Herts Urgent Care HQ NHS111

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

Summary of findings

Contents

Summary of findings

Overall summary

We carried out this inspection of Herts Urgent Care NHS 111 on 3 and 4 November 2015. NHS111 is a 24 hours a day telephone based service where patients are assessed, given advice or directed straightaway to a local service that most appropriately meets their needs. For example that could be to their own GP, an out-of-hours GP service, walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance or late opening chemist.

Herts Urgent Care (HUC) provides NHS111 services for Hertfordshire and Cambridgeshire from two call centres at Ascots Lane, Welwyn Garden City and City Care Centre, Thorpe Road, Peterborough.

The NHS111 service for Hertfordshire is an integrated NHS111/out-of-hours service. The out -of-hours service is subject of a separate inspection and report.

The NHS111 service had not been subject to any previous CQC inspection.

Our key findings were as follows:

- Herts Urgent Care provided a safe, effective, caring , responsive and well-led service.
- There were systems in place to help ensure patient safety through learning from incidents and complaints about the service.
- The provider had taken steps to ensure that all staff underwent a thorough recruitment and induction process to help ensure their suitability to work in this type of healthcare environment.
- The service was high achieving and had consistently met or exceeded the key performance indicators known as the Minimum Data Sets (MDS)
- Patients experienced a service that was delivered by dedicated, knowledgeable and caring staff.
- Staff were supported in the effective use of NHS Pathways. Call review and audit was regular and robust in its application.
- We found that the service was well-led and managed by an effective senior management team and board of directors, and their values and behaviours were shared by staff.
- Staff expressed positive views of the management and leadership and felt well supported in their roles.
- Callers were satisfied with their experience of using the service.

We saw several areas of outstanding practice including:

- At the conclusion of the CQC inspection the provider displayed total openness and honesty as all available staff were invited to listen to the feedback provided by the CQC inspection team.
- The provider had developed links with the University of Hertfordshire in order to develop their clinical advisors by means of courses aimed effective telephone triage through history taking, asking sensitive questions and decision making. Clinical advisors had further been supported to attend the 'Assessment- A Systematic Approach' facilitated by the University which enabled clinicians, if they so wished, to progress further to assess and triage patients face to face as Clinical Navigators .

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Review health advisors awareness and knowledge of the Mental Capacity Act to ensure relevant callers are managed appropriately.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

There were clear procedures and policies that staff were aware of to enable them to recognise and act upon any serious events or incidents. Any learning was shared with staff.

We found that the provider had systems in place to ensure that people seeking to work at Herts Urgent Care were appropriately recruited to ensure their eligibility and suitability to work in a healthcare environment.

All staff, both permanent and temporary underwent a thorough induction process upon starting work.

The provider had good systems in place to identify and safeguard patients at risk of harm.

There were robust systems in place designed to allow continuity of the NHS 111 service in the event of information technology or telephony systems failures or other circumstances that might affect the delivery of the service.

Are services effective?

Good

We found that the service was effective in responding to calls and directing patients to the appropriate healthcare service that best met their needs.

The provider had consistently scored highly in a number of key indicators of performance, especially in times of high demand .

Clinicians were subject to continuing clinical supervision and case review to ensure their effectiveness in delivering the appropriate assessment for patients. All call taking staff were regularly monitored to ensure the effective and safe use of NHS Pathways.

The provider undertook regular measurement of the service effectiveness and achievement to continually assess and improve the service to patients.

There was an effective system in place to ensure information about patients coming into contact with the NHS 111 service was shared at the earliest opportunity.

There was good collaborative working between the provider and other healthcare and social care agencies to help ensure patients received the best outcomes in the shortest possible time.

Summary of findings

Are services caring?

Good

Patient experience surveys showed a high degree of satisfaction with the service provided.

There was a process in place to ensure patients whose first language was not English were able to access the service through interpreter services.

We heard callers to the service being spoken with professionally, courteously and with empathy.

Staff were given the opportunity to attend courses aimed at helping them to ask difficult and sensitive questions of callers.

