Care UK – NHS 111 London

Quality Report

Unit 1
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this 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

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Care UK (NHS 111 London), Unit 1, Square One, Navigator Park, Southall Lane, UB2 5NH on 13 and 14 March 2017, at its single site location.

Our key findings were as follows:

Care UK (NHS 111 London) (the provider/the service) provided a safe, effective, caring, responsive and well-led service to a diverse population in London. Overall, the provider was rated as good.

- There was an open and transparent approach to safety and an effective system in place to report and record significant events. Staff knew how to raise concerns, understood the need to report incidents and considered the organisation a supportive, culture. The provider maintained a risk register and held regular internal and external governance meetings.
- The service was monitored against a National Minimum Data Set (MDS) and Key Performance Indicators (KPIs). The data provided information to the provider and commissioners about the level of service provided.
- Staff had been trained and were monitored to ensure they used NHS Pathways safely and effectively (NHS Pathways is a licensed 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).
- Patients using the service were supported effectively during the telephone triage process and consent was sought. We observed staff treated patients with compassion and respect.
- Staff took action to safeguard patients and were aware of the process to make safeguarding referrals. Safeguarding systems and processes were in place to safeguard both children and adults at risk of harm or abuse, including calls from children and frequent callers to the service.
- The provider was responsive and acted on patients' complaints effectively and feedback was welcomed by the provider and used to improve the service.
- There was visible leadership with an emphasis on continuous improvement and development of the service. Staff felt supported by the management team.
- The provider was aware of, and complied with, the Duty of Candour. Staff told us there was a culture of openness and transparency.

We saw one area of outstanding practice.

Summary of findings

- People are protected by a strong comprehensive safety system that identifies opportunities to learn and shares that learning internally and externally.

There were areas where the provider should make improvements:

- Continue to address the challenges of recruiting substantive staff and the high reliance on agency staff to ensure adequate numbers of skilled staff are available to provide a safe and effective service.
- Improve the process for documenting discussions, decisions and actions for internal meetings for audit purposes, including but not limited to, appraisals and development meetings.
- Consider ways to engage with a variety of patient representative groups.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The provider is rated as good for providing safe services.

- There was an open and transparent approach to safety and an effective system in place to report and record significant events. Staff knew how to raise concerns, understood the need to report incidents and considered the organisation a supportive culture. The provider maintained a risk register and held regular internal and external governance meetings.
- Staff took action to safeguard patients and were aware of the process to make safeguarding referrals. Safeguarding systems and processes were in place to safeguard both children and adults at risk of harm or abuse, including calls from children and frequent callers to the service. Level three safeguarding training had been undertaken by 100% of the clinicians.
- Service performance was monitored and reviewed and improvements implemented.
- Clinical advice and support was readily available to health advisors when needed.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. The provider faced challenges recruiting substantive staff and relied heavily on agency clinicians.

Are services effective?

Good

The provider is rated as good for providing effective services.

- Daily, weekly and monthly monitoring and analysis of the service achievements was measured against key performance targets and shared with the lead clinical commissioning group (CCG) members.
- Appropriate action was undertaken where variations in performance were identified. Staff were trained and rigorously monitored to ensure safe and effective use of NHS Pathways.
- There was evidence that staff received annual appraisals and personal development plans were in place; however, these were not formally recorded. The service confirmed that they had regular informal discussions with staff, which were not

always recorded. They were aware of the issue and had booked management staff to attend courses on how to formally undertake and record appraisals and personal development plans.
- Staff recruited had the appropriate skills, knowledge and experience.
- Staff ensured that consent as required was obtained from people using the service and appropriately recorded. There was an effective system to ensure timely sharing of patient information with the relevant support service identified for the patient and their GP.
- People's records were well managed, and, where different care records existed, information was coordinated.
- Staff used the Directory of Services (DoS) and the appropriate services were selected. (The DoS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.)

Are services caring?

Good

The provider is rated as good for providing caring services.

- We observed staff treated people with kindness and respect, and maintained people's confidentiality.
- Health advisors had access to the Language Line phone facility (a translation/interpreter service) for patients who did not have English as their first language, a text relay service for patients with difficulties communicating or hearing and a video relay service for British Sign Language (BSL) interpreters.
- Feedback from people about the service was predominantly positive.
- People using the service were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services.

- The service had long and short-term plans in place to ensure staffing levels were sufficient to meet anticipated demand for the service.
- There was a comprehensive complaints system and all complaints were risk assessed and investigated appropriately.

Summary of findings

- The provider implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback.
- Action was taken to improve service delivery where gaps were identified.
- Staff were alerted, through their computer system, to people with identified specific clinical needs and for safety issues.
- The provider engaged with the lead Clinical Commissioning Group (CCG) to review performance and agree strategies to improve. Work was undertaken to ensure the Directory of Services (DoS) was kept up to date. (The DoS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.)

Are services well-led?

Good

The provider is rated as good for being well-led.

