# Isle of Wight Trust (NHS 111 service)

## Quality Report

Ambulance Service
St Mary's Hospital
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Newport
Isle of Wight
PO30 5TG
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

| Overall rating for this service | Good |
|---|---|
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Requires improvement |

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out a comprehensive inspection of the NHS 111 service operated by Isle of Wight NHS Trust on 7 and 8 March 2017. Overall the service is rated as good.

The NHS 111 service is a telephone-based service where patients are assessed, given advice and directed to a local service that most appropriately meets their needs. For example that could be an out-of-hours GP service, walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance or late opening chemist. The NHS 111 Service is part of the Ambulance Service of the Isle of Wight NHS Trust. There are operational managers responsible for the day to day running of the service and the overarching governance of the service provision is carried out by the Trust Board.

Our key findings were as follows:

- There were systems and processes in place to identify, manage and mitigate risks.
- The NHS 111 service was monitored against the National Minimum Data Set for NHS 111 services and adapted National Quality Requirements. Performance against indicators was above or aligned with national targets, with the exception of calls answered within 60 seconds which had varied in the last 7 months to just below the target of 95%. We were told however that month to date the figure was 96.15%
- The NHS 111 service was in the process of recruiting additional call handlers to improve their performance in answering calls within 60 seconds.
- Callers received a safe, effective and responsive service. Call handlers were trained to respond to both 111 and 999 calls and were able to use these skills to provide positive outcomes for patients.
- Caller's needs were assessed in a timely manner and received clinician call backs when needed.
- Adjustments had been made to the referral processes to other health and social care providers to enable speedier access. Examples we saw included information on voluntary groups who may be able to offer assistance, in addition to medical help. Also, callers with wheelchair maintenance issues were able to be patched straight through to the maintenance company for speedy and relevant help. This was useful when a caller had broken down in electric wheelchair and needed immediate help but not medical help.
- The NHS 111 service worked closely with the clinical commissioning group who commissioned the service.

# Summary of findings

- Opportunities for learning from internal and external incidents were identified and discussed to support improvement and safety. This included the introduction of a quick reference sepsis guide.
- Staff took action to safeguard patient and were aware of the processes to make safeguarding referrals. Systems and processes were in place to safeguard both adults and children at risk of harm or abuse, including frequent callers to the service.
- Staff were trained to ensure they used the NHS pathways safely and effectively. (NHS Pathways is a Department of Health approved computer based operating system that provides a range of clinical assessments for triaging telephone calls from patients based on the symptoms that report when they call).
- Calls were regularly audited to meet the NHS Pathways licence and to allow the service to identify areas of development and learning.
- Staff were supported to receive appropriate training, supervision and appraisals.
- Callers using the service were supported effectively during the telephone assessment process. Consent to the assessment was sought and individual's decisions were respected.
- The NHS 111 service responded to complaints and to caller feedback when raised and responded to staff feedback.
- There were systems and processes in place for governance of service provision, which included a range of performance reports; meetings at all staff levels; analysis of risks and monitoring of mitigating actions taken.
- During our inspection we found all staff to be dedicated and proud of the important work they were undertaking and they worked cohesively as a team.

The provider should:

- Review arrangements to ensure there is effective leadership for safeguarding patients and recognise that a new member of staff is in the lead role and is appropriately supported.
- Continue to seek ways to gather patient feedback on service provision.

**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.

- Safety was seen as a priority.
- Service performance was monitored and reviewed and improvements implemented.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- All opportunities for learning from internal incidents were discussed to support improvement. Information about safety was valued and used to promote learning and improvement.
- Risk management was embedded and recognised as the responsibility of all staff.
- Staff took action to safeguard people using the service and were aware of the process to make safeguarding referrals.
- Clinical advice and support was readily available to call handlers when needed.
- Capacity planning was a priority for the provider and there were sufficient numbers of trained, skilled and knowledgeable staff available at all times; even at times of fluctuating demand.

**Are services effective?**

Good

The provider is rated as good for providing effective services.

