London Central & West Unscheduled Care Collaborative NHS 111 Service (St Charles Centre for Health and Wellbeing)

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of the NHS 111 service provided by the London Central & West Unscheduled Care Collaborative Limited on 2 and 3 March 2017 at its NHS 111 single site location at St Charles Hospital, London W10 6DZ. NHS 111 is a 24 hours a day telephone based service where people are assessed, given advice or directed to a local service that most appropriately meets their needs.

Our key findings were as follows:

The London Central & West Unscheduled Care Collaborative Limited (LCW UCC) NHS 111 service provided a safe, effective, caring, responsive and well-led service to a diverse population in West and North Central London. Overall the provider was rated as good.

- There was an open and transparent approach to safety and an effective system in place to report and record significant events. Staff knew how to raise concerns, understood the need to report incidents and considered the organisation a supportive culture. All opportunities for learning from internal incidents were discussed to support improvement. Information about safety was valued and used to promote learning and improvement.
- The provider maintained a risk register to identify and take preventative action and promote service resilience, and held regular internal and external governance meetings.
- Staff took action to safeguard patients and were aware of the process to make safeguarding referrals. Safeguarding systems and processes were in place to safeguard both children and adults at risk of harm or abuse, including calls from children and frequent callers to the service.
- The provider had a thorough recruitment and induction process in place for all staff to help ensure their suitability to work in this type of healthcare environment.
- The service was monitored against a National Minimum Data Set (MDS) and Key Performance Indicators (KPIs). These data collection tools provided intelligence to the provider and commissioners about

Summary of findings

the level of service being provided. Data provided showed the provider was meeting the majority of its targets. Action plans were implemented where variation in performance was identified.

- 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).
- Patients using the service were supported effectively during the telephone triage process and consent was sought. We observed staff treated patients with compassion and respect.
- The provider had been part of several collaborative pilots to improve care pathways and enhance access to care and treatment for patients.
- The provider was responsive and acted on patients' complaints effectively and feedback 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. Staff felt supported by the management team.
- The provider was aware of, and complied with, the Duty of Candour. Staff told us there was a culture of openness and transparency.

There were areas where the provider should make improvements:

- Continue to address the challenges of recruiting substantive staff and the reliance on agency staff to ensure adequate numbers of skilled staff are available to provide a safe and effective service.
- Continue to monitor and manage through action plans National Minimum Data (MDS) and Key Performance Indicator (KPI) targets which fall below national targets.
- Ensure that all staff are aware of and understand the principles and responsibilities of the Duty of Candour.

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.

- There was an open and transparent approach to safety and an effective system in place to report and record significant events. Staff knew how to raise concerns, understood the need to report incidents and considered the organisation to have a supportive culture.
- All opportunities for learning from internal 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. The provider maintained a risk register and held regular internal and external governance meetings.
- Staff took action to safeguard patients and were aware of the process to make safeguarding referrals. Safeguarding systems and processes were in place to safeguard both children and adults at risk of harm or abuse, including calls from children and frequent callers to the service. Level three safeguarding training had been undertaken by 100% of the clinicians and level two for 100% of call handlers.
- Service performance was monitored and reviewed and improvements implemented.
- Clinical advice and support was readily available to call handlers when needed.
- Capacity planning was a priority for the provider and there were sufficient numbers of trained, skilled and knowledgeable staff available at all times. The provider had highlighted the challenge of recruiting substantive staff and relied on the use of agency clinicians.

Are services effective?

Good

The provider is rated as good for providing effective services.

- Daily, weekly and monthly monitoring and analysis of the service achievements was measured against key performance targets and shared with the lead clinical commissioning group (CCG) members. Data provided showed the provider was meeting the majority of its performance targets. Action plans had been implemented where variations in performance were identified.
- Staff were trained and monitored to ensure safe and effective use of NHS Pathways.

Summary of findings

- Staff received annual appraisals and personal development plans were in place, and had the appropriate skills, knowledge and experience.
- Staff ensured that consent as required was obtained from people using the service and appropriately recorded. There was an effective system to ensure timely sharing of patient information with the relevant support service identified for the patient and their GP.
- People's records were well managed, and, where different care records existed, information was coordinated.
- Staff used the Directory of Services (DoS) and the appropriate services were selected. (The DoS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.)

Are services caring?

Good

The provider is rated as good for providing caring services.

- We observed staff treated people with kindness and respect, and maintained people's confidentiality.
- People using the service were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We heard staff listened carefully to information that was being told to them, confirmed the information they had was correct and supported and reassured callers when they were distressed.
- Call handlers had access to the language line phone facility (a translation/interpreter service) for patients who did not have English as their first language, a text relay service for patients with difficulties communicating or hearing and a video relay service for British Sign Language (BSL) interpreters.
- Feedback from people about the service was predominantly positive.

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services.

- Care and treatment was coordinated with other services and other service providers and there was collaboration with partners to improve urgent care pathways. Specifically, we saw that the provider had been part of several collaborative initiatives to improve access to care and treatment for patients with multiple sclerosis and patients in mental health crisis who may be at risk of suicide.

Summary of findings

- The service had long and short-term plans in place to ensure staffing levels were sufficient to meet anticipated demand for the service.
- There was a comprehensive complaints system and all complaints were risk assessed and investigated appropriately.
- Action was taken to improve service delivery where gaps were identified.
- Staff were alerted, through their computer system, to people with identified specific clinical needs and for safety issues.
- The service engaged with the lead Clinical Commissioning Group (CCG) to review performance, agree strategies to improve and work was undertaken to ensure the Directory of Services (DOS) was kept up to date. (The DOS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.)

