Hanover House

Quality Report

78 Coombe Road
Kingston-Upon-Thames
Surrey
KT2 7AZ
Tel: 0191 229 7545

Date of inspection visit: 27 July 2017
Date of publication: 10/11/2017

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?	**Requires improvement**
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 this announced comprehensive inspection of Hanover House NHS 111 on 27 and 28 July 2017. Hanover House NHS 111 is a 24 hours a day telephone based service where people are assessed, given advice or directed to a local service that most appropriately meets their needs. For example, this could be to their GP, an out-of-hours GP service, walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, late opening pharmacy, or self-care home management advice.

Overall the service is rated as good. However, we found the service requires improvement for providing effective services.

Our key findings were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events. However, learning from these issues was not shared with all staff.
- The service had reliable systems and processes in place to ensure that patients were safe.
- Staff reported that the London office in particular was understaffed and that at busy times overall capacity was stretched. At the time of the inspection the provider was recruiting to address this.
- Staff were supported in the effective use of NHS Pathways which is a triage software utilised by the National Health Service to triage public telephone calls for medical care and emergency medical services.
- The service had not met all the National Quality Reporting standards and those requirements set by the commissioners of the service. For example, the service had not met the standard for calls answered inside 60 seconds in any of the six months prior to the inspection.
- Calls were audited to ensure that a high quality of service was being provided.
- We observed and listened to calls which demonstrated that people experienced a service that was delivered by dedicated, knowledgeable and caring staff.
- The service had a clear system for managing and learning from complaints, although learning from this was not widely shared among all staff.
- The service had an overarching governance framework in place, including policies and protocols which had been developed at a provider level and had been adapted to meet the needs of the service locally.

Summary of findings

- The provider had a good understanding of the performance of the service. The service was not meeting one target set by National Quality Requirements action plan was in place to address this.
- The service had also built relationships with local patient participation forums at a regional level in order that patients could feed into the service being provided.
- The provider was aware of the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. Systems were in place for notifiable safety incidents however the arrangements to ensure this information was shared with staff to ensure appropriate action was taken were inconsistent.

Importantly, the provider must:

- Develop effective systems and processes to ensure that staffing levels are sufficient to ensure safe care and treatment

In addition the provider should

- Ensure learning from significant events and complaints is being shared with all relevant staff.
- Ensure that the service meets national targets.
- Ensure that all responses to complainants are managed within the services specified 30 day deadline.

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:

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses.Significant events were managed but learning was not shared with all relevant staff.
- Risks to people who used services were assessed to keep people safe.
- Staff took action to safeguard people and were aware of the process to make safeguarding referrals.
- Clinical advice and support was readily available to call advisors when needed.
- The provider was not able to staff the service to the level that it had designated ascomplement at the time of the inspection. We were told that recruitment processes were ongoing.
- The service had systems in place to ensure continuation of service in the event of an emergency.

Are services effective?

Requires improvement

The provider is rated as requires improvement for providing effective services and improvements must be made.

- The service had not met all the National Minimum Data Set and Local Quality requirements for example, failure to achieve the percentage of calls answered within the 60 second time period. The service had worked closely with its commissioners to address this.
- Staff were trained to ensure safe and effective use of NHS Pathways, but in some areas staff appeared not to have completed the provider's mandatory training.
- Daily, weekly and monthly monitoring and analysis of the service performance was measured against key performance targets and shared with the clinical commissioning group (CCG) members. Account was also taken of the ranges in performance in any one time period.
- Staff received annual appraisals and personal development plans were in place; call advisors had the skills, knowledge and experience to perform their role.
- Staff ensured 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.

Summary of findings

- Patient's clinical records were well managed, and, where different care records existed, such as special notes, information was coordinated.
- Staff used the Directory of Services (which was an online directory of local services with information about opening hours) to direct people to the appropriate services.

Are services caring?

Good

The provider is rated as good for providing caring services.

- People using the service were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We observed this in practice when call handlers were speaking to patients.
- Surveys undertaken by the service showed that patient satisfaction levels were generally high.
- The service attended meetings with patient representatives in the South West London area to better enable them to elicit patient feedback.
- Systems were in place to manage patients where they did not agree with a recommendation made by the service.

