South Western Ambulance Service NHS Foundation Trust (NHS 111 Service)

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

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Summary of findings

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection of the NHS 111 service provided by South Western Ambulance Service NHS Foundation Trust (SWAST) on 17, 18 and 19 August 2016. This was to follow up on warning notices the Care Quality Commission served following an announced comprehensive inspection in March 2016.

The warning notice was served relating to regulation 12 Safe care and treatment and regulation 18 Staffing respectively of the Health and Social Care Act 2008. The timescale given to meet the requirements of the warning notices was 8 July 2016. The Trust had kept us regularly informed on action being taken.

During the March 2016 inspection we visited both call centres and the SWASFT Headquarters. The March 2016 inspection highlighted several areas where the provider (SWAST) had not met the regulations. These included:

- Insufficient staff were employed and those employed were not deployed or supported effectively.
- NHS 111 calls were not responded to in a timely and effective manner. There was a lack of systems to ensure associated risks were mitigated for the safety of patient's health and welfare.

At this inspection in August 2016 we found that positive steps had been taken to address the identified issues. We have focused on the warning notice findings in respect of the safe and effective domain and have not re-rated the Trusts provision of the NHS 111 service. The full report published on 16 June 2016 should be read in conjunction with this report.

Our key findings were as follows:

- The Trust had a clear vision that had improvement of service quality and safety as its top priority. The Trust had fully embraced the need to change and there was good evidence of team working. The Trust had actively sought to learn from the previous Care Quality Commission inspection, other NHS 111 providers, performance data, complaints, incidents and feedback.
- There were now systems in place to assess and monitor risks within the NHS 111 Service provided by SWAST and a number of steps had started to mitigate those risks. For example, recruitment and deployment of staff.
- The Trust had reviewed and subsequently de-established the role of Non Pathways Advisors (NPAs). Existing NPAs had been offered conversion training to become call advisors.
- The Trust had introduced systems to monitor and increase the number of appropriate and effective call audits performed to ensure all staff were following the NHS Pathways system and local standard operating procedures (SOPs). The Trust action plans intended to use completed call audits to identify individual and Trust wide areas of development and learning as the number of call audits increased.
- We saw evidence to show the Trust had started to introduce systems to ensure associated risks were mitigated for the safety of patient's health and welfare. This included attempts to increase the number of staff within the NHS 111 call centres. NHS 111 calls were still not responded to in a timely and effective manner. The Trust was aware that it was too early to see systems fully embedded and to demonstrate that the new systems and processes were effective.

Overall there has been significant improvement in the approach of the Trust to the day to day and strategic running of the NHS 111 service that was not previously seen.

However the provider must:

- Ensure staff have further performance observation and support to ensure the needs of callers are correctly responded to.
- Reduce risks to callers by improving delays in call abandonment, initial answering of calls, warm transfer and returning calls by a clinician.

Summary of findings

The NHS 111 service provided by South Western Ambulance Service NHS Foundation Trust rating remains inadequate until a full comprehensive inspection of the Trusts NHS 111 service is carried out by the Care Quality Commission.

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?

On this inspection we found the Trust had made improvements. We found that systems and processes had been focussed and acted upon. However, it was too early to demonstrate that these systems were fully effective.

At the March 2016 inspection, we found patients were at risk of harm because systems and processes were not in place to keep them safe. For example, there were not sufficient numbers of staff to keep patients safe.

- At the August 2016 inspection, we found that action had been taken to increase the number of staff working on the NHS 111 service. This included an accelerated recruitment programme. Evidence reviewed showed there had been an increase of 5% in staffing. Staff in Dorset informed us that they felt there were more staff, but in Devon staff said there were less staff. Data showed us that despite an increase in staffing there were still insufficient staffing numbers in place.

At the March 2016 inspection there was a risk that the role of Non-Pathways Advisors (NPA) may not recognise or respond appropriately to signs of deteriorating health and medical emergencies.

- Following the March 2016 inspection, the Trust had reviewed and subsequently de-established the role of Non Pathways Advisors (NPAs) in July 2016 and had offered them conversion training to become Call Advisors. The Trust told us that until the NPAs had fully completed their conversion training and more Call Advisors had been recruited; call answering performance would continue to be affected. The most recent performance data regarding call answering confirmed this.