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 a high quality service and promote good outcomes for people using the service. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff we spoke with told us they felt supported by management.
- There was an overarching governance framework which supported the delivery of the strategy and a good quality service. This included arrangements to monitor and improve quality and identify risk. The provider maintained a risk register in order to identify and take preventative action and promote service resilience.
- The information used in reporting, performance management and delivering quality care and treatment was accurate, valid, reliable, timely and relevant.
- The provider's policies and procedures to govern activity were effective, appropriate and up to date. Regular governance meetings were held.
- The provider was aware of and complied with the requirements of the duty of candour. The provider and managers 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 people using the service via the contractual patient survey and from staff via an annual staff survey, engagement sessions and suggestion box.

Summary of findings

- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Continue to address the challenges of recruiting substantive staff and the reliance on agency staff to ensure adequate numbers of skilled staff are available to provide a safe and effective service.
- Continue to monitor and manage through action plans National Minimum Data (MDS) and Key Performance Indicator (KPI) targets which fall below national targets.
- Ensure that all staff are aware of and understand the principles and responsibilities of the Duty of Candour.

London Central & West Unscheduled Care Collaborative NHS 111 Service (St Charles Centre for Health and Wellbeing)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and the team included a GP special advisor with experience in urgent care and out-of-hours care and a non-clinical special advisor with experience in out-of-hours care.

Background to London Central & West Unscheduled Care Collaborative NHS 111 Service (St Charles Centre for Health and Wellbeing)

London Central & West Unscheduled Care Collaborative (LCW UCC) operates its NHS 111 service from a single location at St Charles Centre for Health and Wellbeing, St Charles Hospital, Exmoor Street, London W10 6DZ. LCW UCC is a GP-led, not-for-profit organisation founded in 1994. The organisation is a certified social enterprise with the Social Enterprise Mark (the Social Enterprise Mark is the only internationally available social enterprise accreditation, enabling credible social enterprises to prove they put the interests of people and planet before shareholder gain).

LCW UCC is commissioned to provide NHS 111 in Inner North West London (INWL) to the boroughs of Kensington and Chelsea, Westminster and Hammersmith and Fulham and in North Central London (NCL) to the boroughs of Camden, Islington, Enfield, Barnet and Haringey. Overall the service provides NHS 111 services to 2.3 million patients. Data for the period January to December 2016 showed a combined total of 412,142 calls were received (INWL 135,226 and NCL 276,916).

The provider is registered to provide three regulated activities:

- Treatment of disease, disorder or injury;
- Transport services, triage and medical advice provided remotely.

The LCW UCC 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, emergency dentist, accident and emergency department, emergency ambulance or late opening chemist.

The LCW UCC 111 service workforce consists of a service manager and management support team, 131 call handlers (106 whole time equivalents), 46 clinicians (18 whole time equivalents), seven supervisors (seven whole time equivalents) and four senior operations co-ordinators (four whole time equivalents). The service reported an approximate 30% turnover of substantive call handlers and 11% turnover of substantive clinicians. The substantive staff roles are supplemented by regular agency clinical advisors and call handlers.

The LCW UCC 111 service is one of five providers of NHS 111 services in London.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 NHS 111 service, we reviewed a range of information that we held about the service provider, London Central & West Unscheduled Care Collaborative (LCW UCC) NHS 111 and reviewed the information on their website. We asked other organisations such as commissioners to share what they knew about the NHS 111 service.

We carried out an announced comprehensive inspection of the LCW UCC 111 service location in West London on 2 and 3 March 2017. During our inspection we:

- Observed the call centre environment over one and a half weekdays and during a peak weekday evening when GP practices were closed.
- Spoke with a range of clinical and non-clinical staff, including call handlers, clinical advisors, team leaders and senior managers including the medical director, chief executive officer and director of quality and governance.
- Reviewed NHS Pathways, Directory of Services (DOS) and other documentation made available to us. For example, performance data, audits, staff personnel records, staff training, patient feedback, incidents, complaints and meeting minutes.
- Spoke with commissioners and patient representatives.
- Listened to three anonymised call recordings. We did not speak directly with patients who used the service. However, we observed call handlers in the call centre speaking with patients who telephoned the service.

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?

Please note that when referring to information throughout the report this relates to the most recent information available to CQC at that time.

Good

Are services safe?

Our findings

Safe track record

There was an effective system in place for reporting and recording significant events. We saw that the provider recorded all risks and incidents on a risk management software tool (Datix).

There was an effective system in place for reporting and recording significant events.

