

Isle of Wight Ambulance Service 111 Service

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

We carried out this inspection as part of the development of our approach to inspecting NHS 111 services.

Therefore we have not rated the service. We carried out an announced inspection from 4pm to 10.30pm on 17 March 2015 and 11am to 1pm on 18 March 2015.

NHS 111 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.

NHS 111 services are usually area specific, but on occasion will take calls from all parts of England.

Our key findings were:

- The service had suitable systems in place to monitor safety over time, which included learning from incidents and complaints.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents.
- Patients were assessed treated in line with best practice and current national guidance using the latest version of NHS Pathways.
- Training on use of the NHS Pathways was comprehensive and systems were in place to mentor new staff members until they were competent in its use.
- Patients were treated with compassion and respect and their privacy was maintained.
- Patients were involved in care and treatment decisions.
- The service worked with the clinical commissioning group and health and social care providers to respond to and meet patients' needs.
- The directory of services was well maintained and kept up to date by a designated member of staff.
- The vision and values of the service had been communicated well to all staff members.
- There were effective day to day working arrangements within the service, with staff having clear roles and responsibilities.

There were areas where the provider could make improvements and should:

- Consider developing a report which reflects overarching governance of the service provided.
- Consider informing patients when their calls are being listened to for training purposes.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service had suitable systems in place to monitor safety over time, which included learning from incidents and complaints. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Information about safety incidents was recorded, monitored, appropriately reviewed and addressed. Lessons were learnt and areas identified for action as requiring improvement were communicated to all staff members. Staff demonstrated understanding of their roles and responsibility to report safeguarding concerns.

Are services effective?

Patients were assessed and treated in line with best practice and current national guidance using the latest version of NHS Pathways. Training on use of the NHS Pathways was comprehensive and systems were in place to mentor new staff members until they were competent in its use. Staff were able to receive other training appropriate to their roles. Further training needs were identified and planned for through the appraisal system. Intelligence monitoring tools were used to analyse outcomes of calls received to ensure treatment was relevant and effective. There were suitable systems in place to manage incoming and outgoing information from the service to health and social care professionals. Effective processes were in place to gain patients' consent.

Are services caring?

Patients were treated with compassion and respect and their privacy was maintained. Patients were involved in care and treatment decisions. Staff were observed speaking with patients with dignity and respect. The service provided information in a manner which enabled patients to understand the treatment options available to them.

Are services responsive to people's needs?

The service worked with the clinical commissioning group and health and social care providers to respond to and meet patients' needs. The directory of services was well maintained and kept up to date by a designated member of staff. The directory of service details what treatment options are available for patients. The service reported as required on National Quality Requirements as part of its contractual obligations. There was an accessible complaints system with evidence demonstrating that the service responded quickly to issues raised.

Summary of findings

Are services well-led?

The vision and values of the service had been communicated well to all staff members. There were effective day to day working arrangements within the service, with staff having clear roles and responsibilities. The service monitored activity and regular governance meetings had taken place, which included systems to monitor and improve quality and identify risk. The service proactively sought feedback from its patients and staff and this had been acted upon.

Summary of findings

Areas for improvement

Action the service **COULD** take to improve

The provider should consider developing a report which reflects overarching governance of the service provided.

Consider informing patients when their calls are being listened to for training purposes.

Good practice

The NHS 111 service on the Isle of Wight had other health and social professionals based in the integrated care hub, such as community nurses and social workers. This allowed staff to speak directly with other service providers during the other agencies available hours. The vision and values of the service had been communicated well to all staff members. There were effective day to day

working arrangements within the service, with staff having clear roles and responsibilities. The service monitored activity and regular governance meetings had taken place, which included systems to monitor and improve quality and identify risk. The service proactively sought feedback from its patients and staff and this had been acted upon.

Isle of Wight Ambulance Service 111 Service

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and the team included a specialist GP and nurse advisor.

Background to Isle of Wight Ambulance Service 111 Service

The NHS 111 service covers the whole of the Isle of Wight. The NHS 111 service is part of the 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 a sophisticated and robust 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, district nursing, 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 58,000 per year. The NHS 111 service is staffed by 21.42 whole time equivalent (WTE) call handlers; six WTE resource dispatchers; four WTE control managers; and 11.65 WTE clinicians, who are usually paramedics and registered nurses.