Are services effective?

We found the Trust had made improvements:

At the March 2016 inspection, data showed that care and treatment was not delivered in line with commissioned performance standards and guidelines. The service was falling significantly below standards in the the national Minimum Data Set for NHS 111 services and adapted National Quality Requirements, to an extent likely to affect its standards of patient care. Some indicators such as calls being answered in 60 seconds were regularly at unacceptable levels. Necessary action to improve callers' outcomes had not been taken.

Summary of findings

- At the August 2016 inspection, we saw that, despite a number of actions and attempts taken by the Trust to introduce systems to reduce risk, progress had not yet been achieved. NHS 111 calls were still not responded to in a timely and effective manner. Callers did not benefit from warm transfers and there were delays in cold call backs from clinicians.

Furthermore, in March 2016 patient outcomes were hard to identify as little or no reference was made to call audits or quality improvement. There was no evidence to demonstrate that the Trust had been comparing its performance to others, either locally or nationally. For example, in relation to Call Advisor audits, in the three month period between November 2015 and January 2016 only 725 of the 2207 call advisor audits required had been carried out (33.4%).

- During the August 2016 inspection, the Trust demonstrated a significant improvement in the levels of call audits performed and the establishment of a single SWAST wide quality assured audit process. Monitoring tools used to manage call audit activity indicated significant improvement of the numbers of audits performed across both call centres, for example: In Devon, as of 8 July 2016, 100% (127 out of 127) of Call Advisors and Senior Call Advisors had had a call audit performed in the previous calendar month. Furthermore, 100% (25 out of 25) of Clinicians had had a call audit performed in the previous calendar month. In Dorset, as of 8 July 2016, 100% (89 out of 89) of Call Advisors and Senior Call Advisors had had a call audit performed in the previous calendar month. Furthermore, 100% (25 out of 25) of Clinicians had had a call audit performed in the previous calendar month.
- The plan had been to deliver a 5% increase on the previous months audit levels; the actual increase had been recorded at 30.7%. Although improving, as a result of the low numbers of call audits the service was still not rigorously monitoring staff performance on NHS Pathways.

South Western Ambulance Service NHS Foundation Trust (NHS 111 Service)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission inspection manager. The team also included three CQC inspectors, an additional inspection manager, and a NHS 111 specialist advisor.

Background to South Western Ambulance Service NHS Foundation Trust (NHS 111 Service)

South Western Ambulance Service NHS Foundation Trust (SWASFT) was the first ambulance service to be authorised as an NHS Foundation Trust on 1 March 2011. In February 2013, it acquired neighbouring Great Western Ambulance Service NHS Trust.

The Trust's core operations include the following service lines:

- Emergency ambulance 999 services
- Urgent Care Services – GP out-of-hours medical care (Dorset and Gloucestershire)
- Patient Transport Services – non-emergency transport for eligible patients with a medical need for transport (Bristol, North Somerset and South Gloucestershire)
- NHS 111 services for Devon, Cornwall & Isles of Scilly and Dorset

This report relates to the inspection of the NHS 111 services only.

The NHS 111 services operated from two call centre locations:

- Trust Headquarters, Abbey Court, Eagle Way, Sowton Industrial Estate, Exeter, Devon, EX2 7HY (known as Devon in the report)
- East Division Headquarters, Acorn Building, Ringwood Road, St Leonards, Hampshire, BH24 2RR (known as Dorset in the report)

The provision of the service covers the counties of Dorset, Devon, Cornwall and the Isles of Scilly. The area covered has a geographic area of 5,000 square miles, a population of 2.5 million and 17.5 million visitors per year. There are four clinical commissioning groups who have contracts with the Trust for NHS 111 service:

- NHS Dorset Clinical Commissioning Group
- NHS Kernow Clinical Commissioning Group
- NHS Northern, Eastern and Western Devon Clinical Commissioning Group. This contract arrangement was due to finish in September 2016.

Detailed findings

- NHS South Devon and Torbay Clinical Commissioning Group. This contract arrangement was due to finish in September 2016.

The South Western Ambulance Service Foundation Trust NHS 111 service operates 24 hours a day 365 days of the 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 a GP service (in or out of hours), walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance, late opening pharmacy or home management.

