Yorkshire Ambulance Service NHS Trust HQ

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?	Good
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 inspected the NHS 111 service which is provided by Yorkshire Ambulance Service NHS Trust (YAS) on 10 11 and 12 October 2016. We carried out this announced inspection as part of our comprehensive approach to inspecting NHS111 services.

Overall the provider is rated as good.

NHS 111 is a telephone-based service where patients are assessed, given advice and directed to a local service that most appropriately meets their needs. For example, this could be patients registered with a GP during working hours, an out-of-hours GP service, walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance or pharmacy .

Our key findings were as follows:

- The YAS NHS 111 had systems in place to mitigate safety risks. Incidents and significant events were identified, investigated and reported.
- The service was monitored against the Minimum Data Set (MDS) for NHS 111 services and adapted National Quality Requirements (NQRs). These data collection tools provided intelligence to the provider and commissioners about the level of service being provided. Action plans were implemented where variation in performance was identified.
- YAS NHS 111 worked closely with the 23 Clinical Commissioning Groups (CCGs) in the Yorkshire and Humber Region, who commissioned the service. Greater Huddersfield CCG acted as lead commissioner for the associate CCGs.
- Staff were trained and monitored to ensure they used the NHS Pathways safely and effectively. (NHS Pathways is a licenced 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). We saw that regular call audits were carried out; however not all staff received face to face feedback on call audits.
- The provider had responded to reported episodes of bullying and harassment within the service., An independent arbitrator had been appointed to carry out an independent review into the issues. Recommendations and measures to improve staff

Summary of findings

morale had been adopted by the provider.In line with the national mandate the provider had appointed a 'Freedom to Speak Up' Guardian to enable staff to raise concerns safely.
- We saw patients contacting the service were supported effectively during the telephone triage process. Their consent was sought, and their decisions respected.
- The service proactively sought staff and patient feedback, and responded to issues identified.
- The provider had a clear leadership structure in place. However we saw that processes for staff supervision and support at team leader level were variable. Not all staff received regular 1:1s or face to face feedback on performance and call audits.
- We saw evidence that staff were able to access career development and secondment opportunities.
- The service had a clear vision and strategy to deliver high quality, safe and effective healthcare and provide good outcomes for patients.

We saw areas of outstanding practice:

- The provider was part of the West Yorkshire Vanguard and had been part of several pilot schemes to improve access to care and treatment. One of these involved improving access to pharmacist support. They had contributed to the development of a Pharmacy Urgent Repeat Medication Scheme (PURM) across the locality which enabled patients to access essential medicines from participating pharmacists out of hours. This scheme is supported by the NHS111 Pharmacy Team who had won a 'Pharmacy Innovation' award.
- The provider made use of a comprehensive Workforce Management Tool to forecast anticipated call levels and deploy staff accordingly. The development of this tool and the transformation of planning within the organisation was recognised by a National Planning Award from the Professional Planning Forum.

However there were areas where the provider should make improvements.

The provider should:

- Regularly review the changes recently implemented in the management and leadership structure for call handlers, in order to ensure that all staff receive regular face to face feedback on their performance and call audits via the 1:1 process.
- Continue with steps to improve the access for call handlers to clinical advisors through an active recruitment programme.
- Maintain processes and systems which enable staff to safely raise concerns in relation to working relationships.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The provider is rated as good for providing safe services.

- Safety was seen as a priority.
- Service performance was continuously monitored and reviewed and improvements implemented.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- All opportunities for learning from internal and external incidents were discussed to support improvement. Information about safety was valued and used to promote learning and improvement.
- Risk management was embedded and recognised as the responsibility of all staff. Risks to patients were assessed and well managed.
- The provider had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. The provider made use of a comprehensive Workforce Management Tool to predict anticipated demand and deploy staff accordingly.
- We saw that access to clinical advice by call handlers was not always readily available. We saw that the provider was actively recruiting clinical staff, and offering alternative arrangements, such as homeworking opportunities for appropriate staff. At the time of our visit 16 clinicians had been shortlisted for interview. Agency staff were in use to support the permanent staff group. We saw evidence that an average of 21% of call handler time, and 32% of clinical advisor time had been provided by agency staff within the previous 12 months.

Are services effective?

Good

The provider is rated as good for providing effective services.

- Data from the NHS 111 minimum data set showed patient outcomes were generally at or above average for the locality and compared to the national average. We saw that call abandonment rates were lower than national average, and that the percentage of calls answered within 60 seconds was higher than the national average. We saw that call length was longer on average in relation to national averages.

Summary of findings

- The provider described challenges in relation to meeting their KPI targets for clinician call back within two hours.At the time of our visit the service was achieving 85%, with a target of 95%. The provider was addressing this through their recruitment of clinical staff.
- Staff were appropriately trained and monitored to ensure safe and effective use of NHS Pathways and Directory of Services (DOS). DOS is a central electronic directory of local and national services which is integrated with NHS Pathways. We saw that systems to promptly update or report errors in the DOS had been developed
- Information received from patients through the telephone triage system were recorded on the NHS Pathways system. Patients received a text message advising them when a referral to another service, such as out of hours services (OOH) had been made.
- Call audits were carried out regularly. However not all staff received face to face feedback when call audits had been carried out. Staff were able to access call audit details via 'SharePoint' on the internal IT system, but not all staff were aware of this facility. Where staff had 'failed' calls we saw evidence that support or action plans were put in place to improve call handling skills.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of annual appraisals and personal development plans for all staff. However not all staff received regular face to face feedback on their performance throughout the year via the 1:1 process. At the time of our visit we saw evidence that 86% of staff had received appraisals in the previous year.
- Staff had access to specialist expertise from pharmacists, dental nurses and palliative care nurses. Support was also available from mental health nurses who worked within the 999 service. Staff liaised with other agencies and service providers to meet the range and complexity of patients' needs.

