Trust HQ

NHS 111 Inspection report

Abbey Court, Eagle Way
Sowton Industrial Estate
Exeter
Devon
EX2 7HY
www.swast.nhs.uk

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

Ratings

Overall rating for this location	Good
Are services effective?	**Requires improvement**
Are services well-led?	**Good**

Overall summary

This service is rated as Good overall. (Previous inspection May 2018 – Good)

The key questions are rated as:

Are services effective? – Requires Improvement

Are services well-led? – Good

We carried out an announced focused inspection of Trust HQ- South Western Ambulance Service NHS Foundation Trust (SWASFT) NHS 111 service on 23 and 24 July 2019 in response to concerns regarding performance and staffing. We looked at whether the service was providing effective and well led services.

At this inspection we found:

- Performance of the service and outcomes for patients was mixed. The provider has been open with commissioners, staff and regulators about the difficulties the service has faced, future plans and current measures to attempt to keep the service safe.
- The provider worked effectively and had systems of ongoing monitoring of the services. Efforts had been made to address gaps in services (including: ongoing staff recruitment, use of national contingency resources/plans, staff incentives, call audit performance).
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- The service had systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- There were embedded systems in place in relation to learning from adverse incidents and significant events and joint working and sharing with external stakeholders, other providers and patient representatives (Duty of Candour).
- Continued positive feedback from patients about the care received.
- During our inspection we found sections of staff, notably advisors and first line managers to be highly dedicated and proud of the important work they were undertaking. However, they were also open and honest about the challenges they were facing on a daily basis. Staff were positive about the support received from direct line managers. Support from the senior management team was less embedded and needed improvement to improve working relationships.
- There was a continued and focused programme of recruitment.
- There was a focus on continuous learning and improvement at all levels of the organisation.

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

Ensure care and treatment, including call answering, call abandonment and clinical advisor call back rates, are delivered in a safe way for service users.

The areas where the provider **should** make improvements are:

- Continue with the planned programmes to improve staff engagement and disconnect between staff and leadership teams.
- Continue with the ongoing recruitment of staff.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a second CQC Inspector, assistant inspector and an NHS 111 doctor specialist advisor.

Background to Trust HQ

The provider, South Western Ambulance Service NHS Foundation Trust (SWASFT) provides four regulated activities: Treatment of Disease, Disorder or Injury; Diagnostic and Screening Procedures; Transport Services, Triage and Medical Advice provided remotely and Surgical procedures.

The ambulance service have two emergency (999) operation centres, in Exeter and Bristol and an NHS 111 operation centre in St Leonards, Dorset.

This report relates to the inspection of the NHS 111 services provided for the population of Dorset by SWASFT.

The South West Ambulance Trust Headquarters is located at:

Trust HQ, Abbey Court, Eagle Way, Sowton Industrial Estate, Exeter, Devon, EX2 7HY

The Trust operates the Dorset NHS 111 service from one main call centre location:

East Division Headquarters Acorn Building, Ringwood Road, St Leonards, Dorset, BH24 2RR.

Further clinician and quality support is available from the Exeter Trust Headquarters hub base and remotely.

The provision of the NHS 111 service is part of the Integrated Urgent Care Service provided by Dorset Healthcare and covers the county of Dorset. The area covered has a geographic area of 1024 square miles, a population of 422,900 and a high influx of visitors per year. There is one clinical commissioning group (CCG) who have a contract with the Trust for NHS 111 service. (NHS Dorset CCG)

SWASFT NHS 111 service operates 24 hours a day 365 days of the year. It is a telephone based service where patients are assessed, using computer based 'NHS pathways', given advice and directed to a local service that most appropriately meets their needs. For example, this could be a GP service (in or out of hours), walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance, pharmacy or home management. In addition to the standard staffing mix for a 111 service, the service also employ clinicians including GPs, nurses and paramedics during the in hours period who gives additional clinical input to calls.

For this inspection we visited the East Division Headquarters Acorn Building, Ringwood Road, St Leonards, Dorset, BH24 2RR.

Requires improvement

Are services effective?