The service is provided from

St Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, PO30 5TG

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. This inspection was planned to check whether the provider is meeting the legal

Detailed findings

requirements and regulations associated with the Health and Social Care Act 2008, and to look at the overall quality of the service. We inspected this service as part of our new inspection programme to test our approach going forward.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the service and asked other organisations to share what they knew. Including local NHS England, Healthwatch and the clinical commissioning group. We carried out an announced visit on 17 and 18 March 2015, which included out of hours working. During our visit we spoke with a range of staff which included call handlers, clinicians and managers. We reviewed results of patients satisfaction surveys; observed how calls were handled and looked at how the service met the National Quality

Requirements (NQR). These requirements set out standards on activity for the service to achieve to ensure safe, effective and appropriate support. Information from NQR is shared with the local clinical commissioning group.

We asked the service to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included policies and procedures and some audits.

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?

Are services safe?

Summary of findings

The service had suitable systems in place to monitor safety over time, which included learning from incidents and complaints. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Information about safety incidents was recorded, monitored, appropriately reviewed and addressed. Lessons were learnt and areas identified for action as requiring improvement were communicated to all staff members. Staff demonstrated understanding of their roles and responsibility to report safeguarding concerns.

Our findings

Safe track record

The provider had suitable systems and processes in place to manage a safe track record over time. Call handlers used the NHS Pathways system to assess patients' needs. The NHS Pathways system comprised software which call handlers and clinicians used to assess symptoms to decide on the next course of action. When this point was reached the system provided a disposition, which was the recommended action that should be taken. Examples of dispositions included referral to a GP out of hours, or during the next working day; A & E attendance or community support. When there was a complex call, the call handler was able to 'warm transfer' the call to one of the clinicians working. (A 'warm transfer' is when the patient is directly transferred to a clinician during the call, rather than receiving a call back.)

Use of the NHS Pathways meant that other areas of concern were able to be identified and suitable action could be taken if needed. For example, during a call, a call handler identified that there were children at risk in the patient's home.

All telephone calls to the NHS 111 service were recorded, which allowed reviews of calls received to be made. For example, when a serious incident occurred call handlers and their supervisors were able to review and discuss the call to identify what went well and what could be improved on.

The NHS 111 service had monthly clinical governance meetings where all significant events, incidents and auditing of the service were discussed. We found the minutes showed that this information was shared with the medical director and the hospital board.

Learning and improvements

The provider had effective systems and procedures in place to learn and improve. We found that all significant events were recorded and learning and actions taken shared with staff. Each significant event was reviewed fully with all relevant members of staff and when needed action was taken to support staff or manage performance.

We discussed with staff how complaints or incidents were dealt with. They said that if a complaint came in about a call handler, the call was reviewed with a call auditor and actions required were agreed and put into place. Relevant

Are services safe?

learning was shared with all staff members to minimise the risk of reoccurrence. For example, there was one incident where an out of hours dentist could not be identified which meant a patient did not receive timely treatment. As a result of arrangements were made to ensure the NHS 111 service had information on out of hours dental availability. Other examples given, included using NHS Pathways and key questions that staff were required to ask which lacked clarity and how to record this.

A call handler explained that call reviews were held regularly as part of an audit process and a requirement to carry out this work. The member of staff explained that the call audit team would listen to calls they had received and provide feedback. The feedback was provided via email and included how well the member of staff had performed and commentary on where improvements could be made if needed. The call handler said that if the auditors concluded that the call was of an unacceptable standard then this would be discussed personally with them, which was valued. We saw the form that the call auditors used, which confirmed this. We were shown examples of staff call audits and how they had been undertaken, shared with the employee and scored; and actions taken as a result.

The performance support officer (PSO) explained that it is their role to manage the operational aspects of the shift and ensure that the service was managed and delivered smoothly. They also explained how learning from clinical governance call reviews operated. They described and confirmed how calls were reviewed and these were usually undertaken on a 'topic' basis. This is where calls of the same subject matter were listened to by the whole clinical governance committee, with a view to identifying improvements. Learning was shared with all teams within the NHS 111 service. Staff members' line managers would monitor performance of their teams and ensure that actions needed as a result of accident and incidents were completed.

