Isle of Wight Trust (NHS 111)

Quality Report

Ambulance Service
St Mary's Hospital
Parkhurst Road
Newport
Isle of Wight
PO30 5TG
Tel: 111
Website: www.iow.nhs.uk

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

Key findings

Contents

Letter from the Chief Inspector of General Practice

This service is rated as requires improvement overall. (Previous inspection March 2017 – Good)

The key questions are rated as:

Are services safe? – requires improvement

Are services effective? – requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – inadequate

We inspected this service as part of our inspection programme. We planned to carry out a focused inspection, however during the site visit we changed this inspection to a full comprehensive inspection due to concerns identified.

We carried out an 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.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- Records for the ambulance service clinical business unit showed that there were shortfalls in meeting the training targets set by the Trust for safeguarding and the Mental Capacity Act 2005.
- Leaning needs of staff were usually identified through a system of appraisals, meetings and reviews of service development needs. At the time of inspection 49% of appraisals for all staff who worked in the hub had been completed.
- There were shortfalls in facilities and premises for the services delivered. Staff reported that there were broken chairs and the layout of the room was poor; IT systems were slow; and the air conditioning units were not clean.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Performance support officers (PSO) reported that they had to cover shifts instead of being able to concentrate on their substantive role which aimed at ensuring a safe service was provided. This left the service response weakened in the event of a significant incident.
- There was limited resilience for sickness absence and planned annual leave.

Summary of findings

- A report had been produced which highlight constraints on staffing levels and the service operating with minimal staffing levels, which did not allow sufficient resilience and had contributed to staff working excessive hours in a week.
- The resource team allocated hours over a monthly period, but did not take account of actual hours planned for in a week.
- The secondment of performance support officers did not enable effective oversight of the NHS 111 service on a daily basis.
- PSOs were expected to ensure the hospital switchboard was covered; on occasion this led to only minimum levels of call handlers and decreased resilience for unexpected demand.
- Suitable rest breaks were not planned for in line with health and safety guidelines.
- The NHS 111 Service did not have any PSOs on site between the hours of midnight and 8am in the morning; cover between these times was provided by an on-call PSO. Current staffing levels meant that no PSO support was provided on site at weekends until 1pm until midnight on Saturdays and Sundays.
- The NHS 111 service did not consistently meet expected targets on calls handling and response times. There was limited action taken to improve performance.
- Action was taken to minimise the number of calls that were abandoned by the caller. The average figure for the year was 3.73% of call abandoned. Average figures over the preceding three months prior to the inspection showed that call abandonment rates were consistently within the target of less than 5%, with the averages ranging from 2.12% to 4.81%.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- Staff reported that more senior managers, not involved directly with the daily management of the NHS 111 service were not always visible. They were not confident these managers were aware of risks to the service provided, such as concerns around the resourcing system for planning shifts.
- Systems for capturing patient views on the service provided, had not been actioned.
- Staff surveys were completed, but there was limited evidence to show that concerns were being acted upon and resolved.
- Responses to whether staff considered they were well supported had worsened.
- Service performance was discussed at senior management and board level but limited action was taken to improve achievement against national targets.
- Delays in clarifying leader's roles and responsibilities had led to staff not feeling appropriately supported.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed to meet the fundamental standards of care and treatment.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Isle of Wight Trust (NHS 111)

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 a second CQC inspector and a NHS 111 specialist advisor.

Background to Isle of Wight Trust (NHS 111)

The Isle of Wight NHS Trust runs the NHS 111 service which covers the whole of the Isle of Wight and is contracted by one clinical commissioning group NHS Isle of Wight. NHS 111 service operates 24 hours a day 365 days a year. It is a telephone based service where people are assessed, given advice and directed to a local service that most appropriately meets their needs.

This is achieved following initial triage using NHS Pathways, where patients are signposted to the most appropriate professional through the use of a directory of services that includes all services provided on the Isle of Wight and all services nationally available. The service handles on average 74,000 calls per year.

Demographically average annual incomes are below the national levels and the majority of the island is rural. There is a high percentage of children living in poverty and one in four people are aged 65 years or over.

Further information can be found on the provider's website at www.iow.nhs.uk

The service is provided from which we visited a part of the inspection:

Ambulance Service

St Mary's Hospital,

Parkhurst Road,

Newport,

Isle of Wight,

PO30 5TG

Requires improvement

Are services safe?

Our findings

We rated the service as requires improvement for providing safe services, (at our previous inspection in March 2017, this domain was rated good).

The service was rated as requires improvement for providing safe services because:

- Not all staff had received training in adult and child safeguarding.
- There was limited resilience in staff numbers to enable appropriate support and supervision for staff and ensure the service was able to respond to emergency situations at all times.
- There were occasions where a clinician was not available to cover shifts this was outside of the terms of the NHS 111 license.