- Significant events 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 and would inform their manager. We noted that staff had access to an operational policy and process flowchart. There was a recording form available on the provider's computer system with a link of each computer desk top. Staff we spoke with knew how to access this. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that provider of services must follow when things go wrong with care and treatment). Not all staff we spoke with understood the term duty of candour but understood the principle when discussed and told us they felt confident when raising concerns and that management were open and approachable. Staff also told us that there was a whistleblowing policy.
- We noted the provider had recorded 102 incidents from January to December 2016 and we saw evidence that a thorough analysis had been undertaken and key outcomes actioned. For example, reinforcement training of the policy to ascertain a patient's current location had been undertaken following an incident where an ambulance had been dispatched to the wrong address.
- We saw evidence that when things went wrong, people were informed of the incident, 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 provider had contributed information for serious case reviews. An example given to us related to case in which a patient had died. The provider openly and critically examined each aspect of their involvement in the case and had established where lessons could to be learnt from the circumstances of the case. This was one situation whereby the provider had shared learning throughout the organisation in the form of enhanced 'red flag' training defined as a concerning comment mentioned by the caller which the call handler has difficulty using the information in the current NHS Pathways. Staff are instructed to immediately pass call to a clinician or raise an alert card for further assistance. We saw evidence of posters and training material around the call centre.
- The provider had used learning from serious incidents to feedback suggestions for changes to the NHS Pathways algorithm.
- Serious incidents, incidents, complaints, call quality and monitoring, safeguarding and patient experience were reported in a monthly quality report. These were reviewed at weekly internal meeting and at the monthly NHS 111 and clinical commissioning group meetings, known as the 'Clinical Quality Review Group (CQRG) and at external London region Integrated Urgent Care clinical governance group meetings.
- The provider held monthly 'end-to-end' call reviews with the commissioners.
- Staff told us they received feedback from any investigations and changes required as a result of learning from risks and incidents through one-to-one meetings, staff engagement meetings, emails, bulletins and newsletters. We reviewed several issues of a monthly 'safety snippets' bulletin which outlined incidents received each month in a colourful, eye-catching and punchy format. The provider told us that the bulletin supplemented other methods of communicating feedback from incidents to reinforce learning.
- The provider engaged with the CCG Clinical Quality Reference Group and with the external pan-London NHS 111 Clinical Governance Group to peer review and share risk and learning from serious incidents within a 'Being Open' framework.

Overview of safety systems and processes

Good

Are services safe?

The service had clearly defined and embedded systems, processes and practices in place to keep people who used the service safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Safeguarding children and adults policies and process flowcharts were accessible to all staff and staff we spoke with knew where they were located. The policies clearly outlined who to contact for further guidance if staff had concerns about a person's welfare. There was a safeguarding lead nurse and a nominated clinical lead for both safeguarding children and safeguarding adults. All staff we spoke with knew who the leads were. We saw the provider attended local safeguarding children board meetings.
- Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. Training records provided at the time of our inspection indicated 100% compliance with level three safeguarding training for clinicians and 100% compliance with safeguarding level two training for call handlers. Training was both on-line and face-to-face. We reviewed training handouts from a recent training session which included an overview of the referral process, active listening, case scenarios and guidance on useful phrasing to assist staff when approaching the subject of safeguarding and safeguarding referrals with patients. All staff had received safeguarding adults training which included awareness of Female Genital Mutilation (FGM), child sexual exploitation and domestic violence. We saw that Prevent (anti-radicalisation) training was also part of the training schedule and 85% of staff had completed this.
- During the period January to December 2016 there had been 1,250 safeguarding referrals. Of these, 804 related to adults and 446 related to children. Staff were able to discuss any concerns regarding the safety and welfare of a patient in real-time with a clinician prior to making a referral. Assistance was sought by raising a 'assistance required' flag or through the clinical system. Safeguarding concerns could be 'warm transferred' (a direct call transfer where the caller was kept on the telephone) to a clinician to progress the issue. This meant some calls were, at times, ended by the call handler and then a verbal 'hand over' to the clinical advisor made so they could then determine whether a safeguarding issue was relevant. There was a process in place to review each safeguarding referral made and a 'safety netting' procedure to ensure all referrals had been received by social services.
- Call handlers had use of a visual alert system which enabled them to raise a flag and receive immediate assistance for various situations such as life-threatening scenarios. We saw that these were available on workstations in the call centre.
- The safeguarding team undertook regular audits of all calls regarding children to ensure they had been handled appropriately and no safeguarding referrals had been missed. The audits of calls we reviewed showed all calls had been handled appropriately.
- Clinical staff and appropriate administrative staff had access to people's medical or care records which included access to special patient notes and care plans. This included people identified as frequent callers and those on the end of life pathways. Staff were clear about the arrangements for recording patient information, maintaining records and making use of additional information. This made a difference to the management and support given to callers.
- As soon as a call was received by a call handler, a patient record was established including name, age and address. We heard how staff checked information for accuracy whilst at the same time reassuring the caller. Information was recorded directly onto the computer system and all calls were recorded to enable information verification and quality management. Staff were clear about the arrangements for recording patient information and maintaining records.
- Staff had had training in recognising concerning situations and followed guidance in how to respond. Clinical and non-clinical coaches (who provided support to call handlers) were present within the call centre for staff to obtain advice if there were any concerns as to which pathway to use within the clinical decision support software. Staff told us the supervisors and coaches offered good support.
- The provider used the Department of Health approved clinical decision support system NHS Pathways. (This is a set of clinical assessment questions to triage telephone calls from people and is based on the symptoms reported when they call. The tool enables a specially designed clinical assessment to be carried out

by a trained member of staff who answers the call.) Once the clinical assessment was completed a disposition outcome and a defined timescale was identified to prioritise the patients' needs. Call handlers' and clinical advisors' call handling skills using the NHS Pathway systems were monitored to ensure that dispositions reached at the end of the call were safe and appropriate.
- There were clear processes in place to manage the transfer of calls, both internally within the service, and to external services, to ensure a safe service.
- There were systems in place to monitor call handling and response times to ensure a safe service.

The provider had a comprehensive and rigorous recruitment and selection process.