Are services caring?

Good

The provider is rated as good for providing caring services.

- Data from the national NHS patient survey showed patients rated the service higher than others for several aspects of care. The provider ran quarterly patient satisfaction surveys. We saw patients rated staff highly for treating them with respect, listening to them effectively, and providing helpful information.

Summary of findings

- The provider had appointed an' Expert Patient' who linked with the organisation at a strategic level and championed the patient perspective when services were planned or developed.
- During our visit we observed calls with patients. We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Information for patients about the services available was easy to understand and accessible.
- Staff had access to, and made regular use of 'The Big Word', a telephone interpreter service, for patients whose first language was not English. They also made use of 'Talk Type' for hearing impaired callers.

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services.

- The provider understood the needs of the population it served and engaged with the lead commissioner and 22 associate commissioners to provide a service which was responsive to these needs. For example the provider had implemented access to palliative care nurses on weekends and bank holidays, who were able to provide support to patients approaching the end of life. They were able to liaise with local pharmacies via the Pharmacy Urgent Medications scheme (PURM) to obtain medicines during the weekends, and were able to arrange transfer to local hospices rather than accident and emergency departments, when appropriate.
- Staff were able to directly book appointments with the out of hours service for patients who lived in the whole of West Yorkshire, East Riding, Harrogate and Bassetlaw. Patients could also be directed to accident and emergency, local pharmacies or minor injuries units in accordance with the most appropriate disposition (outcome) identified for the caller.
- Call centre staff had access to support from clinical staff including nurses, pharmacists, dental nurses and palliative care nurses. Access to mental health nurses was available via the 999 service.
- Call centre staff had support from the 'effective referrals' team who were able to deal with difficult referrals, such asmental health referrals.
- Care and treatment was coordinated with other services and other providers. There was collaboration with partners to improve urgent care pathways.

Summary of findings

- Information about how to complain was available and easy to understand and evidence showed the provider responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The provider had introduced both internal and external 'end to end review' processes where, with patient knowledge and consent, selected calls were reviewed by a panel, and the patient journey through the healthcare system, including the incoming YAS NHS111 call, was tracked. We saw evidence that learning gained from these processes was disseminated and was improving standards.
- The provider provided evidence that patient demand was increasing and staff recruitment, particularly of clinicians, was challenging. The provider was using innovative approaches to attract and retain staff. A senior clinical grade had been developed, to provide career development options for clinical staff. In addition, a homeworking pilot scheme for clinicians had beenevaluated , and was being implemented. At the time of our inspection these posts were being advertised.

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 service was responsive to feedback and used performance information proactively to drive service improvements. Staff were clear about the vision and their responsibilities in relation to it.
- YAS 111 monitored its performance against the Minimum Data Set (MDS) and Key Performance Indicators (KPIs).Performance was discussed at the monthly quality contract meetings with the CCGs. The provider identified a key challenge of meeting the two hour clinician call back KPI. At the time of our visit we saw they were achieving 85% of a 95% target.
- The provider had responded to some reported bullying and harassment cases within the call centre environment. As a result they had appointed an independent arbitrator to undertake a review and make recommendations for improvement. The provider had adopted the recommendations from the findings. Staff champions had been appointed and staff were able to access support from mental health' first aiders' or staff counselling services. At the time of our visit some staff told us they were still experiencing

difficulties in relation to bullying and harassment issues. The provider told us they were aware of the ongoing issues and were in the process of embedding the recommendations from the independent review.

- In line with the national mandate the provider had introduced a 'Freedom to Speak Up' (FTSU) initiative.An FTSU guardian had been appointed, and FTSU advocates had been appointed to support staff and promote awareness of the initiative.
- The provider carried out regular staff surveys, for example following busy Christmas periods; developed a staff engagement plan and held staff focus groups to monitor staff morale and well-being. There had been a recently launched 'staff recognition scheme' which was awarded to staff on a monthly basis, under various categories, such as the 'over and above' award and the 'call handler and clinician of the month' award.
- The provider had engaged an 'Expert Patient 'who linked with the organisation at a strategic level and championed the patient perspective when services were planned or developed. A 'critical friend' network was being set up to extend the scope of patient engagement.
- There was a clear leadership structure. We saw that the senior leadership team was cohesive and proactive. However some staff told us contact with their team leader was infrequent. We saw that not all staff received face to face feedback on their performance or call audits. Staff were able to access details of completed call audits on 'SharePoint'via the internal intranet system. The provider showed us an action plan which they had developed to improve the call audit processes, to promote the process as a supportive and learning process. Staff usually received face to face feedback on call audits when there had been a 'failed' call.
- The non-clinical team leader role had been split into two roles: shift co-ordinator and team leader role. Shift co-ordinators had responsibility for monitoring staff availability for calls throughout a shift and deploying staff appropriately to meet patient demand, whilst the team leader role had responsibility for carrying out staff appraisals, 1:1s, call audits and other duties such as return to work interviews. As a result some non-clinical team leaders had large teams of up to 40 staff to line manage. The provider told us they were reviewing their systems and processes to address this.
- The provider had a number of policies and procedures to govern activity and held regular governance meetings. All staff had access to policies and procedures via 'The Pulse', the internal intranet system.