Safety systems and processes

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

- The Trust conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health and Safety policies, which were reviewed and communicated to staff. Staff received safety information from the Trust as part of their induction and refresher training. The Trust had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse, such as social services. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The Trust carried out where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff received safeguarding and safety training appropriate to their role, but this was not consistent. Training records for the Hub staff showed that 75% had completed adult safeguarding at level 1 and 21% had completed child safeguarding at level 2 (data supplied by the service for month ending January 2018). The Trust's guidance indicated that performance support officers (PSOs) should be trained to children level 3; clinical support workers (who worked on the clinical support desk (CSD)) and call handlers should be trained to child level 2. The safeguarding lead for the ambulance business unit said that they did not have protected time to fulfil the safeguarding lead role.
- Minutes from an Ambulance Urgent Care and Community and Management and Leadership meeting in December 2017 showed that plans would be made for level 2 safeguarding, but there were no details of who was leading on this action or timescales for completion.
- Staff were able to identify and report concerns. We saw staff had a clear awareness of how to identify concerning situations and respond appropriately. For example, terminated calls or background noise. We observed staff making a safeguarding referral following a call which raised concerns about safety. We noted that this situation was handled sensitively.
- The service ensured that equipment was safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- The NHS 111 Service used the Department of Health approved NHS Pathways system (a set of clinical assessment questions to manage telephone calls from patients). This was based on the symptoms they reported when they called. The tool enabled a specially designed clinical assessment to be carried out by a trained member of staff who answered the call. Once the clinical assessment was completed, a disposition outcome and a defined timescale were identified to prioritise the patient's needs. At the end of the assessment if an emergency ambulance was not required, an automatic search was carried out on the integrated Directory of Services, to locate an appropriate service in the patient's local area.

Requires improvement

Are services safe?

- Staff were able to access patient 'special notes' via their computer system to alert them to patients with, for example, pre-existing conditions or safety risks where the GP practice had submitted these notes on behalf of their patients. There were arrangements for planning and monitoring the number and mix of staff needed but these needed improvements. For example, suitable rest breaks were not planned for in line with health and safety requirements. For example, CSD staff were expected to work between 11pm and 8am without a rest break. There was no PSOs cover on site between midnight and 8am.
- A resourcing team who worked between 8am and 4pm were responsible for organising staff rotas. Outside of these hours it was the responsibility of PSOs to manage arrangements for covering sickness or other absence, this included covering the hospital switchboard if needed. During our site visit the PSO in charge of a shift had to find hospital switchboard cover for the following morning.
- PSOs said that they received the staff rotas from the resourcing team and had to check that they were properly filled with the correct skill mix. We saw copies of staff rotas and it was difficult to determine how many PSOs, CSD staff and call handlers should be working per shift. We requested information on hours worked, but this was not forthcoming. Staff reported than on occasion they had worked 10 weekends in a row and some had worked in excess of 72 hours in a week.
- The NHS 111 Service did not have any PSOs on site between the hours of midnight and 8am in the morning; cover between these times was provided by an on-call PSO. Current staffing levels meant that no PSO support could be provided on site at weekends until 1pm on Saturdays and Sundays.
- PSOs reported that they had to cover shifts instead of be able to concentrate on their substantive role which aimed at ensuring a safe service was provided; appraisals were carried out, along with daily performance supervision and reporting and overseeing statutory mandatory training. This left the service response weakened in the event of a significant incident. There was limited resilience for sickness absence and planned annual leave.
- PSOs said they usually planned to have four call handlers rostered to work to build in some resilience in the service. The minimum level to be safe and effective was three call handlers on shift. However, on occasion a call handler was taken off shift to cover the hospital switchboard. The NHS 111 service did not use a formal rostering programme to predict required staffing levels.
- Staff said cover for gaps in staff rotas for call handlers was reliant on the good will of staff undertaking overtime and bank work, as well as PSOs covering gaps in the rotas which could not be filled. Use of an ambulance dispatcher as a PSO reduced the number of available dispatchers who could work on 999 calls. PSOs also provided breaks for ambulance dispatchers, and without a PSO on duty dispatch staff could work for 12 hours without any rest breaks.
- The resourcing team also authorised annual leave requests. One member of staff requested annual leave for February 2018 in November and December 2017, despite emails from the PSO to the resource manager, this had not been confirmed. The member of staff had also requested leave in the summer of 2018. Eventually the leave for both periods was authorised, but the staff member had to adjust their requirements to fit around service needs,as there were insufficient numbers of staff available to allow equitable opportunities for leave.
- As part of the operating model for delivery of NHS 111 services it is imperative that the service complies with the clinician level requirements of the NHS Pathways system at all times. The NHS Pathways End User License Agreement stipulates that there must be at least one accredited clinician physically present for each shift of non-clinical advisors (call handlers).
- We received information where two incidents had been reported that this had not occurred. For example, on 19 January 2018, a clinician became ill on night duty and was no longer fit to work, as the staffing levels were set at one clinician for the night duty and there was no available cover. An ambulance care practitioner (CP) was taken off their duties and moved to the Hub to provide clinical cover; this left a shortfall in the number of CPs available to cover needs in the community. A report was completed on both these incidents for further review.