- We reviewed details of a recent recruitment assessment day and saw shortlisted call handler candidates had attended an assessment centre and participated in a group session which included an overview of the provider, NHS 111 and NHS Pathways. Candidates undertook role play, written and reading exercises, a typing test and an individual candidate interview.
- We reviewed six personnel files of substantive staff and two of agency staff and found 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 (DBS).
- The provider told us that, as part of its internal governance and audit system, they had discovered that a number of call handlers recruited between October 2016 and January 2017 had commenced and completed their NHS 111 training prior to their DBS clearance being received. The provider utilised a fast track service for DBS clearance but noted some enhanced checks took 13 weeks to be received. An incident investigation and audit of all 207 of its NHS 111 staff revealed that 16 call handlers had commenced work before the DBS was in place. These have since been DBS cleared. In the interim period, the provider undertook a risk assessment. The investigation revealed there was a failure in its internal compliance mechanism when signing staff off from training. The provider demonstrated that it had since put a fail-safe system in place. The commissioners were advised of the incident and when we spoke with them they independently raised this as an example of the provider's transparency.

Staff were provided with a safe environment in which to work:

- Entry to the call centre was via a swipe card. The service operated from NHS hospital trust premises and maintenance and facilities were managed by NHS Property Services. The service had a health and safety team who liaised with the hospital's facilities management team and there was a system in place to report faults and maintenance issues. The provider held internal health and safety meetings every six weeks and we saw that health and safety incidents were recorded in Datix. There had been 13 recorded in 2016.
- We were able to inspect various maintenance schedules and risk assessments to monitor safety of the premises such as health and safety, premises and Legionella (Legionella are bacteria which can contaminate water systems in buildings) risk assessments. We saw evidence that portable appliance testing (PAT) had been undertaken in January 2017.
- The provider had a health and safety policy in place and there was a health and safety poster in the call centre which listed the names of the health and safety representatives. We saw details of a named first aider and a first aid kit in the call centre. We saw that 99% of staff had received training in health and safety, 97% in moving and handling and 96% in infection control.
- The provider had a Display Screen Equipment (DSE) policy in place and we saw evidence that staff had completed Display Screen Equipment (DSE) self-assessment forms. The provider had put some adaptations in place as a result of the findings, for example, back rests, foot and wrist supports.
- A fire risk assessment had been undertaken and there was a weekly fire alarm test. There was a local fire safety policy and fire safety poster in the call centre with detailed the fire evacuation assembly point. The provider had a system in place to identify staff who may require assistance in the event of an emergency evacuation (Personal Emergency Evacuation Plan) but had not identified any of its staff. The provider had nominated and trained fire marshals and we saw all staff, except three call handlers, had undertaken fire safety training (98%). Training records showed that a

reminder had been sent to these personnel with a required completion date of 22 March 2017. A fire training refresher course was undertaken every two years and we saw that the training schedule included the due date.

- There was an infection prevention and control policy in place and the provider had undertaken a local infection control audit in February 2017. We saw evidence that action had been taken to address any improvements identified as a result. Training records showed that 96% of staff, both clinical and non-clinical, had undertaken infection control training.

Monitoring safety and responding to risk

- Risks to people using the service were assessed and well managed.
- Call handlers triaged patient calls using a clinical decision support system (NHS Pathways). This guided the call handler to assess the patient based on the symptoms they reported when they called. It had an integrated Directory of Service (DoS) which identified appropriate services for the patients' care.
- Staff received comprehensive training and regular updates on NHS Pathways. Each call handler's competency was assessed prior to handling patient telephone calls independently, and continuously through regular calls audits.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs using a workforce management tool. Forecasting of services were planned for each financial year based on historical activity, local and seasonal events and staff attrition. Rotas were prepared in advance to ensure enough staff were on duty. All staff received emails to confirm their sessions and sent weekly text reminders to ensure there were no issues with service cover. Call volume and demand was reviewed and monitored on a daily basis and where there was a change to expected activity this was discussed and agreed at monthly contract commissioners meetings. We saw an example of this and how adjustments had been made to meet potential increase in demand during the junior doctor strikes.
- There was an effective process in place to identify, understand and monitor current and future risks.
- Staff we spoke with demonstrated they were able to identify potentially life threatening situations and had systems in place to manage frequent callers. Notes were added to the system which provided call handlers with a course of action to take to ensure their health, safety and wellbeing.

Arrangements to deal with emergencies and major incidents

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

- The provider had a comprehensive business continuity and disaster recovery plan in place to deal with emergencies that might interrupt the smooth running of the service. This included loss of power, evacuation of the building, IT and telephony failure.
- The provider had engaged with other services and commissioners in the development of its plan and had implemented various resilience measures which included power back-up, cloud-based technology and a 'buddy' arrangement with a London 111 provider.
- We noted the plan was regularly reviewed and had recently been updated to reflect a new supplier.
- Staff we spoke with on the day were aware of the plan and we saw that each work station had a resource pack which included a paper copy of adult, infant and children's pathways and manual call documentation in the event of a system failure.
- The provider had undertaken a table top exercise in November 2016 to test its response to various situations, such as building evacuation and telephony failure.
- The provider participated in the Exercise Unified Response Humanitarian Assistance (a multi-agency emergency services exercise) held in London in February 2016.

Good

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 (NICE) best practice guidelines.