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, although there were some gaps in rotas while the service was continuing to recruit.
- There was a comprehensive complaint system and all complaints were risk assessed and investigated appropriately. There was a designated person and team responsible for handling complaints. However, learning from complaints was not consistently shared with staff.
- Action was taken to improve service delivery where gaps were identified.
- Care and treatment was coordinated with other services or providers.
- Staff were alerted, through their computer system, to people with identified specific clinical needs and special notes or any safety issues relating to a patient.
- The service engaged with the clinical commissioning group to review performance, agree strategies to improve the service provided.

Summary of findings

Are services well-led?

Good

The provider is rated as good for being well led:

- There was a clear leadership structure in place, although at the time of the inspection several senior positions were vacant.
- The service had an overarching governance framework in place, including policies and protocols which had been developed at a provider level and had been adapted to meet the needs of the service locally.
- The provider had a good understanding of the performance of the service. In one area the service was not meeting targets set by National Quality Requirements or the commissioner of the service, an action plan was in place to address these areas.
- The service had systems in place to learn from incidents and complaints but these were not shared with all staff.
- The service had also built relationships with local patient participation forums at a regional level in order that patients could feed into the service being provided.

Hanover House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a lead CQC Inspector. The team included two further CQC inspectors, a GP specialist adviser and a service manager specialist adviser.

Background to Hanover House

Hanover House is the base hub for the 24 hour NHS 111 service for South West London covering the boroughs of Wandsworth, Merton, Sutton, Kingston, Richmond and Croydon. The provider is Vocare who have responsibility for several NHS 111, out of hours and urgent care services throughout the UK, and they have managed this service since September 2016. The service is co-located with the hub base for the out of hours service for these areas, although this service is delivered by a separate provider. The service serves a population of over 1,500,000 patients.

Although the main hub site is in London, services from two addresses. The first is 78 Coombe Road, Kingston-Upon-Thames, Surrey, KT2 7AZ. There is a call centre at this site which currently takes approximately 35% of calls and local management for the service is based at this centre. Further services are provided from Vocare House, Baliol Business Park, Newcastle-Upon-Tyne, NE12 8EW. The senior management of Vocare are based at this site, as well as 65% of the call handlers. The provider are currently increasing the number of staff, and as a consequence the proportion of calls taken, at the Hanover House site.

The service covers a large urban area, with large populations of both high and low deprivation. The population of South West London includes a large number of different nationalities and there are substantial populations of patients from ethnic minorities.

A Regional Director and Assistant Group Operations Director currently have responsibility for the service as a Head of Operations post is currently vacant. The service has a Clinical Support Manager and there are Operations Managers in both the London and Newcastle Offices. There is a lead Pathways trainer for all operational staff. The operational teams are led by 11 team leaders in both the London and Newcastle offices, each of whom have responsibility for a shift team.

There are 24.46 WTE (whole time equivalent) clinical advisors for the service, and 51.52 WTE call advisors. There are also 1.20 WTE pharmacy advisors.

The service manages between 27,000 and 33,000 calls per calendar month depending on the time of year. This is equivalent to approximately 1,000 calls per day.

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.

Detailed findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the NHS 111 service and asked other organisations such as the clinical commissioning groups (CCGs), who contracted the service, to share what they knew about the service. We also reviewed the information which the provider submitted before our visit as well as other information which was in the public domain.

We carried out an announced inspection to Hanover House on 27 and 28 July 2017. We were unable to speak directly with people who used the service.

During our visit we:

- Visited the call centres in both Newcastle and London.
- Observed call advisors and clinicians carrying out their role at both locations during periods of peak activity.
- Spoke with a range of clinical and non- clinical staff, such as; call advisors, clinicians, team managers, clinical supervisors, clinical and non-clinical coaches, senior managers, a lead trainer which included NHS Pathways training, and the clinical governance team.
- Reviewed NHS Pathways, Directory of Services (DoS) details and other documentation related to the running of the service.

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

Good

Are services safe?

Our findings

Safe track record

There was a system in place for the reporting and recording of significant events

- Significant events which met the threshold for a Serious Incident or Never Event were declared and investigated in accordance with the NHS England Serious Incident Framework 2015. The service reported all incidents to the commissioner in a monthly report and forums were in place where specific issues were shared. All incidents were shared, and the service had designated four incidents as serious or never events since the service commenced in September 2016. These incidents were categorised and were shared with third party organisations where required. In two incidents that we looked at following patients deaths we saw that investigations were undertaken (with third party providers where appropriate) and that both individual and organisational actions were taken, including those to protect patient safety, where necessary.
- Staff told us they would inform the team leader of any incidents or concerns and there was a recording form available on the provider's computer system for staff to record incidents. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that service/provider of services must follow when things go wrong with care and treatment).