- The provider had a clear vision and strategy to deliver a high quality service and promote good outcomes for people using the service. The vision and values were displayed around the call centre and staff we spoke with were aware of these.
- There was a clear leadership structure and staff we spoke with told us management were supportive and approachable.
- The provider's policies and procedures to govern activity were effective, appropriate and up-to-date. Regular internal and external governance meetings were held.
- There was an overarching governance framework, which supported the delivery of the strategy and a good quality service. This included arrangements to monitor and improve quality and identify risk. The provider held a risk register.
- The provider was aware of and complied with the requirements of the duty of candour. The provider and managers encouraged a culture of openness and honesty. The provider had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The provider sought feedback from people using the service via the contractual patient survey and text messaging. An annual staff survey was also undertaken.
- There was a focus on continuous learning and improvement at all levels.

Care UK – NHS 111 London

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector, a GP specialist advisor with experience in urgent care and out-of-hours care and a non-clinical specialist advisor with experience in out-of-hours care.

Background to Care UK – NHS 111 London

Care UK, was founded in 1982, and the company is a large UK based independent provider of health and social care. Their services include treatment centres, GP practices, NHS walk-in centres, GP out-of-hours, prison health services and clinical assessment.

The service covers arears that are classified as the fourth most deprived decile on the index of multiple deprivation. The majority of the patients are either young or of working age. A small percentage of patients are aged between 65 and 85. The service is above the national average for patients aged between 20 to 40 and 0-14 and below the national average for patients aged between 65 and 85.

The health of people is lower when compared with the national average. For example, 44% of people have a long-standing health condition, comparable to the national average that is 53%. The lower percentage of people with a long-standing health condition could mean a lower demand for services including 111 services.

Care UK (NHS 111 London) was registered as a location in October 2011 and operates from:-

Unit 1

Square One

Navigator Park

Southall Lane

UB2 5NH

The provider holds the contracts for 12 NHS 111 services across a range of geographical areas in England, including the South West and South East of England, London, and parts of the Midlands and East of England.

Care UK (NHS 111 London) provides services in North West London, including Brent, Harrow, Ealing, Hounslow and Hillingdon. It is a telephone-based service where people are assessed, given advice and directed to a local service that most appropriately meets their needs. People can call 24 hours a day, 365 days a year, and calls are free from landlines and mobile phones. The NHS 111 service is staffed by a team of trained health advisors, supported by clinical advisors who are experienced nurses and paramedics.

Care UK (NHS 111 London) employs 165 staff. The service reported an approximate 25% turnover of staff in non-clinical and clinical roles in the past year. The call centre handles around 202,000 calls each year.

The provider is registered to provide three regulated activities:

- Treatment of disease, disorder or injury;
- Diagnostic and screening procedures;
- Transport services, triage and medical advice provided remotely.

This is the first comprehensive inspection of the NHS 111 service provided by Care UK (NHS 111 London).

Detailed findings

Why we carried out this inspection

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.

How we carried out this inspection

Before visiting the NHS 111 service, we reviewed a range of information that we held about the service provider and reviewed the information on their website. We asked other organisations such as commissioners to share what they knew about the provider.

We carried out an announced comprehensive inspection of Care UK (NHS 111 London) on 13 and 14 March 2017, during our inspection we:

- Observed the call centre environment over one and a half weekdays and during a peak weekday evening when GP practices were closed.
- Spoke with a range of clinical and non-clinical staff, including health advisors, clinical advisors, team leaders and senior managers.
- We looked at a range of records including audits, staff personnel records, staff training, patient feedback and complaints.
- We did not speak directly with patients who used the service. However, we observed health advisors in the call centre speaking with patients who telephoned the service.

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?

Please note that when referring to information throughout the report this relates to the most recent information available to CQC at that time.

Good

Are services safe?

Our findings

Safe track record

There was an effective system in place for reporting and recording significant events. We saw that the provider recorded all risks and incidents on a risk management software tool (Datix). We saw evidence of Datix system upgrades and staff notification of these.

- Significant events that met the threshold for a Serious Incident or Never Event were declared and investigated in accordance with the NHS England Serious Incident Framework 2015.
- Investigation of significant events was not confined to those that met NHS England's criteria for a Serious Incident or Never Event. The provider treated significant events including near misses as an opportunity for learning and risk reduction measures.
- Staff told us they were aware of how to escalate incidents and would inform their manager.
- We saw evidence that the management team held monthly quality assurance meetings locally and nationally within Care UK. The monthly meetings included a review of: training needs, performance data, safeguarding concerns, audit results, complaints and significant incidents.
- We noted the provider had recorded two serious incidents in the last 12 months and we saw evidence that a thorough analysis had been undertaken and key outcomes actioned. For example, a patient's relative called the service, the call was placed in the queue for clinical input. The clinical advisor spoke to the relative. The patient during the call went into cardiac arrest; the clinical advisor called an ambulance and gave the relative CPR instructions whilst waiting for the ambulance.As result of the incident, all staff were re-trained on providing telephone CPR advice.
- Internal and external governance meetings with contract commissioning leads were held to review themes from significant events and the provider produced a monthly clinical governance report that detailed both serious incidents and other incidents not meeting the Serious Incident Framework threshold. The report detailed the number and categorised the type of incident. For example, calls referred to an incorrect out-of-hours provider, demographic errors, breaches of procedure.
- The provider engaged with the external pan-London NHS 111 Clinical Governance Group and Integrated Urgent Care Group to peer review and share risk and learning from serious incidents within a 'Being Open' framework.
- Joint reviews of incidents were carried out with other partner organisations. For example, the provider recorded, reported and audited on a monthly basis incorrect referrals to a GP out-of-hours provider.