Are services responsive to people's needs?

Good

There was an efficient complaints system and we saw that any learning from those complaints was shared with staff.

The provider undertook continuing engagement with patients to gather feedback on the quality of the service provided.

The provider undertook regular assessments of the efficacy of the service to ensure that patients' needs were met.

There were systems in place to ensure that during anticipated high levels of demand, sufficient staff were available to maintain a high standard of service.

Are services well-led?

Good

Members of staff we talked with spoke positively about the management of the service and said the management team was keen for staff to continually learn and improve.

There was a strong and stable management structure; senior management were visible and an integral part of the staff team. Both the board of directors and the senior management team displayed high values aimed at improving the service and patient experience and took positive steps to remind and re-enforce those values with all staff.

There was a clear leadership and management structure and staff we spoke with were clear as to whom they could approach with any concerns they might have.

The provider supported both clinical and non-clinical staff by providing a range of training opportunities all aimed at delivering high quality, safe care and treatment to patients.

We saw good examples of the organisation exercising its duty of candour when things had gone wrong.

Summary of findings

We witnessed absolute openness and honesty by the senior management team towards staff at the conclusion of the inspection.

Summary of findings

Areas for improvement

Action the service COULD take to improve

Review health advisors awareness and knowledge of the Mental Capacity Act to ensure relevant callers are managed appropriately.

Good practice

- At the conclusion of the CQC inspection the provider displayed openness and honestlyas all available staff were invited to listen to the feedback provided by the inspection team.
- The provider had developed links with the University of Hertfordshire in order to develop their clinical advisors by means ofcourses aimed effective telephone triage through history taking, asking sensitive questions and decision making. Clinical advisors had further been supported to attend the 'Assessment- A Systematic Approach' facilitatedby the University which enabled clinicians, if they so wished, to progress further to assess and triage patients face to face as Clinical Navigators .

Herts Urgent Care HQ NHS111

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and the team included three further CQC inspectors, a CQC pharmacist inspector, a GP specialist advisor, a GP practice manager specialist advisor and a specialist advisor with experience of NHS 111 services.

Background to Herts Urgent Care HQ NHS111

Herts Urgent Care Limited was formed in 2007 from the merger of two GP co-operatives to create an urgent care social enterprise. It provides a range of healthcare services that includes the contracts for the provision of the NHS 111 services for Hertfordshire since September 2012 and Cambridgeshire since November 2013. The services are commissioned on behalf of the clinical commissioning groups by East and North Hertfordshire CCG and Cambridgeshire and Peterborough CCG respectively.

The service provides for a population of approximately 2.1 million people living in Hertfordshire and Cambridgeshire.

The provider has two call centres located at Ascots Lane, Welwyn Garden City and City Care Centre, Thorpe Road, Peterborough. Calls are directed to the local call centre. If there is a high demand of calls the sister call centre staff are trained in both systems and processes to support services. Both call centres were visited during the course of the inspection.

Herts Urgent Care employs 158 health advisors and 54 clinical advisors across the two sites. They are supported by ten triage dental nurses, shift managers ,team leaders, coaches, floor walkers and auditors. Health advisors are non-clinical staff who are the first point of contact when a caller is connected to NHS111. A clinical advisor is a clinically trained member of staff, typically a nurse or paramedic.

In the period October 2014 to August 2015 the service received in excess of 346,000 calls from patients and others in Hertfordshire seeking assistance. For Cambridgeshire the number of calls amounted to 253,000 during the same period.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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 was planned to check 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.

The NHS 111 service had not been subject to any previous CQC inspection.

Detailed findings

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, we reviewed a range of information we held about this NHS 111 service and asked other organisations to share what they knew about the service. We also reviewed information that we had requested from the provider and other information that was available in the public domain.