Reliable safety systems and processes and practices

The service had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that staff had received relevant role specific training on safeguarding children and vulnerable adults. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to

share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and outside of normal hours. Contact details were easily accessible. Call handlers said that training was accessed on line and they were provided with protected time to complete this. They said that clinicians always made safeguarding referrals.

A call handler gave an example of when a safeguarding referral was made and explained that a direct referral to social services could be made via the computer systems, or if needed the 999 service could be contacted in order that the patient could be seen in their home environment. Another example related to older patients and the service was able to refer these patients directly to the crisis team to provide 72 hours of care in the home, to avoid unplanned admission to hospital and distress to patients.

The service was able to identify when patients did not attend another service, such as accident and emergency, following a call to the NHS 111 service. Such as when parents of children were advised to take them to accident and emergency and this did not occur. The service would then attempt to contact the parent, or liaise with social services or a health visitor dependant on the nature of the concern. The NHS 111 service on the Isle of Wight had other health and social professionals based in the integrated care hub, such as community nurses and social workers. This allowed staff to speak directly with other service providers during the other agencies available hours.

When self-management of a condition was advised we found that all patients were informed that if they had any further concerns or the symptoms did not settle then they should telephone again for further advice. We observed staff providing this information when relevant.

Staff were able to escalate any shortfalls in the NHS Pathways when they believed the system was not correct or changes or improvements were needed. We spoke with the member of staff responsible for making sure the NHS Pathways were current. They explained that on occasion when a Pathway was followed the disposition (where the patient was advised to attend for treatment) did not correlate with the symptoms. For example, one condition where a patient might be experiencing a headache with nausea, the disposition was not sufficient to ensure they were protected from harm. They said they were able to add

Are services safe?

these to the NHS pathways issue log for review by authors for potential changes. Usually NHS Pathways were able to make changes or advise how to overcome the concerns through correct system usage.

The NHS Pathways Directory of Services Lead was also responsible for ensuring information on out of hour's pharmacies and emergency contacts for social services in the area were correct. They explained that the NHS Pathways system was England wide. If they received a call from out of their area, this meant they were able to provide appropriate support and treatment without having to ask the patient to call NHS 111 again to be put through to the correct area. Work arounds were made available when system development was likely to be delayed.

The NHS Pathways system was updated twice yearly with new clinical information and previously the service had been a Beta testing site for this. Beta testing involved working through all the NHS Pathways to ensure they worked and resulted in appropriate dispositions at the end of the assessment. The staff member said that the patient's postcode was vital in ensuring the correct referral was made. Due to being an island, on occasion patients were referred to the mainland, instead of a walk in clinic on the island. Staff were aware of this and able to adjust the referral. They said that if a patient was of no fixed abode, then they would use the postcode of the NHS 111 service as their location.

We saw information on care homes on the island which included the up to date contact details and postcodes, and different names they might be known by. This assisted staff to ensure accurate information was placed on the patient record.

A member of staff said that if a patient was a repeated caller, then this could be flagged on the computer system to alert other staff and if needed contact with the patients GP would be made to support the patient.

Monitoring safety and responding to risk

The service had systems in place to monitor staffing levels and make changes to the rota to ensure there were sufficient staff on duty. We were provided with information on how staffing levels were decided using historical call volumes and call prediction modelling. This included a review of all calls taken using a breakdown of calls from the telephony system. These were downloaded into a call handling modelling system to give an accurate picture of

how many call handlers per 30 minutes were required. This information was then used by the performance support officers to produce the eight weeks of rota patterns required.

Arrangements were in place in the event of staff shortage and there were clear details of the minimum number of staff needed to be on duty in order that it could operate safely. The service was currently using a new rota which included 'float cover'. This involved staff being rostered to work various shifts and additional staff were available to cover where needed. There were also systems in place to deploy extra staff during periods of high demand, for example, bank holidays and weekends. This included generic hub workers and use of fast text for emergency short notice cover. This is where staff who were not working were contacted via a text to ascertain whether they are able to come in for work at short notice.

