# South Central Ambulance NHS Foundation Trust (NHS 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.

## Ratings

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

# Summary of findings

## Contents



## Overall summary

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

We carried out a comprehensive inspection of the NHS 111 service provided by South Central Ambulance Service NHS Foundation Trust on 3 and 4 May 2016. We visited both sites which are located in Bicester, Oxfordshire and Otterbourne in Hampshire.

A responsive inspection of this NHS 111 service was undertaken in November 2015. The service was not rated at this time and not all of the domains were inspected. We found the provider reacted positively to the issues raised during that inspection and had implemented an action plan and made the necessary improvements by May 2016.

**Our key findings were as follows:**

The NHS 111 service provided a safe, caring, responsive and well-led service to a diverse population spread across central and south England. However, improvements were required to provide a fully effective service. Overall the provider was rated as good.

- At the time of inspection, we noted times between January-March 2016 where there was insufficient access to clinical staff, particularly during periods of high demand. However, more recent data showed this had improved in April 2016, with minimum standard clinician ratios being met 91% of the time.
- Regular specialist training was provided to staff and there were a number of different courses for staff to access flexibly. However, some staff indicated that sometimes it proved difficult to find the time to access role specific training due to their busy roles.
- The NHS 111 service had systems in place to mitigate safety risks. Incidents and significant events were identified, investigated and reported. The provider was responsive when things went wrong and was also proactive in the prevention of these incidents. The provider was monitored against the Minimum Data Set for NHS 111 services and adapted National Quality Requirements. These sets of data provided intelligence about the service and showed SCAS performed in line or better than other NHS 111 providers. These were shared with commissioners and action plans were implemented where a variation in performance had been identified. For example, the low performance of clinical call backs.

# Summary of findings

- The provider also worked with outside agencies and charities to secure improvements to services.
- Staff had been trained and were monitored to ensure they used NHS pathways safely and effectively. (NHS pathways is a licensed computer based operating system that provides a suite of clinical assessments for triaging telephone calls from patients based on the symptoms they report when they call).
- Eighty-one percent of nurses and paramedics had undertaken level 2 safeguarding training.
- The trust had also been identified and approved as an appropriate national testing site for new NHS pathways being introduced.
- Staff were supported to report issues and concerns and considered the organisation a supportive, no blame culture to work in.
- Patients using the service were encouraged and supported to respond to the telephone clinical triage and their consent and decisions were respected.
- The provider was responsive and acted on patient complaints and feedback. However, the trust recognised improvements were required and action had been taken since November 2015 to reduce the length of delays and long response times to complaints. Further work to deliver improvements were still in progress.
- Feedback from patients was welcomed by the provider and used to improve the service.
- There was visible leadership, with an emphasis on continuous improvement and development of the service.
- The vision to develop and expand the service in accordance with the trust five-year business plan was being implemented.

The areas where the provider must make improvements are:

- Ensure the provision of clinical advice is managed in line with national targets and callers receive call backs and timely advice to care and treatment.
- Review processes to ensure staff have sufficient time to access the training provided for them required to perform their roles.Ensure all staff receive appraisals within appropriate time periods.
- Ensure all clinical and non-clinical staff are trained to the appropriate level for safeguarding adults and children.

There were areas of practice where the provider should make improvements:

- Raise staff awareness of who the professional leads are within the organisation.
- Review telephone answering messages to ensure patients have the correct advice in an emergency.
- Continue to implement effective changes to ensure complaints are received, recorded, handled and responded to appropriately and in a timely way.
- Review and implement updated business continuity plans for each of the NHS 111 call centre locations. Specifically, updating the key contact details.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Good

The provider is rated as good for providing safe services.

- The provider had systems, processes and practices in place to keep patients safe and safeguarded from abuse. All staff had received level one safeguarding training. Eighty one percent of nurses and paramedics had received the required level two safeguarding training.
- Clinical staff shortages were identified particularly during unprecedented periods of peak demand between January and March 2016. However, in April 2016 the provider was able to evidence the 5:1 clinician to call handler ratio had improved to 91% of the time. Information provided after this inspection showed this performance level had been maintained for the following three months. The provider had commenced with the implementation of improvement actions to address the shortage of clinical staff and ensure other systems and process were in place to mitigate risks to patient care and treatment.
- There was an effective system in place for reporting and recording significant events.
- The provider used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on thorough analysis and investigation.
- Lessons were shared to make sure action was taken to improve safety.
- When things went wrong with care and treatment, patients received reasonable support, truthful information, and a verbal and written apology.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.
- Call handler, coaches and team leader staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.

**Are services effective?**

Requires improvement

The provider is rated as requires improvement for providing effective services.

- Data showed that the call handler to clinician ratio had dropped between January-March 2016.. In April 2016, the clinical ratio had improved to 5:1 for 91% of the time. Information submitted after the inspection identified this level of performance had been maintained. However, the provider

# Summary of findings

had consistently missed the targets for clinician call backs. In the previous 12 months, the for call backs within 10 minutes rate for the provider was between 26% and 28 %, which missed the national target rate of 95%

- There was evidence of appraisals and personal development plans for staff. However, data showed that the trust had achieved 81% of appraisals being completed, which missed their 95% target for NHS 111 staff appraisals for 2015-16.
- Staff said they did not always have sufficient time to access the training planned and not all staff had received the appropriate level of safeguarding training. Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.
- Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. Data from the NHS 111 minimum data set showed performance was at or above average for the locality and compared to the national average. Staff assessed needs and delivered care in line with current evidence based guidance. Clinical audits demonstrated quality improvement.
- The provider celebrated good performance within the organisation. The provider was responsive to poor performance and high staff absences. Poorer performance was monitored effectively. Staff had the skills, knowledge and experience to deliver effective care and treatment. The provider used Quality Assurance Coaches to provide effective support and NHS pathways expertise to the call handlers.
- Staff used the directory of services to ensure the appropriate dispositions were selected.
- The NHS 111 provider had recently received approval from NHS pathways to pilot clinician homeworking to provide additional resilience and increase clinical capacity.

**Are services caring?**

Good

The provider is rated as good for providing caring services.

- Feedback from surveys showed that patients were mainly positive about the care and support they had received.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Staff were trained to respond to callers who may be distressed, anxious or confused. Staff were able to describe to us how they would respond and we saw evidence of this during our visit.

# Summary of findings

- We saw that staff took time to ensure patients understood the advice they had been given, and the referral process to other services where this was needed. This included where an appointment had been made by the NHS 111 provider or where a request was to be made for a future appointment with another health care provider.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

**Are services responsive to people's needs?**

Good

The provider is rated as good for providing responsive services.

- The provider worked closely with other organisations, particularly those providing urgent care, and with the local community in planning how services were provided to ensure that they meet patients' needs.
- The provider also worked with external agencies and charities to improve care for patients.
- The NHS 111 provider had worked collaboratively with Age UK to develop a Sense of Ageing course for all staff in order to raise awareness of the needs of older patients. This course was being shared nationally as an example of good practice.
- Care and treatment was coordinated with other services and providers. There was collaboration with partners to improve urgent care pathways.
- Information about how to complain was available and easy to understand. Learning from complaints was shared with staff and other stakeholders. Improvements to the timescales when responding to complaints had been recognised by the provider. A plan had been implemented from November 2015 to reduce the length of delays and response times to complaints. At the time of inspection, improvements to the complaints system and processes were still in progress.