Why we carried out this inspection

We previously inspected the NHS 111 service provided by South Western Ambulance Service NHS Foundation Trust (SWASFT) as part of the comprehensive inspection programme commenced in March 2016.

This inspection was a focussed inspection and took place on 17, 18 and 19 August 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was performed to look at requirements of the warning notices and regulations associated with the Health and Social Care Act 2008.

How we carried out this inspection

We carried out an announced visit to the NHS 111 service on 17, 18 and 19 August 2016 and looked specifically at the concerns identified in the warning notices served after our inspection in March 2016. We asked the provider to send a report of the changes they would make to comply with the breaches in regulations.

Before visiting the NHS 111 service, we reviewed a range of information that we held about the South Western Ambulance Service NHS Foundation Trust, and reviewed the information and actions detailed in their action plan.

- We asked other organisations such as commissioners to share what they knew about the performance of the NHS 111 service.
- We reviewed the requirements of the warning notice.
- We visited the Trust Headquarters and both call centres in Devon (Exeter) and Dorset (St Leonards).

During our visit, we spoke with a range of staff including directors for the service, Board members, senior managers, clinical managers, Call Advisors and Clinical Advisors. We reviewed records relevant to the management of the NHS 111 service.

Are services safe?

Our findings

At this inspection we reviewed the requirements of the warning notice served on 26 May 2016 following the inspection in March 2016. We found that positive steps had been taken to address the identified issues.

We found that systems and processes had been focussed and acted upon. However, it was too early to demonstrate that these systems were fully effective.

At our inspection in March 2016 we found patients were at risk of harm because systems and processes were not in place to keep them safe. For example, there were not sufficient numbers of staff to keep patients safe. We saw examples where a lack of staff had led to inappropriate transfer of calls to the 999 emergency services and calls being placed into a call back queue without an appropriate triage. Emergency and urgent callers were not being assessed in relation to their medical needs in a timely manner. Staff also told us there were often insufficient clinical staff available.

- At the August 2016 inspection, we found that systems and processes had been established and were being operated to increase the number of staff working on the NHS 111 service. This included an accelerated recruitment programme and an informal consultation with clinicians to review their existing working arrangements including number of hours and shift length. Evidence reviewed included a 'before and after' comparison of clinician hours and showed there had been an increase of 5%. Staff in Dorset informed us that they felt there were more staff but in Devon staff said there were less staff. Despite the additional actions that had been completed by the Trust and ongoing actions, with one of the NHS 111 contracts due to end in September 2016, staff members were leaving to seek alternative permanent employment.

At the inspection in March 2016 there was a risk that staff may not recognise or respond appropriately to signs of deteriorating health and medical emergencies. The Trust had introduced Non-Pathways Advisors (NPA) who would take the patient details and warm transfer to a call advisor (a warm transfer is direct transfer with no delay). However, staff and managers stated that often these calls were placed into a call-back queue which could build to 50-60 patients awaiting a pathways assessment. Although this had a positive impact on performance against the call answering key performance indicators, the pathways triage may not have started for several minutes.

- Following the March 2016 inspection, the Trust had reviewed and subsequently de-established the role of Non Pathways Advisors (NPAs) in July 2016. All existing NPAs had been offered conversion training to become Call Advisors. We saw the majority had been successful in their application and had commenced their training. The Trust told us that until the NPAs had fully completed their conversion training; call answering performance would continue to be affected. Performance data for July 2016 showed the percentage of calls abandoned had increased over all three NHS 111 contracts.

Monitoring safety and responding to risk

At the inspection in August 2016 we found that the processes for monitoring safety and responding to risk had improved.

Following the previous inspection in March 2016 the Trust had established an internal NHS 111 Improvement Team consisting of five senior managers. The improvement team had developed a regulatory consolidated action plan and completed a set of risk assessments with comprehensive action plans which reviewed each risk assessment. We saw evidence that the review of actions had started to mitigate risk and ensure they were embedded into everyday practice.

The Trust had recognised staffing levels had been below those needed and had engaged with commissioners to agree the levels required. The Trust had taken a number of actions to increase the number of staff working on the NHS 111 service to ensure emergency and urgent callers were assessed in a timely manner.