Overview of safety systems and processes

The provider had clearly defined and embedded systems, processes and practices in place to keep people who used the service safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff that included safeguarding flowcharts and referral pathways on their desktop. The policies clearly outlined who to contact for further guidance if staff had concerns about a person's welfare. There was a lead member of staff for safeguarding. Contributions were made to safeguarding meetings when required.
- We noted that the provider had made 136 safeguarding referrals to local authorities in a one-year period (January 2016 to December 2016).Where required the service worked with the local authority post referral to resolve the issues identified.
- Staff we spoke with demonstrated they understood their safeguarding responsibilities and had received safeguarding children and vulnerable adults training relevant to their role. Specifically, training records indicated 100% of non-clinical health advisors had completed level two training. Records showed 100% compliance with level three safeguarding training for the clinicians. One hundred percent of all staff (permanent and agency) had completed adult safeguarding training.
- Clinical staff and appropriate administrative staff had access to people's medical or care records. Staff were

clear on the arrangements for recording patient information and maintaining records. Health advisors and other staff had access to patient special notes, which alerted staff to patients with specific conditions or needs, for example, where they had pre-existing conditions or there were safety concerns.

- Staff had had training in recognising concerning situations and identifying complex calls and followed guidance in how to respond. This included the procedure for terminated and cut off calls. Clinical advice and support was readily available to staff when needed. For example, if a patient answered 'not sure' to three questions the call would be transferred to a clinician. Staff we spoke with demonstrated their understanding of these processes.
- The provider used the Department of Health approved NHS Pathways system (a set of clinical assessment questions to triage telephone calls from patients). The tool enabled a specially designed clinical assessment to be carried out by a trained member of staff who answered the call. At the end of each assessment a disposition (outcome) and defined timescale was identified and an automatic search was carried out on the integrated Directory of Services to locate an appropriate service in the patient's local area.
- We saw evidence that health advisors' and clinical advisors' call handling skills using NHS Pathways were regularly monitored in the form of end-to-end call audits to ensure that dispositions (outcomes) reached at the end of a call were safe and appropriate. The provider shared evidence of call audits for both health advisors and clinical advisors for the period January 2016 to December 2016. Results suggested the provider had met its target of 86% for call handler and clinical advisor call quality compliance for the entire period of the submitted data. End-to-end call audits were also discussed at external Pan-London NHS 111 Clinical Governance Group meetings to share learning.
- There were clear processes in place to manage the transfer of calls, both internally within the service, and to external providers, to ensure a safe service. For example, a referral to a patient's own GP or to an out-of-hours GP service. Standard operating procedures were available on a shared drive.
- We saw that staff had access to advice from clinicians where necessary. Should a clinician not be available for a direct transfer (warm transfer) the patient was placed on a 'call back' queue. We saw these were assigned priority at the end of a call ranging from priority one requiring an immediate response to priority four for health information queries. We discussed this process on the day with the operations manager who oversaw the non-clinical health advisors and clinical supervisors who oversaw clinical advisors within the service.We were told they monitored clinical call backs to ensure those calls most in need are allocated to a clinician first. The provider also has access to a bridge service whereby excess calls can be transferred to one of three other Care UK 111 services throughout England.
- A situation report for clinical call backs for the 24-hour period covering the first day of our inspection showed 53% of call backs had been achieved in less than 10 minutes. A breakdown of the average monthly performance for key performance indicators of call back percentage within 10 minutes suggested the provider performed better than the England average (provider 95%; England average 38%). This was comparable to the contract target of 95%. The provider told us that the clinical quality improvement advisors monitored all call backs and when call back performance did not meet target they would take priority calls themselves. Staff we spoke with on the day confirmed this.
- Health advisors had a coloured flag system (red, blue, green and yellow) available on their workstation that enabled them to raise a flag and receive immediate assistance for various situations such as life-threatening scenarios and technical issues.
- We reviewed five personnel files, including agency personnel, and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). The provider shared with us internal staff communication confirming that DBS renewal checks would be undertaken every three years in line with NHS Employers guidance.
- At the time of our inspection, the service employed 113 staff, which equated to 88 whole time equivalents (WTE) and reported current staff vacancies of 7.9 WTE for

health advisors and 15.5 WTE for clinical advisors. The backfill was predominantly filled with agency staff. The service reported an approximate 25% turnover of staff for both non-clinical and clinical roles in the past year. The provider told us staff tended to leave almost immediately after completion of training, the reason for this being that when they applied for the role they were not aware of the particular skills and commitment required working for service. To resolve the issue the service have developed a more robust requirement process to ensure potential applicants are notified from the outset of the skills and commitment required for the role.

