Care Quality Commission

How CQC regulates:

NHS 111 services

Provider handbook

June 2015

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can.

Contents

Introduction

This handbook describes our approach to regulating, inspecting and rating NHS 111 services.

Our approach includes an inspection team, led by a CQC inspector and supported by specialist advisors with experience of working in NHS 111 services. It includes the methods for listening to people's experiences of care and using the best information across the system.

Our inspectors use professional judgement, supported by objective measures and evidence, to assess services against our five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

We rate services. These ratings will help people to compare services and highlight where care is outstanding, good, requires improvement or inadequate.

Our approach has been developed over time and through consultation. We have worked with the public, people who use services, providers and organisations with an interest in our work, to develop it.

We will continue to learn and adapt as we put our approach into practice. However, the main aspects of our approach, such as the five key questions and the key lines of enquiry for each of these questions, will remain constant.

1. Our framework

Although we inspect and regulate different services in different ways, there are some key principles that guide our operating model across all our work.

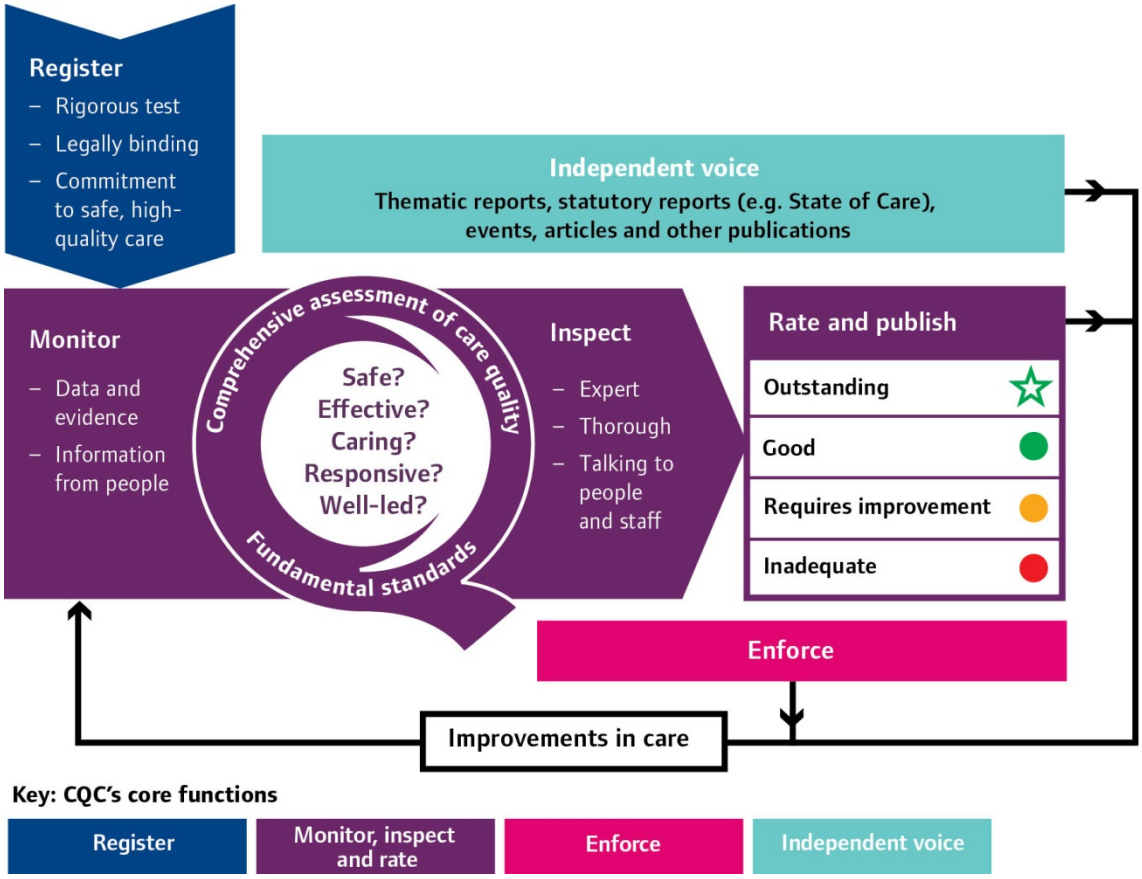
Our operating model

The diagram on the next page shows an overview of our overall operating model. It covers all the steps in the process, including:

- Registering those that apply to CQC to provide services (see section 2).
- Intelligent use of data, evidence and information to monitor services.
- Using feedback from people who use services and the public to inform our judgements about services.
- Inspections carried out by experts.
- Information for the public on our judgements about care quality, including a rating.
- The action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it. Our enforcement policy sets out how we will do this.

Our model is underpinned by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which include the fundamental standards introduced in April 2015. We have published guidance on our website to help providers understand how they can meet these regulations (see section 11).

Figure 1: CQC's overall operating model



The five key questions we ask

To get to the heart of people's experiences of care, the focus of our inspections is on the quality and safety of services, based on the things that matter to people. We always ask if services are:

Safe	By safe, we mean that people are protected from abuse and avoidable harm.
Effective	By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
Caring	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
Responsive	By responsive, we mean that services are organised so that they meet people's needs.
Well-led	By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Key lines of enquiry

To direct the focus of their inspection, our inspection teams use a standard set of key lines of enquiry (KLOEs) that directly relate to the five key questions.

The KLOEs are set out in appendix A.

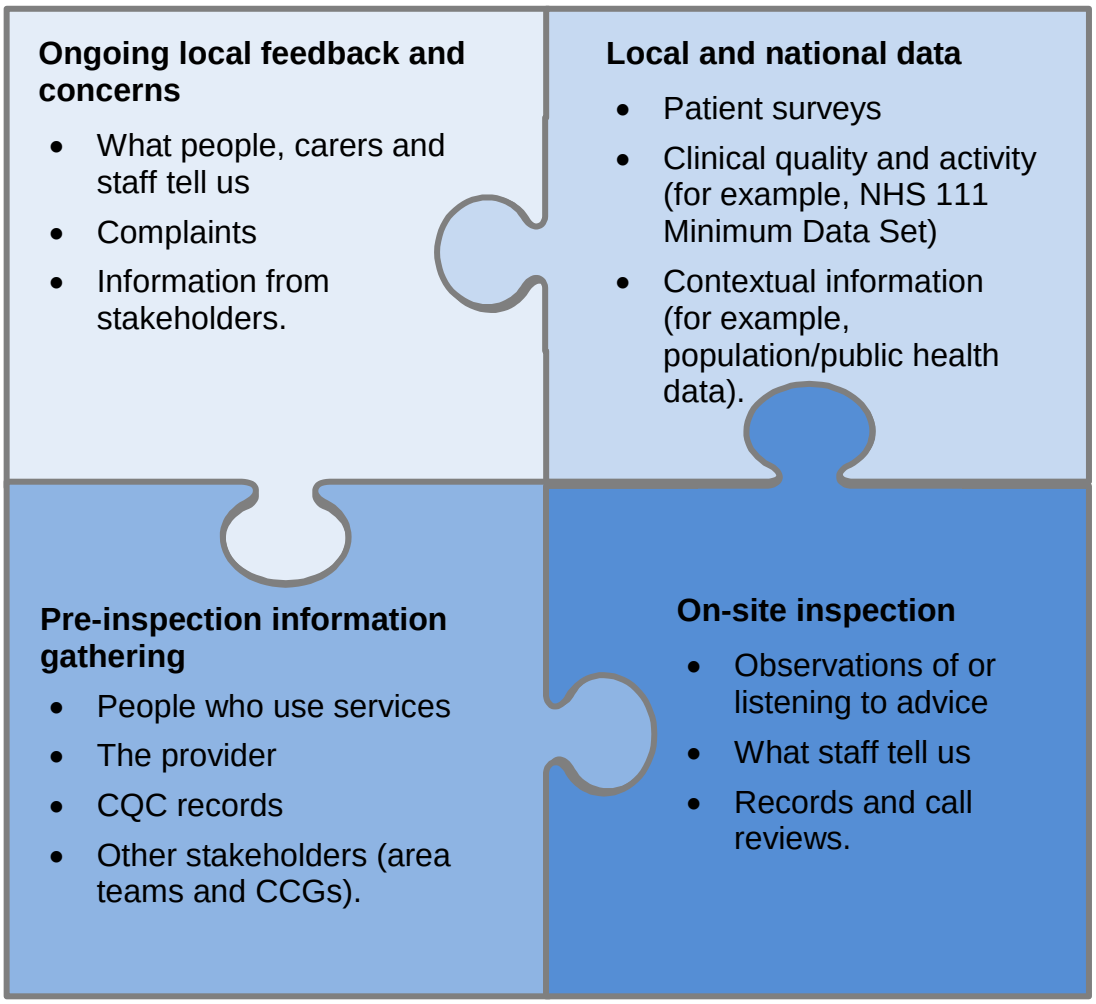
Having a standard set of KLOEs ensures consistency of what we look at under each of the five key questions and that we focus on those areas that matter most. This is vital for reaching a credible, comparable rating. To enable inspection teams to reach a rating, they gather and record evidence in order to answer each KLOE.