**Are services well-led?**

Good

The provider is rated as good for being well-led.

- The provider had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. The NHS 111 provider was an integrated part of the trusts urgent care planning and service provision.
- Staff were clear about the vision and their responsibilities in relation to their individual roles.

# Summary of findings

- There was an overarching governance framework which supported the delivery of the strategy and good quality care across the whole organisation. This included arrangements to monitor and improve quality and identify risk.
- The information used in reporting, performance management and delivering quality care and treatment was accurate, valid, reliable, timely and relevant.
- The provider was aware of and complied with the requirements of the Duty of Candour. The NHS 111 provider encouraged a culture of openness and honesty. There were systems in place for notifiable safety incidents and this information was shared with staff to ensure appropriate action was taken. However, improvements were required in relation to the risk of some areas in the safe domain. For example, clinician call back times.
- The provider proactively sought feedback from staff using a bright ideas suggestion box, appraisals and staff survey. The provider also valued feedback from patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels.
- The provider celebrated good staff performance within the organisation.

# Summary of findings

## Areas for improvement

**Action the service MUST take to improve**

- Ensure the provision of clinical advice is managed in line with national targets and callers receive call backs and timely advice to care and treatment.
- Review processes to ensure staff have sufficient time to access the training provided for them required to perform their roles.
- Ensure all staff receive appraisals within appropriate time periods.
- Ensure all clinical and non-clinical staff are trained to the appropriate level for safeguarding adults and children.

**Action the service SHOULD take to improve**

- Raise staff awareness of who the professional leads are within the organisation.
- Review telephone answering messages to ensure patients have the correct advice in an emergency.
- Continue to implement effective changes to ensure complaints are received, recorded, handled and responded to appropriately and in a timely way.
- Review and implement updated business continuity plans for each of the NHS 111 call centre locations. Specifically, updating the key contact details.

# South Central Ambulance NHS Foundation Trust (NHS 111 service)

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC inspection manager, three CQC inspectors and two specialist advisors with experience of NHS 111 services.

## Background to South Central Ambulance NHS Foundation Trust (NHS 111 service)

South Central Ambulance Service (SCAS) NHS Foundation Trust- NHS 111 (also known as Bucks & Oxon Divisional HQ) was established on 1 July 2006 following the merger of four ambulance trusts. On 1 March 2012 they became a Foundation Trust. The trust's three main functions are the provision of:

- 999 emergency service
- NHS 111 service
- Patient Transport Service

SCAS employs 453 NHS 111 staff (222 whole time equivalent); the NHS 111 Clinical Coordination Centres handle around 1.25 million calls each year.

The provider provides the following regulated activities:

- Treatment of disease, disorder or injury
- Transport services, triage and medical advice provided remotely
- Diagnostic and screening procedures

The NHS 111 service was commissioned by seven Clinical Commissioning Groups (CCGs): Bedfordshire, Berkshire, Aylesbury Vale, Chiltern, Hampshire, Luton and Oxfordshire. The SCAS NHS Foundation Trust NHS 111 service operates 24 hours a day 365 days a year. It 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, this could be an out-of-hours GP service, walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance or late opening chemist.

The provider operates NHS 111 services from two locations: Northern House, Bicester in Oxfordshire and Southern House, Otterbourne in Hampshire. The provision of the service covers the counties of Hampshire, Berkshire, Bedfordshire, Oxfordshire and Buckinghamshire. The area covered has a geographic area of 4,600 square miles and a population of 4.6 million people.

There are 21 CCGs within the area, 836 GP surgeries, 568 dental practices, 791 pharmacies and 380 opticians branches. The area covered contains a mixture of urban areas of high density population such as Portsmouth, Southampton, Reading, Luton, Slough, Oxford and Milton Keynes and large areas of rurality such as the New Forest, North Hampshire, West Oxfordshire and parts of Buckinghamshire.

# Detailed findings

## Why we carried out this inspection

We inspected this provider as part of our comprehensive inspection programme. This was undertaken alongside a trust wide inspection, which included the 999 and patient transport services. We previously undertook a responsive inspection of the South Central Ambulance Service Trust NHS 111 function in November 2015. The provider was not rated as this was a focussed inspection and only the safe, effective, responsive and well led domains were inspected. At the time of the November inspection the provider reacted positively to the concerns raised.

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

## How we carried out this inspection

We carried out an announced visit of Northern House Call centre on 3 May 2016 and visited Southern House on 4 May 2016. During our inspection, we spoke with 27 operational staff and members of the management team including directors for the provider, senior managers, and clinical managers. We also spoke with two representatives from the staff unions.

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

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

Before visiting the NHS 111 provider, we reviewed a range of information that we held about the provider, South Central Ambulance Service NHS Foundation Trust, and reviewed the information on their website. We asked other organisations such as commissioners and Healthwatch to share what they knew about the NHS 111 service.

We were unable to speak with patients who used the service. However, we listened to calls, with patients' consent, and observed how clinical advisors and call handlers spoke with and supported patients who used the service. We looked at a range of records including audits, staff training, patient feedback and complaints.

Good

# Are services safe?

## Our findings

**Safe track record, learning and improvements**

There was an effective system in place for reporting and recording significant events. Staff told us that since concerns about reporting serious incidents within South Central Ambulance Service had been reported in the media, the culture around such reports had improved. Staff told us how they were able to report concerns freely without the fear of reprisals.

- Significant events that that met the threshold for a Serious Incident or Never Event were declared and investigated in accordance with the NHS England Serious Incident Framework 2015.
- Investigation of significant events was not confined to those that met NHS England's criteria for a Serious Incident or Never Event. The provider treated significant events including near misses as an opportunity for learning and risk reduction measures.
- Staff told us they were aware of how to escalate incidents, concerns and events and that this process had been improved through additional training and use of electronic systems. Staff had access to a serious incident recording form available on the provider's computer system.
- We noted that 10 serious incidents required investigation in the last 12 months, which related to the NHS 111 service. Other less serious incidents were similarly investigated. We saw evidence that the provider investigated and liaised with relevant stakeholders where appropriate.
- A monthly internal governance meeting was held to review themes from complaints, concerns, health care professionals' feedback, and significant events.
- We saw examples of effective systems to ensure that learning took place of themes and trends coming out of audits across all the contracts held by the service. The meetings involved representatives from SCAS NHS 111, GP out of hours providers, CCG's and where appropriate frontline ambulance services.
- Information from complaints, significant events and learning was cascaded to all staff by email, a quarterly newsletter and team briefing notices. Staff understanding of these changes was then monitored through the programme of audits and staff supervision.