Summary of findings

- There was an overarching governance framework which supported the delivery of the strategy and good quality care. 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 senior management team encouraged a culture of openness and honesty. The provider had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The provider sought feedback from staff and patients by the use of regular surveys, which it acted on.
- We saw evidence that staff had opportunities to progress, develop and diversify in their role.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Regularly review the changes recently implemented in the management and leadership structure for call handlers, in order to ensure that all staff receive regular face to face feedback on their performance and call audits via the 1:1 process.
- Continue with steps to improve the access for call handlers to clinical advisors through an active recruitment programme.
- Maintain processes and systems which enable staff to safely raise concerns in relation to working relationships.

Outstanding practice

- The provider was part of the West Yorkshire Vanguard and had been part of several pilot schemes to improve access to care and treatment. One of these involved improving access to pharmacist support. They had contributed to the development of a Pharmacy Urgent Repeat Medication Scheme (PURM) across the locality which enabled patients to access essential medicines from participating pharmacists out of hours. This scheme is supported by the NHS111 Pharmacy Team who had won a 'Pharmacy Innovation' award.
- The provider made use of a comprehensive Workforce Management Tool to forecast anticipated call levels and deploy staff accordingly. The development of this tool and the transformation of planning within the organisation was recognised by a National Planning Award from the Professional Planning Forum.

Yorkshire Ambulance Service NHS Trust HQ

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector. The team also included a CQC inspection manager, a second CQC inspector, a GP Specialist Adviser with experience of out of hours services and a Nurse Specialist Adviser with experience of working in NHS 111 services.

Background to Yorkshire Ambulance Service NHS Trust HQ

Yorkshire Ambulance Services NHS Trust (YAS) was formed on 1 July 2006, following the merger of the county's former three ambulance services. The Trust serves a population of over five million people. It covers almost 6,000 square miles of varied terrain, from isolated moors and dales to urban areas, coastline and inner cities. The Trust as a whole employs over 5,000 staff and provides 24 hour emergency and urgent care services to a population of more than five million. The NHS 111 service, provided by YAS, works in partnership with Local Care Direct, which provides out of hours (OOH) GP care in the West Yorkshire area. YAS NHS111 employs 336 whole time equivalent staff.

YAS NHS 111 services operate from three sites –

- Trust headquarters Brindley Way, Wakefield Business Park, Wakefield WF2 0XQ.
- Rotherham call centre site Callflex Business Park, Doncaster Road Wath-Upon-Dearne, Rotherham S63 7EF.
- York call centre site 31 Monkgate, York YO31 7WA.
- The Wakefield site is open 24 hours a day, seven days a week over 365 days, and has separate 999 and 111 call centres.
- The Rotherham site is open from 6am to 12 midnight seven days a week and bank holidays and deals only with 111 calls.
- The York site is open 6pm to 8.30am Monday to Friday, and on weekends from 8.30am Saturday morning, until 7.59am Monday morning, as well as public holidays This site also handles111 calls only.

Our inspection focused on NHS 111 call handling only.

The service covers Yorkshire and the Humber, as well as North and North East Lincolnshire and Bassetlaw.

YAS NHS 111 employs a total of 336 whole time equivalent staff. This includes call handlers, non-clinical and clinical team leaders, shift co-ordinators, clinical advisors, duty managers, clinical duty managers, and a range of management and governance support roles. The substantive staff roles are supplemented by agency clinical advisors and agency call handlers. Staff have access to additional clinical support provided by pharmacists, palliative care nurses and dental nurses. Staff are also able to access support for patients with mental health issues from mental health nurses who operate within the local 999 service.

Detailed findings

Between April 2015 and March 2016 the service answered 1,511,038 calls. This call volume had increased by 8% from the previous year.

Callers ring the NHS111 service where their medical need is assessed by a call handler or clinical advisor, based on the symptoms they report when they call. If a patient needs to be seen by a clinician, appointments are in most cases booked directly into the most convenient out of hours service at one of 12 Out of Hours Services across the region.

Appointments can be booked directly into OOH services in Wakefield, Sheffield and Hull. Patients living in other areas covered by the service are given the number of the OOH provider identified and are able to arrange their own appointment. Home visits are also provided by OOH services when need has been identified.

Callers can also be directed to one of 15 accident and emergency centres, with ambulances provided when appropriate. They may also be directed to out of hours pharmacists or minor injuries units, in accordance with need.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting the YAS NHS 111 service we reviewed a range of information we hold about the YAS NHS 111 service and asked other organisations, including the lead commissioner (Greater Huddersfield CCG), to share what they knew about the service. We reviewed the information which the provider submitted before our vist, as well as other information available in the public domain.

We carried out an announced inspection on 10, 11 and 12 October 2016. During the inspection we:

- Visited all three call handling sites. We spent time at two of the sites during the out of hours period.
- Observed nine call handlers and eight clinical advisors carrying out their role.
- Listened to recorded calls where callers' needs were assessed and dispositions of care were reached.
- Interviewed a range of key senior and middle management personnel including the Head of Nursing and Quality Assurance, Associate Director for Integrated Care, Workforce Planning Manager, Director for Planned and Urgent Care, Head of Investigations and Learning, Duty Managers and Clinical and Non Clinical Team Leaders.
- We spoke with the FTSU Guardian, Expert Patient, Clinical Duty Manager (Safeguarding lead) and Non-Executive Chair of the Board over the telephone.
- We conducted staff 'drop in' sessions at two of the sites, where 15 staff, including call handlers and team leaders attended.
- Reviewed 36 question sheets forwarded before our visit, which had been completed by a range of staff including call handlers and clinical advisors.
- Reviewed NHS Pathways, Directory of Services (DOS) and other documentation made available to us.

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?