Each KLOE is accompanied by a number of questions that inspection teams will consider as part of the assessment. We call these prompts. The prompts are included in appendix A. Inspection teams will take into account the information gathered in the preparation phase and the evidence they gather during the inspection to determine which aspects of the KLOE they should focus on.

Inspection teams will use evidence from four main sources to answer the KLOEs:

1. Information from the ongoing relationship management with the NHS 111 provider.
2. Other nationally available, and local, information that can inform the inspection judgement. This will typically be included in the data packs described in section 6.
3. Information from activity carried out during the pre-inspection phase as set out in section 6.
4. Information from the inspection visit itself.

Figure 2: Examples of the four main sources of evidence

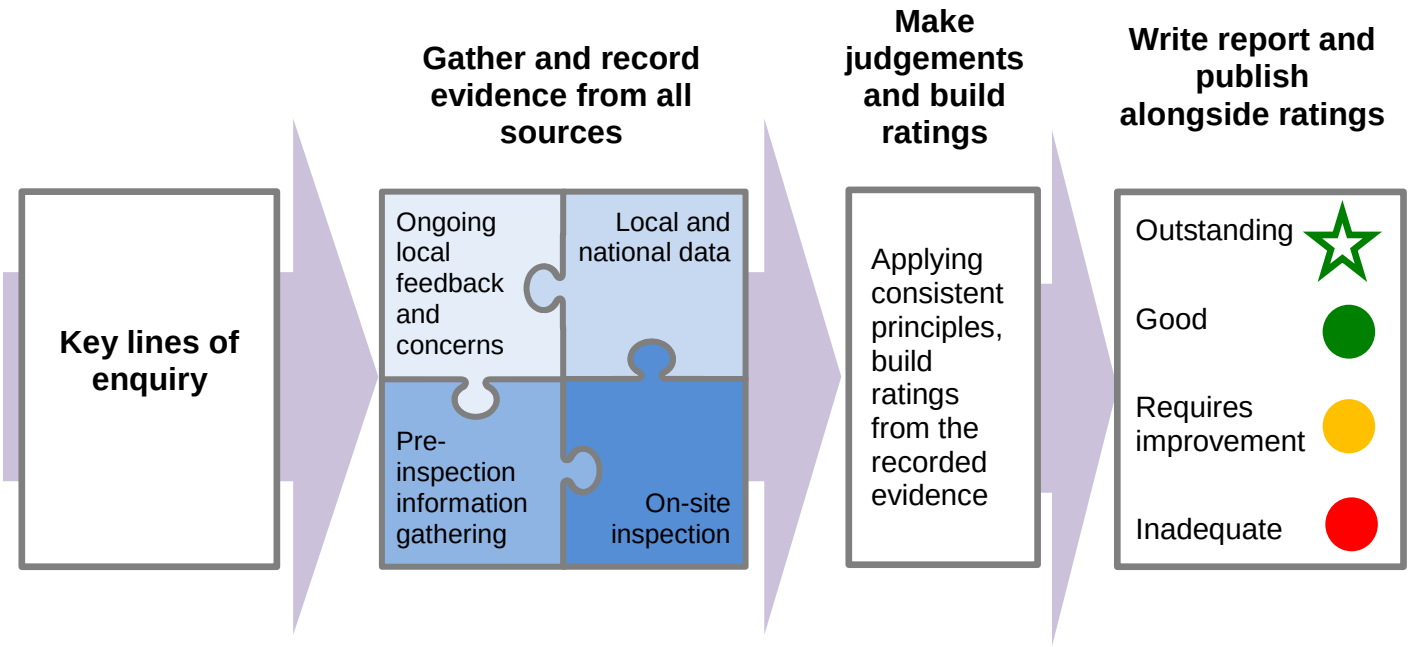


Ratings

Ratings are an important element of our new approach to inspection and regulation.

As set out in figure 3, our ratings are based on a combination of what we find at inspection, what people tell us, local and national data and information from the provider and other local organisations. We will award them on a four-point scale: outstanding, good, requires improvement or inadequate. Providers must display their ratings (see section 10).

Figure 3: How KLOEs and evidence build towards ratings



We have developed characteristics to describe what outstanding, good, requires improvement and inadequate looks like for each of the five key questions. These are set out in appendix B.

These characteristics provide a framework which, together with professional judgement, guides our inspection teams when they award a rating. The inspection team use their professional judgement, taking into account best practice and recognised guidelines, with consistency assured through the quality control process.

Not every characteristic has to be present for the corresponding rating to be given. This is particularly true at the extremes. For example, if the impact on quality of care or on people's experiences is significant, then displaying just one of the characteristics of inadequate could lead to a rating of inadequate. Even those rated as outstanding are likely to have areas where they could improve.

A service does not need to demonstrate every one of the characteristics of good in order to be rated as good.

We will be proportionate in making the judgements and will consider the context within which a service is working, and the specific circumstances of each NHS 111 service.

Ratings are discussed in more detail in section 9.

Equality and human rights

One of CQC's principles is to promote equality, diversity and human rights. This is a means to an end and not an end in itself. The end is good quality care for all. Respecting diversity, promoting equality and ensuring human rights will mean that everyone using health and social care services receives good quality care.

To put this into practice, we have developed a human rights approach to regulation. This looks at a set of human rights principles – fairness, respect, equality, dignity, autonomy, right to life and rights for staff – in relation to the five key questions we ask. Using a human rights approach that is based on rights that people hold rather than what services should deliver also helps us to look at care from the perspectives of people who use services.

These human rights principles are important in the delivery of NHS 111 services. Everyone wants to be treated with dignity and respect when using NHS 111 services. If people do not experience this, it may make them reluctant to use these services in the future. This can lead to a negative impact on people's health, particularly as NHS 111 services are often the way through which a number of other health services and social services are accessed, including in urgent situations.

Monitoring the use of the Mental Capacity Act

The Mental Capacity Act (2005) is a crucial safeguard for the human rights of people who might (or might be assumed to) lack mental capacity to make decisions, in particular about consenting to proposed care or treatment interventions. The Mental Capacity Act (MCA) provides the essential framework for balancing autonomy and protection when staff are assessing whether people aged 16 and over have the mental capacity to make specific decisions at the time they need to be made. This refers specifically to the capacity to consent to, or refuse, proposed care or treatment.

The MCA clearly applies where a service works with people who may have cognitive difficulties due to dementia, an acquired brain injury or a learning disability, but providers must also recognise that a person may lack mental capacity for a specific decision at the time it needs to be made for a wide range of reasons, which may be temporary, and know how they should then proceed.

In particular, we will look at how and when mental capacity is assessed and, where people lack mental capacity for a decision, how that decision is made and recorded in compliance with the MCA.