Requires improvement

Are services safe?

- Systems were in place for managing call backs from clinicians, where possible calls received by call handlers which needed further advice were warm transferred to a clinician, but when this was not possible, the call was put into a call back queue which was usually monitored by PSOs. However, increase in demand was managed by PSOs taking calls, which did not allow them to have oversight of all that was occurring in the Hub to make sure calls were answered in accordance with national requirements and the call queue was managed safely.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. Each desk had a folder with quick reference cards for staff to use if needed which cover topics such as sepsis and safeguarding.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- The service had adequate arrangements in place to respond to emergencies and major incidents. They had engaged with other services and commissioners in the development of its business continuity plan.
- There was a comprehensive business continuity plan in place for major incidents such as power failure or building damage, as well as those that may impact on staff such as a flu pandemic. The plan included emergency contact numbers for staff.
- The plan included arrangements for setting up temporary switchboards, moving the integrated care hub base and back-up systems for power and computer systems. These included use of paper based systems if needed. There were details on actions to be taken at various time stages of the disruption. For example, what actions were needed in the first hour, then in the next 24-48 hours and if needed up to five days disruption. These were set out on 'grab' sheets which were clear and had relevant contact details.
- In the event of the telephone systems being disrupted then there were procedures in place to re-route NHS 111 calls. Computer systems were able to be accessed remotely and there were laptops which had been loaded with the NHS Pathways and access to the NHS Pathways paper based back up system. This would allow staff to continue to work.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

We rated the service as requires improvement for providing effective services, (at our previous inspection in March 2017, this domain was rated good).

The service was rated as requires improvement for providing effective services because:

- The NHS 111 service did not consistently meet expected targets on calls handling and response times. There was limited action taken to improve performance.
- Records for the ambulance service clinical business unit showed that there were shortfalls in meeting the training targets set by the Trust for safeguarding and the Mental Capacity Act 2005.
- Learning needs of staff were usually identified through a system of appraisals, meetings and reviews of service development needs. At the time of inspection 49% of appraisals for all staff who worked in the hub had been completed.

Effective needs assessment, care and treatment

Telephone assessments were carried out using a defined operating model.

- The NHS 111 service used the Department of Health approved NHS Pathways system (a set of clinical assessment questions to manage telephone calls from patients). The tool enabled a specially designed clinical assessment to be carried out by a trained member of staff who recorded the patients' symptoms during the call. When a clinical assessment had been completed, a disposition outcome (i.e. what the patient needed next for the care of their condition) and a defined timescale was identified to prioritise the patients' needs.
- We saw evidence that all call advisors had completed a mandatory training programme to become licensed users of the NHS Pathways programme. Once training was completed, call advisors became subject to call quality monitoring against a set of criteria such as active listening, effective communication and skilled use of the NHS Pathways functionality.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Data showed that between December 2016 and November 2017 calls closed following clinical advice only averaged between 17.6% and 23.8%, which was below the target of 50%. This was an indicator of how clinicians were being used in the NHS 111 service and potential impact on other services such as accident and emergency.
- The NHS 111 service had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.
- There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans/guidance/ protocols were in place to provide the appropriate support. We saw no evidence of discrimination when making care and treatment decisions.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.

It is a condition of the NHS Pathways user licence and a National Quality Requirement for NHS 111 services that the Trust must regularly audit a random sample of patient contacts. The sample must include enough data to review the performance of all staff that provides care. The NHS 111 service had two auditors whose role was to audit calls and ensure the applicable standards were maintained.

- Calls were randomly selected and the auditors listened and scored how the call handler managed the call. The system for audits was set out so that staff in their probationary period were subject to five audits for a period of six months, where the achievement needed to be a pass of 86% or above. After probation this reduces to four per month, as long as staff continued to achieve an average of 86% or above. Members of staff who consistently achieved 94% or above had their audits reduced to three per month. When targets were no achieved, the rate of audits increased and feedback was

provided face to face and via email, rather than via email only. Any learning or development needs were identified and additional support provided to enable staff to meet the expected targets.