With the objective of increasing clinical cover, there had been an informal consultation with clinicians to review their existing working arrangements including number of hours and shift length. Evidence reviewed included a 'before and after' comparison of clinician hours and showed there had been an increase of 5%. It was noted that the Trust had increased the clinician hours at the known peak times, for example:

Are services safe?

- Before the consultation there had been 118 clinician hours each Friday. After consultation this had increased by 16 hours and there was now 134 clinician hours available each Friday.
- Before the consultation there had been 180 clinician hours each Saturday. After consultation this had increased by 22 hours and there were now 202 clinician hours planned each Saturday.
- Before consultation there had been 162 clinician hours each Sunday. After consultation this had increased by 19 hours and there were now 181 clinician hours planned each Sunday.

Within the existing clinical resources this was the maximum that could be achieved through rota re-negotiation. The Trust had also reviewing the effectiveness of the Resource Operations Centre ensuring a system was in place to plan sufficiently in advance.

As a mechanism to retain staff, the Trust had funded and offered retention payments to staff. All clinicians and call advisors at the Devon call centre had been written to and offered a retention bonus to remain working on the NHS 111 service until the Devon contract ended in September 2016. Overtime incentives for expected busy times had also been introduced for both Call Advisors and Clinical Advisors.

During the March 2016 inspection the Trust informed us they had begun recruiting in line with the trajectory set by the commissioners. During the August 2016 inspection we saw an accelerated recruitment programme was in process. This included:

- Appointing the Head of Nursing as the senior manager responsible for the recruitment of NHS 111 Clinical Advisors.
- Monitoring of a comprehensive and live recruitment tracker.
- Communication from the Head of Nursing with each applicant by telephone to discuss the role in more detail and promote working within NHS 111 and working for SWAST.
- Advertising the positions on various recruitment websites including NHS Jobs, Nursing Standard, Royal College of Nursing Bulletin and via SWAST social media. The Trust extended the closing date for applications to allow for as many applications as possible. Despite contacting employment agencies, no clinical advisors met the Trust's criteria for employment. We saw the Head of Nursing had arranged two recruitment opening evenings, to give potential applicants hands on experience of working for NHS 111.

Following the accelerated recruitment programme, five Clinical Advisors had been successful in their applications and were about to commence their training programme.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to identify the required staff to be on duty.

At the March 2016 inspection, we saw the number of staff available was often below those identified as being needed to manage patients' calls. This particularly impacted on clinical staff where, at certain times, there was just one clinician on duty during busy periods. At the August 2016 inspection, we saw evidence that the Trust had contacted other NHS 111 providers to ascertain whether there was external additional call answering availability. The 'provider to provider' contacts had established outsourced support from two external NHS 111 providers and was in place at the time of the inspection. For example, on 2 August 2016, one of the two external providers commenced an agreement to support SWAST and answer, triage and manage 7% of calls with a maximum of 15 calls per hour. During the inspection we were informed this had just increased to 9%.

To secure further additional call answering support and reduce the risk of patients experiencing long delays accessing the service the Trust had escalated the use of the National NHS 111 Contingency plan. The National NHS 111 Contingency plan allows calls to be re-routed at a National level and shared amongst other NHS 111 providers. The Trust had a process and clearly defined triggers that had been agreed with the commissioners and NHS England before the service could be activated. We saw the Trust had been both proactive and reactive in requesting the use of this service. For example, the week prior to the August 2016 inspection, the Senior On-Call Manager from SWAST endeavoured to activate this service during a period of increased call volumes. An example of the Trusts proactive use of this service saw a review of staff levels for the forthcoming Bank Holiday which was expected to be a period of increased demand on the SWAST NHS 111 Service, the Trust had proactively requested activation of

the National NHS 111 Contingency Service when call volumes and predicted staff levels created a potential risk. All Senior Operations Managers we spoke with were aware of the escalation triggers.