**Overview of safety systems and processes**

The provider had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- Arrangements in place to safeguard children and vulnerable adults from abuse reflected relevant legislation. Local requirements and policies were accessible to all staff in the call handler handbooks. We saw the policies that clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The provider had attended safeguarding meetings where appropriate and there was a lead member of staff for safeguarding and information on contacts within local authorities.
- Records showed 100% compliance with level one safeguarding training for all staff. Eighty-one percent of nurses and paramedics had been trained to the required level 2 in safeguarding. Staff had access to and made use of e-learning training modules and in-house training but added that accessing training was difficult because of time constraints and workload.
- Clinical staff and appropriate administrative staff had access to patient records Staff were clear on the arrangements for recording patient information and maintaining records. Call handlers and other staff had access to patient special notes, which alerted staff to patients with additional needs. For example, because they had pre-existing conditions or there were safety concerns.
- 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 if the patient required further support from another health provider, an automatic search was carried out on the integrated Directory of Services, to locate an appropriate service in the patient's local area.
- 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 care and treatment were provided. For example, a referral to the Out of Hour's GP service for a home visit or referral to the patient's own GP. Records of the triage and call were then sent to the out of hours provider or the patient's GP immediately, which promoted effective and timely communication.

Good

# Are services safe?

- Staff were mostly able to access advice from clinicians where necessary. If the clinician was unavailable the patient was placed in a 'call back' queue. However, the national target was for 95% of clinician call backs to take place within ten minutes. Data showed that the trust was missing this on a consistent basis, although their performance was either comparable or slightly better than other NHS 111 providers in the country. In the previous 12 months, the rate for call backs within 10 minutes for the provider was between 26% and 28%, which missed the national target rate of 95%.
- We were informed that since the last inspection in November 2015 the human resources team had expanded and a schedule was introduced to ensure recruitment processes were being followed effectively. This ensured that all newly recruited staff had all the pre-employment checks before commencing their roles.
- We reviewed eight personnel files of staff recently recruited and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. Recruitment of agency or locum staff had been carried out appropriately.

**Monitoring safety and responding to risk**

There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. Key areas of risk that had been identified by the trust were:

- The level of available clinical staff to meet the demands of the service.
- Call back times were often over the 10 minute target.
- Staff sickness levels had been high and actions had been implemented to improve these.

Action plans had been implemented to ensure improvements were seen in all three of these areas. Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw examples of effective day to day operational planning in regard to staffing and skill mix. For example, we saw experienced team leaders take calls where patients were waiting and financial incentives to staff to work additional hours work. There was a rota system in place for different staffing groups. Most of the rotas we reviewed had adequate numbers of staff on duty. However, between January and March 2016 during a period of unprecedented high demand there were shortages of clinical staff and the ratio of clinicians to non-clinical staff was more than the recommended ratio of 5:1. Information provided by the provider demonstrated that in April 2016 the 5:1 ratio had improved to 91% of the time and remained at this level for the following three months.

Call handlers said they sometimes had to wait for a clinician at busy times but that this was not routinely an issue. This presented a risk to call back times for patients requiring clinical advice, which the trust had identified and had taken action to improve and mitigate any risk to patient care and treatment.

The provider had commenced with the implementation of improvement actions to address the shortage of clinical staff and ensure other systems and process were in place to mitigate risks to patient care and treatment. For example, the provider had held recruitment open days, which had meant an increase in clinician employment. A clinical supervisor, a senior clinician such as a nurse or doctor, was provided as additional support at weekends and bank holidays. The provider had also received approval from NHS pathways to pilot clinician homeworking to provide additional resilience and increase clinical capacity.

We saw an improvement in staffing sickness rates from our previous inspection in November 2015 – from 35% to 7%. This was due to a recruitment campaign and the passing of seasonal illnesses. We were informed that the NHS 111 workforce numbers had increased following the recruitment campaign. In March 2016, the whole time equivalent (wte) for the NHS 111 service increased from 222 to 239 wte's.

Comprehensive systems in place to identify, monitor and mitigate risks included:

- Twice weekly meetings of senior managers and scheduling staff to discuss risk.
- An operational plan was issued each day at5pmto all shift managers informing them of any anticipated increased demand so they could mitigate the risks in a timely way and ensure there were sufficient staff members available to work.

Good

# Are services safe?

- Joint working between the two sites to cover fluctuations in increased workload and demand. The shift managers told us they were happy to talk to each other and work on operational plans.
- Bi-monthly meetings with all shift managers and team leaders to discuss trends and issues and the two NHS 111 service heads met regularly. The provider had an overall corporate risk register and a separate register for the NHS 111 service. These registers were discussed at monthly internal clinical governance meetings. Risk registers were updated and officially reported at the board meetings via the Patient Safety Group.

Patients telephoned the NHS 111 service and received an information sharing message before they were delivered to an open line. If a call handler was available the patient's call was transferred straight through to the available staff member. If a call handler was not available then the phone continued to ring until the call was answered. We noted there was no message advising the caller to phone 999 if their condition worsened or was life threatening. At the time of the inspection, this was being reviewed with the commissioners of the service.

The provider had a system to manage repeat callers. Notes were added to the system, which provided call handlers with a course of action to take to ensure their health, safety and well-being. Callers who repeatedly called the service were also discussed with CCGs and other local health providers. For example, discussions with the callers GP practice in order to implement appropriate support for the individual, which led to less frequent calls to the NHS 111 or 999 service.

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

The provider had adequate arrangements in place to respond to emergencies and major incidents. We reviewed a strategic business continuity plan and operational plans for each of its locations. We found that the overarching business continuity plan was clearly set out and detailed what actions staff needed to take to ensure business continuity if there was a disruption. However, the continuity plans for both locations were contained within one document, which did not provide sufficient clarity on what local actions were to be taken. We noted that a large proportion of the plans related to only one of the six clinical commissioning groups that the NHS 111 service was commissioned by. We also found contact details for staff who no longer worked for the service.

Call centre activities were understood and managed to consider foreseeable risk including:

- Changes in demand
- Seasonal or weather
- Loss of facilities or infrastructure
- Disruption to staffing levels

An example of the provider dealing with emergencies included an occasion where the telephone service failed over both call centres resulting in no NHS 111 calls coming through for two hours. Staff followed the national and local business continuity plan and calls were transferred to other NHS 111 providers' until the issue was resolved.

A staffing system was in place which allocated staffing resources based on service demand and fluctuation. Copies of information provided to us and the observations we made showed resources varied across the day and night based on normal patient contacts.

Call centre staff understood their role in major incidents and had received basic life support training. We saw there were defibrillators available at each call centre, first aid boxes and accident books.

Requires improvement

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence best practice guidelines.

Calls were triaged through NHS pathways. Staff told us the NHS pathways was updated regularly and changes communicated to staff through training sessions and formal communication.

All operational call handlers and clinical advisors had completed a mandatory training programme to become a licensed user of the NHS pathways. Once trained and licensed to use NHS pathways, call handlers and clinical advisors had their performance monitored. Any new pathways were only introduced when staff had received training.

The provider monitored that all NHS pathways guidelines were being followed by random auditing of patient calls. Call handlers said they had been told of this process during their induction and probationary period. Records confirmed these audits were being performed, monitored and included competency, effective call control, skilled questioning, and delivering a safe and effective outcome for the patient.

The provider used a Directory of Services which provided call handlers with real-time information about services available to support patients' dependent on the outcome of the call. Since our inspection in November 2015, Quality Assurance Coaches (QACs) were employed and provided effective support and NHS pathways expertise to the call handlers whilst on shift in the call centre over a 24 hour period. Staff told us that since the QACs had been introduced they felt more supported and were able to access senior members of staff to get rapid answers to questions about NHS pathways of care and transfers to the 999 service. The QACs helped maintain high levels of compliance when using the NHS pathways triage tool and other systems.