We rated the service as requires improvement for providing effective services.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- The provider used the Department of Health approved NHS Pathways system (a set of clinical assessment questions to triage telephone calls from patients). The tool enabled a specially designed clinical assessment to be carried out by a trained member of staff who answered the call. At the end of each assessment a disposition (outcome) and defined timescale was identified, and an automatic search was carried out on the integrated Directory of Services (DoS). The DoS is a central directory about services available to support a particular person's healthcare needs and this is local to their location. The directory of services was updated by the clinical commissioning group (CCG). Leaders liaised with the CCG to ensure relevant updates were included, such as details of the mental health crisis team. Staff reported that services were sometimes not profiled correctly. For example, referral to the emergency department or home care advice where services were not provided locally. These concerns were shared with the CCG.
- Patients' needs were fully assessed. Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Clinicians used the triage tool in a sensitive way, allowing time for callers to communicate their concerns.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients and a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans, special notes and standard operating procedures were in place to provide the appropriate support.
- We saw no evidence of discrimination when making care and treatment decisions. The NHS Pathways assessment process ensured patients were supported and assessed on their needs rather than on their demographic profile.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service had a programme of quality improvement activity, routinely shared failures in providing this activity with external stakeholders and regulators ands were still working on areas of improvement.

- Providers of NHS 111 services are required to submit call data every month to NHS England by way of the Minimum Data Set (MDS). The MDS is used to show the efficiency and effectiveness of NHS 111 providers. We saw the most recent results for the service and results since 2017 which showed an increase in calls (offered) received. For example, in 2017/18 18,111 had been received, in 2018/19 20,156 had been received and in 2019/20 21,763 had been received. The following outcomes of the national performance indicators highlighted some areas where the service was not meeting targets:
  - NHS 111 Call answering in 60 seconds targets of 95% had been missed since June 2018 and showed a falling trend. For example, in June 2018 the percentage was reported at 82.4% and June 2019 71.1%. National benchmarking showed that the NHS 111 service for Dorset were lower in the months between April 2019 and June 2019 and although stabilising, not showing signs of receovery.
  - NHS 111 Call abandonment rates were mixed and sometimes exceeded the 5% target. For example, in February 2019 this was reported as 6.71%. These rates had started to improve at the beginning of the months of April, May and June 2019 with rates at the beginning of each month being reported at 3.39%,

4.75% and 4.92% respectively. However, rates mid-month rose again slightly to above the 5% target. For example, 6.93% in April 2019, 5.42% in May 2019 and 6.79% in June 2019. These rates remained consistently lower than the highest national average.

- The percentage of clinical call backs within 10 minutes missed the 95% national target. During February 2019 the weekly percentages ranged between 23.4% and 30.1% compared with the national averages of between 34.4% and 38.1%.
- The whole-time equivalent (WTE) numbers of clinicians had reduced from 20.6 in April 2018 to 15.5 in February 2019, although this was now starting to improve and now was reported at 25 WTE.

There were areas where the Trust were meeting, or were in line with national targets:

- Rates for transferring calls to the ambulance service were in line with national averages.
- The percentage of calls answered by a clinician was in line with national averages. For example, for the month of February 2019 percentages ranged between 49.6% and 50.4% compared with national average rate of between 46.9% and 47.8%.
- The percentage of triaged calls that received clinical input remained above the target of 50% and since April 2018 had ranged between 52% and 62%.

The provider routinely shared the monthly performance reports with the board, regulators, clinical commissioning group and Dorset Healthcare. Wherever the service was not meeting the target, the provider had put actions in place to mitigate and improve performance in these areas and increased the frequency of communication with commissioners to weekly calls and regulators as required. Recent mitigation plans included ongoing recruitment of staff and use of national contingency where required to keep patients safe.

We spoke with a representative from Dorset CCG who stated that the provider had been open and honest about the failure to meet many of the national targets and responsive to suggested actions. The CCG representative said the Trust had always proactively shared performance information on a weekly and monthly basis and had sent regular action plans to describe and monitor actions and mitigation to address the missed targets. These included attempts to change staff rotas, incentives for staff to work additional hours and ongoing recruitment processes. The representative said that despite the efforts made the Trust had made a decision not to extend the contract because of continued poor performance despite efforts made and were working with commissioners and Dorset healthcare to hand over a safe service to a new provider.

It is a requirement of the NHS Pathways licence that a clinician should be available in the same room at all times. The Trust had recorded that where clinicians were not available on site, the CCG and NHS England were informed, and calls put out to other NHS 111 providers. Staff explained that this was also done where clinicians were only based at the Exeter HQ and not on site at the Dorset call centre. The Trust informed us that the service went to national contingency on six occasions during financial year 2018/19- three times in the last year (July 2018 to July 2019). National contingency is where NHS 111 calls can be transferred to other NHS 111 providers when the service could not meet the requirements of the NHS Pathway licence or the needs of patients. A national report showed that the national contingency had been used 169 times across the country by all NHS 111 providers and SWASFT had used this service 11 times themselves. The highest national use was 21 days and lowest two days. All NHS 111 services, including SWASFT, offer this service to support other NHS 111 services.