- Daily, weekly and monthly monitoring and analysis of the service achievements was measured against key performance targets and shared with the lead clinical commissioning group (CCG) members. Account was also taken of the ranges in performance in any one time period.
- Appropriate action was undertaken where variations in performance were identified. Staff were trained and rigorously monitored to ensure safe and effective use of NHS Pathways.
- Most staff received annual appraisals and personal development plans were in place, and had the appropriate skills, knowledge and experience.
- Staff ensured that consent as required was obtained from people using the service and appropriately recorded. There was an effective system to ensure timely sharing of patient information with the relevant support service identified for the patient and their GP.
- People's records were well managed, and, where different care records existed, information was coordinated.

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- Staff used the Directory of Services (DOS) and the appropriate services were selected. (The DOS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.)

**Are services caring?**

Good

The provider is rated as good for providing caring services.

- Staff responded to callers in a caring, empathic and supportive manner.
- Patients using the service were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw staff treated people with kindness and respect, and maintained people's confidentiality.

**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.
- The Trust implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback.
- There was a comprehensive complaints system and all complaints were risk assessed and investigated appropriately.
- Action was taken to improve service delivery where gaps were identified.
- Care and treatment was coordinated with other services. There was collaboration with partners to improve urgent care pathways.
- Staff were alerted, through their computer system, to people with identified specific clinical needs and for safety issues.
- The service engaged with the lead Clinical Commissioning Group (CCG) to review performance, agree strategies to improve and work was undertaken to ensure the Directory of Services (DOS) was kept up to date. (The DOS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.)

**Are services well-led?**

Requires improvement

The provider is rated as requires improvement for being well-led.

- The Trust had a vision and strategy to deliver a quality NHS 111 service and promote good outcomes for patients using the

# Summary of findings

service. Staff were clear about the vision and their responsibilities in relation to it. However there were a number of staff that held interim roles and were not clear what the coming months would look like for them.
- The Trust proactively sought feedback from staff however there was limited action to seek the views of patients using the service.
- 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 were not consistently supported by the Trust Board.

However, there are areas of good practice:

- There was a leadership structure and staff felt supported by management. Staff, including those who did not work conventional office hours knew how to access senior leaders and managers.
- The Trust's policies and procedures to govern activity were generally effective, appropriate and up to date. Regular governance meetings were held.
- There was an overarching governance framework which supported the delivery of the strategy and a quality service. This included arrangements to monitor and improve quality and identify risk.
- The information used in reporting, performance management and delivering quality care and treatment was accurate, valid, reliable, timely and relevant.
- The Trust was aware of and complied with the requirements of the duty of candour. The Trust and managers encouraged a culture of openness and honesty. There were systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- There was a focus on continuous learning and improvement at all levels.

# Isle of Wight Trust (NHS 111 service)

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a Care Quality Commission inspection manager. The team included an inspection manager, two inspectors and a NHS 111 specialist advisor.

## Background to Isle of Wight Trust (NHS 111 service)

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.

The NHS 111 service is part of the Trust's integrated Urgent Care Hub which was established in 2010 in conjunction with the Isle of Wight Council to manage and coordinate all emergency, urgent and unscheduled care for the Island.

The hub aims to provide care closer to the patient's home, avoid unnecessary admission to the acute hospital, deliver high quality coordinated patient care and ensure more efficient use of resources.

The Urgent Care Hub has an IT infrastructure, which enables the sharing of information with all health and social care professionals involved in the patient/client's care package. The hub is a whole system approach, linking the hospital, ambulance, GPs in and out of hours, multi-disciplinary community support teams, mental health and social care through a call centre that promotes interdisciplinary working and provides a single point of contact for patients through two telephone numbers, 999 and 111.

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.

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.

The service handles on average 74,000 calls per year. The NHS 111 service is jointly staffed for the 999 call centre service by 34 whole time equivalent (WTE) call handlers; four WTE resource dispatchers; four WTE control managers; two WTE auditors; and 10 WTE clinicians, who are usually paramedics and registered nurses. In addition there is a directory of services manager and a data specialist.

The service is provided from:

Ambulance Service

St Mary's Hospital,

Parkhurst Road,

Newport,

Isle of Wight

PO30 5TG

# Detailed findings

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

Before visiting the NHS 111 service, we reviewed a range of information that we held about the service provider, Isle of Wight Trust, and asked other organisations to share what they knew about the Trust's provision of the NHS 111 service. This included information from the local clinical commissioning groups (CCGs) and NHS England.

We carried out an announced comprehensive inspection to the NHS 111 service on 7 and 8 March 2017.