We were unable to speak with patients who used the service. However, we observed call handlers and clinical advisors carrying out their role. We saw how clinical advisors and call handlers spoke with and supported patients who used the service. In addition we listened to recorded calls undertaken by call handlers and clinicians. We looked at a range of records including audits, staff training, patient feedback and complaints.

Detailed findings

Please note that when referring to information throughout this report, for example any reference to the MDS data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events

- Staff told us if they had been affected by a significant event they discussed the details with a team leader or clinical team leader, and recorded the event, including concerns regarding patient safety or any other incidents, via an electronic reporting system.
- The provider carried out an analysis of these and developed action plans to learn from the incidents and take steps to prevent a recurrence. For example they gave an example when changes to NHS Pathways had been made following a patient incident which showed omissions in the clinical assessment process in relation to testicular pain.
- We spoke with call handling staff and clinical advisors who told us they received feedback on any such incidents when necessary. Learning from significant events was anonymised and disseminated via the staff newsletter or via interactive hot topics' feedback tool disseminated by email to all staff. 'Real time' learning was shared by staff' huddles' which were held three times a day at Wakefield and Rotherham. These were also held in York during evenings and weekends.
- The NHS 111 Call Report Activity provided evidence that YAS 111 analysed feedback and took action where concerns were identified through professional feedback or patient complaints.

Learning and improvements

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. During our visit we were able to review evidence of lessons learned and disseminated.

When things went wrong with care and treatment, patients received reasonable support, truthful information, a verbal and written apology, and were told about any actions to improve processes to prevent the same thing happening again.

- The NHS Pathways licensing agreement required all call handlers and clinical advisors to have at least three of their recorded calls audited each month to check their competency using the NHS Pathways triage system correctly. All staff completed a self-audit each month with two further calls audited by their team leader or a member of the practice development team. Recently appointed staff received five call audits per month. Where staff had 'failed' call audits they received five call audits in the following month, where they were expected to pass at least four of these. If this was not the case staff were placed on a support plan or action plan, depending on their length of service. Although we saw evidence to indicate that call audits were being carried out, staff told us that face to face feedback from call audits was not provided for all staff. Staff were able to access details of their call audits via 'SharePoint' but not all staff were aware of this. The provider showed us an action plan which sought to address the call audit feedback process, raise awareness of the 'SharePoint' facility and increase the number of face to face 1:1s being held.
- The provider distributed a bi-monthly staff newsletter which updated staff on recent incidents and significant events. In addition staff received 'hot topics' information via email to disseminate learning from such events. The 'hot topics' updates required staff to complete self-reflection and learning templates which were collated by the practice development team to confirm staff completion. We saw an example of a recent 'hot topics' tool relating to dealing with sepsis.
- The provider carried out quarterly 'end to end' reviews in conjunction with commissioners and other key stakeholders. With the consent of the patient, the full patient journey was tracked throughout the healthcare system which included the NHS YAS111 part of the process, from initial contact until satisfactory treatment or other outcome.These enabled the organisation to identify learning points and highlight gaps in service provision or communication. In addition, internal monthly 'end to end reviews' were held at Wakefield and Rotherham. Staff working across all three centres were able to attend internal end to end reviews.Staff were asked to select calls to review through this process. Staff and management told us these provided a helpful and supportive learning experience.
- Staff 'huddles' were held three times daily at two of the call centres. These were facilitated by clinical leads and enabled real time updates and learning points to be

given to staff, and allowed staff to clarify any operational or clinical issues they wished to raise. Answers to any questions raised were highlighted in 'The Pulse', the internal intranet system.

- Internally the Trust had a well-established governance structure which included a clinical governance and quality assurance group, and patient safety group. These fed into the Quality Committee of the Trust Board.

Reliable safety systems and practices

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation. Local requirements and policies were accessible to all staff. Clear information was available outlining who to contact for further guidance is staff had concerns about a patient's welfare.
- Call handlers discussed concerns with clinical team leaders before making a safeguarding referral. Referrals were completed through the Trust's process via the 999 clinical hub, andthen forwarded to the relevant social service department by the referrals team. Plans were in place to create an electronic referral which could be completed by staff for submission by the referrals team. Contact numbers for internal and external safeguarding links were easily accessible. Not all staff knew who their safeguarding lead was, but staff we spoke with understood the process for making a safeguarding concern known. Call handlers and clinical advisors received child safeguarding training to level two, with regular updates delivered via online training. Safeguarding leads were trained to level three.
- We saw that between April 2016 and July 2016 (three months) there had been 557 adult safeguarding referrals made; and 500 child safeguarding referrals. There was a process in place to review each safeguarding referral made.
- Staff received regular safeguarding updates via 'The Pulse' intranet system. The safeguarding leads provided reports for other agencies when necessary, including a monthly report for the Board.
- Staff we spoke with demonstrated their understanding of their responsibilities in relation to identifying, documenting and reporting any safeguarding concerns.
- Special notes were used to identify if children or adults were at risk, for example children on child protection plans, or adults with a learning disability. Systems were also in place to report concerns to health visitors or school nurses for further assessment via the effective referrals team. The safeguarding leads monitored all referrals in order to identify trends, such as within care homes, or for frequent callers, which might indicate vulnerability.
- The call centres maintained appropriate standards of cleanliness and hygiene. We observed the working environment to be clean and tidy. The service had infection prevention and control (IPC) protocol in place and staff had access to appropriate online training.
- Policies and procedures were accessible to all staff via the internal intranet system.
- Call handlers followed NHS Pathways to ensure that dispositions reached at the end of the call were safe and appropriate.
- Call response times, waiting times and abandoned call data was closely monitored throughout each shift and staff were deployed to manage demand at peak times. Shift co-ordinators monitored staff availability throughout the shift. Clinical team leaders and team leaders had oversight of call type on the clinical call back queue and the level of urgency. Senior clinical floor walkers provided additional oversight and support to staff. Calls were triaged to ensure that those callers with more urgent need were prioritised to ensure patient safety.
- Call handlers were able to hold up cards when they required additional support during a call, relating to either support with an emergency call, IT issues or when clinical team leader support was needed. The colour of the card being held up indicated the type of support needed.
- We saw that access to clinical advice by call handlers was not always readily available. We saw that the provider was actively recruiting clinical staff, and offering alternative arrangements, such ashomeworking opportunities for appropriate staff. At the time of our