The importance of this is reflected in our inspections. We have a specific KLOE about consent, which takes account of the requirements of the Mental Capacity Act and other relevant legislation, such as the Children Acts 1989 and 2004. We want to ensure that staff understand and adhere to these requirements, particularly as care and advice provided by a NHS 111 service is delivered over the phone and often in urgent, and sometimes emergency, situations.

Concerns, complaints and whistleblowing

Concerns raised by people using services, those close to them, and staff working in services provide vital information that helps us to understand the quality of care. We will gather this information in three main ways:

- Encouraging people who use services and staff to contact us directly through our website and phone line, and providing opportunities to share concerns with inspectors.
- Asking national and local partners (for example, the Ombudsman and local Healthwatch) to share with us concerns, complaints and whistleblowing information that they hold.
- Requesting information about concerns, complaints and whistleblowing from providers themselves.

We will also look at how providers handle concerns, complaints and whistleblowing in every inspection. A service that is safe, responsive and well-led will treat every concern as an opportunity to improve, will encourage its staff to raise concerns without fear of reprisal, and will respond to complaints openly and honestly. The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England have set out standard expectations for complaints handling that describe the good practice we will look for.

We will draw on different sources of evidence to understand how well providers encourage, listen to, respond to and learn from concerns. Evidence sources may include complaints and whistleblowing policies, indicators such as a complaints backlog and staff survey results, speaking with people who use services, families and staff, and reviewing case notes from investigations.

2. Registration

Before a provider can begin to provide services, they must apply to CQC for registration and satisfy us that they are meeting a number of registration requirements in the regulations. We have published guidance on our website to help providers understand how they can meet these regulations (see section 11).

Registration assesses whether all new providers, whether they are organisations, individuals or partnerships, have the capability, capacity, resources and leadership skills to meet relevant legal requirements, and are therefore likely to demonstrate that they will provide people with safe, effective, caring, responsive and well-led care.

The appendices to this handbook will allow registration inspectors to gather and consider comprehensive information about proposed applicants and the services they intend to provide, including where providers are varying their existing registration, and make judgements about whether applicants are likely to meet these legal requirements.

Judgements are about, for example, the fitness and suitability of applicants; the skills, qualifications, experience and numbers of key individuals and other staff; the size, layout and design of premises; the quality and likely effectiveness of key policies, systems and procedures; governance and decision-making arrangements; and the extent to which providers and managers understand them and will use them in practice.

These judgements will not stifle innovation or discourage good providers of care services, but ensure that those most likely to provide poor quality services are discouraged and prevented from doing so.

3. How we work with others

Good ongoing relationships with stakeholders are vital to our inspection approach. These relationships allow CQC better access to qualitative as well as quantitative information about services, particularly local evidence about people's experience of care. Local relationships also provide opportunities to identify good practice and to work with others to push up standards.

Working with providers

Each registered provider of an NHS 111 service will have a member of CQC's inspection staff as their 'relationship owner'. In some cases there may be a relationship owner for each registered location, rather than for the provider. Their role will include reviewing any information received from or about the provider obtained from a number of sources and stakeholders. They will be supported by our intelligence teams who will analyse some of the information.

Our approach includes continuous monitoring of local data and intelligence and risk assessment.

Service providers also routinely gather and use information from people who use services, carers and other representatives. We will make greater use of this information, including:

- Local patient surveys or other patient experience data.
- Information about the number and types of complaints that people make about their care and how these are handled.

Working with people who use services

People's experiences of care are vital to our work; they help to inform when, where and what we inspect. We want people to tell us about their care at any time through our website and helpline, and we are committed to carrying out public engagement aimed at encouraging members of the public, people who use services and those close to them to share their views and experiences with us.

We will gather and analyse information from people who use services, for example through:

- Comments and feedback sent to CQC from individual people who use services and those close to them.
- Nationally collated feedback from people who use services and those close to them, for example available patient survey data, Health Ombudsman's evidence of complaints, information from NHS Choices.

- Local Healthwatch.
- Organisations that represent or act on behalf of people who use services, including equality groups.
- NHS complaints advocacy services.
- Community, patient and carer groups.
- Engagement activity specifically designed to encourage people to share their experiences of care.

Working with partner organisations

Many national and local partner organisations that we work with have information about providers and about people's experiences and we want to make the best use of their evidence. This particularly includes working closely with commissioners of NHS 111 services. It is important that our inspectors and inspection managers will also have an ongoing relationship with other stakeholders. This particularly includes:

- NHS England area teams.
- Clinical commissioning groups.

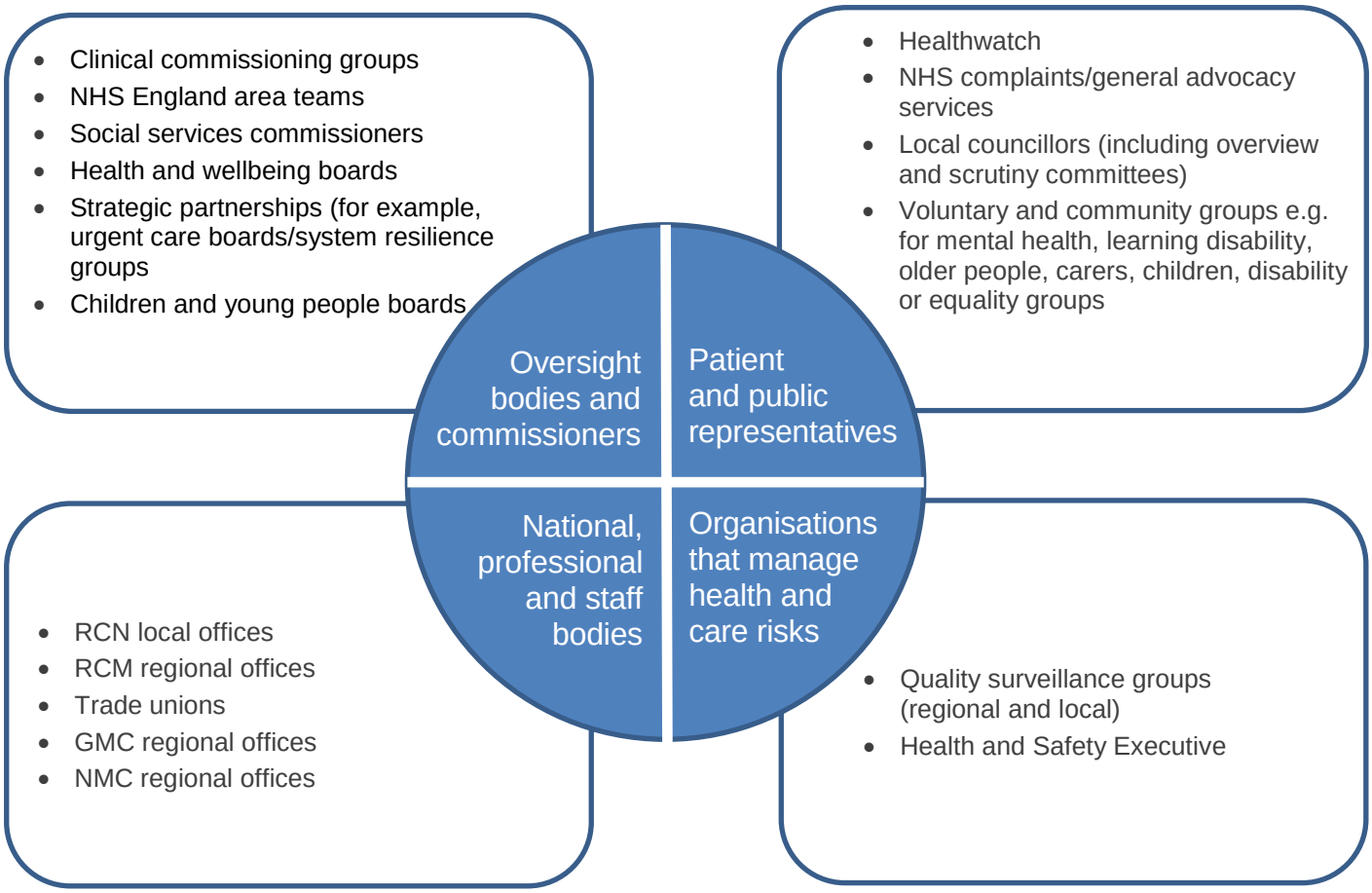
Our inspection managers lead the ongoing relationship with NHS England area teams and clinical commissioning groups.

