Trust Headquarters

Inspection 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 location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

We carried out an announced focused inspection of the NHS 111 at the North West Ambulance Service (NWAS) Trust Headquarters on 12 April 2022. The inspection formed part of a review of urgent and emergency care within the wider healthcare system.

We had an additional focus on the urgent and emergency care pathway and carried out several inspections of other services across a few weeks. This was to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures.

As this was a focused inspection, and we did not look at every key line of enquiry, we did not re-rate the service this time. At our previous inspection in May 2016 we rated The Trust Headquarters as good overall.

A summary of CQC findings on urgent and emergency care services in Lancashire and South Cumbria.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Lancashire and South Cumbria below:

Lancashire and South Cumbria.

Provision of urgent and emergency care in Lancashire and South Cumbria was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff felt tired and continued to work under sustained pressure across health and social care.

We found demand on urgent care services had increased. Whilst feedback on these services was mostly positive, we found patients were accessing these services instead of seeing their GP. Local stakeholders were aware that people were opting to attend urgent care services and were engaging with local communities to explore the reasons for this.

The NHS 111 service which covered the all of the North West area, including Lancashire and South Cumbria, were experiencing significant staffing challenges across the whole area. During the COVID-19 pandemic, the service had recruited people from the travel industry. As these staff members returned to their previous roles, turnover was high and recruitment was particularly challenging. Service leaders worked well with system partners to ensure the local Directory of Services was up to date and working effectively to signpost people to appropriate services. However, due to a combination of high demand and staffing issues people experienced significant delays in accessing the 111 service. Following initial assessment, and if further information or clinical advice was required, people would receive a call back by a clinician at the NHS 111 service or from the clinical assessment service, delivered by out-of-hours providers. The NHS 111 service would benefit from a wide range of clinicians to be available such as dental, GP and pharmacists to negate the need for onward referral to other service providers.

People who called 999 for an ambulance experienced significant delays. Ambulance crews also experienced long handover delays at most Emergency Departments. Crews also found it challenging managing different handover arrangements. Some emergency departments in Lancashire and South Cumbria struggled to manage ambulance handover delays effectively which significantly impacted on the ambulance service's ability to manage the risk in the community. The ambulance service proactively managed escalation processes which focused on a system wide response when services were under additional pressure.

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We saw significant delays for people accessing care and treatment in emergency departments. Delays in triage and initial treatment put people at risk of harm. We visited mental health services delivered from the Emergency Department and found these to be well run and meeting people's needs. However, patients experienced delays in the Emergency Department as accessing mental health inpatient services remained a significant challenge. This often resulted in people being cared for in out of area placements.

We found discharge wasn't always planned from the point of admission which exacerbated in the poor patient flow seen across services. Discharge was also impacted on by capacity in social care services and the ability to meet people's needs in the community. We also found some patients were admitted from the Emergency Department because they couldn't get discharged back into their own home at night.

Increased communication is needed between leaders in both health and social care, particularly during times of escalation when Local Authorities were not always engaged in action plans.

A summary of CQC findings on urgent and emergency care services in Cheshire and Merseyside (Liverpool, Knowsley and South Sefton).

We have summarised our findings for Liverpool, Knowsley and South Sefton within the Cheshire and Merseyside ICS below:

Cheshire and Merseyside (Liverpool, Knowsley and South Sefton)

Provision of urgent and emergency care in Cheshire and Merseyside was supported by services, stakeholders, commissioners and the local authority.

We spoke with staff in services across primary care, integrated urgent care, acute, mental health, ambulance services and adult social care. Staff had continued to work hard under sustained pressure across health and social care services. Services had put systems in place to support staff with their wellbeing, recognising the pressure they continued to work under, in particular for front line ambulance crews and 111 call handlers.

Staff and patients across primary care reported a preference for face to face appointments. Some people reported difficulties when trying to see their GP and preferred not to have telephone appointments. They told us that due to difficulties in making appointments, particularly face to face, they preferred to access urgent care services or go to their nearest Emergency Department. However, appointment availability in Cheshire and Merseyside was in line with national averages. We identified capacity in extended hours GP services which wasn't being utilised and could be used to reduce the pressure on other services. People and staff also told us of a significant shortage of dental provision, especially for urgent treatment, which resulted in people attending Emergency Departments.

Urgent care services, including walk-in centres were very busy and services struggled to assess people in a timely way. Some people using these services told us they accessed these services as they couldn't get a same day, face to face GP appointment. We found some services went into escalation. Whilst system partners met with providers to understand service pressures, we did not always see appropriate action taken to alleviate pressure on services already over capacity.

