London Ambulance Service NHS Trust (NHS 111)

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of the NHS 111 service provided by the London Ambulance Service NHS Trust on 29 and 30 September 2016 at its single site location in Croydon, South London.

Our key findings were as follows:

The London Ambulance Service (LAS) NHS 111 service provided a safe, effective, caring, responsive and well-led service to a diverse population in South East London. Overall the provider was rated as good.

- There was an open and transparent approach to safety and an effective system in place to report and record significant events. Staff knew how to raise concerns, understood the need to report incidents and considered the organisation a supportive, culture. The provider maintained a risk register and held regular internal and external governance meetings.
- The service was monitored against a National Minimum Data (MDS) and Key Performance Indicators (KPIs). The data provided information to the provider and commissioners about the level of service provided. Data provided showed the provider was meeting the majority of its KPI targets.
- Staff had been trained and were monitored to ensure they used NHS Pathways safely and effectively (NHS Pathways is a licensed computer-based operating system that provides a suite of clinical assessments for triaging telephone calls from patients based on the symptoms they report when they call). The provider reported it had fallen below its target for some call and call back timeframes and had implemented operational procedures to address these.
- Patients using the service were supported effectively during the telephone triage process and consent was sought. We observed staff treated patients with compassion and respect.
- Staff took action to safeguard patients and were aware of the process to make safeguarding referrals. Safeguarding systems and processes were in place to safeguard both children and adults at risk of harm or abuse, including calls from children and frequent callers to the service.
- The provider was responsive and acted on patient's complaints effectively and feedback was welcomed by the provider and used to improve the service.
- There was visible leadership with an emphasis on continuous improvement and development of the service. Staff felt supported by the management team.

Summary of findings

- The provider was aware of, and complied with, the Duty of Candour. Staff told us there was a culture of openness and transparency.

There were areas where the provider should make improvements:

- Continue to address the challenges of recruiting substantive staff and the high reliance on agency staff to ensure adequate numbers of skilled staff are available to provide a safe and effective service. Specifically, ensure sufficient staff are available to meet all call performance targets.
- Ensure that the telephony platform issues do not continue to impact on the ability to provide timely and accurate performance data.
- Look at ways to increase the opportunity for all staff to meet as a team to share experiences.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The provider is rated as good for providing safe services.

- There was an open and transparent approach to safety and an effective system in place to report and record significant events. Staff knew how to raise concerns, understood the need to report incidents and considered the organisation a supportive culture. The provider maintained a risk register and held regular internal and external governance meetings.
- Staff took action to safeguard patients and were aware of the process to make safeguarding referrals. Safeguarding systems and processes were in place to safeguard both children and adults at risk of harm or abuse, including calls from children and frequent callers to the service. Level three safeguarding training had been undertaken by 100% of the senior clinicians, training team and clinical managers, where there was consistently one on duty for every shift, and the remaining clinicians were trained to safeguarding level two.
- Service performance was monitored and reviewed and improvements implemented.
- Clinical advice and support was readily available to call handlers when needed.
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. The provider faced challenges recruiting substantive staff and relied heavily on agency clinicians.

Are services effective?

Good

The provider is rated as good for providing effective services.

- Daily, weekly and monthly monitoring and analysis of the service achievements was measured against key performance targets and shared with the lead clinical commissioning group (CCG) members. Data provided showed the provider was meeting the majority of its performance targets. However, the provider reported it had fallen below its target for some call and call back timeframes and had implemented operational procedures to address these.
- Appropriate action was undertaken where variations in performance were identified. Staff were trained and rigorously monitored to ensure safe and effective use of NHS Pathways.

Summary of findings

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

Are services caring?

Good

The provider is rated as good for providing caring services.

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

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services.

- The service had long and short-term plans in place to ensure staffing levels were sufficient to meet anticipated demand for the service.
- There was a comprehensive complaints system and all complaints were risk assessed and investigated appropriately.
- The provider implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback.
- Action was taken to improve service delivery where gaps were identified.
- Staff were alerted, through their computer system, to people with identified specific clinical needs and for safety issues.

Summary of findings

- The provider engaged with the lead Clinical Commissioning Group (CCG) to review performance and agree strategies to improve. Work was undertaken to ensure the Directory of Services (DoS) was kept up to date. (The DoS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.)

Are services well-led?

Good

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

- The provider had a clear vision and strategy to deliver a high quality service and promote good outcomes for people using the service. The Trust's vision and values were displayed around the call centre and staff we spoke with were aware of these. The London Ambulance NHS Trust had recently launched an organisational-wide campaign to promote the vision of 'Making the LAS Great' The LAS 111 service extended the initiative and ran a programme of workshops in June and July 2016 'Making the LAS 111 A Great Place to Work.'
- There was a clear leadership structure and staff we spoke with told us management were supportive and approachable.
- The provider's policies and procedures to govern activity were effective, appropriate and up-to-date. Regular internal and external governance meetings were held.
- There was an overarching governance framework which supported the delivery of the strategy and a good quality service. This included arrangements to monitor and improve quality and identify risk. The provider held a risk register.
- The provider was aware of and complied with the requirements of the duty of candour. The provider and managers encouraged a culture of openness and honesty. The provider had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The provider sought feedback from people using the service via the contractual patient survey. Public engagement was otherwise limited. An annual staff survey was undertaken.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Continue to address the challenges of recruiting substantive staff and the high reliance on agency staff to ensure adequate numbers of skilled staff are available to provide a safe and effective service. Specifically, ensure sufficient staff are available to meet all call performance targets.
- Ensure that the telephony platform issues do not continue to impact on the ability to provide timely and accurate performance data.
- Look at ways to increase the opportunity for all staff to meet as a team to share experiences.