We carried out an announced visit to Welwyn Garden City on 3 and 4 November and Peterborough on 3 November 2015. During our visit we spoke with members of staff at Peterborough and at Welwyn Garden City. They included the Chair, Chief Executive Officer, Director of Human Resources, the NHS 111 and Operations Director, Head of Clinical Governance, Operations Director and the Clinical and Deputy Clinical Lead. We met and spoke with clinical advisors and health advisors, call centre managers and shift managers as well as range of administrative staff.

We listened to call advisors and clinical advisors talking with callers to the service. We did not listen to the caller element of the telephone conversation.

We also reviewed a range of records including audits, staff files, training records and information regarding complaints and incidents.

This inspection and report is limited to the NHS111 service. A simultaneous inspection took place of the out-of-hours service provided by Herts Urgent Care which is subject to a separate report.

Good

Are services safe?

Summary of findings

There were clear procedures and policies that staff were aware of to enable them to recognise and act upon any serious events or incidents. Any learning was shared with staff.

We found that the provider had systems in place to ensure that people seeking to work at Herts Urgent Care were appropriately recruited to ensure their eligibility and suitability to work in a healthcare environment.

All staff, both permanent and temporary underwent a thorough induction process upon starting work.

The provider had good systems in place to identify and safeguard patients at risk of harm.

There were robust systems in place designed to allow continuity of the NHS 111 service in the event of information technology or telephony systems failures or other circumstances that might affect the delivery of the service.

Our findings

Safe track record

Herts Urgent Care was able to demonstrate a good track record in keeping people safe.

Staff we spoke with confirmed they had access to a wide range of procedures, policies and protocols that were available to all relevant staff on the provider's computer system. These covered a range of subjects including everyday activity and service delivery aimed at ensuring the best outcomes for patients. We saw they had been regularly reviewed and updated where necessary.

Staff were clear about their line of management and told us they would have no concerns about reporting any safety incidents and near misses.

Learning and improvements

The provider had a system in place for the reporting, recording and monitoring of significant events and complaints. There was a nominated member of staff who dealt with complaints about the service. There had been 104 complaints in the period October 2014 to September 2015., which represented 0.01% of the calls received. We saw evidence that learning from complaints was cascaded to staff.

We looked at the significant events that had been recorded from December 2014 through to September 2015. They covered a wide range of issues such as clinical assessment through to minor accidents in the workplace involving Herts Urgent Care staff. We saw that they had been clearly recorded and a full root cause analysis undertaken. Steps to prevent any re-occurrence were clearly documented and had been actioned.

Reliable safety systems and processes and practices

Herts Urgent Care had effective systems to ensure the service provided was safe and used NHS Pathways to deliver that service. (NHS Pathways is computer software that provides clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call, linked to a directory of services,(DOS) which best identifies the appropriate healthcare service to meet a patient's needs).

All of the staff we spoke with were able to demonstrate a good working knowledge of what may constitute a

Good

Are services safe?

safeguarding concern and how they would raise a concern. Training records we looked at showed that all staff received training in safeguarding vulnerable adults and children as part of their mandatory training. We saw that it was recorded on NHS Pathways where a safeguarding referral was made and this included a free text field for more detailed information.

Monitoring safety and responding to risk

We saw that there were sufficient staff to meet demand and that as the day progressed into the out-of-hours' period additional staff came on duty to meet the expected increased demand on the 111 service. Waiting times for calls to be answered and the number of calls queued were clearly displayed and were constantly monitored.

Staff at the call centres were seated at 'pods' which consisted of a mix of health and clinical advisors. In addition there was a floor walker who health advisors could summon for advice and assistance by the raising of a coloured card. This included a red card when they were dispatching an ambulance. At weekends a 'coach' was available in addition to the floor walker to assist and support health advisors.

We saw that the provider used detailed forecasting and analysis to predict demand at peak times, for example bank holiday weekends. Data was available to the provider that went back many years and enabled considered and evidenced judgements to be made as to the likely demand. We looked at the historic forecasted demand and compared it with the actual demand and found the forecasting to be very accurate. This enabled the provider to ensure that correct number of staff were available.