The Trust also used significant and adverse incidents to prevent reoccurrence and review mitigation processes. For example, a review of an incident was completed in April 2019 where a manual process to transfer an NHS 111 call to the 999 service was not followed correctly due to a link failure. An audit of the system was completed for cases from Quarter 4, 2018/19. Findings showed that all cases had been transferred correctly.

The service used information about care and treatment to make improvements.

The service made improvements through the use of investigating when things went wrong. We saw examples which showed how the Trust worked with families, coroners, other healthcare providers and stakeholders to improve care for patients locally and nationally. For example, following an unexpected child death, the Trust completed a detailed and comprehensive investigation which identified a missed opportunity in relation to the questions asked by the NHS Pathways system, although it

was uncertain whether different action could have prevented the death. The Trust worked with NHS Pathways to introduce an additional answer to help safely navigate appropriate questioning. Before this was implemented, the Trust introduced a 'workaround' until the pathway was introduced. The Trust introduced many changes which included:

- Development and implementation of guidance
- Developed and completed a specific training course on the identification of the seriously ill child
- Reinforced to Call Advisors the process to follow regarding Repeat Callers
- Completed monthly sessions to ensure consistency of call audits and
- Issued a reminder to all 111 staff reinforcing the definition of a complex caller and the correct process to follow.

The service made improvements through the use of completed audits. All health advisors had completed a mandatory comprehensive training programme to become a licensed user of the NHS Pathways programme. Once training was completed, all health advisors were subject to structured call quality monitoring to ensure continued compliance. The provider shared evidence of call audits for both health advisors and clinical advisors for the period April 2019 to June 2019. Results showed the team had completed over 100% of audits. Call audits were reported on each month and end-to-end call audits were also discussed at external Clinical Governance Group meetings to share learning.

- The service was actively involved in quality improvement activity. For example, the introduction of a remote clinician working so more clinical calls could be managed.

Effective staffing

- Staff had the skills, knowledge and experience to carry out their roles.
- All staff were appropriately qualified.
- The provider had a four-week induction programme for all newly appointed staff. This included training to use the NHS Pathways triage tool, workshops and supervised practice. Staff we spoke with told us the induction programme was valued by staff. Staff participated in subsequent training for the triage system every six months when the system was updated. Records showed that at the time of inspection 100% of staff had completed the core modules 1 and 2 NHS Pathways training.
- The service offered role specific training. Clinical and non-clinical staff were required to attend a learning and development day once per year. Learning and development days were scheduled at various times approximately four times per month.
- The annual learning and development days offered to health advisors and clinicians were tailored to meet current learning needs, including learning from recent adverse incidents. These incidents were now referred to as RLI (Review, Learn, Improve) events. The development session for clinicians had focussed on themes emerging from investigations. Learning from RLI's was also shared in bespoke group sessions. For example, when changes to the sepsis protocol were introduced the learning and development officer facilitated additional teaching sessions to ensure this learning was embedded quickly. Data showed that 91% of clinicians had completed this training within the last year following a drop to 62% following a recent high turnover of staff. Action had been taken to continue to improve on this completion target.
- The provider provided staff with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider had education opportunities in the wider Trust through formalised education and training structures. At the time of inspection data showed that 80% of staff had received a career conversation (appraisal) in the last year.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. For example, learning from call audits or RLI's was shared with individuals on a one to one basis using a support plan and facilitated by a liaison officer. A member of staff we spoke with told us this had been a positive learning experience.

The Trust were monitoring staff turnover and retention rates and were aligning roles with the introduction of the new Integrated Urgent Care Centre in April. Ongoing

recruitment to fill the new posts was ongoing. The Trust had also reported that staff turnover in 2018 had been between 40% and 50% with a sickness rate of between 9% and 10%. A recruitment drive was increased with continuous job adverts on NHS Jobs.

At the time of inspection, the Trust had a funded establishment of 45.95 Whole Time equivalent call advisors and 5 WTE Senior Call Advisors. The Current position was that following the recruitment drive there were 44.77 WTE Call advisors and 5.32 Senior Call advisors in post. The provider shared the ongoing establishment and resourcing plan which showed recruitment continued to be a priority of the service.