- The non-clinical call auditors also identified trends of 'common fails' such as not giving all care advice and not giving information on if a patient's condition worsened. These were then highlighted to all staff via meetings and newsletters to be aware of.
- There were also clinical auditors who monitored clinicians' call handling. The structure for the number of audits was the same as for non-clinical audits. Learning from these audits was also shared with staff when relevant. For example: there were issues around a patient who called with pain in their back, which could have been due to a number of causes such as chest pain or a urinary tract infection. The call handler did not probe deeply enough to select the relevant pathway and it resulted in a disposition for the patient to attend accident and emergency. The call handler had not used the information the patient gave about a potential urinary tract infection and had not sought advice from a clinician before selecting a pathway to follow.
- The disposition had not been verified by a clinician as needed and the patient would not have been able to get to the hospital without support from others, due to their age. Learning points included checking and verifying with the clinical support desk that the disposition was appropriate and the patient was able to get to where they needed to be.

Monitoring care and treatment

Performance support officers (PSO) managed the call centre on a daily basis and were responsible for monitoring call performance. Call advisors and clinicians performance was also monitored through appraisals, review of significant events and meeting requirements for ongoing training.

Clinicians were able to listen into calls if needed and provide advice during the call. When required the call was transferred to a clinician for further triage, as a 'warm transfer', when this was not possible the call was placed into a call back queue which was monitored. This queue was assessed and some calls were prioritised to receive a prioritised clinician call back.

For NHS 111 Providers of NHS 111 services are required to submit call data every month to NHS England by way of the Minimum Data Set (MDS). The MDS is used to show the efficiency and effectiveness of NHS 111 providers.

The NHS 111 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 NHS 111 service had established its performance monitoring arrangements and reviewed its performance each day; weekly and monthly, as well as reviewing real time calls. The NHS 111 service had a real-time wallboard in the Hub which showed call volumes and alerts of incoming calls.

A situation report was sent to NHS England and the clinical commissioning group, on a weekly basis which recorded details of how many calls were received; dispositions made; length of call time and whether call backs had been made within 10 minutes when needed.

Data showed for the period from March to December 2017:

- The average percentage of calls answered within 60 seconds of the number of calls answered ranged between 86.10% and 95.68%, with the target of 95% being achieved for one month out of the ten month period. The average over the year was 91.22%, which was lower than the previous year's total average of 94.44%. We discussed this with PSOs who were aware of the decline and had reported this to their managers but no action had been taken.
- The percentage of calls abandoned (after waiting 30 seconds) ranged between 2.12% and 5.94%; the target of less than 5% was achieved in eight out of the ten month period. The average for the year was 3.73%.
- The NHS 111 service had low numbers of calls where a call back within 10 minutes was required. Figures showed that 0.8% to 1.4% of callers required a call back from a clinician. However, the average of the number of calls which were made within the recommended time of 10 minutes was 36.33%.
- Average performance figures from March to December 2017 showed that the NHS 111 service was not consistently meeting standards for 'warm transfers' with a range of 92.84% to 95.65% of call identified being

transferred (the standard expected is more than 95%). This gave an overall yearly average for 2017 of 94.83%, with the target not being achieved in five out of the ten month period.

Real-time data seen during the inspection on 24 and 25 January 2017 showed:

- 24 January 2018 at 6.15pm: 141 calls answered, nine calls were lost; the longest wait time seven minutes and four seconds. A total of 60 seconds 97.87% calls were answered within 60 seconds and 2% of calls were abandoned.
- 25 January 2018 at 10.20am: 44 answered, two calls were lost; the longest wait time was four minutes and 36 seconds. A total of 86.36% of calls were answered within 60 seconds.
- There were areas where the NHS 111 service was outside of the target range for an indicator. The NHS 111 service was aware of these areas, but there was limited evidence to demonstrate that issues were being effectively managed. Reasons for shortfalls included staff turnover and the need to train new members of staff; and a lack of clear roles and responsibilities to enable performance support officers to effectively have an oversight of calls received.

Effective staffing

The NHS 111 Service had a total of six performance support officer posts. At the time of the inspection two of these posts were vacant, two newly recruited PSOs had been seconded to work on a new computer aided dispatch system which we were informed was due to be implemented in April 2018. This left two permanent PSOs who were supported by an ambulance dispatcher who was acting up into the PSO role.

The service told us that since this inspection they have managed to recruit two additional dispatchers and an additional performance support officer above the current establishment and the service is now meeting national standards. They also considered that periods of sickness and call handlers leaving had affected the performance figures.