A performance support officer said that when bank staff were used checks were made to ensure they had completed the required numbers of hours to continue to take calls. The service had recently experienced a period where call handling audits had not been carried out due to staff sickness. To remedy this they had trained two more members of staff to undertake call handling audits.

Arrangements to deal with emergencies and major incidents

The NHS 111 service had arrangements in place to deal with emergencies which could interrupt the service provision. They had a continuity plan in place which was written when the service began in 2011. This had been updated and reviewed, but not been consistently achieved. However, all the information within the plan was current. 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 999 and 111 calls. (The service also managed 999 calls).

Computer systems were able to be accessed remotely and there were laptops which had been loaded with the NHS

Are services safe?

Pathways and access to the NHS Pathways paper based back up system. This would allow staff to continue to work. In the event of a power failure there was an emergency

generator to provide electricity and sockets supplied by the generator were red. The manager of the service explained that all vital equipment, such as computers, were plugged into these sockets.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patients were assessed and treated in line with best practice and current national guidance using the latest version of NHS Pathways. Training on use of the NHS Pathways was comprehensive and systems were in place to mentor new staff members until they were competent in its use. Staff were able to receive other training appropriate to their roles. Further training needs were identified and planned for through the appraisal system. Intelligence monitoring tools were used to analyse outcomes of calls received to ensure treatment was relevant and effective. There were suitable systems in place to manage incoming and outgoing information from the service to health and social care professionals. Effective processes were in place to gain patients' consent.

Our findings

Effective needs assessment

The service had systems and processes in place to ensure they used the most up to date information to assess patients' needs. We saw they used the latest version of the NHS Pathways and were preparing for a six monthly update.

Two members of staff we spoke with were completing their training on the use of the NHS Pathways and were being mentored. Both members of staff said they had received comprehensive training on the NHS Pathways systems prior to using it 'live'. The training had included wide ranging areas of health and gave them confidence to assess patients' needs correctly. We observed calls being taken by the staff. Throughout the process call handlers were calm and an assessment was completed thoroughly and in an unhurried manner. Clear instructions were provided to patients on what actions to take. When needed referrals to other services were made, such as the ambulance service or social services. We noted that one of the assessments related to a child who symptoms were not improving and the disposition was to see a GP within 12 hours, however, the clinician decided to arrange for an out of hours GP to attend earlier.

Management, monitoring and improving outcomes for people

The service used intelligence data tools to monitor call outcomes and this included the time spent responding to calls and the duration of the conversation with the patient. We looked at results from a survey carried out by the service which included information on whether patients followed the advice given to them. For example, the most recent quarterly survey results showed that 142 patients responded. Of these 85% said they had followed the advice given by the NHS 111 service; 12% had followed some of the advice and 3% did not follow the advice given. Information was also collected on which service the patient had had contact with in the first five days of contacting the NHS 111 service, for example accident and emergency department or their own GP. The patients were also asked about whether their condition had resolved, figures showed that the majority were completely better or much improved.

Are services effective?

(for example, treatment is effective)

Effective staffing

All staff who worked in the service received training specific to their role, which included written assessments and mentoring. The training requirements were set at national level and there were targets that staff had to achieve prior to being able to work alone. At the time of our inspection trainee call handlers and clinicians were being mentored. A trainee call handler was able to explain the NHS Pathways training and considered it was supportive and comprehensive. They had received support from their line manager and mentor, working towards completion the necessary stages of training. The member of staff added that there were further opportunities for professional development.

A clinician who was undergoing training explained that the latter part involved having calls monitored by a mentor. This involved a mentor listening in to calls and offering advice if needed. Staff also told us that their calls were monitored and feedback was provided and support given if improvement was needed.

Trained staff were required to undertake refresher training specific to their role and audits of their calls were undertaken to maintain the license agreement with NHS Pathways.

We were shown the training tracker used by the service, which logged all training staff had undertaken. This included information governance, fire safety and safeguarding, alongside the audits and training for call handling. Individual learning plans were in place and monitored. A member of staff said that as part of their development they were able to shadow a mental health team and observe the 999 dispatcher. (This is the staff member who coordinates and dispatches ambulances and first response vehicles.)

Working with colleagues and other services

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.