The QACs were fully licensed by NHS pathways, had received enhanced levels of training and had a record of strong performance using NHS pathways. The effectiveness of the use of QACs was measured by the provider through comparative period audits. For example, a comparison of call handler absence rates for the first three months following implementation of QACs in 2015, compared with the same months in 2016 demonstrated a 50% reduction in absence. This indicated the effectiveness of QACs in improving support and retention of staff.

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

People had good outcomes because they received effective care and treatment that met their needs. The performance report for March 2016 stated that there had been a 24% year on year increase in call volumes due to seasonal colds and flu and an outbreak of scarlet fever. Data from the provider performance data for April 2016 showed that since March 2016 call answered rates had increased again to 97% compared to 92% in March 2016.

The provider had set up a Health Information Service to manage health information and medicines enquiry calls that were answered by NHS 111. Health Information Advisors (HIAs) worked at Southern House between 9am and 10pm on weekdays and between 8am and 10pm at weekends. The HIA role was non – clinical. Staff completed a comprehensive training programme to prepare them to deal with these calls in a safe and timely manner. The HIAs were trained by a specialist pharmacist and a NHS 111 Team Leader who had a background in health information management.

Patients were assessed using the NHS pathways triage tool as normal. Where an outcome of health information or a medication enquiry was reached, these calls were then passed to the HIAs to respond to the patient. Prior to HIAs being in post, health information calls were handled by clinical advisors. The introduction of this role meant that the clinicians had increased their availability of call handlers and calls could be managed in a timely manner. Health Information calls were also audited for compliance using a specific review tool ensuring any issues and learning activities for the HIAs was recognised and shared.

The provider celebrated good performance within the organisation and identified and acted on poor performance. Call handlers said they felt supported when audits had identified their performance was below acceptable levels. They confirmed how their line manager worked with them supportively to address the improvements needed.

Requires improvement

# Are services effective?

## (for example, treatment is effective)

The service monitored its performance through the use of the National Quality Requirements and the national Minimum Data Set, as well as compliance with the NHS Commissioning Standards. In addition the provider had established its performance monitoring arrangements and reviewed its performance regularly.

We saw data that showed how demand had significantly increased for the NHS 111 service. Data showed that call volumes had increased by 24% between January- March 2016 on the previous year. For example, in March 2015 the number of NHS 111 calls was 105,000 compared with March 2016 of 131,000. At the same time there were recruitment and staff turnover issues which resulted in poor performance in some areas. However, we found the recruitment campaign and increased staffing had begun to improve performance.

The March 2016 board meeting report showed that discussions had taken place regarding the indicator for NHS 111 to 999 referrals. In March 2016, the year to date percentage of calls referred to 999 were:

- Oxfordshire – 8.5% against the target 10%.
- Hampshire- 10.1% against the target 10%.
- Berkshire- 10% against the target 10%.
- Buckinghamshire- 10% against the target 10%.
- Luton and Bedfordshire- 10% against the target 10%.

The board agreed that, although the trust's position remained favourable against the national target of 10%, performance was worsening "due to a variety of factors" and was to be monitored for a short time to see if an improvement was seen. In April 2016, performance data showed improvements and the provider was meeting set key performance indicators in most areas.

The NHS 111 service was monitored against the national Minimum Data Set and adapted National Quality Requirements. Monitoring was carried out using integrated performance reports for all clinical commissioning groups (CCG). The provider was using their own internal targets and monitoring systems which were more stringent than their contractual requirements. Staff and members of the management team explained that the reason for this was to manage their risks more closely and to achieve higher levels of performance.The reports reported on five key measures. These were calls answered within 60 seconds, referrals to 999, calls abandoned, calls transferred to a clinician and call backs from a clinician.

The March 2016 performance report year to date data showed that the trust was performing well for four of the five key measures. For example:

- The provider had answered between 95% and 96% of calls within 60 seconds against the 95% national target. However, between January and March 2016 performance calls answered within 60 seconds had dropped to 56%. The provider advised that this was due to the longer winter, higher numbers of colds and flu and an outbreak of scarlett fever. They referred the increased call volumes and risk to the trust board. Safe targets were agreed and performance management and monitoring was implemented. The provider also communicated with commissioners to advise them of the call volume increase and their plans to address the risks. In April 2016, we noted that figures had increased up to around 88% and were continuing to improve. The performance for this indicator on the two inspection days showed performance was running above 95%.
- Less than 10% of calls had been transferred to the 999 service which was in line with the national average. Data from the March 2016 report reported the provider achieving between 8% and 10% for the different CCG areas. Previous performance reports showed this consistently being achieved.
- Abandoned calls were at 8% in March 2016 reducing to 2% in April 2016 indicating an improved performance which was within the 5% target set within the CCG contracts and NQR's.
- The provider had consistently missed the targets for clinician call backs within 10 minutes. The rate for the service ran at was up to 27% of calls being made within the 10 minutes, which missed the national target rate of 95%.

Data from the last 12 months allowed comparison with the England averages. The percentage of calls answered was higher than average despite the average call length being significantly longer than the England average. For example, calls lasted on average between 23 minutes and 28 minutes compared to a national average call length of 15 minutes. However, the provider recognised their call times were longer than the national averages and was working to reduce this by providing additional staff training and coaching staff who could support staff in dealing with longer calls.

Requires improvement

# Are services effective?

## (for example, treatment is effective)

The national target for clinician call backs was 95% of clinician call backs to take place within 10 minutes. Data showed that the trust was missing this on a consistent basis, although performing either comparable to or slightly better than other NHS 111 services in the country. Data from 2015-16 showed provider performance varied between 17% and 36% over the year. The average performance for the previous three months was 24%. The provider information for call back outcomes showed:

- The average time for a call back in March 2016 was 53 minutes and in April 2016 this was 39 minutes.
- The longest average call back time for March 2016 was for 5.5 hours and for April 2016 4.5 hours.
- In March and April 2016, data showed that some patients had waited over 6 hours for a call back and a smaller number of patients had waited up 10 hours.

This meant that around 75% of patients had waited beyond ten minutes for a call back by a clinician and may have been at risk of not receiving timely advice or treatment.

In March 2016, the yearly percentage of call backs in less than 10 minutes for each area were:

- Oxfordshire- 25% against the national target of 95%
- Hampshire- 27% against the national target of 95%
- Berkshire- 25% against the national target of 95%
- Buckinghamshire- 24% against the national target of 95%
- Luton and Bedfordshire- 27% against the national target of 95%

Data submitted by the provider after the inspection demonstrated the performance of call backs in less than 10 minutes had improved to over 30%.