- We reviewed processes in place with the provider's preferred supplier of agency staff due to their declared high reliance on agency clinicians. We observed effective processes of selection were in place to ensure individuals had the required skills and knowledge to undertake the role. When agency staff had been deployed, they were subject to the same mandatory training and induction processes required for the permanent workforce that included performance reviews. Agency staff we spoke with on the day confirmed this. The provider told us where possible they tried to use the same agency staff for consistency and stability.
- Staff were provided with a safe environment in which to work, entry to the floor space was via security keypad.
- We saw evidence that portable appliance testing (PAT) had been undertaken. A Fire Risk Assessment had been undertaken in September 2016 and there was a weekly fire alarm test record. The provider had a fire evacuation plan that it had shared with all staff through a staff bulletin and was visible around the premises. Staff had undertaken fire safety training (100% call handlers; 100% clinical advisors; 100% management team).

Monitoring safety and responding to risk

Risks to patients were assessed and well managed.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs using a workforce management tool. Forecasting of services were planned for each financial year based on historical activity and local and seasonal events. Call volume and demand was reviewed and monitored on a daily basis and where there was a change to expected activity this was discussed and agreed at monthly contract commissioners meetings. The provider also has access to a bridge service whereby excess calls can be transferred to one of three other Care UK 111 services throughout England.
- Shift rotas were actively managed. Staff told us they were offered overtime to cover absence. The service operated with six teams consisting of call handlers, clinical advisors, a team manager and a clinical quality improvement advisor. There was a ratio of 6 to 1 health advisors to clinical advisors. Staff we spoke with on the day told us the service was busy but felt for the most part that there was sufficient staffing to handle calls effectively.Staff, including agency staff, told us they worked well as a team and all helped each other out and felt supported by the management team. Staff told us they observed good working relationships between managers and staff.
- Staff received comprehensive training and regular updates on NHS Pathways. Each call handler's competency was assessed prior to handling patient telephone calls independently, and continuously through regular calls audits for all members of staff.
- Staff we spoke with demonstrated they were able to identify potentially life-threatening situations and had systems in place to manage frequent callers. Notes were added to the system that provided health advisors with a course of action to take to ensure their health, safety and wellbeing.

There was an effective process in place to identify, understand and monitor current and future risks. The provider held a current risk register on which it had rated some issues as high risk. For example, its high reliance on agency staff.

We saw that the provider had action plans in place to ensure improvements were seen in these areas. For example:

- At the time of our inspection, the provider had no health advisor vacancies and three clinical advisor vacancies. The backfill was predominantly filled with agency staff and additional support from the bridge service during peak times.Data for agency staff usage showed that in January 2017, agency staff provided 1,162 telephony

hours.The provider told us it was a challenge to recruit permanent staff and had held a recruitment open days, we were told they would continue with the recruitment drive.

Arrangements to deal with emergencies and major incidents

The provider had adequate arrangements in place to respond to emergencies and major incidents.

- The provider had a comprehensive business continuity and disaster recovery plan in place to deal with emergencies that might interrupt the smooth running of the service. This included loss of power, loss of utilities, evacuation of the building, pandemic, population disasters and increase in demand. The plan referenced re-directing calls to another Care UK (NHS 111) national service.Staff we spoke with on the day were aware of the business continuity plan. We saw that each workstation had a resource pack that included a paper copy of adult, infant and children's pathways, a list of OOH providers and manual call documentation in the event of a system failure.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The provider had systems in place to ensure all staff were kept up to date, for example through staff bulletins. Staff had access to guidelines from NICE, NHS Pathways and NHS Choices and used this information to help ensure that people's needs were met.

Telephone assessments were carried out using an approved clinical decision support tool (NHS Pathways). All health advisors had completed a mandatory comprehensive training programme to become a licensed user of the NHS Pathways programme. Once training was completed, all health advisors were subject to structured call quality monitoring to ensure continued compliance. A minimum of three calls per month were audited against a set of criteria such as effective call control, skilled questioning, active listening and delivering a safe and effective outcome for the patient.

Staff told us that updates to NHS Pathways were forwarded through formal communication. We saw evidence of staff advanced notification of bi-annual NHS Pathways system upgrades. Staff we spoke with told us they were given protected time to work through changes, took a competency test to ensure the changes had been fully understood and had to be signed off on upgrades before they could resume taking calls. The provider monitored understanding of the changes through one-to-one meetings and audits.