London Ambulance Service NHS Trust (NHS 111)

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to London Ambulance Service NHS Trust (NHS 111)

London Ambulance Service (LAS) NHS Trust has provided NHS 111 services for patients in South East London since November 2013 following a request to 'step in' as a successor to the services previously provided by NHS Direct. The contract is held between the LAS NHS 111 and Bromley Clinical Commissioning Group (CCG) as the co-ordinating commissioner acting for itself and on behalf of Bexley, Greenwich, Lambeth, Lewisham and Southwark CCGs.

The LAS 111 service employs 113 staff (88 whole time equivalents). The service reported an approximate 25% turnover of staff in non-clinical and clinical roles in the past year. The call centre handles around 265,000 calls each year.

The provider is registered to provide three regulated activities:

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

The LAS 111 service operates 24 hours a day, 365 days a year. It is a telephone-based service where patients are assessed, given advice and directed to a local service that most appropriately meets their needs. For example, this could be an out-of-hours GP service, walk-in centre or urgent care centre, emergency dentist, accident and emergency department, emergency ambulance or late opening chemist.

The LAS 111 service operate from a single location in Croydon, South London. The service had previously been located in Beckenham in the London Borough of Bromley but moved to purpose-built location in Croydon in July 2016. The geographical areas the LAS 111 service covers in the contract are Bromley, Bexley, Greenwich, Lambeth, Lewisham and Southwark which accounts for approximately 20% of the resident population of London and a population of approximately 1.75 million. The LAS 111 service is one of five providers of NHS 111 services in London.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

We carried out an announced comprehensive inspection of the LAS 111 service location in Croydon on 29 and 30 September 2016. During our inspection we:

- Observed the call centre environment over one and a half weekdays and during a peak weekday evening when GP practices were closed.
- Spoke with a range of clinical and non-clinical staff, including call handlers, clinical advisors, team leaders and senior managers.
- We looked at a range of records including audits, staff personnel records, staff training, patient feedback and complaints.
- We did not speak directly with patients who used the service. However, we observed call handlers in the call centre speaking with patients who telephoned the service.

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

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

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

Good

Are services safe?

Our findings

Safe track record

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

- Significant events that met the threshold for a Serious Incident or Never Event were declared and investigated in accordance with the NHS England Serious Incident Framework 2015.
- Investigation of significant events was not confined to those that met NHS England's criteria for a Serious Incident or Never Event. The provider treated significant events including near misses as an opportunity for learning and risk reduction measures.
- Staff told us they were aware of how to escalate incidents and would inform their manager. We noted that staff had access to an operational policy and process flowchart. Staff said they felt confident when raising concerns and that management were open and approachable. There was a recording form available on the provider's computer system and staff we spoke with knew how to access this. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that provider of services must follow when things go wrong with care and treatment). All staff we spoke with understood the duty of candour and were able to give examples.
- We saw evidence that the LAS 111 management team had attended risk management training provided organisation-wide in early 2016. The training had included a risk definition refresher, risk identification and risk assessment and reporting.
- Staff told us they received feedback from any investigations and changes required as a result of learning from risks and incidents through one-to-one meetings, team 'huddles' and email bulletins. We saw several examples of staff bulletins. Staff understanding of changes was monitored through audits.
- We noted the provider had recorded three serious incidents in the last 12 months and we saw evidence that a thorough analysis had been undertaken and key outcomes actioned. For example, following a difficult cardiopulmonary resuscitation (CPR) attempt through verbal instruction by a call handler, the provider reviewed its CPR update training and offered all staff the opportunity to undertake training using resuscitation manikins. This was in addition to the standard refresher training on telephone CPR instruction as required in NHS Pathway training. We saw evidence that the provider offered four training dates of which each date had four training sessions. The provider told us the training was well attended and from 2017 would be including manikin resuscitation training in its mandatory training schedule.
- Internal and external governance meetings with contract commissioning leads were held to review themes from significant events and the provider produced a monthly clinical governance report which detailed both serious incidents and other incidents not meeting the Serious Incident Framework threshold. The report detailed the number and categorised the type of incident. For example, calls referred to an incorrect out-of-hours provider, demographic errors, breaches of procedure.
- The provider engaged with the external pan-London NHS 111 Clinical Governance Group and Integrated Urgent care Group to peer review and share risk and learning from serious incidents within a 'Being Open' framework.
- Joint reviews of incidents were carried out with other partner organisations. For example, the provider recorded, reported and audited on a monthly basis incorrect referrals to a GP out-of-hours provider.
- We saw evidence that when things went wrong, people were informed of the incident, received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety. Serious incidents, incidents, complaints, call quality and monitoring, safeguarding and patient experience were reported in the monthly clinical governance report.

Overview of safety systems and processes

Good

Are services safe?