To ensure the call back queues were monitored and managed by staff with clinical authority to intervene and allocate resources whilst gaining a better understanding of the risks relating to long call backs on NHS 111 calls:

- The Trust had implemented a revised procedure for the management of long calls on the clinical call back queue. This specifically included the arrangements and triggers for 'comfort calling' patients. 'Comfort calling' is a procedure whereby a clinician monitors the clinical call back queue. The clinician assessed and arranged a call advisor or senior call advisor to re-assess the patients, determining whether a caller's symptoms had changed and where appropriate taking action to ensure risks are appropriately managed. The Trust told us that the improved 'comfort calling' process also ensured patients experiencing a long call back received regular and planned communication from the NHS 111 service. We saw this procedure detailed the requirement for a retrospective incident and risk investigation to be completed when the procedure was activated. The investigation findings were reviewed and lessons learnt were shared to improve safety in the service. We saw clear trigger points and a line of authorisation as to when to activate the 'comfort calling' process. An example of a trigger point which activated this process was when there were more than 15 calls per NHS Pathways trained Clinician on duty. All staff we spoke with were aware of this revised 'comfort calling' procedure.
- The Trust had discussed and agreed with the commissioners a monthly review of a sample of calls which experienced a long call backs. We were presented with the findings of the first review, the date range of this sample was between 12 May 2016 and 13 June 2016 (19,046 calls within this period, of which a total of 62.5% of clinician call backs were made within 30 minutes and 86.9% within 120 minutes). The review had focussed on the longest waiting 20 calls. Each call was reviewed by a Specialist Senior Paramedic. The outcome was that the review demonstrated that all of the 20 calls reviewed were considered low risk with the vast majority ending with a 'home management advice' endpoint.

During the review of 20 calls between 12 May 2016 and 13 June 2016, two performance issues had been identified. These were both investigated. For one issue it was found that the NHS 111 service had not used a function correctly within the software used when making a call back to a patient. Failure to use this function and log a call correctly did not affect patient safety but resulted in incorrect reporting of performance data. Once identified, the Trust issued a service wide message and raised awareness training to ensure every member of staff in the NHS 111 service was aware of the call log function and understood how to use it.

The second issue finding highlighted the increased use of a deferred call back when arranging call backs. For example, callers who were offered a call back but chose to wait until the following morning for their call. Although responsive to the callers' preferences, this compromised performance data. Similar to the call logging process, awareness training had been arranged and a supporting procedure implemented to ensure deferred call backs were arranged in accordance to the procedure.

A further review of calls of long call back, with a much larger sample size (378 calls), was currently being completed during the August 2016 inspection. This review was supported by two clinical commissioning groups (CCG) GPs for additional assurance. Using the initial review of the 20 calls and the findings from the review of the 378 calls the Trust reviewed and identified whether any clinical risk existed within the clinical queue and how the Trust could manage any risks more appropriately. This enabled the Trust to manage the clinical queue and at times of high demand increase focus on areas identified as being of increased concern.

Staff we spoke with in Dorset felt that the Trust's NHS 111 service had significantly improved since the last inspection. Staff said the NHS 111 service operated by SWAST was now safer due to the endeavours of the Trust, which in turn had a positive effect on the waiting times and patient outcomes. However, staff in Devon, where the contract was due to end, had more concerns and added the service was not sustainable and staff were continuing to leave the service.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

At our inspection in March 2016 we found patients were at risk of harm because the Trust's NHS 111 service was not effective. For example:

- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the Trust was comparing its performance to others, either locally or nationally.
- Data showed that care and treatment was not delivered in line with recognised professional standards and guidelines. Necessary action to improve callers' outcomes was not taken.
- Throughout the March 2016 inspection, information indicated that limited audits had taken place on calls in the previous 12 months.

The inspection team were given audit information for NHS 111 Call Advisors and Clinical Advisors which showed the number of calls being audited against targets and the compliance of the audits being completed. Within the NHS Pathways licence, the NHS Pathways standard advises auditing either three or five calls per month for each individual according to the number of calls taken per month, length of time within role, and achievement level on previous audits. The Trust was aware of a requirement to improve levels of audit, for example:

- In the three month period between 1 November 2015 and 31 January 2016 there were 186,625 calls.
- In relation to call advisor audits, out of a total of 2207 audits which should have been completed only 725 were done equating to 33.4% of the expected amount. In November 2015, only 37.1% of calls which should have been audited were audited. In December 2015, only 30.9% of calls which should have been audited were audited. In January 2016, only 32.3% of calls which should have been audited were audited.
- In relation to clinician audits, in the three month period between 1 November 2015 and 31 January 2016 out of a total of 260 calls which should have been audited only 38 were completed (15.7%). Monthly performance was 7.3% for November 2015, 23.7% for December 2015 and 16.2% for January 2016.
- Of those audits completed, 75.2% of Call Advisor audits were compliant (545 out of 725) and 81% of clinician audits were compliant (93 out of 244).