We noted that the staff rota for Christmas periods, historically a time of increased demand, had been well planned and had 97% of the health advisor and clinical advisor hours filled.

The ratio of health advisors to clinical advisors was better than the suggested 6:1. For example at the time of our inspetion the Welwyn Garden City Call centre had 16 health advisors and six clinical advisors working.We looked at the ratios over time and saw that the ratio was consistently maintained at 6:1 or better.

We noted that there was no use of agency health or clinical advisors. Senior managers we spoke with told us that they had little difficulty recruiting staff and that they found it better and safer to train their own staff to their standards, rather than rely on staff trained by other providers. They considered that thorough training by HUC was a major contributory factor to their high performance.

Arrangements to deal with emergencies and major incidents

We saw that a comprehensive business continuity plan, available electronically and in hard copy format, was in place to inform staff in the event that the normal operation of the service was interrupted by such things as failure of power, telephony, staffing issues or forced evacuation of a call centre. It had been last reviewed in June 2015. We saw that a hard copy was stored in the call centres allowing all staff access to it should the need arise. For example we saw how calls could be routed to the provider's other call centre in the event that one was not functioning. We looked at a serious incident that had necessitated the implementation of part of the plan following a telephony outage.

A paper system of 'NHS Pathways' was available in both call centres in the event of the computer system 'going down'.

There was a rota to ensure that there was always a senior member of the management team, clinical manager and Director on call to assist in the event of a major issue. In addition a member of the information technology team were available 24 hours a day to provide support and assistance in the event of IT problems.

Good

Are services effective?

(for example, treatment is effective)

Summary of findings

We found that the service was effective in responding to calls and directing patients to the appropriate healthcare service that best met their needs.

The provider had consistently scored highly in a number of key indicators of performance, especially in times of high demand .

Clinicians were subject to continuing clinical supervision and case review to ensure their effectiveness in delivering the appropriate assessment for patients. All call taking staff were regularly monitored to ensure the effective and safe use of NHS Pathways.

The provider undertook regular measurement of the service effectiveness and achievement to continually assess and improve the service to patients.

There was an effective system in place to ensure information about patients coming into contact with the NHS 111 service was shared at the earliest opportunity.

There was good collaborative working between the provider and other healthcare and social care agencies to help ensure patients received the best outcomes in the shortest possible time.

Our findings

Effective needs assessment

The provider had introduced GPs working in their call centres, working alongside health and clinical advisors. All calls that, after clinical assessment , were considered to require a referral to accident and emergency departments were reviewed by the GP. The undertaking of this role was aimed at reducing the number of calls directed for an ambulance or emergency department response.

Hertfordshire NHS111 had been involved in a pilot scheme from February to September 2015 which had involved the warm (immediate) transfer of calls to Hertfordshire's mental health trust crisis team. The scheme had ceased due to lack of ongoing funding.

The service had employed six pharmacists since August 2015. They currently worked between Friday and Sunday that being the busiest part of the week for the service. The provider was currently undertaking an audit to assess the outcome and impact on value of these pharmacists, but confirmed that of the calls received by the NHS 111 service, 6% related directly to enquires about medicines. It was too early to provide any robust evidence as to how effective employing pharmacists had been.

Management, monitoring and improving outcomes for people

Staff using NHS Pathways had their calls regularly audited with the frequency dependent upon their length of service in the role and their ongoing performance monitoring. They were assessed as ‘exemplary’, ‘good’ and ‘Level 1 Close monitoring’. Where major performance concerns had been identified there was a process of greatly increased call audits and performance evaluation that meant that they could not work unassisted until a full review of their competence was completed. We looked at examples of health advisors who had been subject to such measures and saw how they had been supported to improve.

Patient surveys showed that 92% of respondents were very or fairly satisfied with their NHS111 experience. This was the fourth highest percentage of the 16 NHS 111 services in the Midlands and East of England Region.

The rate of calls abandoned by the caller averaged 0.6%, well below the key performance indicator of 5%.

Good

Are services effective?

