Not all of the senior managers interviewed knew what the highest risk on the risk register was or the impact that not having calls answered in a timely way had on the safety of people using the service.
- Failure to meet call audit compliance was rated as high risk but the only assurance was a monthly report to the clinical commissioning group. Actions around this included offering current staff overtime, facilitating conversations between the senior management team and service lines, and changes to the audit tool. However, the actions to date had not provided a sustainable or long term solution.
- As a result of low levels of audits, the service had not regularly monitored Pathways performance Key Performance Indicators. This resulted in not having an opportunity to identify where specific staff had gaps in skills and knowledge. As a consequence information was not used for continuous improvement and the Trust could not identify key areas where either additional training or modifications to existing training was required.
- Not all senior managers were aware of the risks within the NHS 111 service including the risks posed with poor performance in access and the call timeliness.
- Although serious complaints were always investigated in a timely way, similar processes were not in place or not followed to monitor other complaints. There was a failure to identify serious incidents that presented to the service as complaints or harm to patients. This led to potential opportunities for learning being missed. A manager told us that there was a high number of complaints that still required an investigation.
- Where some learning from complaints was identified emails were sent to staff to inform them of this. There were tracking systems in place to monitor if staff had opened the email or deleted it without opening it. However, once the email was opened there was not a system in place to identify if they had read and understood the content.
- There were insufficient systems in place to monitor audits to proactively identify risks and poor practice.
- Data provided showed that between April and July 2015 there had been 292 adverse incidents regarding NHS 111 services, an increase from the 224 between April and July 2014. NHS 111 service adverse incidents accounted for 10% of the Trust's total.
- Staff we spoke with said they thought the organisational governance processes were mixed. For example, we were told that locally managers were keen to learn and act on complaints, events and feedback but they rarely had the time or resources to do so. Staff also said they

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had raised concerns about the safety of patients and staff, a number of which they say they have raised through the internal processes of the Trust, but had received no response.

Leadership, openness and transparency

- Senior managers identified that having a low appraisal rate was not good enough and had been identified on the Nursing and Governance Directorate risk register.
- NHS 111 staff we spoke with said that they did not feel part of and felt disconnected from the wider organisation. Some local managers recognised the pressure that the NHS 111 staff were under.
- In Devon, staff we spoke with described that they were always busy and 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 999 emergency services located in the next room. The Trust informed us that this varied from their findings of the staff survey of September to December 2015 that the two services were broadly comparable.
- Some staff felt confident to speak directly with senior management, however, other staff we spoke with felt they did not have the confidence to raise issues with management and felt that where issues were raised, there was little action taken to resolve them. We were given examples where meetings to resolve issues had been cancelled. Staff commented that there was no forum to be able to raise concerns as there were no team meetings. Other staff comments highlighted confusion in the leadership structure. For example, several members of staff we spoke with did not know who their line manager was.
- At the time of the inspection the Trust had a third of their clinical posts vacant. Senior managers told us that this did not have a safety impact but did have a patient experience impact.

Public and staff engagement

- The NHS 111 service from Devon carried out a number of public engagement activities throughout the year. Staff told us about attending country shows using a display vehicle to help raise public awareness about the services they provided.
- Senior managers stated that although there was no formal programme of 'walk arounds' that they walked the floor at least once a week. However, when we asked call advisors about this, of the staff we asked none could remember the last time they saw a senior manager on the floor talking with them.
- The Trust employed a 'Staying Well' lead who had been working in that role for a year. This individual arranged drop in sessions for any staff to either offer advice or to direct them to the organisations or charities that can help. Although anonymous, information was gathered to allow themes to be identified for learning. Some of this learning had led to additional training. Work was being done to align the themes from the staying well sessions, sickness rates, and the staff survey to see if more learning could be identified.
- Staff told us that they thought the 'Staying Well' scheme was good and said the support they had received had been beneficial. Local staff said their immediate colleagues also provided support but that there was a disconnect between senior managers and staff and also between the Dorset and Devon call centres.
- We heard mixed reports about staff support in relation to disabilities and ability to work. We heard a positive example at Dorset of how staff had been supported to return to work following illness and adjustments made for staff with mobility issues. However, we heard of examples in Devon where staff did not feel so well supported.
- Prior to the inspection two incidents occurred related to the stress of the job. At the time of these incidents staff were well supported by managers and were offered psychological and occupational health support where necessary.
- Prior to the inspection the senior management team had limited formal communication with the unions but we were informed that meetings had been set up within the last few weeks. One of these meetings was to discuss clinical safety in the NHS 111 service.
- Union representatives told us that they were allocated sufficient time to manage concerns and to meet with the senior management team when needed.

Continuous improvement

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There was evidence of continuous improvement for the NHS 111 service in that sepsis training had been delivered to all call advisors and clinicians.

Staff in Dorset told us they knew what needed to be done to improve the service and were keen to make these improvements but stated that their ability to do so were restricted due to time pressure and that there was a disconnect between the two call centres.

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 15 HSCA (RA) Regulations 2014 Premises and equipment 15-(1) All premises and equipment used by the service provider must be: c) suitable for the purpose for which they are being used d) properly used and e) properly maintained **How the regulation was not being met:** There were at least 10 workstations where computer monitors were propped up by telephones and boxes. This meant the equipment was not being used for its intended purpose and meant they could not be adjusted according to each member of staff individual requirements. There were at least six chairs in the Dorset call centre which were broken and no longer adjustable.

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 17.1 Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 17.2 Without limiting paragraph (1), such systems or processes must enable the registered person, in particular to - (a) Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

This section is primarily information for the provider

Requirement notices

(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(e) Evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (b).

How the regulation was not being met:

Systems to assess, monitor and improve the quality and safety of the service are not operated effectively.

This section is primarily information for the provider

Enforcement actions

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1) (2) (a) (b) which states:** 12.1 Care and treatment must be provided in a safe way for service users. 12.2 Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include - a) Assessing the risks to the health and safety of service users of receiving the care or treatment; b) Doing all that is reasonably practicable to mitigate any such risks **How the regulation was not being met:** Calls are not responded to in a timely and effective manner. There is a lack of systems to ensure associated risks are mitigated for the safety of patient health and welfare.

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 **Regulation 18 (1) & (2) (a) (b) which states:** 18- (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. (2) Persons employed by the service provider in the provision of a regulated activity must-

This section is primarily information for the provider

Enforcement actions

a) Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

b) Be enabled where appropriate to obtain further qualifications appropriate to the work they perform

How the regulation was not being met:

Insufficient staff are employed and those employed are not deployed or supported effectively.