As a result of low levels of audits the service had not monitored performance on NHS Pathways and had not identified where specific staff had gaps in skills and knowledge. Callers may therefore receive incorrect or inappropriate advice from an advisor whose performance and calls had not been monitored.

Following the previous inspection the Trust had established a regulatory consolidated action plan and internal NHS 111 Improvement Team. This team had reviewed the risk of low levels of call audits and implemented six measurable actions to be completed with the objective to increase call audit activity and call monitoring. For example:

- The Trust had contacted commissioners and the NHS Pathways license team to ascertain and fully understand national monitoring compliance.
- The Trust had contacted all NHS 111 providers to request call audit assistance and support.
- In order to ensure that all staff received at least one call audit per calendar month, a timeframe and tracker was introduced to enable a proactive approach and strategy to increase and monitor call audit activity.
- Further performance and monitoring tools were introduced to ensure the increased activity of audits was managed effectively. Trained call auditors were approached and offered overtime to complete call audits and call levelling exercises were completed. Call levelling is a process when a random selection of calls are listened to by small groups and audited together. After each call, there was a discussion of the scores for the criteria monitored and where there was a wide variation, the reasons.

At the August 2016 inspection, the Trust advised of a significant improvement in the levels of call audit and the establishment of a single SWAST wide quality assured audit process. Monitoring tools used to manage call audit activity indicated significant improvement across both call centres, for example:

Are services effective?

(for example, treatment is effective)

- In Devon, as of 8 July 2016, 100% (127 out of 127) of Call Advisors and Senior Call Advisors had had a call audit in the previous calendar month. Furthermore, 100% (25 out of 25) of Clinicians have had a call audit in the previous calendar month.
- In Dorset, as of 8 July 2016, 100% (89 out of 89) of Call Advisors and Senior Call Advisors had had a call audit in the previous calendar month. Furthermore, 100% (25 out of 25) of Clinicians have had a call audit in the previous calendar month.
- The plan was to deliver a 5% increase on the previous months audit levels; the actual increase was 30.7%.
- Information reviewed during the August 2016 inspection indicated similar success for call audits completed in July 2016 with the exception of those on annual leave or absent from work all (100%) Call Advisors, Senior Call Advisors and clinicians had a call audit.
- Although improving, as a result of the low numbers of call audits the service was still not rigorously monitoring performance on NHS Pathways, or achieving the call audit levels set in the NHS Pathways License agreement.

We saw themes and learning picked up through call audits had been communicated with staff and displayed throughout the call centres.

Staff we spoke with were all aware of an increased activity in call audits and had all received constructive feedback following their call audits. Although some members of staff commented this new approach of audit activity was not sustainable and thought that there was an inconsistent approach to how feedback was delivered.

Management, monitoring and improving outcomes for people

At the March 2016 inspection, data provided by the Trust showed that care and treatment was not effectively delivered in line with recognised professional standards and guidelines.

The Trust monitored the performance of NHS 111 against the National Minimum Data Set (MDS) average performance and adapted National Quality Requirements (NQRs). However, the provider was not meeting NHS 111 Service Quality Requirements.

During the August 2016 inspection we found that systems and processes had been established, were now being operated and the Trust fully embraced the need to change. However, it was too early to say whether these systems were effective. For example it is an expectation of NQRs that:

- NHS 111 providers must send details of all consultations (including appropriate clinical information) to the GP practice where the patient is registered by 8am the next working day. Findings for July 2016 was 96% for all contracts. This was an improvement on previously reported data, as February 2016 indicated findings were lowest for Devon at 84% although the target for this was 95%.