- The operational manager and service delivery manager were aware of performance figures not achieving set targets and they wanted to be able to work proactively and introduce structure and creation of teams to support, supervise and manage staff and improve performance. At the time of the inspection these plans could not be realised due to shortfalls in staff resources. These concerns had been reported to senior managers.
- All call advisors had completed a mandatory training programme to become licensed users of the NHS Pathways programme. Once training was completed, call advisors became subject to call quality monitoring against a set of criteria such as active listening, effective communication and skilled use of the NHS Pathways functionality to maintain their license.
- The Trust had an induction programme for all newly appointed staff and ongoing mandatory and role specific training. The induction training covered topics such as use of display screen equipment; fire safety; information governance; and safeguarding adults and children.
- Staff were expected to receive mandatory training that included: use of the clinical pathway tools, the Mental Capacity Act 2005, safeguarding and fire procedures. Staff had access to and made use of e-learning training modules and in-house training. Records for the ambulance service clinical business unit, where the NHS 111 service sits, showed that there were shortfalls in meeting the training targets set by the Trust for safeguarding and the Mental Capacity Act 2005.
- Learning needs of staff were usually identified through a system of appraisals, meetings and reviews of NHS 111 service development needs. At the time of inspection 49% of appraisals for all staff who worked in the hub had been completed.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together, and worked with other organisations to deliver effective care and treatment.

- The NHS 111 service used a system called Adastra, which is a clinical patient management system designed to manage episodes of care quickly and safely. The entire patients' journey could be measured and analysed from the initial telephone call, through to internal and external referral to another service. The system with the patient's consent, automatically sent

Requires improvement

Are services effective?

(for example, treatment is effective)

details of patient contact with the NHS 111 service to the GP practice they were registered with. This system was also used by the out of hours service and the 999 service which enabled effective communication and access to patient records.

- Call handlers were trained to manage 999 calls and this enabled close working between the teams.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The NHS 111 service was not able to book appointments directly with a patient's GP, but would contact the practice to alert them of a patient's needs. Where patients needed to be assessed by the out of hours GP service, the NHS 111 service would send information to specific queue within those services for follow up. 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.
- Protocols were in place between the ambulance service, hospital consultants and doctors in the A & E department, to assist the NHS 111 service to arrange the most suitable disposition. For example, patients with long term catheters or who were receiving chemotherapy could be referred to the paramedic team, who were able to administer intravenous antibiotics in the community, prior to a hospital transfer.
- The NHS 111 service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances. There were arrangements in place to work with social care services including information sharing arrangements. A range of health professionals were able to access patient notes and record information in them. These included the Palliative Care team; district nurses; and the CRISIS team who provided 72 hour care at home to minimise inappropriate hospital admissions. Staff worked with other services to ensure people received co-ordinated care.
- There were clear and effective arrangements for transfers to other services, and dispatching ambulances for people that require them.
- Issues with the Directory of Services were resolved in a timely manner.

Consent to care and treatment

Staff sought patients' consent in line with legislation and guidance.

- The message greeting callers for the NHS 111 service alerted that continuing with the call showed that they gave consent. When needed consent was also recorded on the computer system, for example when passing the call to a clinician or the caller was not the patient.
- Access to patient medical information was in line with the patient's consent.
- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The NHS 111 service monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the service as good for providing caring services; previous rating in March 2017 was also good.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- We observed members of staff were courteous and very helpful to people calling the NHS 111 service and treated them with dignity and respect.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients. 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.
- The NHS 111 service gave patients timely support and information. Call handlers gave people who phoned into the NHS 111 service clear information. 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.

Involvement in decisions about care and treatment

- Call handlers and clinical advisors were confident in navigating through the NHS Pathways programme and the patient was involved and supported to answer questions thoroughly. The final disposition (outcome) of the clinical assessment was explained to the patient and agreement sought that this was appropriate. In all cases patients were given advice about what to do should their condition change or deteriorate.
- Care plans, where in place, informed the NHS 111 service's response to people's needs, though 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.
- Staff were trained to respond to callers who may be distressed, anxious or confused. Staff were able to describe to us how they would respond and we saw evidence of this during our visit. Staff would adapt questions to enable patients to understand what information they were being asked for. Staff handled calls sensitively and with empathy and compassion. 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. This included care plans and special notes.
- There were established pathways for staff to follow to ensure callers were referred to other services for support as required.
- There was a system in place to identify frequent callers and care plans/guidance/protocols were in place to provide the appropriate support. There were also systems in place to respond to calls from children/ young people.
- The NHS 111 service worked with the local Healthwatch organisation to gather views on patient experience and shared information about complaints they had received to improve patient experience. There was a section on the Trust's website which allowed patients to give feedback specifically on the NHS 111 Service. We found there was limited information available through these sources, as the nature of the NHS 111 service was time and issue specific. We found there was also limited information available via the GP National Patient Survey and the Family and Friends Test (FFT).

Privacy and dignity

The NHS 111 service respected and promoted patients' privacy and dignity.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions.
- The NHS 111 service monitored the process for seeking consent appropriately.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the service as good for providing responsive services; previous rating in March 2017 was also good.