- We saw that the service had systems in place to ensure all staff were kept up to date. Staff had access to guidelines from NICE and NHS Pathways, and used this information to deliver care and treatment that met people's needs. We saw the provider used varied means of communicating these guidelines to staff which included through team meetings, workshops, newsletters, printed information on workstations, information boards and a television monitor. The provider monitored that these guidelines were followed through audits and if the guidelines were not followed staff would receive feedback or training with an action plan if needed.
- Telephone assessments were carried out using an approved clinical decision support tool (NHS Pathways). All call handlers had completed a mandatory comprehensive training programme to become a licensed user of the NHS Pathways programme. Once training had been completed both call handlers and clinicians were subject to a structured quality assurance programme. We saw the provider had experienced health advisors to undertake call auditing, who had received training to do this. Calls managed by both call handlers and clinical advisors were regularly audited using the NHS 111 standard audit tool. The minimum standard was that 1% of calls per call handler were audited. The provider told us it was a challenge to meet the five audits per call handler per month target and an action plan had been put in place, in liaison with commissioners, when variation from performance target was identified.
- Any audit which scored below the required 'pass' threshold was reviewed by a NHS Pathways trainer or a supervisor. Where gaps had been identified from the audit process, or any learning identified from an incident or investigation, discussions were had with staff at a one-to-one meeting. When necessary the staff member received either additional coaching or formal training, an action plan was devised to manage the process. During this time the staff member may work in other areas and not take calls until the issue was resolved, this was determined for each individual case. Following this process, staff would undergo an increased level of auditing, supervision and support each month until managers had been satisfied that the required standard had now been reached.
- Staff we spoke with commented on the positive way feedback was given about their performance even when the process identified areas for improvement.
- The NHS Pathways system was updated twice yearly with new clinical information and the provider was currently a beta testing site for this. Beta testing involved working through all the NHS Pathways to ensure they worked and resulted in appropriate dispositions at the end of the assessment. The provider was using NHS Pathways version 12 at the time of our inspection. We spoke with an NHS Pathways external implementation manager who was positive about the provider's participation.
- Staff told us that updates to NHS Pathways were forwarded through formal communication and they were given protected paid time to work through changes, took a competency test to ensure the changes had been fully understood and had to be signed off on upgrades before they could resume taking calls. Some staff we spoke with told us the last update had been a one-day group training event and had been well organised.

Management, monitoring and improving outcomes for people

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 and provided call centre statistics which highlighted month by month site adherence rates with a week-to-week and hour-to-hour view for the period January to December 2016 for both Inner North West London (INWL) which included the boroughs of Kensington and Chelsea, Westminster and Hammersmith and Fulham and North Central London (NCL) which included the boroughs of Camden, Islington, Enfield, Barnet and Haringey.

Good

Are services effective?

(for example, treatment is effective)

The average monthly performance for the LCW UCC NHS 111 Minimum Data Set for the period January to December 2016 showed the provider compared well to the England average. For example:

Inner North West London

- 0.5% of calls abandoned (better than the England average of 3.1%).
- 92% of calls answered within 60 seconds (better than the England average of 87.1%).
- 86% of calls answered where person triaged (comparable to the England average of 86.6%).
- 17% of answered calls were triaged to clinical advisor (comparable to the England average of 21.9%).
- 7% of answered calls passed for call back (England average 13%).
- 47% of calls backs within 10 minutes (England average 40.2%).
- The average episode length of calls was 13 minutes compared to the England average of 16 minutes.

North Central London

- 0.5% of calls abandoned (better than the England average of 3.1%).
- 92% of calls answered within 60 seconds (better than the England average of 87.1%).
- 90% of calls answered where person triaged (comparable to the England average of 86.6%).
- 21% of answered calls were triaged to clinical advisor (comparable to the England average of 21.9%).
- 10% of answered calls passed for call back (England average 13%).
- 34% of calls backs within 10 minutes (England average 40.2%).
- The average episode length of calls was 15 minutes compared to the England average of 16 minutes.

Data showed that the percentage of abandoned calls was consistently lower than the national target of 5% and the England average of 3%. For example:

Inner North West London

- October 2016: 0.9%
- November 2016: 0.4%
- December 2016: 0.5%

North Central London

- October 2016: 0.7%
- November 2016: 0.4%
- December 2016: 0.6%

A situation report for the 24-hour period covering the first day of our inspection showed 0.2% of calls were abandoned (combined INWL and NCL).

Data showed that the overall average of calls answered within 60 seconds for the period January to December 2016 was 92% which was below the contract target of 95%. However, monthly data showed that the provider had met this target for 10 months out of 12 for Inner North West London and eight months out of 12 for North Central London.

A situation report for the 24-hour period covering the first day of our inspection showed 96% of calls had been answered within 60 seconds (combined INWL and NCL).

The service maintained a constant surveillance over the levels of demand on the service and monitored the numbers and conditions of the people waiting for a clinical advisor call them back. Where possible calls taken by call handlers requiring further advice were warm transferred (a direct call transfer where the caller was kept on the telephone) to a clinician but where this was not possible, the call was put into a call back queue which was monitored. This queue was assessed and some calls were prioritised to receive a clinical advisor call back within ten minutes; others to receive a call back within two hours depending on the presenting clinical need.

The provider told us it had experienced challenges meeting the national 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. Staff we spoke with on the day told us that supernumerary clinical floorwalker were assigned to pick-up and oversee the clinical queue to ensure none get left when busy. When we spoke with the commissioners they told us they were aware of the current situation and the provider kept them apprised of the situation.

Effective staffing

Staff had the skills, knowledge and experience to deliver an effective service.