We work with these organisations to gather information on a regular basis and in the lead-up to an inspection.

We also work closely with:

- Professional regulators, such as the Nursing and Midwifery Council, the Health and Care Professions Council and the General Medical Council.
- The Royal Colleges.
- The Parliamentary and Health Service Ombudsman.
- Local medical committees.
- Local education and training boards.

Figure 4: How we work with local and national partner organisations



Working with local organisations and community groups

It is also important to maintain good relationships with local organisations and community groups that represent people who use services and routinely gather their views. We ask them to share with us the information that they hold. These include:

- Local health overview and scrutiny committees
- Quality surveillance groups
- Health and wellbeing boards
- Local Healthwatch
- Local authorities.

4. Intelligent Monitoring

Our new, more comprehensive model includes ongoing intelligent monitoring of the risks that individual providers are not providing either safe or high-quality care. However, given the small number of data sources available, Intelligent Monitoring will provide only limited information about risk and quality of an NHS 111 service. We will use available data (see Table 1) to provide a background to the services to be inspected, guiding inspectors to the areas that might need to be explored.

Table 1: Indicator sources

Outcome measures and safety events	Information from people who use services and the public	Information from and about staff
• Safeguarding referrals and alerts. • NHS 111 minimum data set. • NHS Pathways Intelligent Data tool. • Patient safety incidents.	• People's experiences shared with CQC (details on page 20). • Feedback left on NHS Choices, and other feedback sites (e.g. www.Iwantgreatcare.org). • Complaints. • Feedback from local Healthwatch.	• Concerns raised by staff to CQC.

5. Inspection

Our inspections are at the heart of our regulatory model and focus on the things that matter to people. Within our new approach we have two types of inspection:

Table 2: Types of inspection

Type of inspection	Description
Comprehensive (section 6 and 7)	• Reviews the provider in relation to the five key questions leading to a rating on each on a four-point scale. • Usually a total of one day on site for each location. We may do this over two days to cover a range of times that the service is being provided. The time we spend on site will vary depending on the number of sites we need to visit and the size of the service. • Usually announced. • At least once every three years.
Focused (section 8)	• Follow up to a previous inspection, or to respond to a particular issue or concern. • May not look at all five key questions. • Team size and composition depends on the focus of the inspection. • The inspection may be unannounced.

Combined providers

CQC has developed a tailored approach to inspection for different types of health and social care services. One of these is the approach for NHS 111 services set out in this handbook. Other examples are acute hospital services, community health services and residential social care services.

We recognise that many providers have a wide range of services that will sit in more than one of our inspection approaches. NHS trusts are the most common example of this type of provider. Others include large social enterprises that provide a range of services to a local population, or an independent health provider with a range of services at one of its locations.

NHS 111 services are provided by organisations that also provide other health or care services. For example, NHS ambulance trusts or providers of GP out-of-hours services.

Where such arrangements exist and the range of services are either provided from one location or to a local population, we want to assess how well quality is managed across the range of services and give ratings for the provider or the location that reflect this. Therefore, when we inspect, we use our different approaches in combination to reflect the range of services that are provided.

Our overall aims in these circumstances are to:

- Deliver a comparable assessment of the five questions for each type of service, whether it is inspected on its own or as part of a combined provider.
- At provider or location level, assess how well quality and risks are managed across the range of services provided.
- Generate ratings and publish reports in a way that is meaningful to the public and people who use services, the provider and to our partners.
- Be proportionate and flexible to reflect the way the services are provided and consider any benefits derived from service integration.
- Use appropriate methods and an inspection team with the relevant expertise to assess the services provided.
- Wherever possible, align steps throughout the inspection process in order to minimise the burden on providers.

Because NHS 111 services are provided by a number of different types of organisations, we will often use our combined provider approach when we inspect them. Using the combined provider approach means we will need to adapt aspects of the inspection process to reflect the type of provider. In practice this means that there will be a longer notice period (12 weeks) for NHS 111 services provided by an ambulance trust compared to NHS 111 services provided by a provider of GP out-of-hours services (6 weeks).

While this means that we will give more notice of our inspections of NHS 111 services for those provided by ambulance trusts, our view is that this approach is preferable as it will ensure that we can look at all services that an organisation provides at one time, rather than inspecting just some of the services it provides. This will also enable us to look at how the NHS 111 service works with the provider's other services. In all inspections of NHS 111 services, the assessment framework we use will not vary: we will always use the KLOEs and prompts for NHS 111 services and will always use specialist inspectors supported by experts in NHS 111 services. This will ensure that we reach comparable judgements and ratings about these services.

Our provider handbooks for ambulance services and GP out-of-hours services can be found here.

6. Planning the inspection

To make the most of the time that we are on site for an inspection, we must make sure we have the right information to help us focus on what matters most to people. This will influence what we look at, who we will talk to and how we will configure our team. The information we gather during this time before the inspection is also used as evidence when we make our ratings judgements.

As described in sections 3 and 4, we will analyse data from a range of sources, including information from people who use services, information from other stakeholders and information sent to us by providers.

We will compile a data pack for NHS 111 service inspections. This pack is primarily for inspectors to use to inform key lines of enquiry. It includes information specific to the NHS 111 service being inspected. The service will be able to access this pack.

The data packs are arranged around the five key questions and incorporate information already held by CQC along with information from NHS England, the Office for National Statistics, the Public Health Observatory and information submitted by the provider. They will be used to identify questions, but not to make final judgements.

In a small minority of cases where we carry out a focused inspection at short notice, a data pack may not be available.

Gathering the views of people who use services in advance

A key principle of our approach to inspecting is to seek out and listen to the experiences of the public, people who use services and those close to them, including the views of people who are in vulnerable circumstances or who are less likely to be heard. The purpose of this is to better understand the issues that are of most concern to people to guide our inspection.

In the weeks before we inspect the NHS 111 service, we gather people's experiences of care through:

- Discussions with local Healthwatch, local overview and scrutiny committees, NHS complaints advocacy services, and identified patient representatives at CCGs and within health and wellbeing boards.
- Publicising our inspections through a range of local communication channels, including through the NHS 111 service.

NHS 111 services are provided over the phone and there are unlikely to be people who use services in the locations when we visit on our inspection. As such, we have adapted the approaches we take to gathering the views from people who use services.

When we announce the inspection we will ask providers to use their existing channels to communicate with people who have used their services to tell them about the upcoming inspection. We will ask providers to encourage them to share their experiences of the service with CQC using our online Share Your Experience form. Providers could use communications channels such as the telephony system that they use to the handle NHS 111 calls (for example, messaging could be relayed during call waiting, at the immediate conclusion of calls, or using a call-back service), and any email, digital and social media channels that they may own.

We will promote the inspection and issue a call for people to share their experiences of the service with CQC, local Healthwatch, clinical commissioning groups, councils and community and voluntary groups. We will also ask these organisations and groups to use their own channels to promote the inspection to the local population served by the NHS 111 service. We will make use of local community and voluntary groups to ensure we promote the inspection to people who are hard to reach and vulnerable because of their circumstances.

We will make use of social media to promote the inspection of NHS 111 services to the populations they serve by a call for people to tell us about their care through our Share Your Experience form.

Where we have specific intelligence that indicates potential concerns with a particular population group served by the NHS 111 service, we will use bespoke engagement activities (for example, focus groups) to support us to explore these issues in more depth.

We are continuing to explore the best ways to gather the views of people who use services in advance of our inspections.