Responding to and meeting people's needs

The NHS 111 service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The NHS 111 service understood the needs of its population and tailored services in response to those needs. The NHS 111 service had a system in place that alerted staff to any specific safety or clinical needs of a person using the NHS 111 service. For example, those receiving palliative care or chemotherapy.
- The NHS 111 service engaged with commissioners to secure improvements to services where these were identified. The NHS 111 service provided reports to the clinical commissioning group, these covered operational and clinical performance activity, serious incidents, complaints, outcomes of investigations and patient feedback. We also viewed minutes of public board meetings where the wider community could gain an understanding of how the NHS 111 service was responding to patients' needs.
- The NHS 111 service made reasonable adjustments when people found it hard to access the service. There were translation services available. The NHS 111 service had in place arrangements to support people who could not hear or communicate verbally, such as text talk, a telephone system which allowed communication via written messages.

Timely access to the service

- Patients were able to access care and treatment at a time to suit them. The NHS 111 service operated 24 hours a day, 365 days a year. The NHS 111 service took account of differing levels in demand when planning services. Nationally recognised times of increased activity to the NHS 111 Service included weekday mornings between 7am and 8am; weekday evening between 6pm and 9.30pm and the 24 hour period on weekends and bank holidays. Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- We saw the most recent National Quality requirement results for the NHS 111 service January 2017 to January 2018 which showed the NHS 111 service was meeting the following indicators:
- People had timely access to advice, including from a call handler or clinical advisor when appropriate. Data showed that the NHS 111 service did not consistently achieve the required standards, for example yearly averages for warm transfers was 94.15%, which is below the target of 95%; and the number of calls answered within 60 seconds averaged 91.22% against a target of 95%.
- Action was taken to minimise the number of calls that were abandoned by the caller. The average figure for the year was 3.73% of call abandoned. Average figures over the preceding three months prior to the inspection showed that call abandonment rates were consistently within the target of less than 5%, with the averages ranging from 2.12% to 4.81%.
- Referrals and transfers to other services were undertaken in a timely way. Details of patients who had contacted the NHS 111 service were sent to their GP by 8am the following morning and referrals to other services such as social services were made via secure information systems. The Isle of Wight health and social care services used the same computer software systems, which enabled timely communication and allowed all services to access patient information once consent had been gained from patients.

Listening and learning from concerns and complaints

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Six complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.
- The NHS 111 service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. , concerns were raised about the NHS 111 service response to a call about a child. The call handler apparently had a dismissive manner and said it was not

Good

Are services responsive to people's needs?

(for example, to feedback?)

a matter for the accident and emergency department. The NHS 111 service investigated the complaint, which included auditing the call with the call handler present.

The NHS 111 service fully upheld the complaint and apologise.Learning was shared with the call handler and clinical advisor involved in the incident in a one to one session and cascaded to all staff via the staff newsletter.

Are services well-led?

Inadequate

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

Our findings

We rated the service as inadequate for leadership; this domain was rated as requires improvement at our previous inspection in March 2017.

The service was rated as inadequate for providing well led services because:

- There was a lack of stable leadership team for the ambulance service, which was responsible for the NHS 111 Service. There was representation of ambulance services at board level but limited information to demonstrate oversight of NHS 111. The trust did not have a succession plan for the development of new leaders.
- At this inspection staff raised concerns about the number of managers in interim roles and their ability to make decisions.
- Staff reported that more senior managers, not involved directly with the daily management of the NHS 111 service were not always visible. They were not confident these managers were aware of risks to the service provided, such as concerns around the resourcing system for planning shifts.
- Systems for capturing patient views on the service provided, had not been actioned.
- Staff surveys were completed, but there was limited evidence to show that concerns were being acted upon and resolved.
- Responses to whether staff considered they were well supported had worsened.
- Service performance was discussed at senior management and board level but limited action was taken to improve achievement against national targets. Since the inspection the service had recruited more staff following a presentation of a business case to the board.
- Delays in clarifying leader's roles and responsibilities had led to staff not feeling appropriately supported.

Leadership capacity and capability

Operational leaders responsible for the NHS 111 service had the capacity and skills to deliver the service strategy and address risks to it.

- Operational leaders were they were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them within the scope of their roles and responsibilities.
- Staff said they were respected, supported and valued by their immediate line managers, but did not consider that more seniors managers were supportive. We were told about constraints and potentially unnecessary delays in getting supplies or implementing changes. Such as when an operational manager was contacted whilst they were not working to authorise an order for a printer cartridge. Staff said they were not consistently empowered to carry out their duties.
- Staff reported that line managers 'walked the floor' and they were approachable.
- Performance support officers were accessible throughout the operational period, with an effective on-call system that staff were able to use. However, performance support officers who oversaw the daily management of the hub were overstretched. We observed that the performance support officer role included - first line management, appraisal, sickness management long and short term, probationary reviews, facilitating pathways training and dispatch cover. Covering the dispatch role was not in the performance support officer job description.
- Call handlers did not have an assigned manager but were managed by the performance support officer on duty that day. This resulted in a lack of cohesive teams within the control room. The operation manager was considering the benefits of implementing a team approach although discussions with the wider staff group had not yet taken place.