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff which included safeguarding flowcharts and referral pathways on their desktop. The policies clearly outlined who to contact for further guidance if staff had concerns about a person's welfare. There was a lead member of staff for safeguarding. Contributions were made to safeguarding meetings when required.
- We noted that the provider had made 481 safeguarding referrals to local authorities in a one year period (1 August 2015 to 31 July 2016). Of these, 229 related to adults and 252 related to children. Staff were able to discuss any concerns regarding the safety and welfare of a patient in real-time with a clinician prior to making a referral. The provider monitored all safeguarding referrals on a monthly basis and any referral considered inappropriate was investigated and any learning outcomes shared.
- The provider had undertaken a safeguarding referral audit to assess the appropriateness of its safeguarding referrals to a local social services team. An end-to-end review meeting with a social service representative present included listening to calls and reviewing call record documentation and referral paperwork. The review concluded that referrals were considered to be appropriate. Staff we spoke with demonstrated they understood their safeguarding responsibilities and had received safeguarding children and vulnerable adults training relevant to their role. The combined training session included awareness of child sexual exploitation, Female Genital Mutilation (FGM), domestic abuse, modern slavery and honour based violence. Training records provided at the time of our inspection indicated 100% of non-clinical call handlers had completed level one training and 97% had also completed level two training. Records showed 100% compliance with level three safeguarding training for the senior clinicians, training team and clinical managers, where there was consistently one on duty for every shift. The remaining clinicians were trained to safeguarding level two.
- Clinical staff and appropriate administrative staff had access to people's medical or care records. Staff were clear on the arrangements for recording patient information and maintaining records. Call handlers and other staff had access to patient special notes, which alerted staff to patients with specific conditions or needs, for example where they had pre-existing conditions or there were safety concerns.
- Staff had had training in recognising concerning situations and identifying complex calls and followed guidance in how to respond. This included the procedure for terminated and cut off calls. Clinical advice and support was readily available to staff when needed. For example, if a patient answered 'not sure' to three questions the call would be transferred to a clinician. Staff we spoke with demonstrated their understanding of these processes.
- The provider used the Department of Health approved NHS Pathways system (a set of clinical assessment questions to triage telephone calls from patients). The tool enabled a specially designed clinical assessment to be carried out by a trained member of staff who answered the call. At the end of each assessment a disposition (outcome) and defined timescale was identified and an automatic search was carried out on the integrated Directory of Services to locate an appropriate service in the patient's local area.
- We saw evidence that call handlers and clinical advisors call handling skills using NHS Pathways were regularly monitored in the form of end-to-end call audits to ensure that dispositions (outcomes) reached at the end of a call were safe and appropriate. The provider shared evidence of call audits for both call handlers and clinical advisors for the period August 2015 and July 2016. Results suggested the provider had met its target of 86% for call handler and clinical advisor call quality compliance for the entire period of the submitted data. End-to-end call audits were also discussed at external Pan-London NHS111 Clinical Governance Group meetings to share learning.
- There were clear processes in place to manage the transfer of calls, both internally within the service, and to external providers, to ensure a safe service. For example, a referral to a patient's own GP or to an out-of-hours GP service. Standard operating procedures were available on a shared drive.
- We saw that staff had access to advice from clinicians where necessary. Should a clinician not be available for

a direct transfer (warm transfer) the patient was placed on a 'call back' queue. We saw these were assigned priority at the end of a call ranging from priority one requiring an immediate response to priority four for health information queries. We discussed this process on the day with the team manager and clinical quality improvement advisors who oversaw the non-clinical call handlers and clinical advisors within a team and provide support as 'floorwalkers.' We were told they monitored clinical call backs to ensure those calls most in need are allocated to a clinician first.

- A situation report for clinical call backs for the 24-hour period covering the first day of our inspection showed 58% of call backs had been achieved in under 10 minutes. A breakdown of the average monthly performance for key performance indicators of call back percentage within 10 minutes suggested the provider performed better than the England average (provider 66%; England average 42%). However, this was below the contract target of 95%. We saw that this had been raised in a contract management meeting with the commissioners and an operational procedure had been implemented. The provider told us that all call backs were monitored by the clinical quality improvement advisors and when call back performance did not meet target they would take priority calls themselves. Staff we spoke with on the day confirmed this.
- Call handlers had a coloured flag system (red, blue, green and yellow) available on their workstation which enabled them to raise a flag and receive immediate assistance for various situations such as life-threatening scenarios and technical issues.
- Call response time, waiting times and abandoned call data were monitored throughout each shift and were visible on call monitor boards. A situation report for the 24- hour period covering the first day of our inspection showed 744 calls had been received of which 95% had been answered within 60 seconds. A breakdown of the average monthly performance for key performance indicators for the 12-month period submitted of calls answered in 60 seconds suggested the provider performed better than the England average (provider 96%; England average 81%) and met its contract target of 95%.
- We reviewed seven personnel files, including agency personnel, and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). The provider shared with us internal staff communication confirming that DBS renewal checks would be undertaken every three years in line with NHS Employers guidance.
- At the time of our inspection the LAS 111 service employed 113 staff, which equated to 88 whole time equivalents (WTE) and reported current staff vacancies of 7.9 WTE for call handlers and 15.5 WTE for clinical advisors. The backfill was predominantly filled with agency staff. The service reported an approximate 25% turnover of staff for both non-clinical and clinical roles in the past year. The provider told us staff tended to leave almost immediately after completion of training. All staff who left the service were encouraged to undertake an exit interview or questionnaire to enable the provider to analyse any trends. Data provided by the provider showed relocation, work-life balance and child dependents were amongst the reasons for leaving the service.
- We reviewed processes in place with the provider's preferred supplier of agency staff due to their declared high reliance on agency clinicians. We observed effective processes of selection were in place to ensure individuals had the required skills and knowledge to undertake the role. When agency staff had been deployed they were subject to the same mandatory training and induction processes required for the permanent workforce which included performance reviews. Agency staff we spoke with on the day confirmed this. The provider told us where possible they tried to use the same agency staff for consistency and stability.
- Staff were provided with a safe environment in which to work. The service had recently moved to new purpose-built premises. Staff told us that this had made a considerable improvement to the working environment. Entry to the floor space was via security key pad. Since the move, 97% of staff had completed Display Screen Equipment (DSE) self-assessment forms. The provider had put adaptations in place as a result of the findings, for example, specifically adjusted chairs and modified equipment. We saw evidence that portable appliance testing (PAT) had been undertaken. A Fire Risk Assessment had been undertaken in September 2016 and there was a weekly fire alarm test record. The provider had a fire evacuation plan which it

had shared with all staff through a staff bulletin and was visible around the premises. The provider had put in place a Personal Emergency Evacuation Plan (PEEP) for those staff who had been identified as requiring assistance in the event of an emergency evacuation. Staff had undertaken fire safety training (100% call handlers; 98% clinical advisors; 100% management team).