Gathering information from the provider

Before we begin inspecting we will write to the NHS 111 service and ask them for some information. We will ask for documents and examples of information that will provide us with helpful pre-inspection insight.

NHS 111 services will have 10 working days to respond to our request.

We will make clear what information to send, where to send information and who to contact with any queries or questions.

The information we will request will include:

- An action plan that addresses the findings from any patient survey carried out.
- A summary of any complaints received in the last 12 months, any action taken and how learning was implemented.
- A summary of any serious adverse events for the last 12 months, any action taken and how learning was implemented. A summary of safeguarding referrals in the last 12 months.

- Evidence to show that the quality of treatment and services has been monitored and evidence of any other audits, with evidence of actions or outcomes taken as a result.
- Recruitment and training policies and procedures (for example, how staff are recruited and vetted before commencing work, arrangements for European Economic Area (EEA) and foreign doctors and what induction they receive).
- Number of staff by role (whole time equivalent).
- Information about the use of agency staff.
- A copy of the current Statement of Purpose.

This list is not exhaustive and we may ask for further information depending on the information available to us.

Gathering information from stakeholders

We may also ask local organisations to provide information, including:

- CCGs and NHS England area teams.
- Local education and training boards (postgraduate deaneries).
- Local authorities.
- Other local health and social care services, including GP practices, services provided by local authorities, hospitals, care homes and public health departments.

We may write to some of these stakeholders to ask for information.

We recognise that NHS 111 services often provide services across large geographical areas and as a result are commissioned by multiple clinical commissioning groups (CCGs) and NHS England area teams. Therefore, we will usually work with the lead commissioner of the service. We may also contact other CCGs that the provider is providing NHS 111 services to gather information about the service.

The inspection team

Inspections will be led by a CQC inspector with input from specialists that have experience of working in an NHS 111 service or a similar service.

The lead CQC inspector is the main point of contact for inspections of NHS 111 services. Our inspection team will vary in size, to reflect the size of the NHS 111 service.

Teams may also include Experts by Experience. Experts by Experience are people who use, or care for someone who uses, an NHS 111 service. Their main role is to talk to people who use services and tell us what they say.

Because there are no people using the service in the premises when we carry out our inspections of NHS 111 services, Experts by Experience will be used in some of our inspections of NHS 111 services, where we identify a need and we will consider how they are able to speak with people using the service. Many people find it easier to talk to an Expert by Experience rather than an inspector. Experts by Experience can also talk to carers and staff.

Experts by Experience are recruited and supported to take part in our work through a number of support organisations. The support organisations also carry out the relevant Disclosure and Barring Service checks. Experts by Experience are trained to carry out their role, and their performance is monitored on an ongoing basis. We match their experience to the services that are being inspected. Further details on the Experts by Experience programme can be found on our website at www.cqc.org.uk/public/get-involved.

Announcing the inspections

Inspections are usually announced. We feel that this is the most appropriate way to make sure our inspections do not disrupt the care provided to people.

Where the provider of an NHS 111 service is an ambulance provider, we will use our approach to inspecting ambulance trusts, and give 12 weeks' notice of the inspection. Where the provider of an NHS 111 service is a GP out-of-hours service, our approach is to give them six weeks' notice of their inspection. This difference is due to the level of information we request from the two types of provider before the inspection. This will mean that the notice period for inspections will vary depending on the type of provider of the NHS 111 service. However we will always ask for the same information about the NHS 111 service irrespective of whether the service is provided by an ambulance trust or a provider of GP out-of-hours services. The inspector will phone the provider to announce the inspection and a letter will also be sent to confirm the date.

After announcing the inspection and throughout the inspection process, the inspection lead and inspection planner will support and communicate with the NHS 111 service by letter, email and telephone to help them prepare for the day and know what to expect.

Unannounced inspections

We may also carry out unannounced inspections, for example if we have concerns about a service or if we are responding to a particular issue or concern. This may be something identified at a previous inspection that we are following up or new information.

At the start of these visits, the team will meet with the senior manager on duty at the time and will feed back at the end of the inspection if there are any immediate safety concerns.

When we are following up concerns from a previous inspection, we will usually carry out an unannounced focused inspection.

Timetable

The inspections of NHS 111 services will go through the following stages:

- Preparation.
- Briefing and planning for the inspection team.
- Inspection of NHS 111 service.
- Draft reporting and awarding a rating.
- Internal quality control.
- Factual accuracy – an opportunity for a provider and registered manager to check the accuracy of the report.
- Final reporting and rating published.
- Provider will be offered the opportunity to request a review of their rating.
- If appropriate, a revised rating will be published.

7. Site visits

Site visits are a key part of our regulatory framework, giving us an opportunity to talk to staff and other professionals to find out their experiences. They allow us to observe care and advice being delivered and to review people's records to see how their needs are managed, both within and between services.

An inspection of an NHS 111 location usually takes place over two days. We will usually arrive early in the afternoon on one day and then leave around the same time the next day. It is unlikely that we will be inspecting throughout this whole period. And, where there are a number of locations providing NHS 111 services, it is likely that the inspections of these locations will take place over a longer period of time. The inspector will provide further information about this prior to the inspection. The time we spend on site will vary depending on the number of locations involved in running the service and the size of the service.

Inspections of NHS 111 services will include inspection time during the out-of-hours period as well as during the daytime. Where services are managed from one location across multiple sites, we are likely to visit a number of the sites during a comprehensive inspection.

Gathering evidence

The inspection team use the key lines of enquiry (KLOEs) and any concerns identified through the preparation work to structure their site visit and focus on specific areas of concern or potential areas of outstanding practice. They collect evidence against the KLOEs using the methods described below.

Gathering the views of people who use services during the site visit

NHS 111 services are provided over the phone and there are unlikely to be people who use services in the locations when we visit on our inspection. As such, we need to adapt the approaches we take to gathering the views from people who use services. The call for people's views before our inspection is the primary method through which we will gather views from people who use the service. We will also look at feedback that services have gathered from people.

Where we are also inspecting other services at the same time, such as the GP out-of-hours service, we will also seek views from these people about their experience of the NHS 111 service when they were accessing a GP-out of-hours service.

We may also ask the provider to enable our inspection team to speak with a random sample of people who have contacted the NHS 111 service in the recent past. This will be through telephone calls.

Gathering the views of staff

The inspection team will speak to staff. On all inspections, we are likely to speak to the following people:

- Call handlers
- Clinical advisors
- Administrative staff and senior management.

In larger providers, the inspection team may also hold focus groups with separate groups of staff.

The inspection team will offer to talk to current and former whistleblowers during the inspection period.

Other inspection methods and information gathering

Other ways of gathering evidence may include:

- Reviewing records and calls.
- Reviewing operational policies and supporting documents.
- Listening to how staff handle calls.
- Contacting people who have used the service to obtain their views.

Our inspection teams will observe care being provided by call handlers and clinical advisors from the call center: this will enable us to observe how staff speak with people who use the service and enable us to reach our judgements about whether the call handler is kind, respectful, compassionate and provides clear information to people who use the service.

In addition the inspection team will ask to review a number of recorded phone calls and will review audits that the service has carried out of its own calls.

In some circumstances inspectors will listen to live calls and hear the patient's voice as well. This will only in some circumstances when it is necessary for us to carry out our functions and will always be done in accordance with our code of practice on personal and confidential information).

The start of the visit

At the start of each inspection of an NHS 111 service, the inspector will meet with the registered manager. If the registered manager is not available the inspector can meet with another senior member of staff. This introductory session will be short and will explain:

- Who the inspection team are.
- The scope and purpose of the inspection, including our relevant powers and the plan for the inspection.
- How we will escalate any concerns identified during the inspection.
- How we will communicate our findings.

At the start of the visit we ask NHS 111 services to present to the inspection team their own view of their performance, particularly in relation to the five key questions and to include any examples of outstanding care and practice. There is no specified format or media for this briefing; the provider can choose whichever format suits them. This should take no longer than 30 minutes.

We want providers to be open and share their views with us about where they are providing good care, and what they are doing to improve in those areas they know are not so good.