- The provider had a comprehensive induction programme for all categories of staff which consisted of

a corporate and local induction and a schedule of core training which included conflict resolution, equality and diversity, fire safety, health, safety and welfare, infection prevention and control, moving and handling, safeguarding adults, safe guarding children, prevent (anti-radicalisation) training, information governance, confidentiality and basic life support. The 10-week call handler and 14-week clinical advisor induction and training programme was a combination of classroom time, self-directed learning packs, time listening in to calls and time supported by an experienced 'buddy.' At the end of each stage of the induction, staff were required to pass an assessment before being allowed to progress onto the next stage. Calls could not be taken independently until all components had been satisfactorily completed. During the inspection we observed coaches supporting new staff in the call centre and staff we spoke with told us support was available when needed.

- 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.
- The provider told us it was committed to providing a safe and healthy environment for its employees and had recently launched an independent Employee Assistance Programme (EAP) to enable staff to get free, confidential advice 24 hours a day, 365 days a year and was due to launch a mental health and wellbeing pilot which consisted of training courses to support the mental health of wellbeing of staff and to build their resilience. The pilot, which was due to roll out to 100 staff, included mental health first aid training and mindfulness stress reduction courses.
- We saw that staff turnover was approximately 30% per year. We explored this with the provider and they us this was partly explained by the rigorous training and testing process, meaning not all staff were able to progress to satisfactory completion whilst other staff left as they found the call centre environment and shift patterns difficult to manage. The provider told us they used the recruitment assessment group session to illustrate to potential candidates how difficult the call handler role could be by use of role-play and listening to redacted difficult calls. In addition, 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.
- The provider monitored performance to ensure the NHS Pathways guidelines were being followed by randomly auditing patient calls against a set of criteria such as effective call control, skilled questioning, active listening and delivering a safe and effective outcome for the patient.
- We saw evidence that NHS Pathways updates were forwarded through formal communication ahead of bi-annual upgrades. Staff we spoke with told us they had to be signed off on upgrades before they could resume taking calls.
- The provider could demonstrate how they ensured role-specific training and updating for relevant staff was managed through the use of a training matrix which the provider shared with us.

Working with colleagues and other services

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

- LCW UCC was commissioned to provide NHS 111 in Inner North West London (INWL) to the boroughs of Kensington and Chelsea, Westminster and Hammersmith and Fulham clinical commissioning groups and in North Central London (NCL) to the boroughs of Camden, Islington, Enfield, Barnet and Haringey.
- The provider met regularly with the contract commissioners to discuss all aspects of performance and was proactive in liaising with other service providers such as out-of-hours services and social services to ensure patients received the best outcomes.
- Work was undertaken to ensure the Directory of Services (DoS) was kept up to date. (The DoS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.)
- The provider was aware of the times of peak demand and had communicated these to the ambulance service.
- Staff knew how to access and use patient records for information and when directives may impact on another service for example advanced care directives or do not attempt resuscitation orders.

Good

Are services effective?

(for example, treatment is effective)

- The provider had systems in place to identify 'frequent callers' and high intensity users and staff were aware of any specific response requirements. There were also systems in place to respond to calls from children/ young people.
- Information about previous calls made by patients was available.
- All information received from a patient through the telephone triage was recorded on the NHS Pathways system.

Consent

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and Gillick competency for children.
- The process for seeking consent was monitored through audits.
- Access to patient medical information was in line with the patient's consent.
- We observed that throughout the telephone clinical triage assessment process the call handlers checked the patient 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 we spoke with gave examples of when they might override a patient's wishes. For example, when there was a potential significant risk of harm to the patient if no action was taken.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed that call handlers speaking to patients who called the service were courteous and very helpful 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 saw that staff had also received conflict resolution and equality and diversity training.

The LCW NHS 111 service conducted patient satisfaction surveys on 4% of eligible calls which was in excess of the 1% contract requirement. Details about completing a patient satisfaction survey was also available on the provider's website. The responses from patients were analysed and reported in the monthly contract report for both the Inner North West London (INWL) patients and the North Central London (NCL) patients . We saw that 61% of patients had reported the service to be very helpful and 33% quite helpful for INWL and that 69% of patients had reported the service to be very helpful and 29% quite helpful for NCL.

To assist access, the service provided:

- A language line phone facility (a translation/interpreter service) to aid communication with patients whose first language was not English.
- A text relay service for patients with difficulties communicating or hearing.
- A video relay service that allowed a patient to make a video call to a British Sign Language (BSL) interpreter. The BSL interpreter would call an NHS 111 advisor on the patient's behalf so they were able to have a real-time conversation with the call handler via the interpreter. To utilise this service the patient would require a webcam, a modern computer and a good broadband connection.

Staff we spoke to on the day were aware of these facilities and we saw that contact details and instructions for all these services were available at all work stations. Some male call handlers we spoke with told us that often female callers request a female call handler. This request was accommodated and calls were transferred to available female call handlers.

Care planning and involvement in decisions about care and treatment

We were unable to speak directly to patients about the service they received. However, we observed that call handlers spoke respectfully with patients and treated callers with care and compassion.

Call handlers were confident using the NHS Pathways system and we observed that the patient was involved and supported to answer questions thoroughly. We also observed that call handlers checked that the patients understood what was being asked of them and that they understood the final disposition (outcome) following the clinical assessment and what to do should their condition worsen. Staff used the Directory of Services (DoS) to identify available support close to the patient's geographical location.

Care plans, where in place, informed the service's response to people's needs. These included notification of Do Not Attempt Resuscitation (DNAR) and access to Coordinate My Care (CMC), a personalised urgent care plan developed to give people an opportunity to express their wishes and preferences on how and where they are treated and cared for. However, staff also understood that people might have needs not anticipated by the care plan.