The service had limited meetings in place where incident reports and patient safety reports could be discussed. The service had developed a weekly newsletter which contained updates on how to raise incidents to ensure that they were accurately captured. There was information to show that some learning from significant events was being shared with clinical staff including locums. However, there was limited evidence that such information was being formally shared with all staff to ensure that safety could be improved.

Reliable safety systems and processes and practices

The service had systems and processes in place to keep people who used the service safe and safeguarded from abuse. This included:

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were required to be trained to child protection or child safeguarding level three and call handlers to level two.
- We saw from records provided by Vocare that the service made a number of safeguarding referrals commensurate with a service of this size.
- All calls with a safeguarding concern were "warm transferred" (a direct call transfer where the caller was kept on the telephone) to a clinician to progress the issue.

The area in which calls were taken contained a number of noticeboards which advised staff of the following:

- A noticeboard containing relevant immediate issues and hot topics.
- A noticeboard positioned next to call handlers that contained all relevant information about tertiary healthcare suppliers to whom NHS 111 might refer, plus information relevant to serious events and safeguarding. There was also information relating to mental health illness and issues relating to the Mental Capacity Act.
- There were prominent screens detailing how the service was performing in line with targets, such as the speed at which calls were answered and abandoned calls.

The service had systems and processes in place to ensure that calls were managed in line with NHS 111 best practice. This included:

- Call advisors triaged patient calls by use of a clinical decision support system (NHS Pathways). This guided the call advisor to assess the patient based on the symptoms they reported when they called. Supporting this clinical decision tool was the directory of services (DoS) which identified appropriate services for the patient's care. Staff confirmed they received comprehensive training and regular six monthly

updates on the NHS Pathways. There was also training in place for times when Pathways was updated and staff needed to show that they had completed this training in order to be allowed to use it. (NHS Pathways is a triage software utilised by the National Health Service to triage public telephone calls for medical care and emergency medical services).

- Clinical advice and support was readily available to staff when needed. Staff told us the team leaders and clinical advisors offered support. Staff had access to special patient notes and care plans, which included supporting information on people identified as frequent callers and those on end of life pathways.
- At the point that the call was received a patient record was established detailing all relevant information about the patient.
- Call advisors and clinicians also had direct access to a supervisor for support or advice if needed during a call through their telephony system.
- 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.
- Call response times, waiting times, abandoned call data were closely monitored throughout each shift and staff were deployed to manage demand at peak times. Team leaders had oversight of call types and these were triaged to ensure that those callers with more urgent needs were prioritised to ensure patient safety. Performance against these targets was collected and reported to the commissioners on a monthly basis.

Staffing

We reviewed staff records and spoke to recruiting managers and staff and found the following:

- We saw that recruitment checks had been completed for staff and that they had completed other relevant checks, for example those for the Disclosure and Barring Service.
- The organisation had a high use of locums, particularly among clinical staff with a rate of approximately 40% in the last three months. We saw recruitment documentation had been sought and obtained for agency locum clinical staff from the agency that provided the staff. This allowed the service to closely monitor training and continuous professional registration of locum staff.
- Individual members of staff told us that there were insufficient staffing at the service. We noted that notwithstanding the use of locum staff there were gaps in rotas that were not filled.
- Shift rotas were planned and implemented using a workforce management tool and staff were scheduled to work against forecasted/anticipated levels of demand. Arrangements were in place to assist in managing staffing levels at times of high demand such as bank holidays, although there were still gaps in rotas.

Monitoring safety and responding to risk

- The service maintained a constant surveillance over the levels of demand on the service and monitored the numbers and conditions of the people waiting for a clinical advisor to call them back. Where possible calls taken by call advisors requiring further advice were warm transferred to a clinician but where this was not possible, the call was put into a call back queue which was monitored. This queue was assessed and some calls were prioritised to receive a clinical advisor call back within ten minutes; others to receive a call back within two hours depending on the presenting clinical need.
- We noted that calls from other regions were transferred to the London and Newcastle call centres at high demand, and similarly calls from London may be transferred to other areas. The service managers told us that at such time that recruitment was completed this would likely only happen in an emergency.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella are bacteria which can contaminate water systems in buildings).