During our inspection:

- We spoke with a range of staff including directors for the service, Board members, senior managers, clinical managers, call advisors and clinical advisors.
- Observed the call centre environment over an evening and day.
- Observed staff completing their role and supported callers who were contacting the NHS 111 service.
- We looked at a range of records including audits, staff personnel records, staff training, and complaints.

We did not speak directly with patients who used the service. However, we observed staff in the call centre speaking with patients who telephoned the service.

Good

# Are services safe?

## Our findings

**Safe track record**

There was an effective system in place for reporting and recording 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 NHS 111 service reported to us that there had been no serious incidents or never events associated with the service.
- The Trust monitored safety through audits of significant events, clinical governance meetings and a range of meetings with different levels of staff, such as operational managers. The Trust also carried out a thorough analysis of the significant events.
- Staff told us they would inform their manager of any incidents and there was a recording form available on the service's computer system. 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).
- Measures were in place to minimise risk to patients. For example, the NHS 111 service had worked with the oncology service to alert call handlers how to respond to callers if they had an intravenous catheter in place that was a cause of concern to ensure that the most appropriate disposition would be made.
- We saw evidence that when things went wrong, people were informed of the incident, received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We saw evidence including safety records, incident reports, patient safety alerts and minutes of meetings that lessons were shared and action was taken to improve safety. Learning was shared in a variety of formats, which included meetings and newsletters. Complaints, concerns, health care professional feedback, significant events and non-compliant call audits were reported on in a monthly clinical governance report. These were reviewed at the monthly NHS 111 and clinical commissioning group meetings, as well as the quarterly Trust Board meetings.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety. For example, in the management of sepsis. All desks in the Hub had quick reference guides of signs and symptoms of sepsis. This was in response to an incident where the condition had not been noted in a timely manner and in accordance with national guidance.

**Overview of safety systems and processes**

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a person's welfare. There was a lead member of staff for safeguarding. They told us that they had had this role for the past five months and further clarification was needed on their remit and how the Trust would support them in this role. They linked with other health and social care providers when needed and were working on reviewing training arrangements for staff.
- Contributions were made to safeguarding meetings when required. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. Clinicians were trained to level 2 and all other staff received training to level 1 in children's' safeguarding. Information received from the service showed that safeguarding alerts were made when needed to the relevant services. The safeguarding lead was working with school nurses to reach children who may be at risk of neglect, for example by reviewing data related to calls for toothache.
- Clinical staff and appropriate administrative staff had access to people's medical or care records. Staff were

clear on the arrangements for recording patient information and maintaining records. Special notes were used appropriately for people with specific conditions or needs and this made a difference to those people.

- Staff had had training in recognising concerning situations and followed guidance in how to respond. Clinical advice and support was readily available to staff when needed.
- There were clear processes in place to manage the transfer of calls, both internally within the service, and to external service/provider, to ensure a safe service.
- 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.
- We reviewed six files of staff employed to work in the 111 service. The service had a system in place to ensure that no new members of staff commenced employment without receiving human resources sign off, which verified that all necessary recruitment checks had been undertaken and were satisfactory. We spoke with the Deputy Human Resources Director who said that this was the system for the whole Trust. Recruitment processes were managed by the hospitals human resources department. All staff were required to apply for vacancies via NHS Jobs and recruitment checks were also in line with NHS standards. All files had all relevant information, which included a check on the performers list, a Disclosure and Barring Service check and evidence of satisfactory conduct in previous employment.
- Staff were provided with a safe environment in which to work. Risk assessments and actions required had been taken to ensure the safety of the premises.

**Monitoring safety and responding to risk**

Risks to people using the service were assessed and well managed.

- Staff were able to identify potentially life threatening situations, such as potentially life threatening chest pains and took appropriate action, such as requesting that an emergency ambulance was dispatch, whilst the call was in progress, as observed during our inspection.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet people's needs. The rota system in place for all the different staffing groups ensured enough staff were on duty.

**Arrangements to deal with emergencies and major incidents**

The Trust had adequate arrangements in place to respond to emergencies and major incidents. The Trust had engaged with other services and commissioners in the development of its business continuity plan.

The Trust had 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 also addressed fluctuations in demand for the service and staff shortages.