Monitoring safety and responding to risk

Risks to patients were assessed and well managed.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs using a workforce management tool. Forecasting of services were planned for each financial year based on historical activity and local and seasonal events. Call volume and demand was reviewed and monitored on a daily basis and where there was a change to expected activity this was discussed and agreed at monthly contract commissioners meetings. We saw an example of this and how adjustments had been made to meet potential increase in demand secondary to the junior doctor strikes. The team responsible for resource planning demonstrated how rotas were prepared four weeks in advance to ensure enough staff were on duty and how planned peaks and fluctuations in demand such as holiday periods and staff sickness was managed. The provider told us there had been an unexpected increase in call volume around February 2016 which had impacted on some performance targets due to the inability to fill all rotas at short notice. This had been placed on the risk register as an ongoing risk and was being monitored.
- Shift rotas were actively managed. Staff told us they were offered overtime to cover absence. The service operated with six teams consisting of call handlers, clinical advisors, a team manager and a clinical quality improvement advisor. There was a ratio of 2 to 2.5 call handlers to clinical advisors. Staff we spoke with on the day told us the service was busy but felt for the most part that there was sufficient staffing to handle calls effectively. Staff, including agency staff, told us they worked well as a team and all helped each other out and felt supported by the management team. Staff told us they observed good working relationships between managers and staff.
- Call handlers triaged patient calls using a clinical decision support system (NHS Pathways). This guided the call handler to assess the patient based on the symptoms they reported when they called. It had an integrated Directory of Service (DoS) which identified appropriate services for the patients' care. We saw shortened NHS Pathways in use for patients with dental problems to facilitate a safe and speedier referral to OOH dental triage service available to patients in London.
- Staff received comprehensive training and regular updates on NHS Pathways. Each call handler's competency was assessed prior to handling patient telephone calls independently, and continuously through regular calls audits for all members of staff.
- Staff we spoke with demonstrated they were able to identify potentially life threatening situations and had systems in place to manage frequent callers. Notes were added to the system which provided call handlers with a course of action to take to ensure their health, safety and wellbeing.

There was an effective process in place to identify, understand and monitor current and future risks. The provider held a current risk register on which it had rated some issues as high risk. For example, its high reliance on agency staff and performance data reporting difficulties arising from the installation of a new 111 telephony platform.

We saw that the provider had action plans in place to ensure improvements were seen in these areas. For example:

- At the time of our inspection the provider had 7.9 WTE call handler and 15.5 WTE clinical advisor vacancies. The backfill was predominantly filled with agency staff. Data for agency staff usage showed that in May, 206 clinical advisor shifts and 64 call handler shifts were provided by agency staff, in June, 232 clinical advisor shifts and 53 call handler shifts and in July, 237 clinical advisor shifts were provided by agency staff and 53 call handler shifts were provided by agency staff. The provider told us it was a challenge to recruit permanent staff and had held a recruitment open day at the beginning of September. We were told they would continue with the recruitment drive as well as looking at redeployment of LAS 999 staff who were unable to maintain operational duties (short and long-term).

Good

Are services safe?

- The provider transitioned to a new telephony platform following joint procurement and sign off by the provider, NHS England and commissioners in March 2016. The provider told us there had been a number of technical issues, specifically access to full reporting functionality in relation to reporting performance of individuals. The commissioners were fully aware of the current situation and the provider told us they were working with the telephony company and with other information management tools to find a solution.

Arrangements to deal with emergencies and major incidents

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

- The provider had a comprehensive business continuity and disaster recovery plan in place to deal with emergencies that might interrupt the smooth running of the service. This included loss of power, loss of utilities, evacuation of the building, pandemic, population disasters and increase in demand. We noted that the plan had been recently reviewed and amended to reflect the new location. The plan referenced a call centre fall-back site within the London Ambulance Service organisation. Staff we spoke with on the day were aware of the fall-back site. We saw that each work station had a resource pack which included a paper copy of adult, infant and children's pathways, a list of OOH providers and manual call documentation in the event of a system failure.
- The provider had undertaken a table top SWOT (strengths, weaknesses, opportunities and threats) analysis of its business continuity and disaster recovery plan for its NHS 111 service prior to the Croydon location move. We saw evidence of minutes and an outcome action plan.
- The provider had engaged with other services and commissioners in the development of its business continuity plan. The service was part of a national contingency plan where in extreme situations calls could be routed to other NHS 111 providers. The LAS 111 service had participated under the umbrella of the London Ambulance Service NHS Trust in the Exercise Unified Response (a multi-agency emergency services exercise) held in London in March 2016.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The provider had systems in place to ensure all staff were kept up to date, for example through staff bulletins. Staff had access to guidelines from NICE, NHS Pathways and NHS Choices and used this information to help ensure that people's needs were met.

Telephone assessments were carried out using an approved clinical decision support tool (NHS Pathways). All call handlers had completed a mandatory comprehensive training programme to become a licensed user of the NHS Pathways programme. Once training was completed all call handlers were subject to structured call quality monitoring to ensure continued compliance. A minimum of three calls per month were audited against a set of criteria such as effective call control, skilled questioning, active listening and delivering a safe and effective outcome for the patient.

Staff told us that updates to NHS Pathways were forwarded through formal communication. We saw evidence of staff advanced notification of bi-annual NHS Pathways system upgrades. Staff we spoke with told us they were given protected time to work through changes, took a competency test to ensure the changes had been fully understood and had to be signed off on upgrades before they could resume taking calls. The provider monitored understanding of the changes through one-to-one meetings and audits.

The provider shared evidence of call audits for both call handlers and clinical advisors for the period August 2015 and July 2016. Results suggested the provider had met its target for both the percentage of calls audited (1%) and call handler and clinical advisor call quality compliance (86%) for the entire period of the submitted data. For example:

- Call Audits

In June 2016 a total of 23,419 calls had been answered of which 374 had been audited (1.6% against a target of 1%).

In July 2016 a total of 25,971 calls had been answered of which 292 had been audited (1.1% against a target of 1%).

- Call Handlers

In June 2016 a total of 196 call handler calls had been audited of which 176 were compliant (89.8%; target 86%).

In July 2016 a total of 143 call handler calls had been audited of which 131 were compliant (91.6%; target 86%).