Vision and strategy

The vision and strategy linked with the Isle of Wight's 'My life, a full life' plan for health and social care on the island.

- The NHS 111 service had a strategy and supporting business plans that reflected the vision and values.
- The NHS 111 service developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. Staff told

Are services well-led?

Inadequate

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

us there were barriers to improvement and full implementation of the vision and values. They considered progress had not been made due to staff being in interim roles, which had only been substantiated in the past few months. They considered that this had been a barrier to make improvement.

- The strategy was in line with health and social priorities across the region. The NHS 111 service planned the service to meet the needs of the local population.
- The NHS 111 service monitored progress against delivery of the strategy.

Culture

The NHS 111 service aimed for a culture of high-quality sustainable care.

- Openness, honesty and transparency in the service were demonstrated when responding to incidents and complaints.
- Staff were able to access occupational health services and a confidential telephone counselling service. However, on occasions staff shortages led to staff taking calls not receiving appropriate support after they had dealt with a difficult calls.
- We saw evidence of staff survey results from January 2017 and January 2018. Comments included concerns or issues not being resolved and communicated to staff; staff being unaware whether any action had been taken; and having to make repeated attempts to get concerns acted upon, with no changes being made.
- Both surveys highlighted staffing as an issue and considered they were working with the minimum numbers, leading to a lack of resilience when there was sickness, which resulted in longer working hours. Staff also reported through surveys and to the inspection team that when they raised any questions about the resourcing and rota management team, they considered they were penalised and were given a poor rota pattern in their view and had holiday declined.
- Staff reported concerns about bullying within the organisation. This had been identified in a full staff survey undertaken by the Trust and was also reflected in the NHS 111 service surveys we looked at. The Trust had introduced systems for staff to be able to report bullying as a result of their survey, but some staff reported that they considered that staff had been de-sensitised to behaviours which were not acceptable.
- We requested any action plans that the NHS 111 service had put into place to address staff views, but these were not provided.
- There were processes for providing all staff with the development they need, but this was not consistent. A total of 49% of staff in the Hub had received an appraisal, which limited their opportunity to discuss training needs linked to their professional development. There was no clear plan in place to demonstrate that all staff would receive an appraisal yearly.

Governance arrangements

The Trust had an overarching governance framework for NHS 111 services to support the delivery of the strategy and service. This outlined the processes and procedures and there were reporting structures in place, from operational front line reports on performance, through senior management meetings and business meetings to board level. However, there were shortfalls in roles and responsibilities and clear lines of communication with more senior managers and the Trust board.

- Communication needed to be improved in order that staff could be assured by the Trust Board that there was a comprehensive understanding of performance and priority was given to sustaining performance.
- Managers who were responsible for day to day management were aware of their responsibilities and what changes they were able to influence and deliver, but felt they were not consistently supported by the Trust Board. The Trust board was made aware of concerns about areas such as staffing and whether targets had been met, but had not acted fully on staff comments about the provision of the NHS 111 Service and the underperformance in achieving expected targets for service provision.
- NHS 111 Service specific policies were implemented and were available to all staff. Staff were able to access Standard Operational Procedures on their computer and we found these were regularly reviewed and updated.

Are services well-led?

Inadequate

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

- Systems were in place for identifying, recording and managing risks. Processes were in place to implement mitigating actions. The NHS 111 service had a risk register which was used to capture this information and monitor actions taken, however progress could be delayed by organisational protocols which needed to be followed, for example confirming substantive posts in the organisation.
- Monthly clinical governance and performance reports were produced and included statistical data related to call activities, audits and trends. Actions to address any performance issues were highlighted and monitored through contract meetings with commissioners of the service.
- Learning from complaints and significant events were shared throughout the NHS 111 service.
- There were systems in place to ensure data was accurate and timely. These included daily, weekly and monthly performance reports which were shared internally with the Trust Board and externally with the clinical commissioning group and NHS England.
- Operational staff knew who to go to in the service for guidance and support. They were clear about their line management arrangements as well as the clinical governance arrangements in place. There were a range of mechanisms to cascade information, which included a 'Don't Trip Up' short focussed newsletter to highlight tips, reminders, information and probing. Staff meetings were held regularly in the Hub and minuted. However, they were not confident that concerns they reported would be fully acted upon by the Trust.

Managing risks, issues and performance

Systems in place for managing risks, issues and performance needed improvement.