We saw that staff took time to ensure people 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.

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 observed call handlers repeating instructions and clarifying information calmly and slowly to ensure the patient understood.

There were arrangements in place to respond to those with specific health care needs such as end of life care and those who had mental health needs. There were established pathways for staff to follow to ensure callers were referred to other services for support as required. For example, pharmacies, GP providers and out-of-hours dentists.

Good

Are services caring?

The provider had a protocol and systems in place to identify 'repeat' and 'frequent callers.' Information about previous calls made by patients was available and staff could use this information where relevant to support the clinical decision process. The provider identified frequent callers through monthly audit with a threshold of three plus calls in four days.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The service engaged with the NHS England Area Team and clinical commissioning groups (CCG) to secure improvements to services where these were identified.
- The provider offered a 24 hours a day, 365 days a week service.
- The service took account of differing levels in demand in planning its service. For example, the provider demonstrated how adjustments had been made to meet potential increases during the recent junior doctor strikes and during national holidays.
- Care pathways were appropriate for patients with specific needs, for example those at the end of their life, and babies and young children.
- The service was able to book appointments for patients directly into several hubs. For example, GP out-of-hours services, urgent care centres and GP extended hours.
- There was a referral pathway to the Pharmacy Urgent Repeat Medication Scheme (PURM) scheme, which enabled patients to access short term supplies of essential medicines from nominated pharmacies in the area.
- The service monitored its performance against the Minimum Data Set (MDS) and Key Performance Indicators (KPIs) and these were discussed at monthly contract management meetings with commissioners. Where variations in performance were identified the reasons for this were reviewed and action plans implemented to improve the service.
- 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 LCW UCC 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 clinical advisor for further assessment.
- Care and treatment was coordinated with other services and other service providers and there was collaboration with partners to improve urgent care pathways. Specifically, we saw that the provider had been part of several collaborative initiatives to improve access to care and treatment for patients with multiple sclerosis and patients in mental health crisis who may be at risk of suicide.

Tackling inequity and promoting equality

- Staff had received training in equality and diversity.
- Discrimination was avoided when speaking to patients who called the LCW NHS 111 service. The NHS Pathways assessment process ensured patients were supported and assessed on their needs rather than on their demographic profile. Call handlers had access to the language line phone facility (a translation/interpreter service) for patients who did not have English as their first language. Data collected for usage of language line for the month of November 2016 showed that 431 calls required the use of language line and interpreters were used for a total of 43 different languages with Turkish, Arabic and Spanish being the main languages requested.
- The provider offered a text relay phone service for patients with difficulties communicating or hearing.
- The provider offered a video relay service that allowed a patient to make a video call to a British Sign Language (BSL) interpreter. The BSL interpreter would call an NHS 111 call handler or clinical advisor on behalf of the patient so they were able to have a real-time conversation with the NHS 111 adviser via an interpreter.
- The provider accommodated patient requests to speak to a specific gender call handler and/or clinician.

Access to the service

The LCW 111 offered a 24 hour a day, 365 days a week service to approximately 2.3 million people living in Inner North West London (the boroughs of Kensington and Chelsea, Westminster and Hammersmith and Fulham) and North Central London (the boroughs of Camden, Islington, Enfield, Barnet and Haringey). Access to the service was via a free-of-charge telephone number.

- People had timely access to advice, including from a call handler or clinical advisor when appropriate. The provider had answered approximately 412,000 calls in the period January to December 2016 at its NHS 111 single site location in West London.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- We saw evidence that the average call abandonment rate for January to December 2016 was 0.5%, compared to the national average of 3%. A situation report for the 24-hour period covering the first day of our inspection showed 0.2% of calls were abandoned.
- We saw that 92% of calls were answered within 60 seconds, compared to the national average of 87%. A situation report for the 24-hour period covering the first day of our inspection showed 96% of calls had been answered within 60 seconds.

Listening and learning from concerns and complaints

The provider had an effective system in place for handling complaints and concerns. Information about how to complain in writing, by telephone or by email was available on the provider's website. We saw operating procedures to guide call handlers, clinical advisors and team managers through the process of dealing with complaints. Staff we spoke with told us they would raise any complaints with their line managers. We reviewed the minutes of weekly complaints meetings held by the management team. Staff told us they received feedback from any complaints through one-to-one meetings, staff engagement meetings, emails, bulletins and newsletters.

The provider had received 66 complaints between January and December 2016. A complaint log was maintained which included a summary, outcome and the learning and action taken. The summary included details of call audits when undertaken. When a call audit had been undertaken we saw evidence that the call handler or clinician involved in the complaint had completed a self-reflection review form which was discussed in their one-to-one meeting. We saw that complaint themes related to attitude, communication, and disposition (outcome) issues. We found all complaints had been handled appropriately, resolved satisfactorily and in a timely manner. When needed an apology letter was provided which included details of the Ombudsman's office in case the complaint was not managed to the satisfaction of the patient. Lessons were learnt from complaints and action was taken to improve the quality of the service. For example, we saw that the provider had organised additional training around handling difficult, demanding and abusive callers after several complaints had been received about perceived poor attitude of call handlers.

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 which it told us was to 'continue to provide patient centred services, ensuring care is timely, consistent, safe and seamless. The vision and values were visible around the call centre, were included in all recruitment and training documentation and were on its website. Staff we spoke with were aware of the vision and values and the 2017 staff survey revealed 90% of staff were aware of the vision and values.

