Hanover House

Inspection report

Hanover House
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Kingston Upon Thames
Surrey
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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	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Overall summary

This service is rated as requires improvement overall. The service was previously inspected on 27 July 2017. At that inspection the rating for the practice was good overall. This rating applied to the safe, caring, responsive and well led domains. Effective was rated as requires improvement.

The report stated where the service must make improvements:

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

In addition, the provider should:

- Develop effective systems and processes to ensure safe care and treatment including learning from significant events and complaints is being shared with all relevant staff.
- Develop effective systems and processes to ensure good governance including ensuring that the service meets national targets.
- Ensure that all responses to complainants are managed within the services specified 30 day deadline.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Requires improvement

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Hanover House on 5 and 6 July 2018. As part of the visit we also visited the sites at Vocare House and Crutes House.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. Learning from incidents was shared at two of the sites from which the service was run, but not the third.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided.
- Staff were supported in the effective use of NHS Pathways which is a triage software utilised by the National Health Service to triage public telephone calls for medical care and emergency medical services.
- The service had not met all the National Quality Reporting standards and those requirements set by the commissioners of the service. For example, the service had not met the standard for calls answered inside 60 seconds in any of the six months prior to the inspection.
- Audits were in place to monitor the performance of staff at the service, but some staff had not been audited.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- The service had a clear system for managing and learning from complaints. However, the service was not following its own policies regarding the timescales in which complaints were managed, and learning from this was not widely shared among all staff and other relevant organisations.
- The service had an overarching governance framework in place, including policies and protocols which had been developed at a provider level and had been adapted to meet the needs of the service locally.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- The service had built relationships with local patient participation forums at a regional level in order that patients could feed into the service being provided.

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

- Develop systems to ensure that the service can deliver local and national performance targets, including ensuring that sufficient clinical call handlers are available.
- Ensure that learning from incidents, safeguarding alerts and complaints is shared with all staff at the Hanover House site.
- Ensure that complaints are followed up in time and that actions are taken even where complainants are unavailable for follow up. To also ensure that complaints, and learning from them are shared with other healthcare providers where it is relevant to do so.
- Ensure that references are taken for all staff, including those working through employment agencies.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Our inspection team

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

Background to Hanover House

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

As part of the inspection we visited three sites. Although the main hub site is in London, services are provided from three addresses. The first is 78 Coombe Road, Kingston-Upon-Thames, Surrey, KT2 7AZ. There is a call centre at this site which currently takes approximately 25% of calls and local management for the service is based at this centre. Further services are provided from Vocare House, Baliol Business Park, Newcastle-Upon-Tyne, NE12 8EW. Head office managers and the executive of Vocare are based at this site, as well as 20% of the call handlers. Finally, there is also a call centre at Crutes House, Fudan Way, Thornaby, Stockton-on-Tees, Cleveland, TS17 6EN, which takes the remainder of the calls.

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

Although the company is based in Newcastle where many senior staff are based, there are clinical and operational leads within regions who have overall responsibility for the delivery of the service. There is a lead Pathways trainer for all operational staff. The operational teams are led by 11 team leaders in both the London and Newcastle offices, each of whom have responsibility for a shift team.

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

The service is registered with the CQC to provide the regulated activity of Transport services, triage and medical advice provided remotely.

Are services safe?

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

Safety systems and processes

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

- The provider conducted safety risk assessments. It had safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Staff we spoke with were clear about their responsibilities and could outline to whom to report.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider had recruitment policies and protocols in place. However, the service utilised a number of temporary agency staff, and in files we checked for these staff there was no record of references having been checked.
- Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- However, individual members of staff told us that there were insufficient staffing at the service. We noted that notwithstanding the use of locum staff there were gaps in rotas that were not filled. Staff told us that at busy times during the winter period there had been insufficient management and clinical cover, although all but one staff said that this had now been resolved. Representatives of the provider told us that they were still actively recruiting for both call advisers and clinical advisers, and that the expansion of the business had meant that some rota gaps could not be filled in the short term. Staff reported that there had been periods where there were insufficient managers and clinical adviserson site. Rotas showed that these issues had been resolved in the past three months.
- When there were changes to services or staff the service assessed and monitored the impact on safety. The service had an action plan in place following the last inspection and had systems of work force planning in place to ensure that shift rotas matched the demand of the service.
- There was an effective induction system for staff tailored to their role.
- 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. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Systems were in place to manage people who experienced long waits.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinical advisers made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Track record on safety

The service had a good safety record.

Are services safe?

