Quality and Safety Report – Norfolk, Wisbech & Waveney OOH and NHS 111

(July – September 2018)

Report Overview

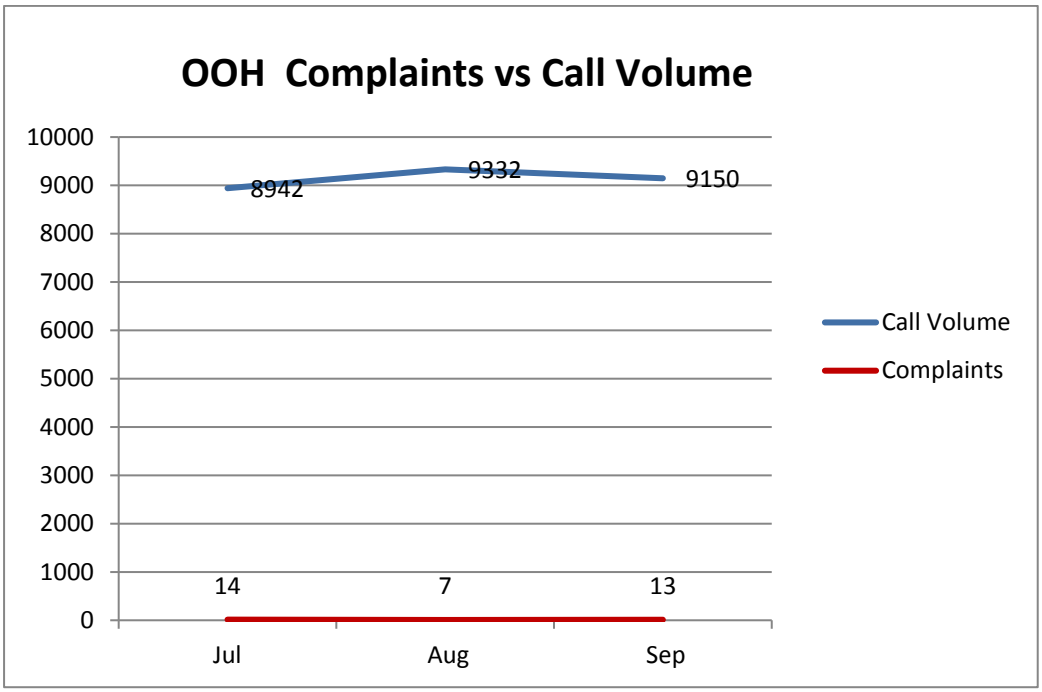
This is the Quality and Safety reported produced for the Norfolk and Wisbech (NOR) locality for both the OOH and NHS 111 service that IC24 provide. This report covers the quarter of July 2018 to September 2018.

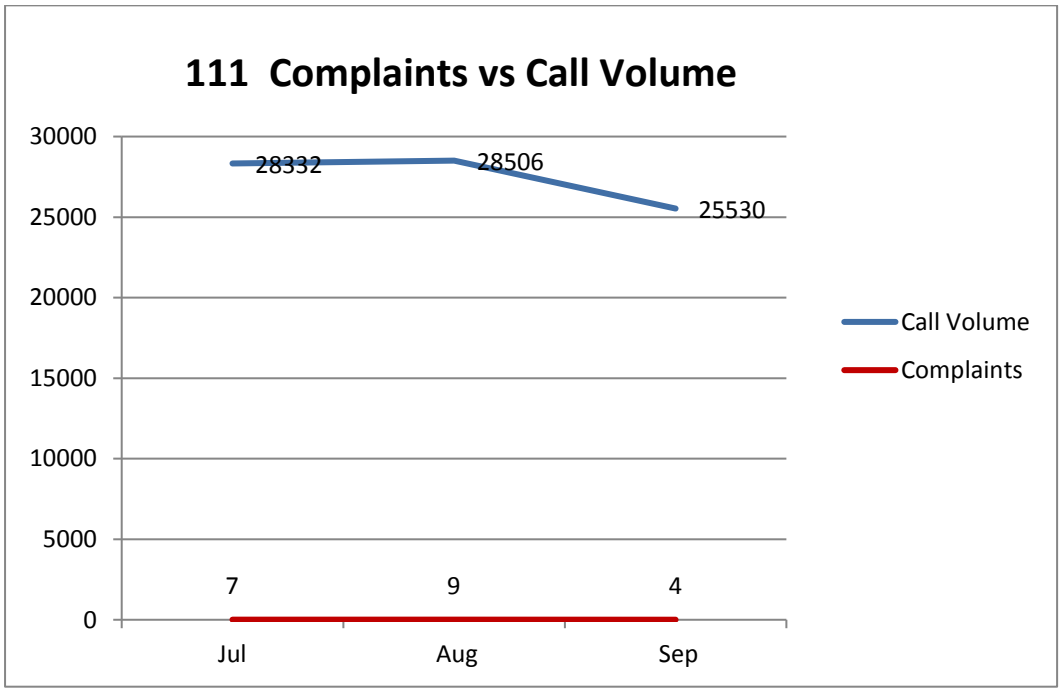
This report provides information on the complaints, incidents (including serious incidents) and compliments that have been raised and received during this period for both services. Some of the incidents reported include negative Patient Experience Questionnaires which are investigated in line with the incident procedures. During this time, there was one long weekend over the August Bank holidays and the report reflects the challenges faced over the hottest summer with increased call volumes vs staffing challenges.