We will judge services more harshly on 'well-led' if we find that they have not been open with us about issues of concern they already know about, and this will affect their rating.

Continual evaluation

Throughout the inspection the inspection team will review the emerging findings together. This corroboration will occur at least once during the inspection. This keeps the team up to date with all issues and enables the focus of the inspection to be shifted if new areas of concern are identified. It also enables the team to identify which further evidence might be needed in relation to a line of enquiry and what relevant facts might still be needed to corroborate a judgment.

Feedback on the visit

At the end of the inspection visit, the inspector will provide feedback to the NHS 111 service, usually to the registered manager. This is to give high level initial feedback only, illustrated with some examples.

The meeting will cover:

- Thanking the service for their support and contribution.
- Explaining findings to date, but noting that further analysis of the evidence will be needed before final judgements can be reached on all the issues.
- Any issues that were escalated during the visit or which require immediate action.
- Any plans for follow-up or additional visits (unless they are unannounced).
- Explaining that further analysis is required before we can award ratings.

- Explaining how we will make judgements against the regulations.
- Whether we need additional evidence or are likely to seek further specialist advice in order to make a judgement.
- Explaining the next steps, including challenging factual accuracy in the draft report, final report sign-off and publication.
- Answering any questions from the service.

8. Focused inspection

There will be circumstances when we will carry out a focused inspection rather than a comprehensive inspection. We will carry out a focused inspection for one of two reasons:

- To focus on an area of concern.
- Where certain changes in the service provider are to occur.

Focused inspections do not usually look at all five key questions; they focus on the areas indicated by the information that triggers the focused inspection.

Areas of concern

We will undertake a focused inspection when we are following up on areas of concern including:

- Concerns that were originally identified during a comprehensive inspection and have resulted in enforcement or a requirement notice.
- Concerns that have been raised with us through other sources, such as local or national data, members of the public, staff or stakeholders.

Change of service provider

We may undertake a focused inspection when there will be a change in a service provider, such as a takeover or merger or an acquisition of a service.

The focused inspection process

Although they are smaller in scale, focused inspections broadly follow the same process as a comprehensive inspection. The reason for the inspection determines many aspects, such as the scope of the inspection, when to visit, what evidence needs to be gathered, the size of the team and which specialist advisers to involve. These visits may be announced or unannounced, depending on the focus of the inspection.

Although smaller in scope, the inspection may result in a change to ratings. The same ratings principles apply as for a comprehensive inspection. The revised ratings resulting from a focused inspection will not necessarily lead to a change to the overall provider rating if the focused inspection was carried out more than six months after the comprehensive inspection. As a focused inspection is not an inspection of the whole of a provider or service it will not produce ratings where they do not already exist. When a focused inspection identifies significant concerns, it may trigger a comprehensive inspection.

9. Judgements and ratings

Making judgements and ratings

Inspection teams base their judgements on all the available evidence, using their professional judgement.

For each individual rating against a key question the judgement is made following a review of the evidence under each key line of enquiry (KLOE). This evidence comes from the four sources of information: ongoing local feedback and concerns, local and national data, pre-inspection information gathering and from the on-site inspection visit itself. This link between KLOEs, the evidence gathered under them, and the rating judgements lies at the heart of our approach to ensuring consistent, authoritative judgements on the quality of care.

When making our judgements, we will consider the weight of each piece of relevant evidence. In most cases, we will need to corroborate our evidence with other sources to support our findings and to enable us to make a robust judgement.

When we have conflicting evidence, we will consider the weight of each piece of evidence, its source, how robust it is and which is the strongest. We may conclude that we need to seek additional evidence or specialist advice in order to make a judgement.

Ratings

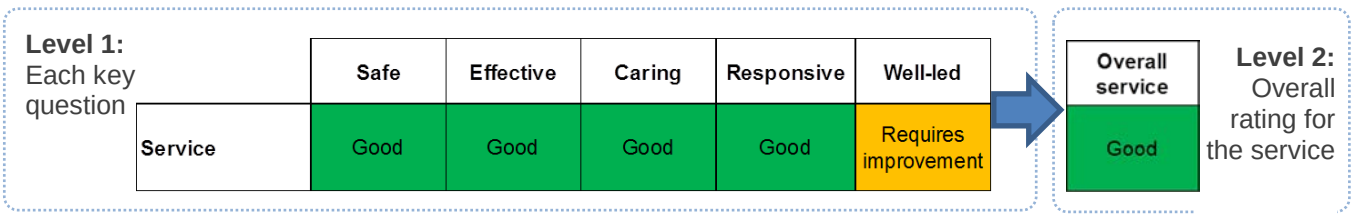
We will report on and rate each NHS 111 service: this will be based on inspections of all locations from which that provider provides NHS 111 services and is the most appropriate way to provide ratings and report in a way that is meaningful to the public and people who use services.

We rate at the following two levels for each NHS 111 service:

Level 1: A rating for each of the key questions for the NHS 111 service.

Level 2: An overall rating for the NHS 111 service. This will be an aggregated rating informed by our findings at level 1.

Figure 6: Rating at two levels for NHS 111 services



In a small number of cases it may not be appropriate to report on and rate all NHS 111 services provided by a provider in one report and to give one rating. In these instances we will take a different, approach and report and rate at the appropriate level. This includes providers that provide NHS 111 services at geographically dispersed sites across England.

Where we have evidence about the quality of NHS 111 services for specific groups of people, particularly where they may be in vulnerable circumstances, we will include this as part of our overall report following the inspection.

Sometimes, we won't be able to award a rating. This could be because:

- The service is new.
- We don't have enough evidence.
- The service has recently been reconfigured, such as being taken over by a new provider.

In these cases we will use the term 'inspected but not rated'.

We may also suspend a rating at any level. For example, we may have identified significant concerns that, after reviewing but before a full assessment, lead us to re-consider our previous rating. In this case we would suspend our rating and then investigate the concerns.

How we decide on a rating

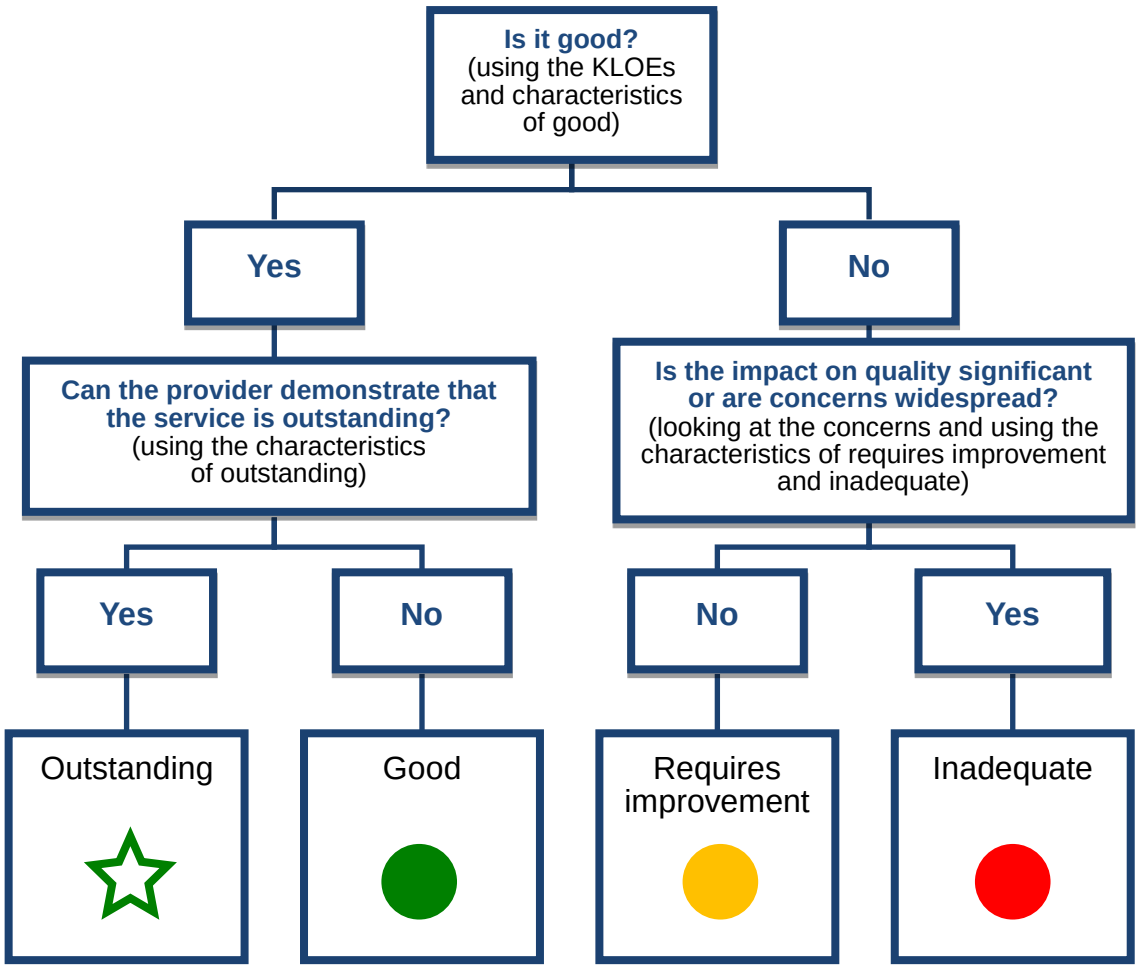
When awarding ratings for the five key questions our inspection teams will review the evidence gathered against the KLOEs and use the guidance supplied to decide on a rating.