visit 16 clinicians had been shortlisted for interview. Agency staff were in use to support the permanent staff group. We saw evidence that an average of 21% of call handler time, and 32% of clinical advisor time had been provided by agency staff within the previous 12 months

- Staff had received guidance on how to deal with child callers, or callers with learning difficulty or mental illness.
- Recruitment checks were carried out and the six files we reviewed showed that appropriate recruitment checks had been made before employment. For example proof of identity, references, qualifications, registration with the relevant professional body and the appropriate checks through the Disclosure and Barring Service (DBS). 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.

Monitoring safety and responding to risk

Risks to patients were assessed and managed.

- Arrangements were in place for planning and monitoring the number of staff and skill mix of staff needed to meet patients' needs. All call centre staffing was scheduled using a comprehensive and detailed workforce management tool. The workforce and planning team had the responsibility of forecasting demand and scheduling staff to that demand based on skill. Staffing rotas were continually monitored, and staff shifts adjusted or overtime offered, to meet demand. Shortfalls were escalated by use of the surge and escalation plan when appropriate. Calls could be answered by staff in all three call centres.Clinical advisors and clinical team leaders were present in all call centres at all times. Additional clinical advice could be sought via the 'hunt' facility on the telephone system. We saw that during busy times access to clinical advice was sometimes delayed. The provider was exploring innovative ways to improve access to clinical advice, by use of palliative care nurses, pharmacists, dental nurses or mental health nurses, as well as by active recruitment of clinicians.
- Call handlers triaged calls by use of the NHS Pathways. This guided the call handler to assess the patient based on the symptoms they reported when they called. It made use of an integrated directory of services (DOS) which identified appropriate local and national services for the patient's care. When staff identified a potential error or omission on the DOS, they were able to report this immediately electronically. These were then verified and checked and changes could be made within 24-48 hours in some cases.
- The provider told us that staff induction training had recently been increased from five weeks to ten weeks in total, which included a period of supported call taking under the guidance of an experienced nominated 'buddy'. Staff returned to the classroom at ten weeks as part of the 'return to learn' initiative, where staff were able to explore any additional learning or difficulties they had encountered in the call taking process.

Arrangements to deal with emergencies and major incidents

The service had adequate arrangements in place to respond to emergencies and major incidents.

We saw the provider had a comprehensive business continuity plan in place to deal with emergencies that might interrupt the smooth running of the service. This included loss of mains power, loss of utilities, loss of staffing, evacuation of the building and loss of the DOS. The plan included emergency contact numbers for key staff.

- Staff told us that in the event of systems failure, calls could be diverted to one of the other call centres within YAS NHS111, or to other call centres in accordance the national escalation plan.
- During the course of the inspection we were told that evacuation of one of the call centres had occurred after our team had left the premises. The evacuation had been carried out in response to a suspected gas leak. The provider told us that the evacuation occurred smoothly and that disruption to service was minimised.
- There were procedures in place for monitoring and managing risks to patient and staff safety. We saw the provider had up to date fire risk assessments and fire evacuation plans. They had a variety of other risk assessments in place to monitor safety of the premises such as infection control and legionella. All electrical equipment had been checked.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Our findings

Effective needs assessment

- All call handlers and clinical advisors were required to complete a comprehensive mandatory training programme to become a licensed user of the NHS Pathways. Once trained and licensed, call handlers and clinical advisors were required to have their performance monitored on a monthly basis. A minimum of three calls per month were audited against a set criteria such as active listening, effective communication and skilled use of the NHS Pathways functionality. We saw that although call audits and performance monitoring was being undertaken, not all staff received face to face feedback on their performance on a monthly basis. Staff were able to access their call audit details via 'SharePoint 'on the internal intranet system; but not all staff were aware of this facility. The provider showed us a detailed action plan demonstrating how this was being addressed.
- When calls were found to have 'failed' in any of the required domains, staff were notified, with details of the criteria for failing. Following this staff received five call audits in the following month, and were required to pass four out of the five. When staff failed to achieve this, newly appointed staff were placed on a support plan to develop their skills further; whilst longer standing employees were placed on an action plan to address any identified shortfalls.
- We saw records of call audits and of feedback provided to staff by email or via 1:1s. Staff told us they understood the importance of regular call audits. We saw that not all staff received monthly face to face feedback on performance and call audits or 1:1s. The provider told us they had plans in place to address this to ensure consistency in approach for all staff. The provider showed us an action plan which sought to promote staff perception of the call audit process as a supportive learning exercise, rather than a punitive one. At the time of our visit we saw evidence that 86% of staff had received an appraisal in the preceding year.
- The Clinical Governance and Quality Assurance group provided monthly reports on call activity for commissioners each month. These reports identified any issues raised and facilitated requests for changes to NHS Pathways.
- Staff had received online training on mental capacity and dementia awareness. YAS NHS111 staff were able to access support from mental health nurses employed within the 999 service.
- We spoke with a range of staff who confirmed they had easy access to policies and protocols electronically, via 'The Pulse' or staff newsletters.
- Discrimination was avoided when speaking with patients who called the YAS NHS111 service. The assessment process ensured callers were supported and assessed on their needs rather than on their demographic profile. Call handlers had access to 'Big Word' telephone interpreter service for callers whose first language was not English; and 'Type Talk' for patients with hearing impairment. In addition British Sign Language (BSL) interpreter services were available from 8am until midnight.