- All immediately life threatening conditions should be passed to the ambulance service within three minutes. The national target is 100%. In March 2016, information provided by the Trust reported: 94.9% of Devon calls with immediately life threatening conditions were passed to the ambulance service within three minutes and 93.8% of Dorset calls with immediately life threatening conditions were passed to the ambulance service within three minutes. Performance data between 8 July 2016 and 18 August 2016, reported of the 50 calls (combined Devon and Dorset calls) which highlighted life threatening conditions, 90% were passed to the ambulance service within three minutes.

The national target for call abandonment is that no more than 5% of calls should be abandoned before being answered.

- In March 2016, 3.5% of Dorset calls were abandoned before being answered, 9.4% of Devon calls were abandoned before being answered and 10% of Cornwall calls were abandoned before being answered. Performance data supplied by the Trust indicates that the percentage of calls abandoned increased after the March inspection, though it has subsequently returned to the March 2016 level in Devon. Calls abandoned is a marker of patient experience, a high call abandoned rate is considered not to be safe and may reflect a high level of clinical risk for patients.
- In July 2016, the Trust had reviewed and subsequently de-established the role of Non Pathways Advisors (NPAs). The Trust told us until the NPAs had completed their conversion training to become Call Advisors and more Call Advisors were recruited, call answering performance would be affected. We reviewed the data performance for July 2016 and for August 1 to 17 2016.

Are services effective?

(for example, treatment is effective)

The data showed the percentage of calls abandoned had increased on all three NHS 111 contracts although there were some days where the level was met: For July 2016; 5.4% of Dorset calls were abandoned with 16 days below 5% abandoned; 11.1% of Devon calls were abandoned with three days below 5% abandoned and 10.6% of Cornwall calls were abandoned with three days below 5% abandoned. For 1 August 2016 to 17 August 2016 5.6% of Dorset calls were abandoned with eight days below 5% abandoned, 9.2% of Devon calls were abandoned with two days below 5% and 9.5% of Cornwall calls were abandoned with two days less than 5% abandoned.

The national target is 95% of calls to be answered within 60 seconds of the end of the introductory message.

- At the time of the March 2016 inspection, 84% of calls were answered within 60 seconds in Dorset and 69% in Devon and Cornwall combined.
- More recent performance data supplied by the Trust indicated a reduction in call answering performance and showed that care and treatment was still not delivered in line with standards and guidelines. The Trust recognised that the removal of the NPA role was only one factor in a complex set of factors. In July 2016, 75.8% of Dorset calls were answered within 60 seconds of the end of the introductory message and 53.9% of Devon and Cornwall combined calls were answered within 60 seconds of the introductory message.

A further NHS 111 Service Quality Requirement is for all calls which were referred to a clinician should have received a call back within 10 minutes of being referred.

- In the three month period between 1 November 2015 and 31 January 2016 an average of 45.5% received a call back within 10 minutes of being referred.
- More recent performance data supplied by the Trust indicated callers were still not receiving a call back from a clinician with 10 minutes. In July 2016, 53.2% of Devon calls which required a clinician call back within 10 minutes had a call back in this time frame, 22.8% of Cornwall calls which required a clinician call back within 10 minutes had a call back in this time frame and 17% of Dorset calls which required a clinician call back within 10 minutes had a call back in this time frame.

In the three month period between 1 November 2015 and 31 January 2016 we saw examples of delayed call backs, for example:

- The longest wait for a call back in Devon was over 21 hours.
- More recent performance data supplied by the Trust indicated measures implemented had reduced the number of delayed call backs and the time the delayed call backs had been waiting. However, there was still a delay and this could have placed patients at significant risk to their health and welfare. For example, in July 2016 the longest wait for a Devon call back was 14 hours.

Benefits to callers had not yet shown to have improved and would need to be evidenced over time that changes implemented had been sustained.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment **How the regulation was not being met:** The Trust did not ensure that all callers had the care and treatment or assessment needed. Although the Trust had implemented systems to ensure associated risks are mitigated for the safety of patient health and welfare, it remains that there are risks to callers due to delays in initial answering of calls, warm transfer and returning calls by a clinician.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing **How the regulation was not being met:** Staff skill and competency had started to be reviewed however the performance monitoring of staff such as through observation, supervision and call audits had not been established on an ongoing basis to allow them to carry out their duties they are employed to perform.