In deciding on a rating, the inspection team will look to answer the following questions:

- Does the evidence demonstrate a potential rating of good?
- If yes – does it exceed the standard of good and could it be outstanding?
- If no – does it reflect the characteristics of requires improvement or inadequate?

The following flowchart (figure 7) shows how this works.

Figure 6: How we decide on a rating



Aggregating ratings

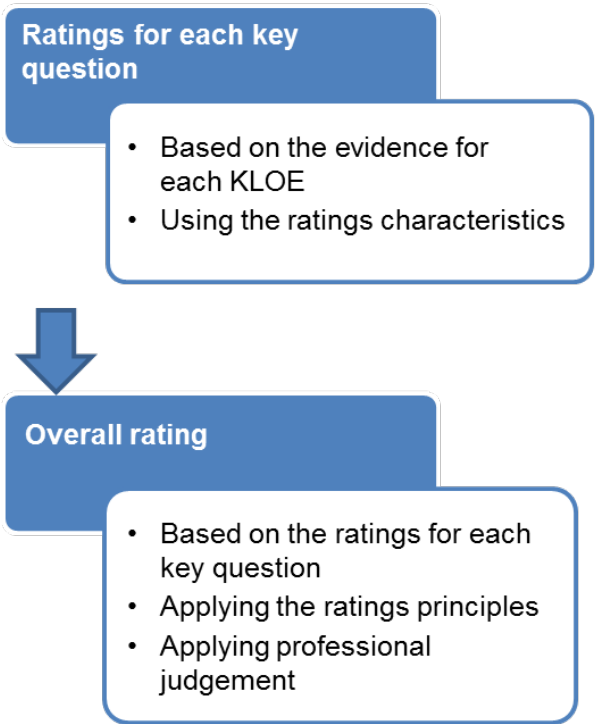
When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. Our principles are set out in appendix C.

The principles will normally apply but will be balanced by inspection teams using their professional judgement. Our ratings will be based on all of the available evidence.

Examples of when we may use professional judgement to depart from the principles include:

- Where concerns identified have a very low impact on people who use services.
- Where we have confidence in the service to address concerns or where action has already been taken.
- Where a single concern has been identified in a small part of a large service.

Figure 7: How we aggregate ratings – NHS 111 services



Where a rating decision is not consistent with the principles, the rationale will be clearly recorded and the decision reviewed by a national quality control and consistency panel. The role of this group is to ensure the quality of every report is high, ahead of it being shared with the organisation being inspected.

Rating NHS 111 services when they are part of a combined provider

We will report on and rate each NHS 111 service: this will be based on inspections of all locations providing NHS 111 services and is the most appropriate way to provide ratings and report in a way that is meaningful to the public and people who use services.

In addition to providing the rating of the NHS 111 service, where the provider is an NHS ambulance trust, the rating for the NHS 111 service will be included in the existing aggregation of ratings up to the overall trust rating. Full details of how we rate ambulance trusts can be found in our ambulance provider handbook.

We do not currently aggregate the ratings for providers (other than NHS trusts) to form overall provider ratings. When we inspect an NHS 111 service run by any other provider (for example a provider of GP out-of-hours services), we will not aggregate these ratings into an overall provider rating.

10. Reporting, quality control and action planning

Reporting

After each inspection we produce a report. The report is drafted in collaboration with members of the inspection team and is written in clear, accessible plain English. Our reports include our ratings judgements.

Our reports focus on what our findings about each of the five key questions mean for the people who use the service. We describe the good practice we find, as well as any concerns we have. In our reports we clearly set out any evidence about breaches of the regulations.

Quality control

Consistency is one of the core principles that underpins all our work. We have put in place an overall approach for CQC to embed consistency in everything we do. The key elements of this are:

- A strong and agreed core purpose for CQC.
- A clear statement of our role in achieving that purpose.
- Consistent systems and processes to underpin all our work.
- High-quality and consistent training for our staff.
- Strong quality assurance processes.
- Consistent quality control procedures.

We have made a commitment to strong internal quality control and assurance mechanisms, including panels that consider a sample of rating judgements to check consistency.

Following quality checks, the draft report is sent to the provider for comment in relation to factual accuracy. The report is finalised following any necessary changes and sent to the provider.

Action planning by NHS 111 services

We expect NHS 111 services to respond to areas of concern that we have identified and to make the recommended improvements. This is their responsibility and includes developing an action plan to address any concerns raised.

Publication

CQC will publish the inspection reports on our website after the end of the inspection. We encourage CCGs and individual NHS 111 services to publish their action plans on their own website.

CQC will also summarise, within the inspection report, our key findings from the inspection.

Displaying ratings

From April 2015, providers must clearly display their CQC ratings at each and every premises from which they provide a regulated activity, at their head office and on their website(s) if they have one. This is to make sure that the public see them, and that they are accessible to all the people who use their services.

We have published information on what and how to display CQC ratings on our website. Providers must display their rating no later than 21 calendar days after it has been published on CQC's website.

We encourage providers to raise awareness of their most recent rating when they are communicating with people who use their services by letter, email or other means.

11. Enforcement and actions

Types of action and enforcement

Where we have identified concerns we decide what action is appropriate to take. The action we take is proportionate to the seriousness of the concern and whether there are multiple and persistent breaches.

Where the concern is linked to a breach in regulations, we have a wide range of enforcement powers given to us by the Health and Social Care Act 2008 as amended by the Care Act 2014.

Our enforcement policy describes our powers in detail and our general approach to using them.

We may also recommend areas for improvement, even when a regulation has not been breached, to help a provider move to a higher rating.

We include in our report any concerns, areas for improvement or enforcement action taken and expect appropriate action to be taken by the provider and local partners.

We follow up any concerns or enforcement action we take. If the necessary changes and improvements are not made, we can escalate our response, gathering further information through a focused inspection. However, we always consider each case on its own merit and we do not rigidly apply the enforcement rules when another action may be more appropriate.

Relationship with the fundamental standards regulations

We have published guidance for existing registered providers and managers, and those applying for registration, to understand what they need to do to meet the regulations introduced in April 2015. These regulations include fundamental standards, below which the provision of regulated activities and the care people receive must never fall.