Arrangements to deal with emergencies and major incidents

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

- The provider had been provided with a corporate business continuity plan to deal with emergencies that

Good

Are services safe?

might interrupt the smooth running of the service. This included loss of mains power, loss of utilities, loss of staffing, evacuation of the building and loss of the Directory of Services.

- The service could make use of other locations managed by Vocare throughout the UK.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The provider ensured that staff were kept up to date and that guidelines and standards reflected best practice standards for NHS 111 services:

- We saw that the service had systems in place to ensure all staff were kept up to date. Staff had access to relevant clinical guidelines. We saw the provider used varied means of communicating these guidelines to staff which included team meetings, workshops, printed information on workstations and information boards in the rest area.
- All call advisors and clinicians completed a mandatory training programme to become licensed in using the NHS Pathways software. There were local and national trainers in place for the Pathways system, and training was completed on a six monthly basis, or when updates were issued. We saw that staff were removed from the rota if their training was not up to date.
- When staff were not able to make a direct appointment on behalf of the patient, clear referral processes were in place and seen by the inspectors. These were agreed with senior staff and a clear explanation was given to the patient or person calling on their behalf.

Management, monitoring and improving outcomes for people

The service monitored performance through the use of quality outcome monitoring as set by National Quality Requirements (NQRs). In some areas the commissioners had set targets that differed from those that are nationally required.

In several areas the provider had not met targets that had been set by the commissioner. The provider had met with the commissioners on a regular basis to discuss how they were going to meet these targets in the future and monthly briefings provided by the provider contained updates.

Details of performance against standards between December 2016 and May 2017 showed the following:

- Between 1.18% and 2.91% of calls per month had been abandoned. This met the national standard of 5%.
- Between 84.22% and 94.04% of calls per month were answered within 60 seconds. The NQR for this is 95% of calls to be answered within 60 seconds. The service managers told us that this target was being reviewed with the commissioner. In more recent months the service's performance in this area had improved.

The service conducted Pathways audits where required and conducted end to end call reviews to ensure that Pathways were correctly applied and that the correct advice and action was implemented. Newer staff members had five calls per month audited and this was reduced to three calls per month for staff who had been at the service for more than six months. There was scope within call auditing to increase the number of calls audited if a member of staff was subject to performance review. The audits were in line with the requirements for the service.

Effective staffing

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

- The provider had an induction programme for all newly appointed staff. This covered such topics as information governance, health and safety, NHS Pathways training, safeguarding, call control, mental health awareness, performance and quality assurance processes, communication requirements and specific procedures relating to their place of work. Call advisors completed mandatory training e-learning modules such as equality and diversity and work station health and safety awareness, before they started operationally within their new role. All locum staff had to show that they had completed training that the provider considered to be mandatory before they were able to work.
- We observed that mandatory training for all staff currently undertaking shifts was up to date in most cases. Some staff had not yet completed safeguarding training, however, the service had implemented a system which meant that those who had not completed mandatory training were not able to undertake shifts until training was complete.
- Staff told us their learning needs were identified through a system of appraisals, one to one meetings and reviews of service development needs. These staff had individual personal development plans and access to appropriate training to meet their learning needs and to

Requires improvement

Are services effective?

(for example, treatment is effective)

cover the scope of their work. The call advisors and team leaders we spoke with had had an appraisal within the last 12 months, and there was a system in place to ensure that appraisals were completed.

- Staff told us that at busy times there were insufficient staff to take calls, and as a consequence targets that the service targets could not be met. Representatives of the provider told us that they were still actively recruiting for both call handlers and call advisers, and that the expansion of the business had meant that some rota gaps could not be filled in the short term. They told us that they had plans to complete recruitment by November 2017, but that in the meantime they were assured that the staff could meet the demands of the service. NQR results showed that the service was meeting targets in some areas and the action plan detailed how workload could be managed in the short term until such time that the recruitment was complete.
- The provider ensured non-mandatory training was available to staff on request through the appraisal process.