The NHS 111 service, which covered all of the North West area including Cheshire and Merseyside, were experiencing significant staffing challenges across the whole area. During the COVID-19 pandemic, the service had recruited people from the travel industry. As these staff members returned to their previous roles, turnover was high, and recruitment was particularly challenging. Service leaders worked well with system partners to ensure the local Directory of Services was up

Overall summary

to date and working effectively to signpost people to appropriate services. However, due to a combination of high demand and staffing issues people experienced significant delays in accessing the 111 service. Following initial assessment and if further information or clinical advice was required, people would receive a call back by a clinician at the NHS 111 service or from the clinical assessment service, delivered by out-of-hours (OOH) provider.

We found some telephone consultation processes were duplicated and could be streamlined. At peak times, people were waiting 24-48 hours for a call back from the clinical assessment and out of hours services. We identified an opportunity to increase the skill mix in clinicians for both the NHS 111 and the clinical assessment service. For example, pharmacists could support people who need advice on medicines. Following our inspections, out of hours and NHS 111 providers have actively engaged and worked collaboratively to find ways of improving people's experience by providing enhanced triage and signposting.

People who called 999 for an ambulance experienced significant delays. Whilst ambulance crews experienced some long handover delays at the Emergency Departments we inspected, data indicated these departments were performing better than the England average for handovers, although significantly below the national targets. However, crews found it challenging managing different handover arrangements at different hospitals and reported long delays.

Service leaders were working with system partners to identify ways of improving performance and to ensure people could access appropriate care in a timely way. For example, the service worked with mental health services to signpost people directly to receive the right care, as quickly as possible. The ambulance service proactively managed escalation processes which focused on a system wide response when services were under additional pressure.

We saw significant levels of demand on emergency departments which, exacerbated by staffing issues, resulted in long delays for patients. People attending these departments reported being signposted by other services, a lack of confidence in GP telephone appointments and a shortage of dental appointments. We inspected some mental health services in Emergency Departments which worked well with system partners to meet people's needs.

We found there was poor patient flow across acute services into community and social care services. Discharge planning should be improved to ensure people are discharged in a timely way. Staff working in care homes (services inspected were located in Liverpool and South Sefton) reported poor communication about discharge arrangements which impacted on their ability to meet people's needs.

The provision of primary care to social care, including GP and dental services, should be improved to support people to stay in their own homes. Training was being rolled out to support care home staff in managing deteriorating patients to avoid the need to access emergency services. We found some examples of effective community nursing services, but these were not consistently embedded across social care. Staffing across social care services remains a significant challenge and we found a high use of agency staff. For example, in one nursing home, concerns about staff competencies and training impacted on the service's ability to accept and provide care for people who had increased needs.

We found some care homes felt pressure to admit people from hospital. Ongoing engagement between healthcare leaders and Local Authorities would be beneficial to improve transfers of care between hospitals and social care services. In addition, increased collaborative working is needed between service leaders. We found senior leaders from different services sometimes only communicated during times of escalation.

This report covers the inspection of the Trust Headquarters NHS 111 service. The reports of previous inspections can be found by selecting the 'all reports' link for Trust Headquarters on our website at www.cqc.org.uk.

Overall summary

This report comprises information from a combination of:

- What we found when we inspected the provider
- Information from our ongoing monitoring of data about the provider and information from the provider, patients, staff, the public and other organisations.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **should** make improvements are:

- Continue to proactively monitor call demand to ensure staffing levels are appropriate.
- Continue to review call audit data to meet the required national targets.
- Continue with plan of safeguarding training for all clinicians.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC inspection manager, a GP specialist adviser and two CQC inspectors.

Background to Trust Headquarters

The provider, North West Ambulance Service (NWAS) NHS Trust, serves more than 7.5 million people across the communities of Cumbria, Lancashire, Greater Manchester, Merseyside and Cheshire.

The service covers 23 local authority areas and the following integrated care systems (ICS):

- Cheshire and Merseyside
- Greater Manchester Health
- Lancashire and South Cumbria
- North Cumbria as part of the North Cumbria and North East ICS
- Glossop as part of the Derbyshire ICS

The NHS 111 service is based at two call centres in Bolton and Liverpool and some clinicians work from home.

The NHS 111 service responded to 1.96 million telephone calls and online contacts in 2021.

The provider's vision is to be the best ambulance service in the UK, providing the right care, at the right time, in the right place; every time for patients accessing its urgent and emergency (999) care service, non-emergency patient transport service and NHS 111 service. The NHS 111 service is available 24 hours 7 days a week.