All staff said that they worked together as a team and supported each other. They considered that communication with other health and social care providers was effective. Partly due to members of these team working together in the integrated care hub and also by use of computer software systems. Protocols were in place, which had been devised in collaboration 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 managed the direct helicopter airlifts to Portsmouth hospital and there were protocols to follow if bad weather prevented an immediate transfer.

The NHS 111 service were 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. Data collected by the NHS 111 service during the April to September 2014, showed that 89% of respondents to a survey followed the advice given by the NHS 111 service.

Information sharing

Staff were able to indicate on the Adastra system which patients had care plans, for example for palliative care. These were known as special patient notes, which were able to be accessed by a local walk in centre and other health care providers. There was also information on patients who had a do not resuscitate order in place and those with long term catheters. A call handler gave an example of where they had contacted the district nursing team directly to see patients who had problems with their catheters.

Another call handler explained that they knew the team in the GP out of hours service and were able to anticipate what assistance would be provided by the out of hours service. This was outside of the usual parameters of their role, but showed how closely the NHS 111 service worked with other providers. The example given was when a child was ill and the parents requested that the child was seen by a doctor. The call handler said that they were aware a

Are services effective?

(for example, treatment is effective)

GP in the out of hours service would advise that a face to face consultation would be needed, so this was arranged. This demonstrated that there was clear understanding of the people, processes and systems in their area.

A performance support officer said that shift patterns had been altered to enable effective handover of information. This involved shift start and end times being staggered to allow for short handovers and eliminated whole shift changes of staff.

Consent to care and treatment

All staff had received training in consent procedures, this included supporting patients in decision making and assessment of capacity as far as possible during telephone conversations. We observed that staff always asked for a

patient's consent prior to sharing their information with other services. This was recorded on the computer system. We noted that patients were not routinely informed if a trainee was being mentored and their calls were being listened to. If needed staff would make decisions based on best interest principles if they considered that a patient was unable to give informed consent.

Staff were able to give examples of where consent requested when a patient was unable to do this for themselves. A staff member also gave an example of when a person telephoned on behalf of a patient and the call handler requested contact details for the patient in order that the service could contact the patient directly.

Are services caring?

Summary of findings

Patients were treated with compassion and respect and their privacy was maintained. Patients were involved in care and treatment decisions. Staff were observed speaking with patients with dignity and respect. The service provided information in a manner which enabled patients to understand the treatment options available to them.

Our findings

Dignity, respect and compassion

Throughout our inspection all staff who worked in the NHS 111 service verbally demonstrated caring and empathy to patients. One example was when a patient was distressed and the call handler continually reassured the patient throughout the call and was calm and polite.

Staff received training on being professional, efficient and friendly and treating patients in a manner in which they would like to be treated themselves. This was monitored in reviews of calls.

Results from the quarterly survey showed that 88% of patients were reassured by the NHS 111 service and 95% considered that staff were helpful.

Involvement in decisions about care and treatment

Patients were given information about care and treatment in accordance with NHS Pathways and in a manner that they were able to understand. We observed call handlers and clinicians taking time to explain what would happen and asking if a patient understood. Call handlers and clinicians were aware of the need to protect patient's confidentiality. Such as, when a mother called on behalf of their adult child. The member of staff asked whether the patient was aware of the call and requested that they spoke with the patient.

Results from the service's quarterly survey showed that 91% considered the questions asked by the NHS 111 service were relevant and 91% considered their problems were dealt with quickly. 80% were very satisfied with the way the whole process was handled.

Patient/carer support to cope emotionally with care and treatment

Staff at the NHS 111 service were aware of special patient records, such as those who were receiving end of life care and frail older patients. They were able to refer to a 72 hour crisis team who would provide care in the home to prevent unnecessary hospital admission. Patients who were experiencing mental health problems could be referred to the out of hours Serenity team, which was composed of the police and mental health workers. The team aimed to avoid sectioning of patients and provide support in the community. A member of staff said there was a programme

Are services caring?

of education for care homes, provided by the ambulance service in conjunction with NHS 111, on symptom control and management, to make sure relevant information was received by the service.