Management, monitoring and improving outcomes for people

YAS NHS111 service monitored their performance against the National Minimum Data Set (MDS) and Key Performance Indicators (KPIs), some of which were locally agreed. Performance was monitored by the Clinical Governance and Quality Assurance Group.

The average monthly performance for the YAS NHS 111 Minimum Data Set August 2015 to July 2016 showed:

- 89% of calls were answered within 60 seconds compared to the England average of 87%.
- 2% of calls were abandoned after at least 30 seconds compared to the England average of 3%.
- 86% of calls were triaged compared to the England average of 87%.
- 19% of calls were transferred to a clinical advisor compared to the England average of 22%.
- 16% of calls were placed on a 'call back' queue compared to the England average of 13%.
- The average episode length of calls was 22 minutes compared to the England average of 16 minutes.

Good

Are services effective?

(for example, treatment is effective)

- The provider showed us evidence which indicated they were in the upper quartile nationally for ambulance dispositions of 8% and referral to emergency departments at 6%.

The provider acknowledged difficulties with access to clinical advisors for call handlers. The Trust was carrying out active recruitment drives for clinicians, and had developed a home working protocol which was being used to attract suitably experienced clinicians to undertake these roles. A senior clinical advisor grade had been introduced to provide clinicians with career development options.

The provider had established a Nurse Leadership Forum. The forum had been instrumental in developing a professional framework for nurses, acquiring online tools to help with nurse revalidation requirements and exploring means of improving recruitment and retention of nurses within the NHS 111 service.

We saw that the provider had experienced challenges in meeting their two hour KPI target for clinical call backs to patients. In order to mitigate risk to patients, the clinical advice call back queue was closely monitored by clinical team leaders, utilising a standard operating procedure to ensure that urgent calls were prioritised, and clinicians were directed to deal with these.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The service had a comprehensive and rigorous recruitment and selection and induction programme for all staff. Induction included training on information governance, safeguarding, infection prevention and control, equality and diversity and confidentiality. In addition call handling and clinical advisor staff undertook a 10 week induction programme which included classroom time, time listening in to calls and time supported by an experienced 'buddy' to take calls before taking calls independently. On week 10 staff returned to the classroom for a 'return to learn' week. Staff were provided with training in 'soft' skills such as customer service skills. At the end of each stage in the induction, staff were required to pass an assessment before being allowed to progress onto the next stage.
- The service had a mandatory on-line training programme covering topics such as safeguarding adults and children and dementia awareness training. We saw that staff received reminders when mandatory or other training was required. Completion of the training was monitored by the practice development team.
- We saw evidence that staff received an annual appraisal, where learning and development needs were discussed. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work.
- We saw that staff attrition rate was approximately 40% per year. We explored this high attrition rate with the provider. They told us this was partly explained by the rigorous training and testing process, meaning not all staff were able to progress to satisfactory completion. In addition they told us that some staff were able to access career development opportunities to train in other roles such as paramedics and nurses, whilst other staff left as they found the call centre environment and shift patterns difficult to manage. They told us they had introduced a feedback tool for staff to use following completion of their training programme to identify any trends or issues identified. They also told us they had extended the use of the exit questionnaire provided to staff on leaving the service, to enable the service to better understand and mitigate the reasons staff were leaving.

Working with colleagues and other services

The YAS NHS111 service was jointly commissioned by 23 Clinical Commissioning Groups (CCGs) Greater Huddersfield CCG was lead commissioner.

The accuracy and quality of information held in the DOS was the responsibility of each CCG. The data was continuously reviewed and updated to maintain an up to date and complete record of the local and national services available for patient referral. The service development team had introduced a real time system where call handlers and other staff were able to report any potential errors or omissions on the DOS, which were then verified and changes made and updated as appropriate.

- We observed both call handlers and clinical advisors move patients through the clinical assessment provided by NHS Pathways to reach the final disposition and then make contact with the appropriate service for the geographical location of the patient, as identified by the DOS. Call handlers were able to directly book appointments with OOH providers in Wakefield, Sheffield and Hull.

Good

Are services effective?

(for example, treatment is effective)

- Staff told us that some patient electronic records contained a 'special notes' section. This allowed call handlers and other staff to see additional relevant information relevant to the patients, for example frequent callers or other vulnerability factors.

Information sharing

- All information received from a patient through the telephone triage was recorded on the NHS pathways system.
- Staff told us the' effective referrals' team made contact with other services such as district nursing teams and mental health services as necessary. Details of all these contacts were recorded on the patient's electronic record.

Consent to care and treatment

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing telephone triage to children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- We observed several calls to the service. Throughout the telephone clinical triage assessment the call handler checked the patient's understanding of what was being asked of them. Patients were also involved in the final disposition (outcome) identified by NHS Pathways and their wishes were respected.
- Staff also gave examples of when, with support from a clinical team leader, they might override a patient's wishes, for example when they believed there was significant risk of harm to the patient if no action was taken.

Good

Are services caring?