NWAS sub-contracts approximately 15% of calls to NHS 111 to Fylde Coast Medical Services (FCMS) out-of-hours service. The subcontractor provides a NHS 111 service on specific days and at specific times as agreed with NWAS. The leadership, management and responsibility for the contract to provide NHS 111 in the North West lies with NWAS who has developed a partnership approach to delivering NHS 111 services in the North West.

The service employs call handlers (health advisors and service advisors), clinicians and various other leadership and managerial roles.

NWAS NHS 111 was last inspected in May 2016 and rated good overall and for all key questions.

Inspected but not rated

Are services safe?

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had safety policies, including Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard those whose circumstances may make them vulnerable from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service worked with other agencies to support patients and protect them from neglect and abuse such as local safeguarding teams. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The provider had identified that clinical staff should be working towards level three child and adult safeguarding training and had a plan in place to achieve this. All other staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. The provider had identified people were contacting the service at different times of the day and week than what was traditionally experienced pre COVID-19 pandemic. As well as a peak in calls in the evening, the service also experienced a peak in demand on weekday mornings, particularly on Mondays and Tuesdays. They were in the process of adapting the staff rota's to meet this additional demand.
- The provider carried a 12.5% vacancy rate for call handling staff. This affected the ability to answer calls. This was due to large numbers of staff employed during the COVID-19 pandemic going back to their respective sectors, including the travel industry and additional non-recurrent funding in response to the COVID-19 pandemic. Regular recruitment days were held where the provider was successful at recruiting new staff. Additional staff had been trained to support and guide new staff coming into the organisation.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need.
- Systems were in place to manage people who experienced long waits.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Inspected but not rated

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, following a delay to a referral to the 999 service a change to the system was reviewed and updated so the correct pathway could be followed. In addition, shift lead staff had oversight of patients referred to other services for immediate care and treatment and could view when the care episode had been completed.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including agency staff.

The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service.

Inspected but not rated

Are services effective?

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- Telephone and online assessments were carried out using a defined operating model. Staff were aware of the operating model which included the transfer of calls from health advisor to clinician, and the use of a structured assessment tool.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. For example, staff had access to care plans for some patients which detailed their preferred care provider, in times of need, to support continuation of care.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with patients who contacted the service again. There was a system in place to identify frequent callers and patients with particular needs, for example palliative care patients, and care plans were in place to provide the appropriate support.
- Clear referral processes were in place when the patient was referred to another service. A clear explanation was given to the patient or person calling on their behalf and what to do if the patients condition changed.

Monitoring care and treatment

The provider had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Providers of NHS 111 services are required to submit call data every month to NHS England by way of the Minimum Data Set (MDS). The MDS is used to show the efficiency and effectiveness of NHS 111 providers.

We saw the most recent results for the provider (April 2021 to January 2022) which showed the provider was meeting the following national performance indicators:

- During the period the provider exceeded the KPI target of 95%, for a post event message to be sent to a patient's GP practice by 8am the following day.

There were areas where the service was outside of the target range for an indicator during the same period. For example:

- 25% to 28% of calls were closed as self-care. The recommended target for this is 50%. However, patients were referred onwards to other providers for further clinical advice as the service did not employ GP's, advanced nurse practitioners and pharmacist.
- Calls answered within 60 seconds ranged between 24% to 62% with the recommended target at 95%.
- The provider was consistently below target for referral and management of patients within the Clinical Assessment Service. Further training had been arranged for staff to promote the benefits the service could provide patients.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Inspected but not rated

Are services effective?

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered such topics as safeguarding adults and children, NHS pathways training and health and safety matters.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- Staff were provided with ongoing support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The provider had identified that all clinicians needed to be trained to level three for safeguarding adults and children and had plans in place to achieve this.

Coordinating patient care and information sharing

Staff worked together and with other organisations to deliver effective care and treatment.

- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that required them. Staff were empowered to make direct referrals and/or appointments for patients with other services. However, staff told us that these arrangements were not always effective during busy times due to the volume of patients being passed onto the clinical assessment service (CAS) and out-of-hours services, delivered by other providers. For example, further calls were made to 111 from people who experienced a delay in another service contacting them. In order to manage this, NWAS NHS 111 service had developed a real time tool for other providers to input their call back times. Staff could then inform people of expected call back times when their care was passed to the other provider.
- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. Care and treatment for patients in vulnerable circumstances was coordinated with other services. Staff communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established pathways for staff to follow to ensure callers were referred to other services for support as required. The service worked with patients to develop personal care plans that were shared with relevant agencies.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- An electronic record of all consultations was sent to patients' own GPs.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- Issues with the Directory of Services were resolved in a timely manner. For example, we saw that representatives from each local area worked with NHS 111 staff to keep directories up to date when the time and locations of services being delivered changed.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

Inspected but not rated

Are services effective?