- There were comprehensive risk assessments in relation to safety issues. The provider had recently implemented a monthly service assessment booklet for each site following staff recommendation. These included health and safety, infection prevention and control and medicines management assessments that were carried out monthly for each site. Results and issues were fed back to the management team and where appropriate issues were placed on the risk register for escalation and action.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, including the local NHS Ambulance service. The service reviewed cases where ambulances were called unnecessarily.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. Staff at Vocare House and Crutes House were aware of how to access “hot topics” and said that there were formal systems by which learning was shared. However, those at Hanover House were unaware of learning from incidents and were unaware of processes to support this.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and acted to improve safety in the service. For example, in all cases where we could see there had been an error in the management of a case by a call adviser or clinical adviser, there were recorded details of discussions and learning points, including learning for all staff where relevant.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Are services effective?

At our previous inspection on 27 July 2017 we rated the provider as requires improvement for providing effective services and stated that the service must:

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

At this inspection we rated the service as requires improvement for providing effective services.

Effective needs assessment, care and treatment

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

- Clinical advisers 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. These were available on the intranet system and emailed to staff.
- Telephone assessments were carried out using a defined operating model which included processes for assessing patients' symptoms through a triage algorithm, with options including transferring the call to a clinician for further review.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. 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 considered the needs of those whose circumstances may make them vulnerable.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients, including engaging with the local NHS acute trust to share information to identify, monitor and support those patients who frequently called the NHS 111 service and those who also frequently attended the hospital emergency department. This was to both develop services, and to ensure that patients were contacting their GP where relevant.
- There was a system in place to identify frequent callers and patients with additional needs, for example patients receiving palliative care, and care plans and protocols were in place to ensure the service provided the appropriate support.
- When staff were not able to make a direct appointment on behalf of the patient, clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.

Monitoring care and treatment

The service had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. However, we saw that the service was an outlier in several monitoring standards.

- From 1 January 2005, all providers of out-of-hours services were required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to their clinical commissioning group (CCG) on their performance against the standards which includes: audits; response times to phone calls: whether telephone and face to face assessments happened within the required timescales: seeking patient feedback: and, actions taken to improve quality. Although these are national targets, the commissioning CCGs may alter targets as they wish within the contract.
- 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 which showed the provider was performing in line with national averages in some areas but below national averages in others:
    - The abandoned call rate was between 1.9% and 6.1% for each of the 12 preceding months, compared to the England average of 3% and the national target of less than 5% and the commissioner key performance indicator (KPI) of 5%;

Are services effective?

- The percentage of calls answered within 60 seconds was between 64% and 88.5% for each of the 12 months prior to the inspection (England 84%, national target 95%, National KPI 95%);
- The percentage of calls triaged that were dealt with by a clinician was 38.9% (England 43%);
- The percentage of answered calls transferred to a clinical advisor with the patient still on the line was 33.38% (England 40%);
- The percentage of calls either warm transferred or called back in ten minutes for ambulance or emergency department dispositions was below 80% in all but two of the last 12 months.

The provider had an action plan in place to address the areas where performance was below national standards and the standard set in the contract. Staff told us that when Crutes house had opened there were insufficient clinical advisers and managers. Recruitment had been ongoing and staff told us that this issue was now improved, which was reflected in better results in the past two months. The provider utilised work force planning software to determine the fill required for shifts, and in the past 12 months the percentage fill for shifts had improved.

- The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. We saw an audit of clinical call back breaches between March and May 2018. We saw that all high-risk breaches were themselves fully audited and the results and learning shared with staff.
- The service had systems in place to meet the national quality requirements for auditing at least 1% of clinical patient contacts. However, we noted that some clinicians in the service appeared not to have been audited as part of this process.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. However, staff at Hanover House reported that this was less clear than at the other two sites, and a worker who worked from home said that supervision lines were unclear.
- The level of clinical adviser support over the previous 12 months had been below the level required, and staff told us that clinical support had sometimes been unavailable. However, they reported that this had been improved in more recent months.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained, although we noted that not all staff had completed fire safety training.
- The provider had not maintained references for agency staff, and it was therefore not possible to determine whether or not references had been checked.
- 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 could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach through the service quality audit programme for supporting and managing staff when their performance was poor or variable. Measures included direct staff feedback, mentoring and supervision,

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services. Staff communicated promptly with patients' registered GP's so that the GP was aware of the need for further action. There were established pathways for staff to follow to ensure callers were referred to other services for support as required.
- 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.

Are services effective?

- 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.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.
- Issues with the Directory of Services were resolved in a timely manner. We saw that changes were made where relevant, including the prioritising of mental health services where indicated.

Helping patients to live healthier lives

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

- The service identified patients who may be in need of extra support such as through alerts on the computer system.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.

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.

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs including training, awareness seminars and bulletins for specific staff groups.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

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

Are services responsive to people's needs?