Working with colleagues and other services

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

- 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 than expected. The provider had developed a system by which ambulance staff contacting the service could more easily be provided with telephone support.
- Vocare worked closely with the provider of out of hours services in the same area. The services were colocated in the same building and they attended joint meetings with the commissioners and other groups where necessary. Although the services were separate they worked jointly as a single entity.
- There were arrangements in place to work with social care services including information sharing arrangements. Evidence was seen that information was available to ensure that safeguarding concerns followed the correct referral pathway for each of contracted local authority areas.
- The provider had systems in place to identify 'frequent callers' and staff were aware of any specific response requirements. The provider had a clear operating procedure to deal with these and when required had met with these individuals to explain the purpose of the NHS 111 service. They encouraged the individuals to contact other services which could be more appropriate for their needs. They also explained the impact their frequent calls may have on other people trying to contact the service.
- Information about previous calls made by people was available so staff could access this information and discuss any relevant issues with people and assist them in the decision making for that specific call.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, Deprivation of Liberty Safeguards 2007 and Gillick competency for children and adolescents. Staff had received training in these areas as part of their induction and as part of their ongoing development.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Good

Are services caring?

Our findings

Dignity, respect and compassion

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

- Staff were provided with training in how to callers and deal with patients who may respond negatively to callers. We overheard a number of calls and all call handlers and advisers were courteous and respected patients' dignity.
- The provider undertook the contractual telephone six monthly telephone survey of people who had used the service. The results for the period covering October 2016 – July 2017 from 207 respondents were that 190 patient (92%) would be likely or extremely likely to recommend the service.
- The provider had started using the NHS England-GP Patient Survey two months before the inspection but there had been insufficient feedback to determine whether or not patients were satisfied with the service being provided.

The service had reviewed ways in which it could increase patient participation for a service where patients do not typically meet a practitioner face to face. Vocare had requested that they sit on the South West London Patient Participation Forum with a view to eliciting patient feedback, and had subsequently agreed to attend several other patient led panels. At the time of the inspection they were in the process of requesting patients to attend its own internal meetings to improve patient participation. The service also met regularly with local Healthwatch groups.

Involvement in decisions about care and treatment

- 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 with another service.
- We heard people's preferences being accounted for during calls and we observed call advisors checking that people had understood what had been said to them, and that they understood the next steps for their treatment. People were offered information about the healthcare services which were local to them to access.
- We found the service could access special notes or care plans, where the patient's usual GP shared information about their patients who might need to access the local GP out-of-hours service.The use of care plans supported person centred care sharing an individual's wishes in relation to care and treatment. Care plans, where in place, informed the service's response to people's needs, though staff also understood that people might have needs not anticipated by the care plan.
- The service had access to language line for those patients for whom English was not a first language.

Patient/carer support to cope emotionally with care and treatment

Call advisors and clinical advisors were clear on the standard operating procedures in place which detailed the actions they would take in the event that a patient declined the final disposition.

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 clinical commissioning group (CCG) to secure improvements to services where a need for these was identified. Although there was a lead commissioner (Sutton CCG), we were told that Vocare regularly met with representatives of all six of the CCGs.
- The service was provided 24 hours a day, 365 days a year.
- The service also had the flexibility to utilise staff from other NHS 111 services provided by Vocare across England during periods of high demand.
- The provider described the steps they took to ensure that the care pathways were appropriate for people with specific needs. The service had a system in place that alerted staff to any specific safety or clinical needs of a patient, this included special patient notes and patient specific care plans.
- The service used text talk for people with a hearing impairment.

Tackling inequity and promoting equality

- The service was designed to ensure that all patients had access to the service. The service had systems in place to ensure patients who had a disability, or those for whom English was not their first language could access services. Staff were also trained in elements of the Mental Capacity Act and had specific training in assisting patients, or family members of patients with dementia.
- All staff received training in equality and diversity.

Access to the service

- The provider was monitored against the National Minimum Data Set (MDS) (A national tool to benchmark provider performance) overall performance was similar to national averages. In particular the service had lower than the 5% national target for abandoned calls.
- The telephone system was easy to use and supported people to access advice.
- The service had a dedicated clinical advice line to support clinical advisors.
- The service prioritised people with the most urgent needs at times of high demand and could triage patients waiting for the call back service in order of priority.

The service was able to directly request appointments at out of hours centres, and referrals could be made to other health and social care providers. The out of hours service was based in the same building as the NHS 111 service which could help with managing any difficulties that either service might face.