The aim of the new regulations is to increase transparency about the quality of health and care services, encourage improvement and help people who use services to make choices about their care and to hold providers to account. There are also three new regulations: a statutory duty of candour (Regulation 20), a fit and proper person requirement for directors (Regulation 5), and a requirement for providers to display their CQC rating (Regulation 20A). See section 10 for further information on displaying your CQC rating.

New requirements: fit and proper person requirement and the duty of candour

Two new regulations – Regulation 5: Fit and proper persons: Directors; and Regulation 20: Duty of candour – apply to all providers from April 2015.

The intention of Regulation 5 is to ensure that people, who have director-level responsibility for the quality and safety of care, and for meeting the fundamental standards, are fit and proper to carry out this important role. It applies to all providers that are not individuals or partnerships. Organisations retain full responsibility for appointing directors and board members (or their equivalents). CQC may intervene where we have evidence that a provider has not met the requirement to appoint and have in place fit and proper directors, using the full range of our enforcement powers.

The intention of Regulation 20 is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, and providing truthful information and an apology. This statutory duty on organisations supplements the existing professional duty of candour on individuals.

These new requirements are incorporated into our inspection assessment framework and registration processes. Where we find that providers are not conforming to these regulations we will report this and take action as appropriate. Further information is included in the guidance on our website.

Responding to inadequate care

We want to ensure that services found to be providing inadequate care do not continue to do so. We have therefore introduced special measures.

The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to cancel their registration.

Providers rated as inadequate overall will be placed straight into special measures.

Providers awarded a rating of inadequate for a key question will be re-inspected within six months. If there remains a rating of inadequate for any key question after six months, the service will be placed into special measures.

Once a provider is placed in special measures we will re-inspect within six months to check that sufficient progress has been made. If we feel sufficient progress has been made following inspection, we will remove the provider from special measures.

If sufficient progress has not been made when we re-inspect, and there is a rating of inadequate for any key question or overall further action will be taken to prevent the service from operating, either by proposing to cancel their registration or vary the terms of their registration. There will then be a further inspection, normally within six months. If sufficient progress has not been made, and there is a rating of inadequate for any key question, or overall it is likely that we will proceed to cancel their registration or to vary the terms of their registration. This will result in the registration of the affected provider being cancelled.

Special measures does not replace CQC's existing enforcement powers: it is likely that we will take enforcement action at the same time as placing a provider into special measures. And in some cases we may need to take urgent action to protect people who use the service or to bring about improvement, in accordance with our enforcement policy.

We have published detailed guidance about our approach to special measures for these services.

For NHS trusts

Where an NHS 111 service is provided by an NHS trust, the approach to special measures is slightly different.

We will work with organisations, including other regulators and commissioners, to ensure action is taken on concerns that we identify. If we identify the need for significant improvements in quality, but do not have confidence in the leadership of an NHS trust or foundation trust (FT) to make the necessary improvements without additional support, we have the option to recommend to the NHS Trust Development Authority (NHS TDA) or Monitor that the trust is placed into special measures.

During the special measures period we will discuss progress and keep up to date with the trust/FT and with NHS TDA/Monitor. We will inspect at any time during that 12 months if we have any new concerns.

We will normally re-inspect 12 months from the trust being placed into special measures, but NHS TDA/Monitor may recommend an earlier inspection if there is sufficient evidence of good progress. If, following

inspection, we feel sufficient progress has been made, we will recommend it is taken out of special measures.

If sufficient progress has not been made when we re-inspect we will consult with NHS TDA/Monitor as to whether the trust remains in special measures or if further action is needed.

Further information can be found in the joint NHS TDA, Monitor and CQC document, ‘A guide to special measures’.

Challenging the evidence and ratings

We want to ensure that providers can raise legitimate concerns about the way we apply our ratings process, and have a fair and open way of resolving them.

NHS 111 services can challenge the factual accuracy of reports and make representations about the evidence in Warning Notices. These steps will normally be the means by which providers will also challenge the ratings CQC has awarded, because ratings are awarded on the basis of the evidence about the quality and safety of their service.

The following routes are open to NHS 111 services to challenge our judgements.

Factual accuracy check

When an NHS 111 service receives a copy of the draft report (which will include their ratings) they are invited to provide feedback on its factual accuracy. They can challenge the accuracy and completeness of the evidence on which the ratings are based. Any factual accuracy comments that are upheld may result in a change to one or more rating. NHS 111 services have 10 working days to review draft reports for factual accuracy and submit their comments to CQC.

Warning Notice representations

If we serve a Warning Notice, we give registered persons the opportunity to make representations about the matters in the Notice. The content of the Notice will be informed by evidence about the breach that is in the inspection report. This evidence will sometimes have also contributed to decisions about ratings. Therefore, as with the factual accuracy check, representations that are upheld that also have an impact on ratings may result in relevant ratings being amended.

Under our process for factual accuracy checks and Warning Notice representations, unresolved issues can be escalated to managers in CQC who were not involved in the inspection.

Request for a rating review

Providers can ask for a review of ratings following publication of the report.

The only grounds for requesting a review is that CQC did not follow the process for making ratings decisions and aggregating them. NHS 111 services cannot request reviews on the basis that they disagree with the judgements made by CQC, as such disagreements would have been dealt with through the factual accuracy checks and any representations about a Warning Notice if one was served.

Where an NHS 111 services thinks that we have not followed the published process properly and wants to request a review of one or more of their ratings, they must tell us of their intention to do so within 5 working days of publication of the report. Providers will be sent instructions for submitting their request for review, which must be received within 15 working days of publication of the report.

NHS 111 services will have a single opportunity to request a review of their inspection ratings. In the request for review form, they must say which rating(s) they want to be reviewed and all relevant grounds. Where we do not uphold a request for review, providers cannot request a subsequent review of the ratings from the same inspection report.

When we receive a request for review, we will explain on our website that the ratings in a published report are being reviewed.

The request for a review will be led by CQC staff who were not involved in the original inspection, with access to an independent reviewer.

The outcome of the review will be sent to the NHS 111 service following the final decision. Where a rating is changed as a result of a review, the report and ratings will be updated on our website as soon as possible. It should be noted that following the conclusion of the review, ratings can go down as well as up.

The review process is the final CQC process for challenging a rating. NHS 111 services can challenge our decisions elsewhere, for example by complaining to the Parliamentary and Health Services Ombudsman or by applying for judicial review.

Complaints about CQC

We aim to deal with all complaints about how we carry out our work, including complaints about members of our staff or people working for us, promptly and efficiently.

Complaints should be made to the person that the provider has been dealing with, because they will usually be the best person to resolve the matter. If the complainant feels unable to do this, or they have tried and were unsuccessful, they can call, email or write to us. Our contact details are on our website.

We will write back within three working days to say who will handle the complaint.

We will try to resolve the complaint. The complainant will receive a response from us in writing within 15 working days saying what we have done, or plan to do, to put things right.

If the complainant is not happy with how we responded to the complaint, they must contact our Corporate Complaints Team within 20 days and tell us why they were unhappy with our response and what outcome they would like. They can call, email or write to our Corporate Complaints Team. The contact details are on our website.

The team will review the information about the complaint and the way we have handled it. In some cases we may ask another member of CQC staff or someone who is independent of CQC to investigate it further. If there is a more appropriate way to resolve the complaint, we will discuss and agree it with the complainant.

We will send the outcome of the review within 20 working days. If we need more time, we will write to explain the reason for the delay.

If the complainant is still unhappy with the outcome of the complaint, they can contact the Parliamentary and Health Service Ombudsman. Details of how to do this are on the Parliamentary and Health Service Ombudsman website.

Note: Please also see the separate appendice to this handbook, which contains important information:

Appendix A: Key lines of enquiry

Appendix B: Characteristics of each rating level

Appendix C: Ratings principles

How to contact us

Call us on:	**03000 616161**
Email us at:	**enquiries@cqc.org.uk**
Look at our website:	**www.cqc.org.uk**
Write to us at:	**Care Quality Commission** **Citygate** **Gallowgate** **Newcastle upon Tyne** **NE1 4PA**

Follow us on Twitter: @CareQualityComm