- Clinical Advisors

In June 2016 a total of 178 clinical advisor calls had been audited of which 161 were compliant (90.4%; target 86%).

In July 2016 a total of 149 clinical advisor calls had been audited of which 144 were compliant (96.6%; target 86.6%).

Discrimination was avoided when speaking to patients who called the LAS 111 service. The NHS Pathways assessment process ensured patients were supported and assessed on their needs rather than on their demographic profile. Call handlers had access to the language line phone facility (a translation/interpreter service) for patients who did not have English as their first language, a text relay service for patients with difficulties communicating or hearing and a video relay service for British Sign Language (BSL) interpreters. Data was collected by the provider for language line and we saw that in June 2016, 121 calls required the use of language line and interpreters were used for a total of 27 different languages with Spanish the main language requested.

Management, monitoring and improving outcomes for people

The service monitored its performance through the use of the National Quality Requirements and the national Minimum Data Set, as well as compliance with the NHS Commissioning Standards. In addition the provider had established its performance monitoring arrangements and reviewed its performance and provided call centre statistics which highlighted month by month site adherence rates with a week-to-week and hour-to-hour view for the period July 2015 to June 2016. The data for this period showed that the average monthly performance of key performance indicators for the provider compared well to the England average. For example:

- 0.6% of calls abandoned (England average 3.1%).
- 95.6% of calls were answered within 60 seconds (England average 87.1%).
- 83.5% of calls answered were triaged (England average 86.6%).

Good

Are services effective?

(for example, treatment is effective)

- 25.5% of answered calls were triaged to clinical advisor (England average 21.9%).
- 11.5% of answered calls passed for call back (England average 13%).
- 66% of calls backs within 10 minutes (England average 40.2%).

The service prioritised people with the most urgent needs at time of high demand. Capacity and demand was monitored constantly and action taken to ensure callers received a timely response. We discussed this process on the day with the team manager and clinical quality improvement advisors who oversaw the non-clinical call handlers and clinical advisors and they told us they monitored clinical call backs to ensure those calls most in need are allocated to a clinician first. A situation report for clinical call backs for the 24-hour period covering the first day of our inspection showed 58% of call backs had been achieved in under 10 minutes. A breakdown of the average monthly performance for key performance indicators of call back percentage within 10 minutes suggested the provider performed better than the England average (provider 66%; England average 42%). However, this was below the contract target of 95%. We saw that this had been raised in a contract management meeting with the commissioners and an operational procedure had been implemented.

Data showed that the percentage of abandoned calls was consistently lower than the national target of five percent. For example, the monthly average for the period July 2015 to June 2016 was 0.6% (England average 3.1%; national target 5%). Current data for August showed:

- Week commencing 7 August 2016: 0.8%
- Week commencing 14 August 2016: 1%
- Week commencing 21 August 2016: 0.5%
- Week commencing 28 August 2016: 0.7%

The provider reported that although they compared well to the England average for calls answered within 60 seconds they had dropped below the contract target of 95% in February (92.4%; England average 79.7%), March (93.4%; England average 70.7%), April (94.8%; England average 87.1%), May (93.6%; England average 88.2%) and June (94.2%; England average 90.6%). Minutes of the contract management meetings showed that they had attributed this to a unexpected rise in calls. For example, call volumes were 2.4% higher in February 2016 than they were in February 2015. Furthermore, the provider had noted that there had been a large volume of silent calls delivered from one landline number which the phone provider had confirmed was a technical cable fault and had therefore not necessitated a welfare check. The provider also noted that they had had difficulty filling some rotas at short notice. We noted that unexpected and unplanned increase in call volume which exceeded staffing capacity causing a potential detrimental effect on service delivery had been added to the risk register.

On the day of the inspection we looked at more recent data of calls answered within 60 seconds and found for the month of August 2016 the LAS 111 performance was 95.9%.

A situation report for the 24-hour period covering the first day of our inspection showed 95% of calls had been answered within 60 seconds.

There was evidence of improvements through the use of completed audits. The provider had undertaken two audits looking at the identification of sepsis in those under two years of age and emergency department referrals.

The purpose of the sepsis audit undertaken in March 2016 was to determine the accuracy of the use of NHS Pathways, determine the accuracy and management of sepsis indicators and review the effectiveness of the tools currently available to evidence safe and effective recognition and management of suspected sepsis in the under two year olds. A total of 256 patients were included in the audit. The results of the audit suggested that overall both call handlers and clinical advisors utilised NHS Pathways to conduct safe and appropriate assessment. An area of learning was identified related to clinical advisors' lack of probing and recognition of the relevance of a recent or current infection. The provider indicated that this had been addressed through further training.

An audit of emergency department referrals was undertaken in March 2016 to establish the reason for the increase in referral rates from 7.9% in March 2015 to 11.4% in February 2016. A total of 217 calls were audited for all clinical advisors from 1 March to 31 March 2016. Of these, 76 calls had the final disposition (outcome) of either 'emergency department referral one hour' or 'emergency department referral four hours'. The audit identified that out of the 76 calls, 27 were found to be inappropriate emergency department referrals, a rate of 35.5%. The inappropriate referrals were categorised into four groups: poor probing leading to inappropriate answers; no validation (not all of the call handlers questions had been

Good

Are services effective?

(for example, treatment is effective)

addressed); wrong Pathway selected, and downgrade from Green Ambulance. The provider shared the outcome data with frontline clinical staff, discussed in one-to-one meetings and told us they would continue to monitor emergency department referrals rates. Data provided for the month of August 2016 showed 11.8% of calls had been referred to the emergency department. Since our inspection, the provider has advised us that it will undertake an end-to-end audit with the local accident and emergency department to review the appropriateness of referrals and use outcome data to influence ongoing training.