Coordinating care and treatment

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

There were clear processes in place to manage the transfer of calls, both internally within the service, and to external providers, to ensure a safe service. For example, a referral to a patient's own GP or to an out-of-hours GP service. Standard operating procedures were available on a shared drive.

- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances. For example, accessing 'special notes' explaining the health needs of the patient.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them.
- Issues with the Directory of Services were resolved in consultation with the commissioners.
- The provider met regularly with the contract commissioners to discuss all aspects of performance and was proactive in liaising with other service providers such as out-of-hours services and social services to ensure patients received the best outcomes.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health.

- The service identified patients who may be in need of extra support. For example, those with mental health needs or vulnerable patients.
- Where appropriate, staff gave people advice, so they could self-care or access services including pharmacists, dentist and midwives. Systems and staff rotas were available to facilitate this.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Good

Are services well-led?

We rated the service as good for leadership.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care. However, the significant staffing issues meant that leaders recognised delivering quality care was becoming harder.

- The leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- The Trust had communicated with commissioners, regulators and other stakeholders its decision to withdraw from the contract to provide NHS 111 services across Dorset at the end of their contract or before if another provider could be sourced. Staff had been informed of this decision on 10 July 2019 and this information was released to the public shortly afterwards. The Trust explained an awareness that this was due to difficulty to manage the high turnover of staff associated with the service. The Trust gave assurances that an action plan remains to continue to recruit staff with an aim to hand over a safe service to a new provider.
- Leaders had the experience and skills to deliver the service strategy and address risks to it. For example, the leadership structure within the communications centre worked well. Accountability was shared between operational and clinical leaders.
- There was a clear leadership structure and rotas were available to ensure senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use. For example, staff always had access to a duty manager for operational leadership and a clinical team leader for clinical advice 24 hours a day, seven days a week.
- Feedback from staff indicated senior leaders at all levels were not always visible or approachable. Local managers had tried new strategies to improve their visibility. For example, representatives from the leadership team had introduced a rota for managers to take it in turns to work alongside the health advisors and clinicians on the ground floor of the building. Managers informed staff by email and bulletin which managers were rostered to be available. Staff feedback about this approach was mixed, depending on the manager. During the inspection management availability information was displayed on a screen in the communication centre.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. For example, 350 leaders from across the Trust had been invited to attend the Aspire, Connect, Transform Leadership development programme which began in July 2019 and was due to be completed by March 2020. This was a mandatory programme for leaders to attend.
- There had been an increased promotion of the Freedom to Speak Up Agenda with roadshows, meetings for staff. Freedom to speak up ambassadors were present within the building and there was a dedicated Twitter feed established.

Vision and strategy

The service had a Trust wide 'Mission, Vision, Values and Goals' statement which set out a strategy to attempt to deliver high quality care and promote good outcomes but had recognised they were unable to deliver this strategy for the NHS 111 service.

- The Trust wide vision and set of values was clear and had been developed jointly with patients, staff and external partners.
- NHS 111 staff were aware of and understood the vision, values and strategy and their role in achieving them but were also aware the Trust were unable to continue with the service.

Culture

The service promoted a culture of high-quality sustainable care but recognised their limitations in fully implementing this.

- Staff felt respected, supported and valued by their colleagues, although less so by some of the management team. Staff said they were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

Good

Are services well-led?

The Trust had listened to staff feedback and had commissioned a cultural review in October 2018 which found:

- The attempt to introduce a new rota review was not popular with staff and had not been handled well.
- There remained reports of bullying within the organisation
- Strained working relationships and friction identified in the NHS 111 part of the Trust.
- Staff expressing concerns that there was no equity when treating staff who were involved in incidents.
- Allegations that no other unions were recognised by the Trust

Findings were shared with staff, the board and external organisations, including CQC. An action plan was implemented and kept under review. At the time of inspection 28 of the 49 actions had been completed within timescales. These included staff development plans, reviewing of policies, review of training and induction, engagement programmes and review and implementation of welfare processes. The remaining 22 actions were 'on track and due to be completed between August 2019 and December 2019'. Staff were aware of this review and programme and said they were beginning to see improvements, including more visible management, introduction of mental first aid processes and review of policies.

- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. We looked at seven adverse incidents and saw that all of these had been managed with openness, honesty and transparency. The duty of candour was demonstrated in all of these examples, although timescales missed in a small number where contact information for patients relatives was not readily available and required to be sourced by the provider.
- The provider had introduced a new approach and had rebranded the management of serious incidents and the significant event process to focus on a culture of continuous learning and improvement and the development of an open, reflective workforce. The system was now called 'Review, Learn, Improve' (RLI).
- Staff we spoke with told us they were able to raise concerns about clinical issues and were encouraged to do so. Staff said that any learning was communicated by email or within the development days.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual 1-1 meetings appraisals during the in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Some staff were positive about the imminent changes to the contract and saw this as an opportunity for development. For example, leaders had offered staff the opportunity to become emergency care assistants in the emergency and urgent care service.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. Following feedback from staff and monitoring of sickness there had been 130 Mental Health First Aiders trained and introduced across the trust.A revised Health and Wellbeing Policy together with a Critical Illness toolkit was introduced to help manage sickness in a more person centred way.
- The service actively promoted equality and diversity and had recently revised their Dignity and Respect at work policies to ensure the staff member was treated as an individual. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- The relationships between staff and leadership teams was mixed. For example, a number of staff told us that managers at a local level were supportive and caring, whereas others said this support and care was not as effective in previous years. Staff said the timing of communications about the changes to the contract had not worked well as several staff were unable to attend the meeting. Staff felt they had not been supported well during the rota review. However, some of the staff we spoke with were excited about the changes and saw the new contract as a fresh start.

Staff told us demand had increased during evening periods and peaked at weekends. All staff we spoke with told us

they felt under pressure citing there were not enough staff to meet the demand. They told us this impacted upon working relationships because staff felt they were too busy to greet one another or enquire into each other's well-being. However, staff told us that the team were friendly, and others said the service was a good place to work.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The service made sure that correct governance procedures were in place prior to implementing service wide changes. For example, the further recruitment of band two service advisors was on hold until the clinical effectiveness group had signed off the governance for the introduction of this new role.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. For example, the quality manager attended the Trust Partnership board meeting to discuss pertinent risks, for example, staffing and call performance.
- Staff were clear on their roles and accountabilities including in respect of safeguarding.
- Leaders had established proper policies, procedures, standard operating procedures and activities to ensure safety and assured themselves that they were operating as intended.
- The provider monitored trends in feedback, compliments, complaints and adverse incidents as part of the wider ranging governance processes. There had been a slight reduction in the number of complaints. For example, 39 complaints had been received by the Trust in 2018/19 compared with 42 in 2017/18. Themes included call back delays, concerns with the NHS Pathways process and callers not being happy with the information provided. The Trust had received 14 plaudits for the NHS 111 service. These included positive feedback of assessment, prompt service and care provided and relating to caring, professional, sensitive and understanding staff.
- The provider monitored statistics relating to adverse incidents. Data showed between March 2018 and July 2019 the number of incidents ranged between 10 per month and 32. Monitoring of the processing of these took place and showed there was a reduction of 126 outstanding incident investigations between January and July 2019 to 34 at the time of the inspection.

Managing risks, issues and performance

There were clear and effective processes for monitoring, managing risks, issues and performance and were in progress where shortfalls had been identified.

There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. For example:

- Staff told patients when to seek further help. They advised patients what to do if their condition got worse. Staff managed effective conversations whilst delivering he script of the triage tool. Health advisors gave advice to callers to follow if their condition worsened.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. Patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Call advisors could locate a clinician in the room for advice when needed using a speed dial system on their computer. We saw health advisors used instant messaging to flag any patients who were particularly vulnerable. For example, a health advisor asked the clinician to prioritise the review of a small baby with persistent high temperature lasting three days.

The provider had processes to monitor current and future performance of the service and were aware where performance was poor. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of MHRA (Medicines and Healthcare products Regulatory Agency) alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly

discussed at senior management and board level, with the local CCG as part of contract monitoring arrangements and was shared with the Care Quality Commission (CQC) and NHS 111 staff via a weekly email.

Comprehensive risk assessments were in place to monitor the risks within the service. For example, the Trust had recognised:

- The potential inability to meet NHS 111 performance, because of demand and/or resources, resulting in the failure to meet performance targets for call answering (95% within 60 seconds) and calls abandoned, or delay in contact by a clinician or increase in 999 transfers. In response, controls had been introduced; including comfort calls for patients waiting, staff overtime incentives, ongoing targeted recruitment and use of escalation plans. Data showed call answering rates, although remaining under the 95% target had not consistently fallen month on month. For example, in April 2018 rates were at an average of 89% dropping to 64% in January 2019 but starting to increase to 70% in May 2019 and 71.1% in June 2019. In addition, call abandonment rates were met in four of the 14 weeks between April 2019 and July 2019 and the Trust were lower than the national lowest average for all 14 weeks monitored.
- The increased 'clinical call back times' which could affect patient safety. As a result, the Trust had increased the recruitment and use of remote clinical staff from two staff to over 32 staff, continued with the daily operational conference call weekly reporting of staff numbers, continued reporting of concerns to the county commander and executive team.There was ongoing communication with stakeholders: commissioners, Dorset Healthcare Trust and other providers to discuss clinical support patients might need.
- The providers had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. However, the information technology systems used locally in Dorset, did not always work well to facilitate seamless care. For example,

- Health advisors could not access the booking system for out of hours treatment centre appointments. The Trust had 'workaround' solutions to address this.
- Clinicians could advise patients to go to the emergency department. However, local emergency departments had chosen to not receive notification of these incoming referrals.
- When the triage system identified calls as category one emergencies, these calls were automatically redirected to the emergency ambulance service. However, there were times when this electronic transfer system did not work, and health advisors were required to manually facilitate the transfer of the call.

Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses and improvements were underway.

The service submitted data or notifications to external organisations as required.

- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- Patient experience surveys were used to shape services. 677 surveys were returned in 2018/19. Of these 91% of respondents reported they were likely to recommend the NHS 111 service.

Good

Are services well-led?

- Managers had taken steps to improve staff engagement following a reported unsuccessful review of the staff rota. In the weeks prior to our inspection, clinicians had met with the deputy director of patient safety and local managers to reconsider a way forward for managing the rota. Clinical staff planned to trial self-rostering and another meeting was planned in October 2019 to monitor progress against this goal.
- There were opportunities for staff to engage with the leaders regarding service developments. For example, leaders arranged several staff engagement events to discuss the rota review. However, staff attendance and participation at these events had been poor.
- Staff were able to describe the systems in place to give feedback or raise concerns. This included verbally to their line manager or through use of the 'Datix' system which was an electronic system to escalate concerns. Staff also added there was a whistleblowing policy and 'speak up guardians' within the organisation. Staff felt confident that serious issues were addressed appropriately. However, feedback about whether their general concerns were listened to was mixed. Of the 23 staff that answered this question 17 said no, three were mixed and added it depended upon the manager and three said yes. The 17 staff told us although the leadership team may listen there was little confidence that the leadership team would act on this. We saw the provider had attempted to introduce a rota review and noted this was discontinued after consultation with staff.

The service was transparent, collaborative and open with stakeholders about performance. For example, sharing the recent performance report and staff culture review findings with the CCG and CQC. The Trust had shared concerns with the CCG, board and CQC that they were missing national targets. Action plans were shared to show mitigation to maintain as safe a service as possible. For example, we were told that staff attrition figures were well below national targets. The provider gave assurances and demonstrated evidence of continuous advertising of jobs, review of job description and skill mix, use of agency and overtime incentives and successful roll out of clinical remote working.

The Trust continued to monitor staff turnover rates which at the point of inspection were at 40% and sickness rates at 9%. The Trust also monitored staff compliance with attendance at learning and development days. For the period April 2018 to April 2019, 72% of staff attended, this equated to 91.5% of clinicians and 60% of non-clinicians. A tactical decision had been made by the Trust to hold more than required training courses to account for the calculated dropout rate.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement at all levels within the service. The Trust had rebranded the serious incident process to focus on learning and sharing from where things went wrong and to further promote a culture of reporting and learning.
- Staff knew about improvement methods and had the skills to use them.

The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. For example, learning from RLI's was shared outside the organisation. For example, investigation from an RLI had identified a gap in the assessment of children presenting with dark green vomit. Leaders had proactively collaborated with NHS Pathways to influence changes to the tool to ensure future versions incorporated the learning. The team had participated in testing the new versions of the tool. Where necessary, the service made changes to protocols to incorporate learning from RLIS's, such as the addition of a 'work-around' for staff to follow where the algorithm did not meet patient safety needs.

- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

There was a strong culture of innovation evidenced by the number of pilot schemes and joint working the provider was involved in. For example, working proactively with NHS Pathways to improve and introduce additional safety checks and options following learning from significant and adverse events.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider was failing to provide care and treatment in a safe way for service users.** **For example, failing to achieve national targets in,** • NHS 111 Call answering in 60 targets. • NHS 111 Call abandonment rates. • Missing the percentage of clinical call backs within 10 minutes.