(for example, treatment is effective)

The number of calls answered with 60 seconds was 97%.

The clinical commissioning group responsible for commissioning the NHS111 service for Hertfordshire told us that Herts Urgent Care did not have any problems in meeting any of the minimum data set KPIs.

Effective staffing

We saw that the provider had robust systems in place for managing poor and variable performance and behaviour which included advice, additional training, personal development plans through to an example of a dismissal.

The provider had a system in place for all staff to receive and annual appraisal from their manager. For example we saw that of 92 call centre staff due an appraisal 90 had been completed.

There was a wide range of training opportunities available to staff that were applicable to their roles both using online resources and face to face training. This included infection control, basic life support, health and safety, conflict resolution and information governance.

Staff were encouraged to develop their careers and we spoke to several members of staff who had been promoted to more senior posts whilst working for Herts Urgent Care.

We saw that all new staff underwent a thorough induction process that included very detailed information for clinicians.

Working with colleagues and other services

There were clear structures in place to monitor the performance of NHS111 service through contract and quality review meetings, clinical governance group meetings, daily situation reporting and monitoring and the monitoring of complaints and incidents by the service commissioners. In addition a range of stakeholders were members of the 111 Clinical Governance group. These stakeholders included the ambulance service, health and community services, the community t rust, acute trusts, CCGs and patient representatives. The purpose of the group included, but was not limited to maintaining a focus on the patient journey to ensure safe services, review and to develop protocols to ensure a safe patient pathway.

Herts Urgent Care held weekly telephone conferences with the commissioning CCGs to discuss performance and share learning.

Herts Urgent Care was able to book patients directly into the GP out-of-hours service for the residents of Hertfordshire, but not for Cambridgeshire GP out-of-hours who arranged their own appointments having been informed of the requirement by the 111 service.

The Directory of Services (DOS) was maintained by the commissioning CCGs but with close liaison with Herts Urgent Care.

Information sharing

Clinical advisors were able to view special patient notes (generally started by a patients GP). These included such information as end of life care, people with long term conditions, those with a do not attempt cardio pulmonary resuscitation notices and frequent callers to the service.

A designated member of staff contacted GP surgeries to inform them if any of their patients were frequent callers to 111. This enabled the GP practice to update the special patient notes with this information.

Consent to care and treatment

We listened to both health advisors and clinical advisors talking with callers. We did not listen to the caller side of the conversation. We heard the advisors ask the caller for consent to share their personal data, for example with the out-of-hours service.

Training available to staff included dementia awareness through the Dementia Friends program.

A health advisor we spoke with was unable to demonstrate a working knowledge of the Mental Capacity Act and said they had not received any training in this area. They told us that if they had any concerns they would seek advice from a clinical advisor.

However we did speak to a clinical advisor who also had a training role. They told us that gave staff an introduction to personality disorders, psychosis and awareness of the Mental Capacity Act and the deprivation of liberty safeguards. We also viewed records including the NHS Pathways training that showed that mental health awareness was part of the training and induction for health advisors. We also saw that the provider was working with other agencies including the University of Southampton in an on-line training pilot to further up skill staff in this area.

Good

Are services caring?

Summary of findings

Patient experience surveys showed a high degree of satisfaction with the service provided.

There was a process in place to ensure patients whose first language was not English were able to access the service through interpreter services.

We heard callers to the service being spoken with professionally, courteously and with empathy.

Staff were given the opportunity to attend courses aimed at helping them to ask difficult and sensitive questions of callers.

Our findings

Dignity, respect and compassion

We listened to both health advisors and clinical advisors talking with callers. We did not listen to the caller side of the conversation. We heard staff speak to callers in a professional yet caring manner. Good clear health care instructions were given together with an explanation for the disposition reached.

Involvement in decisions about care and treatment

Staff we spoke with were aware that some callers needed extra help and support to help them understand or be involved in their care and treatment and this included callers who were unable to understand English well enough to be able to make an informed choice. All health advisors and clinical advisors had access to translation services. Staff told us that it was time consuming and delays in obtaining an interpreter by Language Line could have a detrimental effect on the recorded performance of individuals, as calls were aimed to be completed within ten minutes. However we were assured by advisors and the provider that this did not influence the use of interpreter services and we saw no evidence that this was the case.