LCW UCC was a GP-led, not-for-profit organisation, and a certified social enterprise with the Social Enterprise Mark (the Social Enterprise Mark is the only internationally available social enterprise accreditation, enabling credible social enterprises to prove they put the interests of people and planet before shareholder gain). The leadership team recognised the organisation had undergone considerable change and development since its inception in 1994 and commencement of the NHS 111 service in 2011. The leadership team embraced the challenges this had given their service and utilised opportunities to continually review the systems, processes and development of services. The provider had held a strategy day to look at development of the service in the immediate (one year), near (two to three years) and medium term (five years). The provider shared strategy with staff in meetings, engagement sessions, workshops and by newsletters.

The senior management team told us they promoted a culture of openness, honesty, respect and continuous improvement. The staff we spoke with were clear on their role and responsibilities and their contribution to the vision of the NHS 111 service to deliver high quality care and promote good outcomes for people.

Governance arrangements

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

- There was a clear clinical and operational team structure and 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.
- There was a risk register in order to identify and take preventative action and promote service resilience.
- 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 which 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.

Leadership, openness and transparency

The leadership team demonstrated they were committed to promoting a culture of working together and openness. Staff we spoke with in a variety of different roles knew who their team members were and there were effective systems of communication and supportive working implemented. We spoke with staff who had lead roles; for example, in human resources, staff development and safeguarding referrals. All confirmed that there were positive working relationships between the different teams.

There were clear lines of accountability within the NHS 111 service. Leaders had the capability and experience to lead effectively. Operational staff we spoke with were clear who to go to for guidance and support. The provider had implemented a system of coloured lanyards to identify different staff groups. For example, yellow for a coach, purple and white for a trainer and green and white for a clinical staff member. Staff were clear about their line management arrangements as well as the clinical governance arrangements in place. They told us leaders were supportive and approachable.

There were arrangements in place to provide support and pastoral care to staff coping with the effects of a traumatic incident. There was an organisational policy and leaflet available to staff. The provider had also launched an independent Employee Assistance Programme (EAP). Support and guidance was also available for staff writing witness statements or attending coroner's court.

Are services well-led?

Good

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

Commissioners we spoke with described the organisation as open and transparent with a focus on continuous development.

Public and staff engagement

- The provider engaged with the public through a number of methods including patient satisfaction surveys, and a range of options to give feedback or raise complaints of concerns through their website. The service had recognised the importance of links with patients representatives and the patient reference group. We received positive feedback about the service and the provider from a patient representative we spoke with by telephone.
- Staff were provided with opportunities to feedback formally through one-to-one meetings, staff surveys, staff engagement sessions, workshops, yearly appraisals and a staff suggestion box. The provider used a 'you said, we did' format to feedback to comments received.
- The provider undertook an annual staff survey and we reviewed the results of the 2016 survey and a comparative with the 2017 survey which had been undertaken shortly before our inspection. We found staff feedback in some areas had improved. For example, feel proud to work for the organisation 83% (2016: 59%); believe communication from management was effective 60% (2016: 44%); have been unwell in the last 6 months due to work related stress 27% (2016: 51%) and have thought about leaving the organisation in the last month 45% (2016: 75%). However, some responses had scored lower than the previous year. For example, have a good work-life balance 58% (2016: 68%), have the support and resources to help them do their job well 69% (2016: 81%). The provider told us it would address these finding through further staff engagement. In addition, the provider had added some additional questions to the 2017 survey which included: senior management consider patient safety of utmost importance (84% answered yes); I am aware of LCW UCC's vision and values (91% answered yes) and my line manager always considers staff suggestions for improving patient safety (78% answered yes).
- Staff we spoke with in the call centre said it was a friendly and enjoyable place to work. Staff considered they made a difference to people and did a worthwhile job and that the management team supported them and made them feel their worth.
- We observed there was high morale and a supportive culture across managerial and operational frontline staff. Compliments received about service were shared with staff and certificates of achievement were issued to staff.
- We saw that the provider organised a winter party for all staff and that lunch and buffet catering was provided for staff who worked over the festive period in December.
- The provider told us it was committed to providing a safe and healthy environment for its employees and had recently launched an independent Employee Assistance Programme (EAP) to enable staff to get free, confidential advice 24 hours a day, 365 days a year. Support was available over the telephone or online on a range of topics which included consumer rights and legal information, debt management and budgeting, emotional support, family relationships, work and career issues and health and wellbeing. Where appropriate face-to-face counselling could be accessed. In addition, it was due to pilot a mental health and wellbeing pilot for its staff which consisted of training courses to support the mental health of wellbeing of staff and to build their resilience. The pilot, which was due to roll out to 100 staff, included mental health first aid training and mindfulness stress reduction courses.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the service. The service maintained a risk register in order to identify and take preventative action and promote service resilience.

The provider had been part of several collaborative pilots to improve access to care and treatment. For example:

- The development of a mental health warm transfer pathway model with local mental health provider organisations for patients in mental health crisis who may be at risk of suicide. (A warm transfer is when a patient in the care of a service is referred via telephone to another service. Throughout the handover of care the patient is kept on the line and connected once handover is agreed with receiving service. This means that the patient is not cut off from the call).
- The development of a pathway and enhanced community-based response project in collaboration with Queens Square National Hospital for Neurology

Are services well-led?

Good

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

and Neurosurgery for the early detection and intervention of urinary tract infection (UTI) to reduce the risk of admission for a cohort of patients with multiple sclerosis.