- The performance support officer (PSO) role was an essential role to the provision of a safe and well performing service.They had a significant role in the Trust's major incident plan. There were also concerns that due to the secondment of performance support officers there were insufficient PSOs available to oversee the NHS 111 service effectively on a daily basis. This had delayed plans to develop the NHS 111 service to ensure clarity in leader's roles and responsibilities and suitable support, such as designated supervisors being identified for call handlers
- There were processes in place to identify, understand, monitor and address current and future risks including risks to patient safety. These were not fully embedded into the overall governance structure. For example, staff reported that more senior managers, not involved directly with the daily management of the NHS 111 service were not always visible. They were not confident these managers were aware of risks to the service provided, such as concerns around the resourcing system for planning shifts.
- Issues and concerns were reported through the appropriate channels to the Trust board, but staff considered there was a lack of action and response to these concerns. For example, a report had been produced which highlight constraints on staffing levels and the NHS 111 service operating with minimal staffing levels, which did not allow sufficient resilience and had contributed to staff working excessive hours in a week. The resource team allocated hours over a monthly period, but did not take account of actual hours planned for in a week.
- The service told us that since this inspection they have managed to recruit two additional dispatchers and an additional performance support officer above the current establishment and the service is now meeting national standards.
- Operational leaders also had a good understanding of NHS 111 service performance against the national and local key performance indicators. This performance was discussed at senior management and board level. However, minutes of board meetings showed that the NHS 111 service was not discussed in detail, in particular reporting on achieving targets, was described as improving, when the figures showed that the NHS 111 service consistently did not meet expected levels.
- There were shortfalls in facilities and premises for the services delivered. Staff reported that there were broken chairs and the layout of the room was poor; IT systems were slow; and the air conditioning units were not clean.
- The Trust had plans in place and had trained staff for major incidents.

Are services well-led?

Inadequate

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

Engagement with patients, the public, staff and external partners

The NHS 111 service was open to receiving complaints although rarely had any feedback on those service although information was provided to callers so that complaints or compliments would be made via their website; in writing; or verbally on the telephone.

We found there was limited information available via the GP National Patient Survey and the Family and Friends Test (FFT). The latest FFT response in July 2017 showed there were no comments on the NHS 111 service.

At our inspection in March 2017, the NHS 111 service was reviewing how they could capture patient feedback in the future. They informed us that they were redesigning a patient survey, which could be access via digital means; there had been no progress on this work.

Staff were able to describe to us the systems in place to give feedback. These included surveys; appraisals; and formal or informal meetings. We were told that although regular meetings were planned, these could be cancelled at short notice. We saw evidence of staff survey results from January 2017 and January 2018. We noted there similar concerns in each of the surveys, for examples, concerns over inadequate staffing levels and more specific clinical training in addition to the required Pathways training.

Responses to whether staff considered they were well supported had worsened. For example, results from January 2017 showed staff considered they were supported, but this was dependant on who else was on shift and times management teams were not able to do what was needed was compromised. In January 2018, staff reported they considered they were not supported fully, for example when PSOs had to cover the ambulance dispatch desk.

The service had staff groups meeting, which enable representatives to discuss with their managers concerns or issues they may have in a safe manner. Staff reported they were aware of the meetings and had contributed to them.

Continuous improvement and innovation

There were shortfalls in the systems and processes for learning, continuous improvement and innovation.

- Staff were not confident that improvements would be made and sustained; such as ensuring the management roles were clear.
- The Trust had produced a booklet related to how they would address shortfalls across the whole of the Trust, but there was no information on the NHS 111 service.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **How the regulation was not being met** The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • Systems for capturing patient views on the service provided had not been actioned. • Staff surveys were completed, but there was limited evidence to show that concerns were being acted upon and resolved. • Service performance was discussed at senior management and board level but limited action was taken to improve achievement against national targets. • Performance support officers' reported that they had to cover shifts instead of being able to concentrate on their substantive role which aimed at ensuring a safe service was provided. This left the service response weakened in the event of a significant incident. • There was limited resilience for sickness absence and planned annual leave.

This section is primarily information for the provider

Requirement notices

- A report had been produced which highlight constraints on staffing levels and the service operating with minimal staffing levels, which did not allow sufficient resilience and had contributed to staff working excessive hours in a week.

Regulation 17(1)

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Requirements in relation to staffing **How the regulation was not being met** The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • Records for the ambulance service clinical business unit showed that there were shortfalls in meeting the training targets set by the provider for safeguarding and the Mental Capacity Act 2005. Minutes from an Ambulance Urgent Care and Community and Management and Leadership meeting in December 2017 showed that plans would be made for level 2 safeguarding, but there were no details of who was leading on this action or timescales for completion. • Leaning needs of staff were usually identified through a system of appraisals, meetings and reviews of service development needs. At the time of inspection 49% of appraisals for all staff who worked in the hub had been completed. • **Regulation 18(2)**