- The service identified patients who may be in need of extra support. For example, the service employed mental health nurses who could offer specific advice and support for those with poor mental health.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Inspected but not rated

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those experiencing poor mental health.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times.

Inspected but not rated

Are services responsive to people's needs?

Responding to and meeting people's needs

The service had seen a significant increase in demand as a result of the COVID-19 pandemic.

- In January 2019 there were 178,728 calls made to the service, of which 7.9% were abandoned.
- In January 2022 there were 210,472 calls made to the service, of which 22.4% were abandoned.

The provider understood the needs of its population and tailored services in response to those needs. NWAS NHS 111 was the first point of contact for people to access care delivered by other providers in the area, particularly the 14 separate clinical assessment services and all GP out-of-hours provision. NWAS NHS 111 engaged with commissioners to secure improvements to services where these were identified following on from the COVID-19 pandemic.

- Over the past two years the profile of calls to the service had changed. Pre COVID-19 pandemic the service became busier in the evening. During and since the pandemic the service was also busier on Monday and Tuesday mornings between 8am to 10am and again in the evening. Staff were rostered 12 weeks in advance. This change in demand had led to a change in rosters for some staff.
- The provider was successful during the COVID-19 pandemic in recruiting staff from other sectors, such as the travel sector. As lockdown eased these staff returned to their previous roles which peaked at 45% attrition rate in February 2022. As a result, the provider analysed staff exit interview feedback and had introduced additional staff benefits for those remaining in post and clinics to support staff booking annual leave.
- The provider had a system in place that alerted staff to any specific safety or clinical needs of a person using the service. For example, those receiving end of life care.
- Care pathways were appropriate for patients with specific needs. For example, babies, children and young people.
- A pilot was in place to offer specialist advice to children and young people in the Merseyside and Cheshire areas.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

The NHS 111 service can be accessed 24 hours a day on every day of the year either by ringing 111 or via NHS 111 online.

Patients were not always able to access care and treatment from the provider within an appropriate timescale for their needs.

During the period April 2021 to January 2022:

- The abandoned call rate ranged between 7.7% in April 2021 to 32% in January 2022. The national target and commissioner key performance indicator is 5% or less.

The provider was aware of the areas where they were not meeting targets and we saw evidence that attempts had been made to address them through close working with their commissioners. Measures included advanced monitoring and reporting of performance data, recruitment of staff and increased use of call handling networking capabilities. For example, increasing the capacity from another provider to answer the calls. We saw that patients with the most urgent needs had their care prioritised.

The provider undertook audits of calls to ensure the outcomes for patients. The number of the required audits undertaken had increased to 90% in March 2022 compared to 70 % in January 2022. Due to the COVID-19 pandemic the service experienced high numbers of staff absence in January 2022. To increase the number of audits undertaken further staff had been recruited to the quality assurance team to undertake the required audits.

Inspected but not rated

Are services well-led?

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it. They were cited on the risks and had plans in place to mitigate them. For example, planning ahead to ensure adequate trainers and support staff were available to induct new staff into the organisation and roles.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them and were working with commissioners and other service providers to improve care for patients. For example, reviewing patient pathways with other providers to reduce duplication of assessment.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Culture

The service had a culture of high-quality sustainable care and staff worked hard to maintain this despite lower staffing levels.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff told us they were kept informed of learning from feedback. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. For example, following feedback information staff needed for their role could be made more accessible a small working group was convened to improve the shared drive and implement the improvements required. This resulted in staff having access to specific information at the time they needed and could convey this information to patients.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. For example, during the COVID-19 pandemic call taking staff were given an additional 20 seconds between each call to prepare for the next.
- The provider had identified the impact of working throughout the COVID-19 pandemic had on staff and their wellbeing. Some staff had been trained as mental health first aiders to support their colleagues at work. This included offering confidential conversations with colleagues about mental health matters to promote wellbeing. We received feedback that this was a great initiative and safe space to have conversations with others who were there to support and guide.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Inspected but not rated

Are services well-led?

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations and referral decisions. Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local commissioning CCG as part of contract monitoring arrangements.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The provider had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.