Data showed that the call handler clinician ratio routinely ran at 5:1 and at times between January and March 2016 we noted the ratio increased to 7:1. (The national recommended ratio is 5:1). However, information submitted by the provider after the inspection demonstrated that in April 2016 the 5:1 ratio had been achieved 91% of the time and continued at this level of performance for the next three months. At the time of inspection staff representatives were concerned about this and said these issues had been reported to senior managers and actions taken. Call centre staff were aware that there had been fewer clinicians available during peak hours. We saw that this had been reported at the Board meeting, was within the risk register and saw evidence of continued on going recruitment. The home working clinician pilot had provided some improvement to the ratios during peak periods. Remote or homeworking was designed to provide additional resilience to the clinical element of the NHS 111 service provided. In the event of increased demand or events such as adverse weather, it enabled clinicians to work from home to maintain service provision.

In response to immediate and medium term needs they had introduced additional support to staff to help improve performance. Call centre staff said this was sometimes an issue during peak times but that they were always able to access support from senior call handlers, team leaders, QACs, if clinical staff were not available. None of the 27 staff we spoke with said that a lack of clinicians had caused them concern in the event of emergencies or urgent calls.

This risk of clinical staff availability was discussed with members of the senior management team who were aware of lower performance levels and were continuing with an ongoing clinician recruitment campaign. They had introduced processes to reduce the risks associated with low clinician numbers within the organisations. These included the introduction of daily operational plan meetings and clinical supervisor for additional support at peak times, weekends and bank holidays. The provider explained the shortfall of clinicians was due to high vacancies and added that a robust workforce plan was in place and that new staff were becoming “work effective”.

### Effective staffing

Most staff had the skills, knowledge and experience to deliver effective care and treatment. However, improvements were required in the provision of safeguarding training and the undertaking of staff appraisals.

- The provider had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Since our last inspection in November 2015 the induction training had increased from three weeks to four weeks. Quality assurance coaches provided support to new and existing staff. During our inspections we saw coaches supporting new staff within the call centres. New staff said this support was appreciated to

bridge the gap between the classroom and call centre. Staff also explained that this support was flexible and that if staff required additional time for induction this was offered.

- The majority of staff had on going support during sessions, one-to-one meetings, appraisals, coaching and mentoring. Staff we spoke with told us they had received an appraisal within the last 12 months. However, data showed that the trust had not achieved their 95% target for NHS 111 staff appraisals for 2015-16. For example, the appraisal achievement showed 81% of staff had received an appraisal in the last 12 months. The provider showed us a plan which outlined the deadlines for completion of all staff appraisals in 2016.
- The provider monitored performance to ensure the NHS pathways guidelines were being followed by randomly auditing patient calls. New staff told us they had a minimum of six of their calls audited each month and existing staff told us they had five audits a month, this was in line with the policies we reviewed. Records confirmed the audit included competency, effective call control, skilled questioning and active listening.
- Pathways updates demonstrated that staff were trained ahead of any new upgrade date.There was a current training plan to ensure all staff are trained in Adastra.
- The management team received monthly updates on the results of the monthly assessments run by the providers training and education department. Areas that require d formal update were recorded through an organisational action plan which encompassed side by side training with a team leader or shift manager.
- The NHS111 service offered a flexible approach to training sessions. For example, through self-directed study. Sessions were run in and out of core hours and some sessions had been made into modules to accommodate flexible or part time workers.
- The service had also invested in new technology to ensure updates were read and understood by all staff.
- Through local colleges, the provider offered certificate level courses in nutrition, mental health, end of life, diabetes, learning difficulties, dementia and infection control. This also included national vocational qualifications in business administration and customer service.
- Internal training was supported through a Pre Hospital Consultant Practitioner who organised training sessions with guest speakers. Staff who were not on duty were able to claim overtime or excess hours in order to attend the training. The provider showed us recent evidence of these sessions, which included topics such as Sepsis and Head injuries.
- The provider could demonstrate how they ensured role-specific training and updating for relevant staff through the use of a comprehensive training matrix. This worked alongside IT systems which identified in advance when staff were due refresher training. However, 19% of nurses and paramedics had not undertaken the required level two training for safeguarding .

Training was provided to staff to ensure they remained up to date with the demands of the role. For example:

- NHS 111 staff had access to winter workshops which were designed to enhance and extend their knowledge and practice and offer staff the chance to develop in areas of particular seasonal relevance to them. The workshops offered staff the opportunity to focus on core areas of development. The feedback from these workshops was positive and provided an opportunity to study areas they find particularly interesting, sometimes challenging, in the safety of small personal groups. The provider had recognised the benefits of these workshops had included support for personal development, knowledge and skills, had enhanced inter-professional working and had widened the scope of subjects.
- Training sessions for shift managers and team leaders were provided on sickness absence, referral to occupational health and return to work interviews. As a result of this pilot absence in the NHS 111 Otterbourne call centre had reduced from 8.5% to 2.2%. The improved staff attendance at work meant less pressure on colleagues in the call centre and improved customer service for callers using the NHS 111 service and an increase in performance. Two staff who had recently returned from long term sick, both reported phased returns to work and excellent support from their managers with this. Reviews of staff files also evidenced this and involvement of occupational health where required.
- Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. However, many staff told us accessing this was difficult because of the demands of work. The provider was aware of the limitations which impacted on staff being

able to complete training and had changed their approach to ensure staff on all shifts were able to access training during their working hours. Training was available on line and also face to face training had been introduced through the night so staff could attend training whilst at work. The provider also advised that the recent recruitment campaign should ease this issue.

- The trust had an active trade union who represented staff regarding employment issues. We met with two union representatives who shared what the current challenges for staff were. These included improving retention of staff and staff training. They had recognised the training and recruitment of staff had improved in recent months.

Staff we spoke with told us they received excellent and very good support from peers and managers. One member of staff described an occasion where their line manager came to work on their day off to offer support as they knew the staff member had experienced a difficult call.

The provider was responsive when areas of improvement were recognised. For example, in the 'what we do well document, the provider had received feedback from staff and recognised that sickness in one of the NHS 111 call centres was high and had set up a pilot group initiative called Being healthy, Be happy, Be here. The trust set up focus groups and sent out questionnaires which highlighted issues regarding upper limb discomfort and perceived lack of breaks away from the desk. A physiotherapist was introduced to support staff. A nurse was also available to offer blood pressure checks between calls. Other initiatives included introducing "Fruity Friday" across both call centres which focused on healthy eating, reducing caffeine and increasing water consumption and exercise.

### Working with colleagues and other services

Staff worked with other providers to ensure patients received co-ordinated care.

The details of calls into the NHS 111 service were shared in an appropriate, secure and timely way with the appropriate care provider.

- This included an immediate summary to the patients GP, the GP out of hours provider and acute trusts. The information shared the concerns raised initially by the patient and the subsequent assessment undertaken by the NHS 111 service.
- Staff had access to information shared by GP practices and other health care professionals. For example, the computer system had pop up boxes to alert call handlers to information such as when a patient was a vulnerable adult or if they had a care plan or end of life care plan in place.
- There was a member of staff who was the clinical lead for mental health and learning disability. This role was introduced to improve the quality of care for people with mental health problems and/or learning disabilities. The role incorporated many levels, from working with external stakeholders and health care professionals, providing strategic guidance to direct patient care and included a significant element of education for all roles where there was a direct contact with patients.
- Similarly, there was a member of staff who was the clinical lead for patients living with dementia whose role had a similar function to that of the mental health lead.
- The trust worked closely with other urgent care providers to ensure the care and treatment needs were met for all patients in the region. For example, the trust had worked closely with the West Call out of hours service in relation to the early bird scheme.