The provider shared evidence of call audits for both health advisors and clinical advisors for the period January 2017 and February 2017. Results suggested the provider had met their internal target for both the percentage of calls audited (1%) and call handler and clinical advisor call quality compliance (86%) for the entire period of the submitted data. For example:

- Call Audits

In January 2017, 19,523 calls had been answered of which 4% had been audited (against a target of 1%).

In February 2017, 16,173 calls had been answered of which 4.3% had been audited (against a target of 1%).

- Health advisors

In January 2017, 649 call handler calls had been audited of which 82% were compliant.

In February 2017, 581 call handler calls had been audited of which 85.1% were compliant.

- Clinical Advisors

In January 2017, 136 clinical advisor calls had been audited of which 90% were compliant.

In February 2017, 191 clinical advisor calls had been audited of which 98% were compliant.

Discrimination was avoided when speaking to patients who called the service. The NHS Pathways assessment process ensured patients were supported and assessed on their needs rather than on their demographic profile. Health advisors had access to the Language Line phone facility (a translation/interpreter service) for patients who did not have English as their first language, a text relay service for patients with difficulties communicating or hearing and a video relay service for British Sign Language (BSL) interpreters. Data was collected by the provider for Language Line and we saw that in February 2017, 267 calls required the use of Language Line and interpreters were used for 39 different languages with Polish, Punjabi and Romanian being the main languages requested.

Management, monitoring and improving outcomes for people

The service monitored its performance through the use of the National Quality Requirements and the national Minimum Data Set, as well as compliance with the NHS Commissioning Standards. In addition, the provider had established its performance monitoring arrangements and reviewed its performance and provided call centre statistics that highlighted month-by-month site adherence rates with a week- to-week and hour-to-hour view for the period January 2016 to December 2016. The data for this period showed that the average monthly performance of key performance indicators for the provider compared well to the England average. For example:

- 1.18% of calls abandoned (England average 3.3%).

Good

Are services effective?

(for example, treatment is effective)

- 92.29% of calls were answered within 60 seconds (England average 86.2%).
- 21.9% of answered calls were triaged to clinical advisor (England average 21.5%).
- 12.5% of answered calls passed for call back (England average 13.5%).
- 52.3% of calls backs within 10 minutes (England average 38.7%).

One key performance indicator was below the national average, for example:

- 80% of calls answered were triaged (England average 86.2%).These results were discussed with the provider on the day of the inspection.The provider confirmed that they were aware of the result and had recruited additional staff to improve the outcome for the coming year.

On the day of the inspection, we looked at more recent data of calls answered within 60 seconds and found for the month of January 2017 performance was 95%.

A situation report for the 24-hour period covering the first day of our inspection showed 99% of calls had been answered within 60 seconds.

There was evidence of improvements through the use of completed audits, for example;

The provider conducted an analysis of calls answered by health advisors on a monthly basis. The audit identified probing, as an area were health advisors consistently scored lower the expected. As a result of the first audit cycle further training was provided to all health advisors to improve their probing skills. During the second audit cycle, the provider found that overall scores had improved as a result of the further training. Furthermore, the provider asked health advisors for feedback regarding the training they had received, health advisors confirmed that the training equipped them to be more confident when answering complex calls.

Effective staffing

Staff had the skills, knowledge and experience to deliver an effective service.

- The provider had a corporate induction programme for all newly appointed staff. This covered such topics as governance and risk, safeguarding, counter fraud, manual handling, health and safety and equality and inclusion.
- The internal induction period for new health advisors is the first two days of a four-week training programme (six weeks for clinical advisors). The two-day induction covered topics such as information governance, safeguarding level one, fire safety and evacuation, basic life support, equality and inclusion and slips, trips and falls. All elements of the induction produced a certificate on completion that was recorded in a training passport and maintained by the training team. During our inspection we observed coaches supporting new staff within the call centre.
- The learning needs of staff were identified through a system of informal appraisals, one-to-one meetings and reviews of service development needs. There was evidence that staff received annual appraisals and personal development plans were in place; however, these were not formally recorded.
- Staff had access to training that included the use of the clinical pathway tools, how to respond to specific patient groups, Mental Health Act, Mental Capacity Act, safeguarding, fire procedures and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.
- The provider monitored performance to ensure the NHS Pathways guidelines were being followed by randomly auditing patient calls. New staff had a minimum of five calls audited each month and existing staff a minimum of three calls per month were audited against a set of criteria such as effective call control, skilled questioning, active listening and delivering a safe and effective outcome for the patient. If a call failed the audit process the employee concerned was suspended from taking any further callas until they were retrained in the particular area their call failed in. If the employee failed their next call audit their contract with the service would be reviewed and possibly terminated, dependant on the circumstances.

Good

Are services effective?

(for example, treatment is effective)

- The provider could demonstrate how they ensured role-specific training and updating for relevant staff was managed through the use of a training matrix that the provider shared with us.

Working with colleagues and other services

Staff worked with other providers to ensure people received co-ordinated care.