Listening and learning from concerns and complaints

- The provider had a process in place for handling complaints and concerns. Information about how to complain was available and easy to understand and evidence showed the provider responded to issues raised.
- Since the service commenced it had received 53 complaints (as of the date of the inspection) since the service commenced in 2016. Complaints were categorised and we saw timeliness, communication and staff attitude were the most common concern raised. Where appropriate to do so the service had audited individual calls in order that feedback could be provided to staff. We saw in several cases that call handlers and advisors had been provided with formal feedback when feedback was received about staff attitude. Complaints were included in the monthly report to commissioners detailing service performance.
- We looked at all the complaints received in the last 10 months and reviewed six of them in full detail. In each of the six cases that we looked at there had been a full investigation and the service had apologised to the patient where relevant. The responses provided were thorough and covered all of the issues raised by the complainant. Where patient's expectations needed managing the service did so in full.

We noted that none of the six complaints reviewed were managed within the organisations time line of 30 days. In one case the response from an issue in November 2016 was not issued until June 2017.

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 provider had a clear vision to provide a service which was making a difference to people and deliver a high quality service.
- The service had a strategy and supporting business plans that reflected the vision and values and were regularly monitored. In addition the regional director had an action plan to address areas of known concern and risk.

Governance arrangements

The service had an overarching governance framework in place, including policies and protocols which had been developed at a provider level and had been adapted to meet the needs of the service locally. Locally clinical governance procedures and reporting pathways were established and regular clinical governance meetings were undertaken by the senior management team. We found that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- The provider had a good understanding of the performance of the service. In one area the service was not meeting targets set by National Quality Requirements or the commissioner of the service, an action plan was in place to address these areas. In particular, the provider had noted that staffing levels needed to be increased and there was an ongoing recruitment procedure in place.
- We saw that the service audited staff performance against fixed criteria, and that where there were learning points for either the individual or the organisation, actions were taken.
- Significant event and complaint processes were in place and were managed in line with best practice and the providers own policies. However, learning from events was not formally shared with all staff, particularly call handlers.
- Hanover House participated in the Vocare national quality monitoring programme against internal targets as well as clinical commissioning group contractual targets.The service had produced an action plan where shortfalls had been identified.

Leadership, openness and transparency

There was a local leadership structure with both operational and clinical leads within the service. We noted at the time of the inspection that both Director of Operation and Clinical Director posts were vacant, but these roles were being carried out by other members of staff pending recruitment to these posts.

The local leadership team demonstrated they were committed to promoting a culture of working together and openness. Staff we spoke with in a variety of different roles knew who their team members were. However, they pointed out that because members of the operational team were based on a separate floor from the management and support team that senior members of staff were not visible. The majority of staff that we spoke to said that communication was good.

- Operational staff were clear who to go to for guidance and support. Staff told us the leadership team were supportive.
- Staff told us that they were supported in dealing with any particularly difficult or abusive telephone calls. Notices in the communal staff areas highlighted the importance of seeking support and help if they had experienced any difficult or traumatic calls.

Public and staff engagement

The service engaged with the public through the contractual patient surveys, and had a range of options to give feedback or raise complaints of concerns through their website. The service had also built relationships with local patient participation forums at a regional level in order that patients could feed into the service being provided.

The staff we spoke with were clear on their role and responsibilities and their contribution to the NHS 111 service to deliver high quality care and promote good outcomes for people..

Are services well-led?

Good

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

- Staff told us that they had an opportunity to provide feedback by way of 1:1 meetings and through the appraisal process and they had an opportunity to feedback on difficulties relating to the role and their job satisfaction.
- The service had recently undertaken a staff satisfaction survey to gauge staff wellbeing. Of particular note was that the survey showed that staff considered the service to be understaffed and that this led to them feeling pressured. On the basis of this feedback and the provider's own understanding of staffing issues they had implemented an action plan which included a recruitment process set to be concluded by November 2017.
- Staff told us that they felt engaged to improve the service.

Continuous improvement

The service demonstrated a clear understanding of areas in which it needed to improve and action plans were in place where necessary. There was a wide range of learning opportunities available to staff, which supported their professional development.

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
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing levels at the service were lower than complement, and although the service had taken action to address this, at the time of the inspection staff reported that the service was understaffed. This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.