### Consent to care and treatment

We listened to telephone calls to the service. All patients were informed that their call would be recorded. Throughout the telephone clinical triage assessment process the call handlers and clinical advisors checked the patients understanding of what was being asked of them. Patients were also involved in the final outcome (disposition) identified by the NHS pathways and their wishes respected. For example, callers were asked if they were happy to contact the GP themselves.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. This was a core component of staff induction.

Good

# Are services caring?

## Our findings

**Dignity, respect and compassion**

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. Staff were provided with training in how to respond to a range of callers, including those who may be abusive. Our observations were that staff handled calls sensitively and with compassion.

We reviewed the most recent survey data (April 2015 to March 2016) available from NHS England on patient satisfaction for people who had used the South Central Ambulance Service (SCAS) NHS Trust 111 service during this period.

The results indicate that caller satisfaction was comparable to the England average for Buckinghamshire, Berkshire, Oxfordshire, the Isle of Wight and Southampton. For example:

- 87% of respondents from Oxfordshire stated they were 'very or fairly satisfied' with their NHS 111 experience and 6% were 'dissatisfied'.
- 95% of respondents from the Isle of Wight stated they were 'very or fairly satisfied' with their NHS 111 experience and 3% were 'dissatisfied'.
- 89% of respondents from Southampton and Portsmouth stated they were 'very or fairly satisfied' with their NHS 111 experience and 7% were 'dissatisfied'.
- 83% of respondents from Buckinghamshire stated they were 'very or fairly satisfied' with their NHS 111 experience and 11% were 'dissatisfied'.
- 87% of respondents from Berkshire stated they were 'very or fairly satisfied' with their NHS 111 experience and 8% were 'dissatisfied'.
- The South region average responses showed 88% of respondents stated they were 'very or fairly satisfied' with their NHS 111 experience and 7% were 'dissatisfied'.

Results from surveys, CCG feedback and NHS Choices showed patients felt they were treated with compassion, dignity and respect. The NHS 111 provider had surveyed seven of the twenty one clinical commission group areas they covered in October 2015 and produced individual reports on each CCG area in February 2016. Results from all these surveys showed patients indicated high levels of satisfaction with how staff responded to their calls.

- 96% of Buckinghamshire patients, 92% of Hampshire patients and 86% of Berkshire patients felt staff were helpful.
- 90% of Buckinghamshire patients, 92% of Hampshire patients and 90% of Oxfordshire and Berkshire patients would use the service again.

We received feedback from two Healthwatch teams within the SCAS NHS Trust area. They reported that patients were generally satisfied with the service provided by the NHS 111 provider.

Feedback from surveys carried out locally by the NHS 111 provider in 2015 showed that patients were mainly positive about the care and support they had received. Comments included that patients were reassured by advice given and the patient manner of call handlers when they were distressed. The results of the SCAS NHS 111 survey showed that patient experience and satisfaction had improved in 2015.

- 77% of patients felt quite or very assured by the service provided, which had improved from 70% in 2014.
- 55% of patients felt their problem has been resolved or had improved after the call, which was a slight improvement from 52% in 2014.
- Patients were also asked whether the NHS 111 service had helped them make contact with an appropriate healthcare service. Seventy percent of patients agreed it had, which was the same as in 2014.
- Patients were also asked how satisfied they were with the service and 78% were either very satisfied or fairly satisfied with the way the NHS 111 provider handled their call. This was an increase on 72% of patients being satisfied in 2014.
- 78% of patients were extremely likely or likely to recommend the service to a friends or family if they needed similar care and treatment.

The trust reviewed patient feedback at a regular patient experience reference group and produced a report, which combined patient experience data for NHS 111 services

provided by SCAS. The feedback brought together patient feedback from multiple sources including patient opinion, results from the patient experience survey, and results from the NHS Family and Friends test.

New staff received training in equality and diversity during their induction and this training was updated for all staff on an annual basis. Staff we spoke with were aware of the language line phone facility (a translation service) to aid communication with patients who first language was not English. We saw Language Line contact details were available on each work station area in the call advisors handbook and were told it was rarely needed.

NHS 111 services also offered a video relay servicethat allowed a patient to make a video call to a British Sign Language (BSL) interpreter. The BSL interpreter would call an NHS 111 adviser on the patients' behalf so they were able to have a real-time conversation with the NHS 111 adviser, via the interpreter.

**Care planning and involvement in decisions about care and treatment**

Our observations of call handlers demonstrated how they all involved the caller throughout the assessment process, with responses to the questions. Each of the call handlers we observed were confident in using NHS pathways, whilst supporting the caller. When callers were struggling to understand a question the call handler took extra time to explain or ask the question in a way the caller would understand. At the end of the assessment a clear explanation was given to the caller about the options for care and treatment or a referral onto an alternative service. Call handlers provided this support whilst understanding the callers' preferences and wishes.

- Where one was in place patients were responded to in line with their care plan.
- We saw that staff took time to ensure patients understood the advice they had been given, and the referral process to other services where this was needed. This included where an appointment had been made by the NHS 111 service or where a request was to be made for a future appointment.
- Comments from the surveys that had been carried out were mainly positive. Comments included that patients felt involved in the decision making and information provided was clear and concise.
- Negative comments included the number of questions that were asked, as some patients considered this delayed assistance being provided. The national NHS 111 service had addressed these concerns and was working on a shortened minor injuries pathway with NHS pathways, to reduce the number of questions.

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

Staff were trained to respond to callers who may be distressed, anxious or confused. Staff were able to describe to us how they would respond and we saw evidence of this during our visit. For example, we heard calls from patients who required instructions to be clarified or repeated. Call handlers did this calmly ensuring the patient understood.

There were arrangements in place to respond to those with specific health care needs such as those with palliative care needs. This included access to care plans agreed between patients and their GP and access to voluntary sector organisations such as the Samaritans.

There were established pathways for staff to follow to ensure callers were referred to other services for support as required. For example, to out of hours dentists, pharmacies and GP providers.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

We found the provider was mostly responsive to callers' needs. The trust had systems in place to maintain the levels of responsiveness required for their NHS 111 service and the systems these were utilised effectively. For example, call waiting queues were routinely monitored to escalate concerns about delays or abandoned calls.

The majority of national targets were being met and ensured calls to the NHS 111 were handled within the national limits. For example, a national key performance indicator stated that 95% of calls should be answered within 60 seconds. In March 2016, performance data showed:

- The provider had answered between 95% and 96% of calls within 60 seconds.
- No more than 5% of calls should be abandoned before being answered. The Trust's combined abandonment rate for averaged 0.6%.
- SCAS targets for the number of 111 transferred to 999 was set at 9%. The achieved rate was between 9-10% consistently.
- Between 17% and 19% of calls had been transferred to a clinician, which was below the 20% national target rate.

Feedback from Oxfordshire Clinical Commissioning Group (CCG) raised concerns about the performance of the trust and their response rates to calls answered between January and March 2016. However, the CCG also shared how when this was raised with the trust they had already identified the concerns and had implemented a plan to improve the performance. In April 2016, performance data showed that the trust performance was similar to or exceeding the national or trust targets for most of the national data set indicators.