- The provider had systems in place to support and encourage the regular exchange of up-to-date and comprehensive information between all those who may be providing care to patients with predefined needs, for example, the provider had an effective process in place to promptly notify the patients GPs of their interaction with the 111 service.
- The provider met regularly with the contract commissioners to discuss all aspects of performance and was proactive in liaising with other service providers such as out-of-hours services and social services to ensure patients received the best outcomes.
- Work was undertaken to ensure the Directory of Services (DoS) was kept up to date. (The DoS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.)
- The provider was aware of the times of peak demand and had communicated these to the ambulance service. This included the arrangements to alert the ambulance service when demand was greater or lower than expected.
- Staff knew how to access and use patient records for information and when directives may impact on another service for example advanced care directives or do not attempt resuscitation orders.
- The provider had systems in place to identify 'frequent callers' and high intensity users of the service. Information about previous calls made by patients was available and staff could use this information where relevant to support the clinical decision process. The provider identified frequent callers through monthly audit with a threshold of five calls or more. The provider had lines of communication with 999 services, GPs and OOH providers to ensure a coordinated approach in the management of frequent callers. We saw that staff had access to an operational procedure for the management of frequent callers.

Consent

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and Gillick competency for children.
  Mental health awareness training was a component of the core module training for health advisors and clinical advisors. In addition, staff were also offered the opportunity to attend one of six training sessions offered by Mind, the mental health charity. The provider offered overtime payment for staff to attend outside their scheduled work hours. We saw that staff had access to information on assessing mental capacity and consent and capacity.
- The process for seeking consent was monitored through audits.
- Access to patient medical information was in line with the patient's consent.
- We observed that throughout the telephone clinical triage assessment process the health advisors checked the patient understanding of what was being asked of them. Patients were also involved in the final disposition (outcome) identified by NHS Pathways and their wishes were respected.
- Staff we spoke with gave examples of when they might override a patient's wishes. For example, when there was a potential significant risk of harm to the patient if no action was taken.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed that health advisors speaking to patients who called the service were courteous and very helpful and treated them with dignity and respect. Staff were provided with training in how to respond to a range of callers, including those who may be abusive. Our observations were that staff handled calls sensitively and with compassion.

In the month of February 2017, the service sent out approximately 540 surveys to obtain feedback from patients, 140 (23%) patients responded to the survey. The responses from patients were analysed and reported in the monthly contract report. For example:

- In February 2017, 140 patient satisfaction surveys were returned. Of these, 135 patients were fully satisfied with the service, five complained about the service, four reported that they would have gone to accident and emergency had not been able to call 111, three would have dialled 999 if they had not been able to call 111 and 135 would recommend the service to friends and family.

In the month of January 2017, 140 patients responded to the friends and family test. The responses from patients were analysed and reported in the monthly contract report. For example:

- 90% of patients said they would recommend the service.
- 7% of patients said they would not recommend the service.
- 3% of patients were neutral.

The provider shared with us 22 compliments they had received for the period February 2017. These related to helpful and sympathetic health advisors and clinical advisors. Positive patient feedback was shared with staff in one-to-one meetings.

New staff received training in equality and diversity during their induction and this training was updated for staff on an annual basis.

To assist access, the service provided:

- A Language Line phone facility (a translation/interpreter service) to aid communication with patients whose first language was not English. We saw Language Line contact details were available at workstations.
- A text relay service for patients with difficulties communicating or hearing.
- A video relay service that allowed a patient to make a video call to a British Sign Language (BSL) interpreter. The BSL interpreter would call an NHS 111 advisor on the patient's behalf so they were able to have a real-time conversation with the call handler via the interpreter. To utilise this service the patient would require a webcam, a modern computer and a good broadband connection.

Staff we spoke to on the day were aware of these facilities and we saw that information and links to all these services were on the NHS Choices website.

Care planning and involvement in decisions about care and treatment

We were unable to speak directly to patients about the service they received. However, we observed that health advisors spoke respectfully with patients and treated callers with care and compassion.

Care plans, where in place, informed the service's response to people's needs. These included notification of Do Not Attempt Resuscitation (DNAR) and access to Coordinate My Care (CMC), a personalised urgent care plan developed to give people an opportunity to express their wishes and preferences on how and where they are treated and cared for. However, staff also understood that people might have needs not anticipated by the care plan.

We saw that staff took time to ensure people understood the advice they had been given, and the referral process to other services where this was needed. This included where an appointment had been made by the NHS 111 service or where a request was to be made for a future appointment.

Patient/carer support to cope emotionally with care and treatment

Staff were trained to respond to callers who may be distressed, anxious or confused. Staff were able to describe

Good

Are services caring?

to us how they would respond and we saw evidence of this during our visit. For example, we observed health advisors repeating instructions and clarifying information calmly and slowly to ensure the patient understood.

There were arrangements in place to respond to those with specific health care needs such as end of life care and those who had mental health needs.