Our findings

Our findings

Dignity, respect and compassion

- We reviewed the most recently available Friends and Family Test (FFT) and patient satisfaction survey results and found that between January and March 2016:
- 93% of respondents said that they were likely or extremely likely to recommend the service to friends and family.
- 93% of patients were happy with the responsiveness of the service in answering their call
- 92% of patients said the call handler listened to the effectively
- 90% of patients said the call handler was reassuring
- 96% of patients said they understood what the call handler said to them
- 96% of patients said they had been treated with dignity and respect
- 96% of patients said they understood the information and advice they were given
- 89% of patients said the information and advice they received was helpful

We observed call handlers and clinical advisors taking calls and noted they were polite, calm, courteous and respectful to patients.

Involvement in decisions about care and treatment

We were unable to speak with patients directly about their service they received. However we listened in to six recorded calls, and observed call handlers and clinicians taking several more calls. We observed that staff spoke respectfully with patients, and checked patient understanding throughout the assessment process.

Staff we observed were confident in traversing the NHS Pathways programme and we saw that the patient was involved and supported to answer questions thoroughly. The final disposition (outcome) of the clinical assessment was explained to the patient, and in all cases patients were given self-care advice, and advice about what to do should their condition worsen. Staff effectively used the DOS to identify available support close to the patients' geographical location.

Patient/carer support to cope emotionally with care and treatment

- We observed staff taking calls, and heard how patients/ carers were informed of the final outcome of the NHS Pathways assessment. We also saw that staff repeatedly checked that the patient understood what was being asked of them, and that they understood the final disposition following the clinical assessment.
- We observed that the patient's decision to accept the final disposition was respected. We saw that when a patient did not agree with the final disposition this was recorded on the patient's record, and discussed with a clinical team leader when necessary.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Our findings

Responding to and meeting people's needs

The service reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Groups (CCGs) to secure improvements to services where these were identified. For example, they had identified difficulties with patients having access to repeat medicines during weekends and bank holidays, and the locality has successfully introduced the Pharmacy Urgent Repeat Medication Scheme (PURM) scheme, which enabled patients to access short term supplies of essential medicines from one of 200 nominated pharmacies in the area. In addition, they had recognised that patients approaching end of life (palliative care patients) had sometimes been inappropriately directed to accident and emergency when they experienced unexpected difficulties during these periods. As a result they had obtained access to input from specialist palliative care nurses over weekends and bank holidays, who were able to deal with these calls, arrange for supply of essential medicines, and enable these patients to be seen in hospices, or cared for at home, rather than accident and emergency when appropriate.

- The service monitored its performance against the Minimum Data Set (MDS) and Key Performance Indicators (KPIs) and these were discussed at regular Clinical Governance and Quality Assurance Group meetings. Where variations in performance were identified, the reasons for this were reviewed and action plans implemented to improve the service. Services were planned and delivered to take into account the needs of different patient groups to help provide flexibility, choice and continuity of care.
- Systems were in place to electronically record additional information for vulnerable patients via the 'special notes' system. The information was available to call handlers and clinical advisors at the time the patient or their carer contacted the YAS NHS 111 service. This assisted the staff member to safely manage the needs of these patients.
- All staff had received training to help them identify and support confused or vulnerable callers. Advice could be sought from a senior clinical floor walker, or transferred to a clinical advisor for further assessment. We saw that the clinical call back queue was closely monitored by a clinical team leader through means of a standard operating procedure. More serious calls were prioritised for assessment. Where patients had been on the call back queue for longer than the two hour KPI target, patients were given a 'comfort call' to check their symptoms had not worsened, and advise on anticipated call back time. The provider reported any calls waiting four hours or more to the CCGs on a monthly basis.
- The service was able to book appointments for patients direct with out of hours (OOH) .services in Wakefield, Sheffield and Hull. In other areas patients were given contact details of the OOH service concerned, in order to arrange their own appointment booking. Patients were issued with a text message advising them when an appointment had been made, and clarifying the venue and the time of the appointment.
- The DOS provided comprehensive details of local and national services, such as mental health support services. All staff had access to the DOS during calls, and were able to report any identified errors or omissions to the service development team, who assessed the information and updated the DOS as appropriate

Tackling inequity and promoting equality

- The NHS Pathways assessment process ensured patients were supported and assessed on their presenting symptoms, not on their personal, cultural or religious beliefs.
- Call handlers and clinical advisors had access to a telephone interpreter service 'The Big Word' for patients whose first language was not English, and to 'Type Talk' for patients with any hearing impairment.

Access to the service

- YAS NHS111 telephone number was a free, 24 hours a day 365 days a year telephone number for people living in Yorkshire and the Humber, as well as North and North East Lincolnshire and Bassetlaw.
- Calls were answered at any of the three call centres, based in Wakefield, Rotherham or York.
- The Wakefield site was open 24 hours a day, seven days a week over 365 days, and has separate 999 and 111 call centres.
- The Rotherham site was open from 6am to 12 midnight Monday to Friday and dealt only with 111 calls.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The York site was open 6pm to 8.30am Monday to Friday, and on weekends from 8.30am Saturday morning, until 7.59am Monday morning. This site also handled 999 and 111 calls.
- We saw evidence that the call abandonment rate was 2%, compared tothe national average of 3%.
- We saw that 89% of calls were answered within 60 seconds, compared tothe national average of 87%.
- The service prioritised people with the most urgent need at times of high demand. Capacity and demand was estimated using a comprehensive workforce management tool, and was monitored closely at all times. A daily conference call was held across all three sites to assess staffing capacity and patient demand, with staff being offered shift slides or overtime to accommodate anticipated surges in demand. In addition the service held weekly and monthly organisational planning meetings to co-ordinate staff cover to best meet anticipated patient demand.