Effective staffing

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

- The provider had a corporate induction programme for all newly appointed staff. This covered such topics as governance and risk, safeguarding, counter fraud, manual handling, health and safety and equality and inclusion.
- The internal induction period for new call handlers is the first two days of a four week training programme (six weeks for clinical advisors). The two day induction covered topics such as information governance, safeguarding level one, fire safety and evacuation, basic life support, equality and inclusion and slips, trips and falls. All elements of the induction produced a certificate on completion which is recorded in a training passport and maintained by the training team. During our inspection we observed coaches supporting new staff within the call centre.
- The learning needs of staff were identified through a system of appraisals, one-to-one meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support during sessions, mentoring, clinical supervision and facilitation and support. Staff told us they were given protected time to undertake mandatory training and paid overtime if training was not delivered during their shift.
- The provider declared an 88% compliance rate for appraisals in last 12 months. However, we noted at the time of the inspection that all staff available for work, except one, had had an appraisal within the last 12 months. The outstanding staff appraisal was due to be completed shortly after our inspection. The 12% non-compliance rate included staff members who were unavailable for appraisal due to long-term sickness leave and maternity leave. We were told appraisals for those returning from maternity leave would be undertaken within three to six months of their return depending on the length of their maternity leave.
- Staff received training that included the use of the clinical pathway tools, how to respond to specific patient groups, Mental Health Act, Mental Capacity Act, safeguarding, fire procedures and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. For example, duty of candour, equality and inclusion, fire safety and evacuation, infection prevention and control, information governance, manual handling, safeguarding.
- The provider monitored performance to ensure the NHS Pathways guidelines were being followed by randomly auditing patient calls. New staff had a minimum of six calls audited each month and existing staff a minimum of three calls per month were audited against a set of criteria such as effective call control, skilled questioning, active listening and delivering a safe and effective outcome for the patient.
- We saw evidence that NHS Pathways updates were forwarded through formal communication ahead of bi-annual upgrades. Staff we spoke with told us they had to be signed off on upgrades before they could resume taking calls.
- The provider could demonstrate how they ensured role-specific training and updating for relevant staff was managed through the use of a training matrix which the provider shared with us.

Working with colleagues and other services

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

- The provider met regularly with the contract commissioners to discuss all aspects of performance and was proactive in liaising with other service providers such as out-of-hours services and social services to ensure patients received the best outcomes.

Good

Are services effective?

(for example, treatment is effective)

- Work was undertaken to ensure the Directory of Services (DoS) was kept up to date. (The DoS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.)
- The provider was aware of the times of peak demand and had communicated these to the ambulance service. This included the arrangements to alert the ambulance service when demand was greater or lower than expected.
- Staff knew how to access and use patient records for information and when directives may impact on another service for example advanced care directives or do not attempt resuscitation orders.
- The provider had systems in place to identify 'frequent callers' and high intensity users of the service. Information about previous calls made by patients was available and staff could use this information where relevant to support the clinical decision process. The provider identified frequent callers through monthly audit with a threshold of six calls or more. The provider had lines of communication with 999 services, GPs and OOH providers to ensure a coordinated approach in the management of frequent callers. We saw that staff had access to an operational procedure for the management of frequent callers.

Consent

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and Gillick competency for children.
- Mental health awareness training was a component of the core module training for call handlers and clinical advisors. In addition, staff were also offered the opportunity to attend one of six training sessions offered by Mind, the mental health charity. The provider offered overtime payment for staff to attend outside their scheduled work hours. We saw that staff had access to information on assessing mental capacity and consent and capacity.
- The process for seeking consent was monitored through audits.
- Access to patient medical information was in line with the patient's consent.
- We observed that throughout the telephone clinical triage assessment process the call handlers checked the patient understanding of what was being asked of them. Patients were also involved in the final disposition (outcome) identified by NHS Pathways and their wishes were respected.
- Staff we spoke with gave examples of when they might override a patient's wishes. For example, when there was a potential significant risk of harm to the patient if no action was taken.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

The LAS 111 service sent out approximately 200 survey forms per month to obtain feedback from patients. The responses from patients were analysed and reported in the monthly contract report. For example:

- In March, 23 patient satisfaction surveys were returned. Of these, 16 (70%) were fully satisfied with the service,11 (48%) reported that they would have gone to accident and emergency is they had not been able to call 111, three (13%) would have dialled 999 if they had not been able to call 111 and 20 (87%) would recommend the service to friends and family.
- In April, 28 patient satisfaction surveys were returned. Of these, 17 (61%) were fully satisfied with the service, nine (32%) reported that would have gone to accident and emergency is they had not been able to call 111, nine (32%) would have dialled 999 if they had not been able to call 111 and 23 (82%) would recommend the service to friends and family.
- In May, 20 patient satisfaction surveys were returned. Of these, 15 (75%) were fully satisfied with the service, six (30%) reported that would have gone to accident and emergency is they had not been able to call 111, four (20%) would have dialled 999 if they had not been able to call 111 and 15 (75%) would recommend the service to friends and family.

The NHS Choices website allows users to comment on the service and to give a star rating. Two reviews had been placed on the website in the last 12 months, One review was positive and praised an efficient service and the other review was negative and criticised the unprofessional attitude of a clinician.

Patient Opinion is an independent non-profit feedback platform for health services which aims to facilitate honest and meaningful conversations between patients and providers. Five reviews relating to the LAS 111 service had been placed on the Trust's profile. Two of the reviews were positive and described an efficient, effective and 'marvellous' service. Three of the reviews were negatives with criticism regarding an inefficient service, lengthy questions and the unprofessional attitude of a clinician.

We saw evidence that patient experience results were highlighted in the monthly clinical governance report, to staff through a monthly newsletter and individual cases discussed directly with the staff concerned in one-to-one meetings.The provider shared with us 22 compliments they had received for the period 1 July 2015 to 31 July 2016. These related to helpful and sympathetic call handlers and clinical advisors. Positive patient feedback was shared with staff in one-to-one meetings and in a monthly newsletter.