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.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The NHS 111 service assessed callers' needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- We saw the NHS 111 service had systems in place to ensure all staff were kept up to date. Clinical staff, notably clinical advisors had access to guidelines from NICE and used this information to help ensure that people's needs were met. We saw the NHS 111 service monitored that these guidelines were followed.
- 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.
- Performance support officers managed the call centre on a daily basis and monitored call performance, along with a member of staff responsible for data capture. 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 callback. For example performance figures for December 2016 to February 2017 average figures showed that the NHS 111 service was meeting standards for 'warm transfers' with a range of 95.31% to 97% of calls identified being transferred. (The standard expected is more than 95%).
- It is a condition of the NHS Pathways user licence and a National Quality Requirement for NHS 111 services that providers 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.
- Aggregated figures between May 2015 and April 2016 showed the majority of staff were achieving audit scores of 90% or over on average.
- We spoke with the non-clinical auditors who explained that they would carry out three to six call audits per month on call handlers, dependent on previous performance. Calls were randomly selected and the auditors listened and scored how the call handler managed the call. If a call handler achieved 86% or over then the results of the audits were feedback on a quarterly basis. If there was caused for concern, with the pass mark of 86% not being achieved then feedback would be given face to face and via email. Support would be given when needed to improve performance and the number of audits increased for the next month to assess performance.
- 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, the management team had identified that when ambulances were not available and the disposition was changed to account for this, which could have resulted in a delay in patients receiving appropriate treatment. All clinical staff and non-clinical staff were reminded not to change the disposition and continue to request an ambulance if the outcome of the triage showed that this was needed.

Good

# Are services effective?

## (for example, treatment is effective)

- Real time performance was monitored and action taken to ensure where performance was at risk of reducing. The NHS 111 Service had a member of staff who was responsible for data capture and monitoring calls received and how they are managed. The service has seen the number of call they receive double since it began and staff were concerned that this had not been matched by an increase in staff numbers. They were unable to describe any real changes made as a result of increase call volume and data presented to managers and the Trust Board. We noted on two occasions during our inspection that call waiting times for one call on each occasion were nearing or above five minutes. Staff were not surprised by this and attributed it to lack of call handlers and the system not enabling calls to be automatically transferred to a clinician if one was available, who could then triage the call.

**Management, monitoring and improving outcomes for people**

- Real-time data seen during the inspection on 7 March 2017, showed at 8pm 91.96% of calls had for that day been answered within 60 seconds. On 8 March 2017 at 11.20am 97.08% of calls had been answered within 60 seconds. Daily reported figures for the period 1 March to 6 March 2017 showed the figures ranged from 93.29 % to 98.47%. The number of calls received for the same period ranged from 134 to 250 daily. Average figures for the period April 2016 to February 2017 showed that the range was between 91.90% to 95.82% and action had been taken to improve on this by reviewing job roles within the hub to make sure more staff were available to take calls.
- The service monitored its performance through the use of the National Quality Requirements and the national Minimum Data Set, as well as compliance with the NHS Commissioning Standards. In addition the provider had established its performance monitoring arrangements and reviewed its performance each day; weekly and monthly, as well as reviewing real time calls. The 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:

- The average percentage of calls answered within 60 seconds of the number of calls answered was 94.44% on average in 2016 and for the current year to January 2017, the average was 92.64%, which is below the target of 95%. At the presentation the Trust informed us that call answering month to date was 96.15%.
- As a result of increased calls, an independent workforce review had been carried out, which recommended that call handler numbers were increase by five or six members of staff. The Trust approved the NHS 111 service to recruit to four of these positions and these applications were in progress at the time of inspection.
- The service had low numbers of calls where a call back within 10 minutes was required. Figures for the period 1 April to 6 March 2017 showed that 0.4% to 2.1% of callers required a call back from a clinician.
- Figures for timely 'warm transfers' to a clinician in the same period ranged between 92.11% to 100%.
- The NHS 111 service was in the process of recruiting four call handlers to improve performance. Data on call handling was discussed at daily 'huddles'; weekly and monthly operation meetings; and presented to the Trust Board on a regular basis.
- The percentage of calls abandoned (after waiting 30 seconds) was consistently better than the target of less than 5%. For example. The figures for the period 1 March to 6 March ranged between 0.4% and 4.97%. For the period of December 2016 to February 2017 the average percentages per month of calls abandoned ranged from 2.20% to 3.42%.