However, the trust performance data still showed that the number of call backs within 10 minutes by a clinician was still below the national target of 95%. Which demonstrated how the provider was not always responsive to patient demand or providing effective care and treatment advice.

The provider reviewed the needs of its local population and engaged with the NHS England Area Team and CCG to secure improvements to services where these were identified. For example, the provider had a designated dental call handling team for one CCG area in response to a shortage of NHS dentists.

- The NHS 111 service offered a standard 24 hours a day, 365 days a week service.
- The provider took account of differing levels in demand in planning the service. For example, bank holidays and national events including the junior doctors strike. We reviewed rotas for the periods of higher demand and the trust was able to demonstrate the increased staff levels and how they successfully managed these situations. However, clinical staff ratios required improvement.
- There were specific care pathways for patients with specific needs, for example those at the end of their life, and babies and young children.
- The provider had a system in place that alerted staff to any specific safety or clinical needs of a patient.
- There were translation services available.

The NHS 111 provider had worked collaboratively with Age UK to develop a "Sense of Ageing" course for all staff in order to raise awareness of the needs of older people. This course was now being shared with other 111 service providers as an example of good practice.

**Tackling inequity and promoting equality**

- New staff received training in equality and diversity during their induction and this training was updated for all staff on an annual basis. Staff we spoke with were aware of the language line phone facility (a translation service) to assist patients to communicate better. We saw language line contact details were available on each work station area in the call advisors handbook and were told it was rarely needed.
- NHS 111 services also offer a video relay servicethat allows a patient to make a video call to a British Sign Language (BSL) interpreter. The BSL interpreter will call an NHS 111 adviser on the patients' behalf so they are able to have a real-time conversation with the NHS 111 adviser, via the interpreter.
- The telephone system was easy to use and supported people to access advice. Technology was used to support timely access. For example, a system of call recording, listing and queuing was used to ensure patients had their calls answered promptly to ensure patients received a response appropriate to their needs.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

**Access to the service**

The NHS 111 telephone number was a free telephone number to anyone living in England.

- Referrals and transfers to other services were undertaken in a timely way. For example, patients had access to advice, including from a clinician where appropriate. However, call transfers to clinicians were often delayed. On the day of inspection, we observed how some staff had tried to transfer a call or seek advice from a clinician and there was not one immediately available. Team leaders were on duty at each call centre. They used the wall boards to monitor demand and call handler activity. Team leaders contacted each other at the other call centre to discuss workflow and availability.The staff were able to explain when peak times were. For example, we were informed that demand normally increased 6pm to 6.30pm period where people had called their GP surgery but had been told they are closing.
- The senior leadership recognised the importance of social media. They had developed a strategy and delivery plan to use the medium as a way of engaging with patients and delivering information. We were given examples of staff responding to patient feedback and sometimes being used to promote the service.

**Listening and learning from concerns and complaints**

The provider had recently implemented a new electronic system for handling complaints and concerns. Information about how to complain was available and easy to understand and evidence showed the provider responded to issues raised. The provider had undertaken a review of the complaints system in November 2015 and identified that changes and improvements were required. At the time of the inspection, the provider was still implementing some of the changes from their action plan. We found that some complaints had been open for long periods (since 2015) and had not been fully responded to. We spoke with the head of complaints who was aware of this. They had looked at why there were complaints open for long periods and had noted that these were mostly due to gaining a patient's consent to investigate concerns when these were raised by a third party. We saw action that this was beginning to be resolved. However, there were a small number of complaints that were delayed due to inadequacies in the system previously used. The complaints team were working through these as a priority.

The complaints lead and patient experience staff said that there had been many changes to the complaints handling team and at the time of the inspection they had processes in place to ensure open complaints were resolved as soon as practically possible. The aim was to complete this piece of work by July 2016. Amendments were also being made to the computerised records system used to record complaints to make it streamlined and relevant to the team. The provider had moved to an electronic reporting and recording system on 1 April 2016 and was continuing to embed this system. All concerns or complaints were now logged electronically. These changes would allow fuller audits of the stage of each complaint. This included improved reporting and analysis of complaints for organisation governance.

The provider had received 103 complaints in the last 12 months, of these 25 were ongoing. We found that most of the resolved concerns or complaints had been satisfactorily handled, with openness and transparency. When needed an apology was provided. However, there were still complaints which had not been responded to in a timely manner and a resolution to the complaint investigation recorded.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, a complaint was made about the attitude of a clinician when dealing with a call and we noted how effectively the provider investigated the incident, supported staff and provided further training. Complaints of this nature required the clinician involved to complete a critical reflective tool and further training was often provided to improve how calls are managed. This training was monitored through audits of calls. Leaning from complaints was also shared with the clinical governance team for the NHS 111 service and more widely with staff.

The provider responded to feedback from other services and there was evidence of change as a result. For example, a complaint was received from a CCG regarding referrals to GP practices which were not open out of hours (OOH). This was addressed by the operations and directory of service teams and the outcome provided to OOH providers and all CCGs who commissioned the NHS 111 service.

# Are services well-led?

Good

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

## Our findings

**Vision and strategy**

South Central Ambulance Service (SCAS) NHS Trust had a clear vision to deliver high quality care and promote good outcomes for patients.

- The trusts' vision 'Towards excellence, saving lives and enabling you to get the care you need.' applied to the NHS 111 service, the 999 and patient transport service. The Chief Executive told us the trust values were team working, innovation, professionalism and caring. This ethos was continued through all levels within the organisation. From senior managers to frontline call centre staff. Whilst staff could not relay the exact values and vision they were able to explain the overall theme and understood they existed. Staff said they thought their peers and managers displayed these values.
- On the day of inspection, it was evident that the NHS 111 service was an integral part of SCAS's urgent care provision.
- The provider had a robust overarching strategy and supporting business plans which reflected the vision and values and were regularly monitored for all elements of the service. Planning and service provision involved managers and leaders from all functions within the trust and included NHS 111 teams.
- The provider had a mission statement which was displayed throughout the call centres.
- Staff referred to a culture that was supportive, encouraging and patient centred.

**Governance arrangements**

SCAS leaders had clinical oversight of the NHS 111 service. NHS 111 senior colleagues participated in key governance and performance meetings and were part of the trust wide strategic governance framework. The governance structure and processes in place held staff to account. NHS 111 senior team colleagues provided reports to strategy meetings and the trust board. This ensured the provider had an effective overarching governance framework which supported the delivery of the strategy and good quality care.