New staff received training in equality and diversity during their induction and this training was updated for staff on an annual basis.

To assist access, the service provided:

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

Staff we spoke to on the day were aware of these facilities and we saw that information and links to all these services were on the NHS Choices website.

Care planning and involvement in decisions about care and treatment

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

Call handlers were confident using the NHS Pathways system and we observed that the patient was involved and supported to answer questions thoroughly. We also

observed that call handlers checked that the patients understood what was being asked of them and that they understood the final disposition (outcome) following the clinical assessment and what to do should their condition worsen. Staff used the Directory of Services (DoS) to identify available support close to the patient's geographical location.

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

The provider was introducing the use of MyBrainBook, an electronic tool/device used for people with dementia to store information about themselves (who they are, friends and family, interests, likes and dislikes, how they wish to be supported now and in the future). This information is used to inform their own personalised care and support plan which is owned by the person with dementia, and shared with people and organisations of their choosing to help keep in contact and coordinate care and support.

We saw that staff took time to ensure people understood the advice they had been given, and the referral process to other services where this was needed. This included where an appointment had been made by the NHS 111 service or where a request was to be made for a future appointment.

Patient/carer support to cope emotionally with care and treatment

Staff were trained to respond to callers who may be distressed, anxious or confused. Staff were able to describe to us how they would respond and we saw evidence of this during our visit. For example, we observed call handlers repeating instructions and clarifying information calmly and slowly to ensure the patient understood.

There were arrangements in place to respond to those with specific health care needs such as end of life care and those who had mental health needs.

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

The provider had systems in place to identify 'frequent callers' and high intensity users of the service. Information about previous calls made by patients was available and staff could use this information where relevant to support the clinical decision process. The provider identified frequent callers through monthly audit with a threshold of six calls or more. We saw procedures were in place to provide the appropriate support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service engaged with the NHS England Area Team and the lead Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, they had participated in a number of pilot schemes such as hosting a GP in the room, GP out of hours direct booking, enhanced triage of low acuity ambulance calls, shortened NHS Pathways for patients with dental problems to facilitate a safe and speedier referral to Out-of Hours (OOH) dental triage services available to patients in London.

- The provider offered a 24 hours a day, 365 days a week service.
- The service took account of differing levels in demand in planning it service. For example, the provider demonstrated how adjustments had been made to meet potential increases during the recent junior doctor strikes.
- There were specific care pathways for patients with specific needs, for example those at the end of their life, and babies and young children.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service.
- The service was able to book appointments for patients directly with some GP out of hours services, urgent care centres and extended hours 'hubs'.

The service monitored its performance against the Minimum Data Set (MDS) and Key Performance Indicators (KPIs) and these were discussed at monthly contract management meetings with commissioners. Where variations in performance were identified the reasons for this were reviewed and action plans implemented to improve the service.

Tackling inequity and promoting equality

- New staff had received training in equality and diversity during their induction and this training was updated for all staff on an annual basis.
- Staff we spoke with were aware of the language line phone facility (a translation/interpreter service) for patients who did not have English as their first language We saw language line contact details were available on each work station.
- The provider offered a text relay phone service for patients with difficulties communicating or hearing.
- The provider offered a video relay service that allowed a patient to make a video call to a British Sign Language (BSL) interpreter. The BSL interpreter would call an NHS 111 call handler or clinical advisor on behalf of the patient so they were able to have a real-time conversation with the NHS 111 adviser via an interpreter.

Access to the service

The LAS 111 offered a 24 hour a day, 365 days a week service for people living in South East London. Access to the service was via a free-of-charge telephone number. Call were answered at a single location in Croydon, South London.

Listening and learning from concerns and complaints

The provider had an effective system in place for handling complaints and concerns. Information about how to complain was available on the provider website. We saw operating procedures to guide call handlers, clinical advisors and team managers through the process of dealing with complaints. Staff we spoke with told us they would raise any complaints with their line managers.

The provider had received 33 complaints between 1 July 2015 and 31 July 2016. A complaint log was maintained which included a summary, outcome and the learning and action taken. The summary included details of call audits when undertaken. Complaint themes related to attitude, communication, and disposition (outcome) issues. Lessons were learnt from complaints and action was taken to improve the quality of the service. Nine of the complaints had concluded with an action of individual learning and four with site-wide learning. For example, the provider had coordinated some additonal training with the mental health charity Mind as it had identified mental health awareness as a theme.

We found all complaints had been handled appropriately, resolved satisfactorily and in a timely manner. When needed an apology was provided. For example, we saw an apology letter to a patient regarding a complaint about the unhelpful manner of a clinical advisor and poor experience of the 111 service. The letter concluded with information on how to contact the Health Service Ombudsman in line with guidance. The provider told us the complaint had been shared and discussed with the clinician involved.

Are services well-led?

Good

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

Our findings

Vision and strategy

The LAS 111 service had a clear vision to deliver a high quality service and promote good outcomes for people using the service.

- The Trust's vision and values 'care, clinical excellence and commitment' were displayed around the call centre and staff we spoke with were aware of the vision and the values of the service.
- In June 2016 the London Ambulance NHS Trust launched an organisational-wide campaign to promote the vision of 'Making the LAS Great'. The LAS 111 service extended the initiative and ran a programme of workshops in June and July 2016 'Making the LAS 111 A Great Place to Work'. The workshop saw specific issues emerge. For example, staff welfare, communication, training, LAS integration, recruitment, rotas, monitoring and performance. The provider shared with us an outcome document of 'what you said' and 'our response' which outlined feedback and action taken in response. For example, to improve communication a monthly newsletter 'Team Talk' had been launched and to make training more interactive face-to-face training opportunities had been arranged as a variance to the usual on-line training.
- The LAS 111 service had organised for staff in other roles from other areas of the Trust to come and visit the call centre in 'a day in the life of' initiative so other staff could see how the call centre operated. Feedback data was very positive. All responses indicated that the facilities were good and all would recommend a visit to a colleague.