**Effective staffing**

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

- The Trust had an induction programme for all newly appointed staff. This covered such topics as use of display screen equipment; fire safety; information governance; and safeguarding adults and children.

Good

# Are services effective?

## (for example, treatment is effective)

- The Trust could demonstrate how they ensured role-specific training and updating for relevant staff. For example safeguarding training to the appropriate levels.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, appraisals, coaching and mentoring, clinical supervision and facilitation and support. At the time of inspection a total of 93% of staff had had an appraisal within the last 12 months, other than in exceptional circumstances (such as long-term sick leave), which were clearly documented.

Staff received training that included: use of the clinical pathway tools, how to respond to specific patient groups, safeguarding, fire procedures, and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

**Working with colleagues and other services**

Staff worked with other service/provider to ensure people received co-ordinated care.

- The NHS 111 service operated in a Hub, where other health professionals, such as ambulance dispatchers and community staff were also based. This allowed face to face conversations when needed and enabled effective communication between different health and social care services.
- Call handlers were also trained to manage 999 calls and this enabled close working between the teams.
- 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 provider. The system with the patient's consent, automatically sent 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.
- 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 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.
- The Trust was aware of the times of peak demand and had communicated these to the ambulance service. This included the arrangements to alert the ambulance service when demand was greater or lower than expected.
- Staff knew how to access and use patient records for information and when directives may impact on another service for example advanced care directives or do not attempt resuscitation orders.
- The trust had systems in place to identify 'frequent callers' and staff were aware of any specific response requirements. There were also systems in place to respond to calls from children/young people.
- 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.

**Consent**

Staff sought patients' consent 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 and Gillick competency for children. There was no stand alone training or policy on the Mental Capacity Act 2005; this was included in safeguarding training and policies.

Good

# Are services effective?

## (for example, treatment is effective)

- 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.

Good

# Are services caring?

## Our findings

**Kindness, 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 respond to a range of callers, including those who may be abusive. Our observations were that staff handled calls sensitively and with compassion.

**Care planning and 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 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. This included where an appointment had been made by the NHS 111 service or where a request was to be made for a future appointment.
- The Trust had reviewed its patient survey and was in the process of redesigning it to capture views of patients who accessed the 111 service as at the time of inspection there was little feedback from callers of the NHS 111 service. The National GP Survey and Family and Friends Test had only captured one patient's response which was positive.

**Patient/carer support to cope emotionally with care and treatment**

Staff were trained to respond to callers who may be distressed, anxious or confused. Staff were able to describe 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 established pathways for staff to follow to ensure callers were referred to other services for support as required. For example, callers with wheelchair maintenance issues were able to be patched straight through to the maintenance company for speedy and relevant help. This was useful when a caller had broken down in electric wheelchair and needed immediate help but not medical help.

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 local NHS England Area Team and Isle of Wight clinical commissioning group (CCG) 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. It was highlighted at one meeting that calls being answered within 60 seconds were below the expected target, as a result of this an independent workforce review had been carried out, and the Trust had recruitment of staff underway as a result.

- The service offered a 24 hours a day, 365 days a week service.
- The service took account of differing levels in demand in planning it service. 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. Staffing rotas where scheduled up to eight weeks in advance. The NHS 111 service had low usage of bank staff and would ask permanent staff to undertake extra hours to cover busy periods. Figures for the period between February 2016 and January 2017 showed a total of 533.25 hours were used. This range from three to 36 hours on the weeks that bank staff were used, with an overall average of 10 hours per week. Staffing levels were monitored on a daily basis and data of calls received was used for forward planning, particularly during the summer holiday season when the number of people on the Isle of Wight could double.
- Care pathways were appropriates for patients with specific needs, for example those at the end of their life, and babies and young children.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. For example, those receiving palliative care or chemotherapy.
- The service used all available data to ensure it was responsive to people's needs. For example, the call backs queues were monitored and clinicians were able to intervene and allocate resources when needed.
- There were translation services available.
- The 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.