- The provider had implemented governance structures, processes and systems of accountability. Service specific policies were up to date and were available to all staff. However, improvements were required to ensure staff received suitable training and appraisals and the performance of call back times increased.
- Regular clinical governance meetings were held with set agenda items to respond to and discuss. These included discussions of the NHS 111 clinical governance report, NHS pathways Data, risk management, statutory and mandatory training, NHS pathways and update training, stakeholder concerns, complaints and concerns, patient and staff experience surveys. We saw minutes of these meetings and comprehensive action plans with timescales and review notes demonstrating the system was manged effectively.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The provider maintained a corporate risk register and a strategic corporate risk meeting was held quarterly. We reviewed the risk register, which included the impact and severity of risk and the actions required to mitigate the risk areas. All staff we spoke with new how to identify and report risks.
- A comprehensive understanding of the performance of the service was maintained. The organisation had the processes and information systems to manage current and future performance. The information used in reporting, performance management and delivering quality care was accurate, valid, reliable, timely and relevant. Integrated reporting throughout the trust supported effective decision-making.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. For example, the performance indicator which records call back by clinicians within 10 minutes was below the national and trust target. The trust had identified the low performance and taken action to improve this.
- The management of partnerships, joint working arrangements and shared services, were clearly set out, understood and effective. For example, the close working with West Call Out of Hours Service had led to improved urgent care for patients when new initiatives were developed such as the early bird GP scheme. This service ensured GP home visits were undertaken earlier in the morning to prevent calls to NHS 111/999 service or attendance at hospitals
- Board meetings were held every other month. The meeting minutes showed that the performance of the

# Are services well-led?

Good

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

NHS 111 service was continually monitored against contracts and staffing issues. These meetings also routinely covered updates on quality and patient safety reports including Care Quality Commission updates and operational performance reports. The March 2016 board meeting report showed that discussions had taken place which demonstrated the board compared performance with national targets and had processes in place to monitor performance and request action was taken to improve.

**Leadership, openness and transparency**

There were clear lines of accountability within the trust and NHS 111 service. Leaders had the capability and experience to lead effectively ensure the trust strategy was delivered and understood the challenges of providing good quality care including identifying the actions needed to address them. Staff told us leaders were approachable and how they felt supported, respected and valued.

Candour, openness, honesty and transparency and challenges to poor practice were encouraged. The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The provider encouraged a culture of openness and honesty. The provider had systems in place to ensure that when things went wrong with care and treatment:

- The provider gave affected people reasonable support, truthful information and a verbal and written apology.
- The provider kept written records of verbal interactions as well as written correspondence.

The leadership model encouraged cooperative, supportive relationships among staff so that they feel respected, valued and supported. We noted throughout the inspection that there was a culture of collective responsibility in providing a high quality service to patients. Staff said that communication within the organisation by leaders was good, for example, through the staff newsletter. This was a method of communication written by, and specific to, staff within the call centres in Hampshire and Bicester. Leaders recognised the need to communicate with staff through a range of media including using digital screens which were installed across both sites as part of an ongoing project to replace the corporate Intranet. The screens situated in Northern House and Southern House were the first stage of a communications plan to improve the information produced. The screens showed a mixture of corporate news, national NHS messages and positive feedback from the public.

Senior leaders celebrated success which staff said made them feel appreciated and valued. We were informed that each year there was an award ceremony which celebrated the dedication and commitment shown by staff to the trust and its patients.

Staff said they received support from their peers, line managers and from other managers within the organisation. However, many staff were unaware of who the clinical nurse and paramedic leads within the organisation were.

**Public and staff engagement**

The leadership actively shaped the culture through effective engagement with people who used services and those close to them and stakeholders. Their aim was to be seen as a vital, valued and visible service and to promote regular and new public awareness campaigns. The NHS 111 service had provided a programme of public education events across all four counties. These included NHS 111 road shows as part of winter pressure campaign, patient forums, constituency meetings, specific campaigns for younger people, events with other Trusts and attendance at major county events and local community events.

Staff explained that these events had been very popular and had been used to gather feedback from its members and the public to ensure the NHS 111 service continued to deliver high quality care. The provider had engaged with people who used the service. There were approximately 13,400 members on the public board who were representative of the local population. Public board members had the opportunity to take part in various activities which influenced the organisation and patient experience. These activities included: patient forums, surveys, consultations, staff and governors group, governors election and health and governors talks at various locations.

Regular patient surveys were used to obtain feedback from patients. We saw examples where the response rate to

# Are services well-led?

Good

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

surveys had been lower than anticipated. The patient experience reference group had met and discussed this and increased the sample size to get more statistically significant feedback results.

Processes and systems to manage complaints were in the process of being improved. The provider had identified that complaints were not always handled and responded to in a timely way. An improvement plan was in place and corrective action was due to be completed in July 2016. The patient experience reference group reviewed the top themes from complaints, concerns, healthcare professional feedback, compliments and friends and Family Test outcomes. The review looked at the themes and made recommendations to senior managers to address any concerns.

The provider also valued feedback from staff and had introduced a 'Bright Ideas' scheme to give any staff member of the opportunity to suggest an improvement to the way the organisation worked. This included any ideas to improve patient care, the working lives of staff or services that were provided. For example, staff had requested that the overtime payments for senior staff be bought in line with staff from the 999 service. This had been approved and implemented recognising the additional skills and experience these staff held.

A staff survey had been designed using the Manchester Patient Safety Framework. This was a system where an organisation could have its current patient safety culture evaluated by its employees. Positive areas noted in the latest report published in January 2016 included being able to do the job to an acceptable standard; sufficient staff numbers; and satisfaction with opportunities for flexible working patterns. Areas for improvement included a lack of face to face team meetings and being able to communicate closely to achieve team objectives. The provider had addressed any areas of concerns, for example, team meetings were being reintroduced to facilitate communication and provide opportunities for feedback.

**Continuous improvement and innovation**

There was a strong focus on continuous learning and improvement at all levels within the service.

The provider had been approached by NHS England and Health and Social Care Information Centre to facilitate a national trial into sepsis recognition in children under five years old. This trial had started and had been communicated to all staff in the Clinical Coordination Centres. This work intended to inform decisions in the future about how children under the age of five years were assessed. To support this, clinical staff were asked to complete a mandatory "Spotting the sick child" assessment workbook.

The NHS 111 provider had recently received approval from NHS pathways for clinician homeworking. Remote or homeworking was designed to provide additional resilience to the clinical element of the NHS 111 service provided.

The provider was also looking at ways to further public engagement. These included working with young adults about a planned new website for younger people and the development of a children's specific website.

The provider had recently embarked on monthly media campaigns, starting in February 2016 with a 'Healthy Heart' campaign. The campaign was designed to increase the chances of people across the South Central region surviving a heart attack or cardiac arrest. It was a proactive, integrated campaign introducing ways to help people across Berkshire, Buckinghamshire, Hampshire and Oxfordshire recognise symptoms of a potential heart attack. The campaign helped people to know what to do, promoted training in basic life support and encouraged more people to download the South Central Ambulance Service App that identified where the nearest AED (automatic external defibrillator) was located.

The provider worked positively and proactively with other stakeholders to drive up quality and improvement. For example, since February 2016 the provider had been working with the Samaritans charity on an initiative. (The Samaritans are an organisation who provides emotional support for people to talk about problems that are causing emotional distress and/or putting them at risk of suicide.) The Samaritans had agreed to take direct calls, including low risk calls, from NHS 111 following clinical assessment regardless of the time of day or night.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br><br>Transport services, triage and medical advice provided remotely<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>**Regulation:**<br><br>18 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.<br><br>**How the regulation was not being met:**<br><br>The registered provider had not ensured that persons employed received appropriate, training to enable them to carry out the duties they were employed to do.<br><br>Not all staff received appropriate support, training, and appraisal to enable them to carry out the duties they were employed to perform.<br><br>Regulation 18 (1) (2) |