Results from the services quarterly survey showed that 87% considered the NHS 111 service worked well in practice and

87% considered that the NHS 111 service helped them make contact with the right health service. A total of 90% of respondents were completely happy with the service provided.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Patients were treated with compassion and respect and their privacy was maintained. Patients were involved in care and treatment decisions. Staff were observed speaking with patients with dignity and respect. The service provided information in a manner which enabled patients to understand the treatment options available to them.

Our findings

Responding to and meeting people's needs

The NHS 111 service had systems in place to respond to and meet patients' needs. This involved the input of commissioners and patient groups and worked under the island 'my life, a full life' banner for health and social care services. Discussion was also held with the hospice and end of life strategy group. The NHS 111 service piloted a service known as 'Check it out' for teenagers to email or chat on line to a clinical advisor on a confidential basis.

They also ensured that if a young patient contacted the service and needed contraceptive or sexual health advice, then this information was not passed to their GP, but advice only was given and referral onto another provider. However, if needed a safeguarding referral would be made. Pregnant women who had reached 13 weeks were automatically referred to the hospital maternity team where appropriate. The service was aware of higher than the national average of suicides on the island and could refer directly to mental health workers to provide a fast response to concerns.

Gap analysis of the directory of services was carried out to identify areas where additional services for the NHS 111 service to refer to were needed. For example, the 72 hour Crisis team had been developed over the past two years in response to a high incidence of frail older patients experiencing falls. However, not all providers on the Directory of Services list were available 24 hours a day, therefore the NHS 111 service was not always able to refer to their service. An example we were given was a clause which stated that no referrals would be accepted by a provider before 6pm. The NHS 111 service was aware of this and clinicians were able to override the disposition and change it with special agreement with the service.

Part of the National Quality Requirements included monitoring of dispositions to ensure that appropriate advice and support was given to patients.

Tackling inequity and promoting equality

The NHS 111 service had systems in place to promote equality, for example they used text speech for patients who were deaf and language interpretation services were available through the local hospital. All staff received mandatory equality and diversity training to ensure they

Are services responsive to people's needs?

(for example, to feedback?)

had the knowledge and skills to meet patients' needs. Staff were able to demonstrate their awareness of treating patients appropriately, for example, when a patient had learning disability.

Access to the service

The NHS 111 service was working with the clinical commissioning group and social care providers towards an integrated care system to meet patients' needs. Information was flagged on computer systems of patients with triage bypass cards, for example patients with complex needs or those with long term catheters. There was also information on patients who were receiving ventilation at home.

Feedback received from patients showed that they considered that the service was easy to use and calls times were monitored. There was a large electronic display in the integrated care hub which showed how many call handlers and clinicians were available, how many calls were in progress and how many were waiting for a response. When needed performance support officers would take calls during periods of high demand. If a call was received that was an emergency, then it was passed to the 999 service without delay. Audits showed that 'warm transfers' were carried out safely and quickly in response to need.

The timeliness of activity was supervised through internal audit and external audit by the clinical commissioning group and end to end reviews of calls.

Information from the NHS 111 minimum data set (January-December 2014) showed that the service was performing in line or above the national average on how calls were handled. For example, 96.3% of calls were answered within 30 seconds, compared with a national average of 92.9%; 0.9% of calls were abandoned after 30 seconds compared with a national average of 1.7%; and there were 93.7% of calls where a patient was triaged compared with a national average of 85.1%.

Listening and learning from concerns and complaints

The service had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and there was a designated responsible person who handled all complaints. We reviewed the complaints records and found that complaints were investigated and resolved as far as possible to the complainant's satisfaction. Learning points as a result of complaints were discussed at meetings and shared with relevant staff. When needed information was shared with the clinical commissioning group. Staff told us that if the service received a complaint about how they handled a call then the particular call would be listened to by their supervisor and themselves to identify if the complaint was valid. When needed support and further learning was provided to support staff. Actions taken in response to complaints were monitored until these were fully resolved.

Are services well-led?

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

Summary of findings

The vision and values of the service had been communicated well to all staff members. There were effective day to day working arrangements within the service, with staff having clear roles and responsibilities. The service monitored activity and regular governance meetings had taken place, which included systems to monitor and improve quality and identify risk. The service proactively sought feedback from its patients and staff and this had been acted upon.