**Access to the service**

- People had timely access to advice, including from a call handler or clinical advisor when appropriate. Data showed that the NHS 111 service consistently achieved the required standards, apart from the number of calls which were answered within 60 seconds, which were above 90% but below 95% on average. The service was recruiting four more call handlers to improve this situation.
- Action was taken to reduce the length of time people had to wait for subsequent care or advice.
- Action was taken to minimise the number of calls that were abandoned by the caller. The real-time board in the Hub showed how long callers had been waiting and the number of calls 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 2.2% and 3.42% of calls being abandoned.
- 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**

The Trust had an effective system in place for handling complaints and concerns. Information about how to complain was available and easy to understand and evidence showed the Trust responded quickly to issues raised.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

We looked at three complaints received in the last 12 months and found these were satisfactorily handled, and dealt with in a timely way. There was openness and transparency when responding to complaints. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of the service. For example, an ambulance was not dispatched to a patient within the recommended timeframe. An audit of the call showed that there had been a lack of communication between the NHS 111 service and the Ambulance Service. Further support and training was provided to relevant staff members and this was monitored.

# Are services well-led?

Requires improvement

(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 vision to deliver a quality service and promote positive outcomes for patients using the service.

- The service had a mission statement that was understood by staff. The staff we spoke with had a clear understanding on their role and responsibilities. They understood their contribution to the vision of the NHS 111 service to deliver high quality care and promote good outcomes for patients. They were proud of the work they undertook.
- 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 service had a strategy and supporting business plans that reflected the vision and values and were regularly monitored.
- Senior managers told us they placed quality at the heart of the service that was provided.

**Governance arrangements**

The Trust had an overarching governance framework for NHS 111 services which supported the delivery of the strategy and service. This outlined the processes and procedures and there were clear reporting structures in place, from operational front line reports on performance, through senior management meetings and business meetings to board level. 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 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 fully implemented recommendation made by independent reviews or acted fully on staff comments about the provision of the NHS 111 Service.

- 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.
- An understanding of the performance of the service was maintained at all levels in the organisation.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- Improvements were needed to ensure there was effective leadership for safeguarding patients and recognise that a new member of staff was in the lead role and was appropriately supported where needed.
- 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.
- 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. This had included information from an independent review of staffing levels which had recommended an increase of five or six call handlers; the NHS 111 service had been able to recruit four additional call handlers.
- Learning from complaints and significant events were shared throughout the NHS 111 service
- Data was used to improve performance and 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.

**Leadership, openness and transparency**

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. The leadership of the NHS 111 service had recently been restructured. Many of the leadership roles were interim, due to human resources processes and legal

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proceedings. This meant that staff did not all know what the coming months would mean for their roles. Staff reported that line managers 'walked the floor' and they were approachable.

- We observed that the whole team worked cohesively and were enthusiastic about the roles they undertook. Staff were proud to work for the NHS 111 service.
- Operational staff knew who to go to for guidance and support. They were clear about their line management arrangements as well as the clinical governance arrangements in place. They described to us how they received updates about important issues, such as learning from Trust complaints. They said there was a range of mechanisms to achieve this, which included a 'Don't Trip Up' short focussed newsletter to highlight tips, reminders, information and probing. Staff meetings were held regularly and minuted.
- There were arrangements to support joint working by staff, for example through team meetings. Staff who did not work office hours (e.g. night shift workers) were supported in joint working and engaging with members of their team, even if their working hours did not allow them to attend team meetings.

There were arrangements in place to provide support to staff in the event of a death or serious incident. Staff were able to access occupational health services and a confidential telephone counselling service

The NHS 111 service was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

**Public and staff engagement**

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 October 2016 showed one person had responded to feedback for the NHS 111 service and they gave it five stars and would recommend the service.

The NHS 111 service was reviewing how they could capture patient feedback in the future and informed us that they were redesigning a patient survey, which could be access via digital means. The website for the Trust had areas where patients could leave feedback on service provision and they also worked with local community groups, such as Healthwatch to gather patient views.

Staff were able to describe to us the systems in place to give feedback. These included surveys; appraisals; and formal or informal meetings.

We saw evidence of the most recent staff survey and how the findings were fed back to staff. We also saw staff engagement in responding to these findings. The latest staff survey 2016 encompassed the NHS 111 service staff, who were part of the Ambulance Service and it was not possible to determine levels of satisfaction of working in the NHS 111 service.

Staff had access to the NHS 111 service's intranet where they could access policies, procedures. Learning and development such as NHS Pathways and updates.

**Continuous improvement**

There was a focus on continuous learning and improvement at all levels within the service. The NHS 111 service was aiming to be the single point of contact for people living on the island for health and social care as part of the 'My life, a full life' programme.