There were established pathways for staff to follow to ensure callers were referred to other services for support as required. For example, to out of hours dentists, pharmacies and GP providers.

The provider had systems in place to identify 'frequent callers' and high intensity users of the service. Information about previous calls made by patients was available and staff could use this information where relevant to support the clinical decision process. The provider identified frequent callers through monthly audit with a threshold of six calls or more. We saw procedures were in place to provide the appropriate support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service engaged with the NHS England Area Team and the lead Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, they participated in a number of pilot schemes such as the Calderdale Framework scheme. The scheme was intended to look at workforce deployment opportunities, for example, apprentice schemes.

- The provider offered 24 hours a day, 365 days a week service.
- The service took account of differing levels in demand in planning it service. For example, the provider demonstrated how adjustments had been made to meet potential increases during the recent junior doctor strikes.
- There were specific care pathways for patients with specific needs, for example those at the end of their life, and babies and young children.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service.
- The service was able to book appointments for patients directly with some GP out of hours services, urgent care centres and extended hours 'hubs'.

  The service monitored its performance against the Minimum Data Set (MDS) and Key Performance Indicators (KPIs) and these were discussed at monthly contract management meetings with commissioners. Where variations in performance were identified the reasons for this were reviewed and action plans implemented to improve the service.

  The majority of national targets were being met and ensured calls to NHS 111 were handled within the national limits. Average monthly performance data for the period January 2016 to December 2016 showed the provider compared well to the England average. For example:

- 1.18% of calls abandoned (England average 3.3%).
- 92.29% of calls were answered within 60 seconds (England average 86.2%).
- 21.9% of answered calls were triaged to clinical advisor (England average 21.5%).
- 12.5% of answered calls passed for call back (England average 13.5%).
- 52.3% of calls backs within 10 minutes (England average 38.7%).

One key performance indicator was below the national average, for example:

- 80% of calls answered were triaged (England average 86.2%).These results were discussed with the provider on the day of the inspection.The provider confirmed that they were aware of the result and had recruited additional staff toimprove the outcome for the coming year.

Tackling inequity and promoting equality

- New staff had received training in equality and diversity during their induction and this training was updated for all staff on an annual basis.
- Staff we spoke with were aware of the Language Line phone facility (a translation/interpreter service) for patients who did not have English as their first language We saw Language Line contact details were available on each work station.
- The provider offered a text relay phone service for patients with difficulties communicating or hearing.
- The provider offered a video relay service that allowed a patient to make a video call to a British Sign Language (BSL) interpreter. The BSL interpreter would call an NHS 111 call handler or clinical advisor on behalf of the patient so they were able to have a real-time conversation with the NHS 111 adviser via an interpreter.

Access to the service

- The service offered a 24 hour a day, 365 days a week service for people living in North West London. Access to the service was via a free-of-charge telephone number. Calls were answered at a single location in North West London.
- The service prioritised people with the most urgent needs at time of high demand. Capacity and demand was monitored constantly and action taken to ensure callers received a timely response. We discussed this

Good

Are services responsive to people's needs?

(for example, to feedback?)

process on the day with the deputy contact centre manager and clinical lead who oversaw the non-clinical health advisors and clinical advisors and they told us they monitored clinical call backs to ensure those calls most in need are allocated to a clinician first. A situation report for the 24-hour period covering the first day of our inspection showed 740 calls had been received of which 99.2% had been answered within 60 seconds.

Listening and learning from concerns and complaints

The provider had an effective system in place for handling complaints and concerns. Information about how to complain was available on the provider website. We saw operating procedures to guide call handlers, clinical advisors and operational supervisors through the process of dealing with complaints. Staff we spoke with told us they would raise any complaints with their line managers.

The provider had received 85 complaints between January 2016 and February 2017. A complaint log was maintained which included a summary, outcome and the learning and action taken. The summary included details of call audits when undertaken. Complaint themes related to attitude, communication, and disposition (outcome) issues. Lessons were learnt from complaints and action was taken to improve the quality of the service. Twenty-five of the complaints had concluded with an action of individual learning and 10 with site-wide learning. For example, the provider had coordinated some additional training with the mental health charity Mind as it had identified mental health awareness as a theme.

- We found all complaints had been handled appropriately, resolved satisfactorily and in a timely manner. When needed an apology was provided. For example, we saw an apology letter to a patient regarding a complaint about the unhelpful manner of a clinical advisor and poor experience of the 111 service. The letter concluded with information on how to contact the Health Service Ombudsman in line with guidance. The provider told us the complaint had been shared and discussed with the clinician involved.

Are services well-led?

Good

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

Our findings

Vision and strategy

The 111 provider had a clear vision to deliver a high quality service and promote good outcomes for people using the service.

- The provider's vision and values were displayed around the call centre and staff we spoke with were aware of the vision and the values of the service.
- The service in January 2017, launched an organisational-wide campaign to promote wellbeing amongst all staff.The service ran a programme of workshops promoting specific issues, for example, staff welfare, communication and training.The provider encouraged staff uptake for the programme by offering them paid time to participate in the programme.