Our findings

Vision and strategy

The NHS 111 service gave a presentation at the start of our inspection and their vision and strategy was working together 'beyond boundaries' to deliver quality care for everyone, every time. Staff said that they were aware of this vision and felt involved in the development of the service. A call handler said that all staff members worked as a team to provide the service patients needed.

The NHS 111 service worked with the local clinical commissioning group and other stakeholders to provide a patient centred service. The service was the conduit for patients to access other services and hub working with services, such as the Crisis team allowed integrated working.

Governance arrangements

There was a clear leadership structure with named members of staff in specific roles. For example, there was a member of staff whose main role was to update the directory of services. Another member of staff was responsible for training. All staff members were clear about their roles and responsibilities. They all said they felt valued, well supported and knew who to go to with any concerns.

There were suitable governance arrangements in place. Meetings were held regularly and included complaints review, significant events and review of the directory of services. Clinical governance meetings were held monthly and areas reviewed included staff cover, out of area calls received and audit of practice. The information from the clinical governance meetings was shared with the hospital board at their meetings and was a standing item on the agenda. We were told that each area covered, such as complaints or incidents had its own written summary and this was verbally reported and recorded in the board meetings minutes. Minutes of the meetings confirmed this. The service did not collate all information to be reported to the board in an interim report to be shared, but relied on individual reports, which did not consistently provide an overarching view of how the service was operating.

Are services well-led?

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

Delivery of the National Quality Requirements were monitored on a monthly basis and reported. Areas covered included matching capacity with demand for the service and contingency policies in place to ensure appropriate cover.

Leadership, openness and transparency

The NHS 111 service had close links with the NHS Trust board and the chief executive and senior management often visited the contact centre to engage and meet with staff. Staff we spoke with confirmed this. The management team for the NHS 111 service was based in the integrated care hub and a performance support officer who coordinated each shift worked in the call centre. Clinicians and call handlers said that their line managers and the senior team were regularly in the contact centre and they were always approachable. Throughout our inspection we observed that all staff interacted positively with each other regardless of position.

Staff said that there was an open culture which encouraged the sharing of information and learning. All the staff we spoke with told us they felt valued and listened to. A senior manager said that the service encouraged candour and learning. They also considered that ideas from front line staff should be explored and implemented when appropriate. An example shared with us by a member of staff related to the rosters. This idea was shared with the management team and at the time of our inspection a 'new style' duty rota was being trialled. There was a clear understanding that patient and service needs were the priority but staff appreciated being listened to and engaged in the process and were and hopeful that a new rota system may arise out of the trial.

Public and staff engagement

The service gathered feedback from staff through staff meetings, appraisals and discussions. Staff said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said they felt engaged and involved to improve outcomes for both staff and patients. Managers were responsive to ideas and when possible took action to implement them. They said they felt valued and supported to do their job and enjoyed coming to work.

Health professional feedback forms were available for stakeholders to comment on the service provision and regular patient surveys were carried out. Surveys covered areas such as how quickly calls were answered; what happened during the call, for example transfer to a clinician and how helpful the service was. All areas had high positive scores for patient experience.

Continuous improvement

The NHS 111 service held operational meetings every six months which covered staffing and progress on recruitment and training. Information on staff planning was shared with NHS England, for example proposals for cover over bank holidays. Reviews of frequent callers were also carried out and learning was implemented and shared with staff.

As part of National Quality Requirements call audits were carried out monthly. A recent audit of calls taken showed that 95.33% of calls were answered within 60 seconds, 96.22% of calls were taken and 96.9% warm transfers were completed within given timescales. The audit showed that the target for making clinician call backs within ten minutes was low, with only 35% being made during the specified timescale. Improvements and monitoring were on going to increase the number of call backs within the stated time.

The service had a risk register which was used to review significant events. An example given was when a patient lost a tooth and there was a delay in appropriate treatment. The involvement of the NHS 111 service had been thoroughly investigated and as a result of this incident accurate information on out of hours dentist availability was added to the directory of services (DOS).

The member of staff responsible for the DOS said they linked with the regional lead for DOS and any improvements needed were actioned. They added that any feedback received from patients GPs or other service who considered an inappropriate referral was made was reviewed and changes made to the DOS if needed.