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

Responding to and meeting people's needs

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

- The provider understood the needs of its population and tailored services in response to those needs by providing access to local and regional out of hours bases.
- The provider had regular contract meetings with the commissioner to discuss performance issues and where improvements could be made. The service was actively engaged in contract monitoring activity with commissioners and had made a number of commitments to address performance issues including National Quality Requirement statistics.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service, for example there were alerts about a person being on the end of life pathway. Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

Patients could access care and treatment from the service within an appropriate timescale for their needs.

- Patients could access care and treatment at a time to suit them. The NHS 111 service operated 24 hours a day.
- The service had introduced a system by which patients could access 111 services electronically rather than by telephone. This service was new and at the time of the inspection had only taken a small number of referrals. Translation services were also available where required.
- Patients had timely access to initial assessment, diagnosis and treatment. We saw the most recent local and national key performance indicator (KPI) results for the service for the 2017-18 financial year which showed the provider was meeting the following indicators:
  - The percentage of calls answered within 60 seconds was between 64% and 88.5% for each of the 12 months prior to the inspection (England 84%, national target 95%, KPI 95%);
  - The percentage of answered calls transferred to a clinical advisor with the patient still on the line was 33.38% (England 40%);
- Where the service was not meeting the target, the provider was aware of these areas and we saw evidence that attempts were being made to address them through close working with the service commissioner. Measures included advanced monitoring and reporting of performance data, recruitment of staff and increased used of call handling networking capabilities across the providers network.
- Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care. However, we saw that the provider did not respond to complaints in a timely way, and where patients were not contactable these complaints were not taken further.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. 63 complaints were received in the last year. We reviewed 12 complaints and found that seven were satisfactorily handled in a timely way. However, four of the complaints we reviewed were not completed in line with the organisation's own time lines, and one of the complaints were not taken any further when the provider was unable to contact the provider. A further complaint related to the 111 service. Although this did not relate to the provider there was no record of it having been forwarded to the out of hours' service.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant. For example, where patient notes were not available from the patients NHS GP practice, this was fed back to the provider.
- The service learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care. We saw examples of learning from complaints and other patient feedback being shared through the service's internal bulletin, in

Are services responsive to people's needs?

developing staff training packages and through management of staff performance. However, the staff at Hanover House were generally not as aware of these bulletins as staff at the other two sites.

Are services well-led?

We rated the service as requires improvement for leadership.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care. However, in several areas the provider was missing national targets and as such the care being provided was not of a high quality.

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it.
- Managers at the service were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them, and had developed action plans so that these areas might be addressed.
- Staff at Crutes House and Vocare House told us that leaders at all levels were visible and approachable, and that they worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. However, staff at Hanover House were generally unaware of who filled leadership roles and told us that they rarely heard from senior staff.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients. However, issues that required improvement and had been highlighted in a previous CQC report remained unaddressed.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities. However, a previous CQC report had highlighted staffing, national outcomes, complaints management and sharing information as issues that the provider either should or must address. These issues remained areas to address for the provider at this inspection.
- The service developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

The service had a culture of high-quality sustainable care. However, historically low staffing levels and information not being shared at the Hanover House site impacted upon this.

- Most staff told us that they felt respected, supported and valued, although some at Hanover House said they felt isolated from operational and clinical leads, or were unaware who they were. All staff told us that 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.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. However, learning from these incidents was not shared at Hanover House where 25% of all calls were taken. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

Are services well-led?

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 governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

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

The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of MHRA 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.

Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.

The providers had plans in place and had trained staff for major incidents.

The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- 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.
- The service used information technology systems to monitor and improve the quality of care. There were developed services by which the provider was able to undertake workforce planning.
- 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

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- 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. The provider in conjunction with the out of hours provider in the area met regularly with patient groups across the CCGs for which it had responsibility and shared information with them as relevant.
- Staff could describe to us the systems in place to give feedback, including written through feedback forms, staff surveys and verbal feedback through internal meetings and service delivery managers. We saw evidence of the most recent staff survey and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- Staff knew about improvement methods and had the skills to use them.

Are services well-led?

- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There were systems to support improvement and innovation work.

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
Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • Staff at the Hanover House site were not aware of learning from incidents, complaints and safeguarding. • The service was not delivering service in line with standards defined by national quality requirements and other local and national guidelines. • Not all staff had their work audited as part of the 1% audits to which all operational staff should be subject. • Patient complaints were not managed in line with the provider's own policies and learning was not shared with other relevant third-party organisations. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** • Clinical advisers were not available as the service at Crutes House was launched. The number of warm transfers to clinical advisers was significantly lower than national targets. • Staff had not been trained in fire safety. This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.