The provider had an overarching strategy that reflected the vision and values and was regularly monitored. Planning and service provision involved managers and leaders from all functions within the organisation and included the 111 team. Staff we spoke with on the day referred to a culture that was supportive and open and that the management team were approachable. Several agency staff told us it was a good place to work and they felt supported.

Governance arrangements

The provider had an overarching governance framework that supported the delivery of the strategy and a good quality service. This outlined the structures and procedures in place and ensured that:

- There was a clear corporate and organisational staffing structure led by the centre operations manager who was supported by a management team responsible for operations, human resources, training, resource and planning. The direct patient service was delivered by six call centre teams comprising health advisors, clinical advisors, operational supervisors and clinical quality improvement advisors overseen by a clinical operations manager. Staff we spoke with told us they were aware of their own roles and responsibilities within the structure.
- At the time of our inspection, the service employed 165 staff members.There had been an approximate 25% turnover of staff for both non-clinical and clinical roles in the past year. Agency staff predominantly provided the backfill.The provider had listed its high reliance on agency staff as a risk on its risk register.
- Service specific policies were available to all staff and were up-to-date. Staff we spoke with on the day knew how to access policies and operating procedures on a shared drive.
- A comprehensive understanding of the performance of the service was maintained at all levels in the organisation. The provider attended monthly contract management and performance meetings with the commissioners and we saw evidence of minutes and performance reports.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The provider maintained a risk register that was visible to all staff. We observed that when gaps in service quality and performance were identified they were risk assessed and planned action implemented. We saw minutes of regular internal and external governance meetings and the provider produced a monthly clinical governance report that detailed both serious incidents and other incidents not meeting the Serious Incident Framework threshold. All staff we spoke with knew how to identify and report risks.

Leadership, openness and transparency

There were clear lines of accountability within the 111 service. Leaders had the capability and experience to lead effectively. Staff we spoke with were clear who to go to for guidance and support. They were clear about their line management arrangements as well as the clinical governance arrangements in place. They told us leaders were supportive and approachable.

- The learning needs of staff were identified through a system of informal appraisals, one-to-one meetings and reviews of service development needs.
- There was evidence that staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included on-going support during sessions, mentoring, clinical supervision and

Are services well-led?

Good

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

facilitation and support. Staff told us they were given protected time to undertake mandatory training and paid overtime if training was not delivered during their shift.

Team mangers, operational supervisors and leaders were visible in the call centre. All staff we spoke with told us their immediate manager was approachable and feedback was given in real-time through one-to-one meetings] however, these discussions were not formally recorded. Due to the different working patterns, team meetings were not possible. However, operations supervisors and clinical supervisors met together. The provider produced monthly staff bulletins that included service updates, performance data, training opportunities, patient survey feedback and achievement and celebrations.

We saw that candour, openness, honesty and transparency were encouraged. Staff we spoke with confirmed a culture of openness and said they felt comfortable raising issues and understood the duty of candour (the duty of candour is a set of specific legal requirements that provider of services must follow when things go wrong with care and treatment) and were able to give examples.

Senior leaders celebrated success and each year had an award ceremony for employee of the month. This celebrated the dedication and commitment shown by staff to the service and its patients. We saw an award noticeboard with photographs of monthly award winners.

Public and staff engagement

The service carried out regular surveys of patients who used the service and send out approximately 540 surveys via text messages per month to obtain feedback from patients. There was an average response rate of 23% of patients. The responses from patients were analysed and reported in the monthly contract report. The most current patient responses available on the day of our inspection. The figures for January 2017 showed:

- 140 patient satisfaction surveys were returned. Of these, 59% were fully satisfied with the service, 39% reported that would have gone to accident and emergency is they had not been able to call 111, 20% would have dialled 999 if they had not been able to call 111 and 82% would recommend the service to friends and family.

The service said that they were in the process of exploring options to regularly engage with a variety of local patient representative groups, however, this had not yet been implemented.

We saw an effective system in place for handling complaints and we saw evidence that the provider responded quickly to issues raised. All complaints were reported in a monthly clinical governance report and discussed in internal and external governance meetings.

We reviewed the most recent staff survey undertaken in 2016. One hundred and sixty seven questionnaires were sent out to all staff. In total 83 responses were received (52%). Responses to the following questions showed:

- I feel proud of the work I do, 89% positive.
- I know what is expected of me at work, 86% positive.
- Where I work, the care of our patients/customers is the priority, 82% positive.

The 2017 staff questionnaire was due to be carried out later in the year.

The provider encouraged staff to come forward with ideas that could have a positive impact on our and staff experience and had launched an evidence for change protocol and form to submit ideas to the management team.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. We saw the following examples of continuous improvement and innovation within the service. For example, they participated in a number of pilot schemes such as the Calderdale Framework scheme. The scheme was intended to look at workforce deployment opportunities, for example, apprentice schemes.