The provider had an overarching strategy which reflected the vision and values and was regularly monitored. Planning and service provision involved managers and leaders from all functions within the Trust and included the NHS 111 team. Staff we spoke with on the day referred to a culture that was supportive and open and that the management team were approachable. Several agency staff told us it was a good place to work and they felt supported.

Governance arrangements

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

- There was a clear corporate and organisational staffing structure led by the centre operations manager who was supported by a management team responsible for operations, human resources, training, resource and planning. The direct patient service was delivered by six call centre teams comprising call handlers, clinical advisors, team managers and clinical quality improvement advisors overseen by a clinical operations manager. Staff we spoke with told us they were aware of their own roles and responsibilities within the structure.
- At the time of our inspection the LAS 111 service employed 113 staff, which equated to 88 whole time equivalents (WTE). The provider reported that there were 7.9 WTE call handler and 15.5 WTE clinical advisor vacancies. There had been an approximate 25% turnover of staff for both non-clinical and clinical roles in the past year. The backfill was predominantly provided by agency staff.The provider had listed its high reliance on agency staff as a risk on its risk register.
- Service specific policies were available to all staff and were up-to-date. Staff we spoke with on the day knew how to access policies and operating procedures on a shared drive.
- A comprehensive understanding of the performance of the service was maintained at all levels in the organisation. The provider attended monthly contract management and performance meetings with the commissioners and we saw evidence of minutes and performance reports.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. Specifically we saw evidence of end-to-end audits of call handlers and clinical advisors to ensure the safe and appropriate handling of calls using NHS Pathways. The provider also shared with us audits looking at the identification of sepsis in those under two years of age and emergency department referrals.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. The provider maintained a risk register which was visible to all staff. We observed that when gaps in service quality and performance were

Are services well-led?

Good

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

identified they were risk assessed and planned action implemented. We saw minutes of regular internal and external governance meetings and the provider produced a monthly clinical governance report which detailed both serious incidents and other incidents not meeting the Serious Incident Framework threshold. All staff we spoke with knew how to identify and report risks.

Leadership, openness and transparency

There were clear lines of accountability within the 111 service. Leaders had the capability and experience to lead effectively. Staff we spoke with were clear who to go to for guidance and support. They were clear about their line management arrangements as well as the clinical governance arrangements in place. They told us leaders were supportive and approachable. We saw a team notice board of 'who's who' to assist staff to visually understand the organisation structure.

Team managers and leaders were visible in the call centre. All staff we spoke with told us their immediate manager was approachable and feedback was given in real-time through 'huddles', and one-to-one meetings. Due to the different working patterns, team meetings were not possible. However team managers and clinical quality improvement advisors from the six teams met together. The provider produced a monthly staff bulletin 'Team Talk' which included service updates, performance data, training opportunities, patient survey feedback and achievement and celebrations.

We saw that candour, openness, honesty and transparency were encouraged. Staff we spoke with confirmed a culture of openness and said they felt comfortable raising issues and understood the duty of candour (the duty of candour is a set of specific legal requirements that provider of services must follow when things go wrong with care and treatment) and were able to give examples.

Senior leaders celebrated success and each year had an award ceremony which celebrated the dedication and commitment shown by staff to the service and its patients. We saw an award noticeboard with photographs of award winners which had included one of the LAS 111 team.

The provider demonstrated structured governance, organisation and management oversight by the Trust. We evidenced performance management scrutiny through Integrated Performance Reports presented at Trust Board level and quality and clinical governance at a Trust Board Sub Committee level.

Public and staff engagement

The service carried out regular surveys of patients who used the service and send out approximately 200 survey forms per month to obtain feedback from patients. The responses from patients were analysed and reported in the monthly contract report. The most current patient responses available on the day of our inspection for July showed:

- 40 patient satisfaction surveys were returned. Of these, 29 (59%) were fully satisfied with the service, 19 (39%) reported that would have gone to accident and emergency is they had not been able to call 111, 10 (20%) would have dialled 999 if they had not been able to call 111 and 40 (82%) would recommend the service to friends and family.

We saw an effective system in place for handling complaints and we saw evidence that the provider responded quickly to issues raised. All complaints were reported in a monthly clinical governance report and discussed in internal and external governance meetings.

We reviewed the most recent staff survey undertaken in September 2015. One hundred and three questionnaires were sent by post to all staff followed by two reminders in October and November. In total 48 responses were received (47%). Responses to the following questions showed:

- I look forward to going to work (44% sometimes; 15% often; 13% always).
- I am trusted to do my job (49% agree; 34% strongly agree).
- I am able to do my job to a standard I am pleased with (37% agree; 37% strongly agree).
- How satisfied I am with support from work colleagues (65% satisfied; 19% very satisfied).
- My immediate manager values my work (31% agree; 33% strongly agree).
- I know who the senior managers are here (49% agree; 25% strongly agree)
- My organisation encourages us to report incidents (54% agree; 17% strongly agree).
- I would feel secure raising concerns about unsafe clinical practice (58% agree; 8% strongly agree).

Are services well-led?

Good

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

- Care of patients is my organisation's top priority (33% agree; 38% strongly agree).
- If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation (57% agree; 13% strongly agree).

The 2016 staff questionnaire was due to be carried out shortly after our inspection.

The provider encouraged staff to come forward with ideas that could have a positive impact on our and staff experience and had launched an evidence for change protocol and form to submit ideas to the management team.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. We saw examples of continuous improvement and innovation within the service. For example, the service participated in a pilot study to review all DX011(Red Call) dispositions (outcomes). The ambulance service defines a Red Call as possible death and risk of imminent death. The purpose of the study was to better understand why the NHS Pathways assessment resulted in a higher than expected ambulance category disposition (outcome) than calls triaged through the 999 system and whether findings would support the future development of the NHS Pathways algorithms.