Patient/carer support to cope emotionally with care and treatment

The provider had in place clear systems to signpost callers to other services, for example mental health services and to the voluntary sector.

Staff used the clinical software, NHS Pathways to reach the correct disposition and fully involved the caller in the process. We noted that 89% of respondents to the patient survey had stated they had fully followed the advice given.

Staff were given the opportunity to attend courses aimed at helping them to ask difficult and sensitive questions of callers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

There was an efficient complaints system and we saw that any learning from those complaints was shared with staff.

The provider undertook continuing engagement with patients to gather feedback on the quality of the service provided.

The provider undertook regular assessments of the efficacy of the service to ensure that patients' needs were met.

There were systems in place to ensure that during anticipated high levels of demand, sufficient staff were available to maintain a high standard of service.

Our findings

Responding to and meeting people's needs

Herts Urgent Care works closely with the commissioner of the 111 services to ensure that services are planned and delivered in line with patient needs. The various stakeholders including community and acute trusts, ambulance services, clinical commissioning groups and patient representatives worked with Herts Urgent Care to best identify and meet those needs. This was achieved by formal governance arrangements including monthly reporting on performance, quality, clinical governance and complaints and incident monitoring.

Tackling inequity and promoting equality

We found that the service responded appropriately to callers diverse needs such as religion, ethnicity, gender, age, disability and sexual orientation. Staff had received training in equality and diversity.

Access to the service

NHS 111 is a free telephone service; callers were not charged whether they call from a landline or a mobile telephone. There is no restriction of who can use the service and it is open to the whole population, whether or not they are registered with a GP.

Figures from the Minimum Data Sets showed that both NHS111 services had performed consistently highly. For example we saw that the percentage of calls answered within 60 seconds for the Cambridge and Peterborough service was 97.8% The national average was 90.3%. Call backs within ten minutes were 86.9% against a national average of 40.7%.

The service had worked hard to anticipate and respond to increased levels of demand on the service that was illustrated by the performance over the Christmas period of 2014.

The Hertfordshire NHS111 service answered 97% of calls within 60 seconds (national average 93.2%),72% of call-backs were in less than ten minutes (national average 47.8%). Referrals to 999 were 9% (national average 10.8%) and referrals to accident and emergency were 6.3% (national average 7.5%).

Good

Are services responsive to people's needs?

(for example, to feedback?)

The commissioners of the service told us that the provider consistently met the requirements of the minimum data sets.

Listening and learning from concerns and complaints

Herts Urgent Care had received a total of 104 complaints regarding the NHS 111 service in the period October 2014 to September 2015. These consisted of 57 for Hertfordshire and 47 for Cambridgeshire and Peterborough. This represented approximately 0.01% of the calls received.

We looked at the records of the complaints and saw they had been correctly recorded, investigated and responded to. The investigations included reviews of the calls and where appropriate an apology to the complainant.

All complaints had been categorised, for example staff attitude, disposition, process etc. to help identify any trends. Analysis of the complaints had been completed but this did not show that any one theme was significantly higher than others, the predominant issues being assessment outcome, assessment process, staff attitude and incorrect process. Learning from complaints was evident and individual call advisors and nurse advisors involved in the complaint were involved. Where necessary action was taken to prevent any re-occurrence by means of additional support, training, supervision or reflection. For example it was identified that there had been a number of complaints regarding a particular health advisor. Training issues had been identified as a result and appropriate action taken.

Records clearly showed that the provider fulfilled its duty of candour and people were told when they were affected by something that went wrong. We saw that letters of apology had been sent where it was appropriate.