Listening and learning from concerns and complaints

The provider had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for NHS111 services in England. There was a designated person who handled all complaints in the organisation.

- The service had received 510 complaints in the previous 12 months. This represented less than half of one percent of the total calls received by YAS NHS111 during that period.
- Documents we saw demonstrated that all complaints received were investigated and responded to within contractual timeframes. Investigations included reviewing the call made to the service to assess the quality of the call and the responses provided to the patient. Where the call review identified shortfalls in the performance of a call handler or clinical advisor, this was discussed with the individual concerned; and additional support by means of a support or action plan, was provided. In some instances call handlers or clinicians were removed from call lines to enable comprehensive training to be undertaken.
- In addition, the service conducted end to end reviews of calls where significant incidents had been identified. A quarterly external end to end review meeting took place in conjunction with Commissioners and other key stakeholders In addition two internal end to end reviews were held each month, where a panel tracked the patient journey, from the time when the patient entered the healthcare system, until the resolution of the problem. This included the NHS111 call. In all cases the consent of the patient concerned was obtained, and patients were given clear feedback on the conclusions and learning points gained as a result of the process.

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

The provider had a clear vision and strategy. They told us their strategic objectives were:

- To deliver world class health outcomes in urgent and emergency care
- To secure continuous service improvement and innovation
- To develop and retain a highly-skilled, engaged, diverse and motivated workforce
- To build on partnerships to provide system leadership and resilience
- To maintain a safe and caring service using resources efficiently

They had a mission statement which was:

W –working together for patients

E-everyone counts

C-commitment to quality

A-always compassionate

R- respect and dignity

E-enhancing and improving lives.

The statement was displayed across all three call centres.

The provider had a mission statement which was “Saving Lives, Caring for You”

The senior management team told us they promoted a culture of openness, honesty, respect and continuous improvement. However during the drop in sessions we held for staff, we received mixed responses from staff in relation to this.

Governance arrangements

The service had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Service specific policies were implemented and were available to all staff
- A comprehensive understanding of the performance of the service was maintained. The Clinical Governance and Quality Assurance Group identified key areas of risk and put strategies in place to reduce risks to patients
- A programme of continuous internal audit, including end to end reviews and call audit was used to monitor quality and make improvements.
- There were arrangements for identifying, recording and managing risks and issues, and implementing mitigating action plans.
- The provider supplied monthly performance reports to the CCGs via the Contract and Performance Management Meeting, which summarised the ongoing work across the region and included statistical data relating to call activities, audits and trends as well as quality and patient safety updates. This gave an overview and assurance of the service for Commissioners. A risks and issues log was created, update action logs monitored progress towards completion of identified actions.

Leadership, openness and transparency

- We saw that team leaders, shift co-ordinators and clinical team leaders were visible in all three call centres. Not all staff we spoke with had regular face to face contact with their team leader, however staff were aware of who their team leader was, and described how they were able to access support if needed from a team leader or clinical team leader.
- The provider showed us a detailed action plan to address access to face to face meetings with team leaders, to ensure consistency across the service in relation to performance measures and call audit feedback.
- We saw that the provider had responded to a number of bullying and harassment issues within the call centre environment.An independent arbitrator had been appointed to assess the issues and made recommendations for actions to be carried out.The service had accepted the findings and adopted the recommendations, which included the appointment of mental health ‘first aiders’ within the call centre;

Are services well-led?

Good

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

development of the staff champion role and access to staff counselling for affected staff. The 'bullying and harassment' policy was being changed to a 'dignity and respect' policy, to widen the scope of the policy.

- In line with the national mandate the provider had appointed a 'Freedom to Speak Up' (FTSU) Guardian. FTSU staff champions had also been appointed to promote understanding and awareness of this initiative.

Public and staff engagement

- The provider received feedback via the Friends and Family Test (FFT) and patient satisfaction surveys. The results were shared with staff via the bi-monthly newsletter.
- The website for YAS included a patient feedback link which enabled the public to make a complaint, report a concern, provide a compliment or make a comment (the four Cs).
- An 'Expert Patient' had been appointed who linked with the organisation at a strategic level and championed the patient perspective when services were planned or developed. We were given evidence to suggest that feedback from the patient champion was acted upon, for example, changes to the questions used in the NHS Pathway when dealing with callers who had a learning disability.
- The provider carried out regular staff surveys, for example following busy Christmas periods. They had developed a staff engagement plan and held staff focus groups to monitor staff morale and well-being.
- In August 2016 a 'staff recognition scheme' had been launched. Certificates and badges were awarded to staff on a monthly basis, under various categories, such as the 'over and above' award and the 'call handler and clinician of the month' award. We saw some staff wearing their badges. Staff we spoke with told us they felt the scheme provided encouragement and acknowledged the hard work being carried out by call handlers and clinicians.

Continuous improvement

The provider was innovative and forward looking in approach. They were part of the West Yorkshire Vanguard and had undertaken several pilot schemes, many of which they had adopted, such as improved access to pharmacy support, the PURM scheme, access to palliative care nurses and the Home Working Initiative.

They had received the Pharmacy Innovation Scheme award for showing innovation in the evaluation and development of an NHS Pharmacy team which supported the work of the PURM scheme. They had also been awarded a national planning award for the Workforce Management Tool used to anticipate patient demand and map staff availability to meet this demand.

The service was continually looking at further ways to innovate and improve the service. An online NHS111 system was being explored at the time of our visit, whereby patients would have opportunity to self-assess their symptoms, and access appropriate support services in accordance with the findings provided by the assessment tool.