When we viewed the minutes of meetings we saw that complaints and serious incidents were referred to together under the same heading. We saw how this apparent confusion had resulted in one example of a complaint being delayed as it was passed over to the serious incident team to take forward and the complaint not acted upon. The provider needs to make the difference clear to staff so that the procedures and policies relating to the investigation of complaints and serious incidents can run in parallel. We pointed this out to the provider who took immediate action to ensure that this was rectified.

Are services well-led?

Good

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

Summary of findings

Members of staff we talked with spoke positively about the management of the service and said the management team was keen for staff to continually learn and improve.

There was a strong and stable management structure; senior management were visible and an integral part of the staff team. Both the board of directors and the senior management team displayed high values aimed at improving the service and patient experience and took positive steps to remind and re-enforce those values with all staff.

There was a clear leadership and management structure and staff we spoke with were clear as to whom they could approach with any concerns they might have.

The provider supported both clinical and non-clinical staff by providing a range of training opportunities all aimed at delivering high quality, safe care and treatment to patients.

We saw good examples of the organisation exercising its duty of candour when things had gone wrong.

We witnessed absolute openness and honesty by the senior management team towards staff at the conclusion of the inspection.

Our findings

Vision and strategy

Herts Urgent Care demonstrated that they put quality and safety as a top priority with the vision and values being clear to all staff. Staff we spoke with clearly understood that quality and safety were paramount and we saw that the organisation took every opportunity to re-enforce the messages through, for example, the innovative use of computer screen savers.

Governance arrangements

Herts Urgent Care had governance arrangements in place and number of committees were responsible for service delivery. These included: stakeholder council, finance and scrutiny committee, clinical governance committee, integrated governance committee and remuneration committee. Each had clear reporting lines and responsibilities.

Leadership, openness and transparency

Herts Urgent Care was led by an experienced management team who were supported by a board of directors with wide ranging experience including pharmacology, finance, urgent care provision, human resources and GP services.

We noted that senior members of staff, including the Chief Executive and Director of Human Resources had their offices as an integral part of call centre at Welwyn Garden City making them visible and accessible to staff. Staff that we spoke with told us that senior management were visible and approachable. The atmosphere at both Welwyn Garden City and Peterborough call centres was excellent. Staff portrayed themselves and the provider in a positive light and morale appeared to be high.

At the conclusion of our inspection the inspection team gave feedback to the senior management team regarding the preliminary findings. The management took a very positive and open course of action and opened the feedback session to all available staff to hear what was being said. The inspection team considered this to be an outstanding example of leadership, openness transparency and honesty.

Public and staff engagement

HUC commissioned an independent company to carry out satisfaction surveys with people who had called the 111

Are services well-led?

Good

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

service, with 35% (415) questionnaires being returned for the period April to June 2015. Of the respondents 90% were either very satisfied or fairly satisfied with the NHS111service they had used.

The provider had a Whistleblowing policy that had been reviewed in January 2015 and had an equality impact assessment tool template attached.

The provider published a quarterly staff newsletter, 'Touchpoint' and a monthly 'Touchpoint update' that was well presented, professional looking and covered a range of subject areas including staff news and social events as well as performance statistics and other material affecting the staff and service delivery.

Herts Urgent Care had embraced technology and sought patient and public feedback and comment through social media. QR codes on cards given to every patient who attended the out-of-hours service invited comment of their experience of NHS111 as well as out-of-hours.

Continuous improvement

We looked at the training that was provided to staff and saw that it was appropriate and fitting to their role, helping them to maintain and improve the patient experience. This included both non mandatory and mandatory training such as safeguarding children and vulnerable adults and basic life support as well as essential training such as information governance, health and safety, integrated clinical governance and equality and diversity.

Licensed users of NHS Pathways received the training and updates as required under the licensing agreement.

The provider had developed links with the University of Hertfordshire in order to develop their clinical advisors by means of courses aimed effective telephone triage through history taking, asking sensitive questions and decision making. Clinical advisors had further been supported to attend the 'Assessment- A Systematic Approach' facilitated by the University which enabled clinicians, if they so wished, to progress further to assess and triage patients face to face as Clinical Navigators.