Components of this report are discussed in Monthly Call Review meetings and specific attention is given to key incidents and complaints upheld following investigation, audit results and incidents raised by other organisations.

Key lessons identified from the triangulation of audits, complaints and incidents, have been derived from the information reported, with clear actions taken to improve the overall quality of the NHS 111 and OOH service.

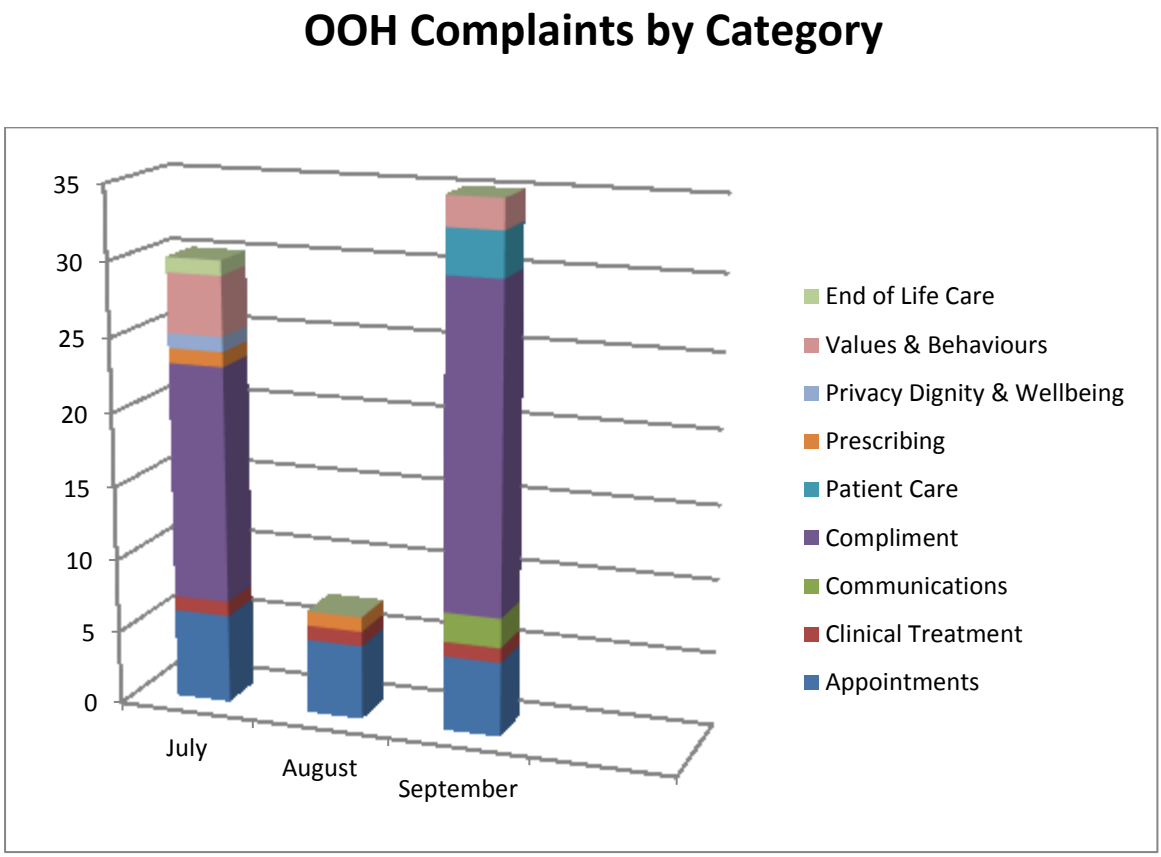
1. Complaints (111 and OOH)





The above figures include complaints where consent was not received but investigation completed, as well as complaints which were withdrawn.

1.1 Complaint Themes



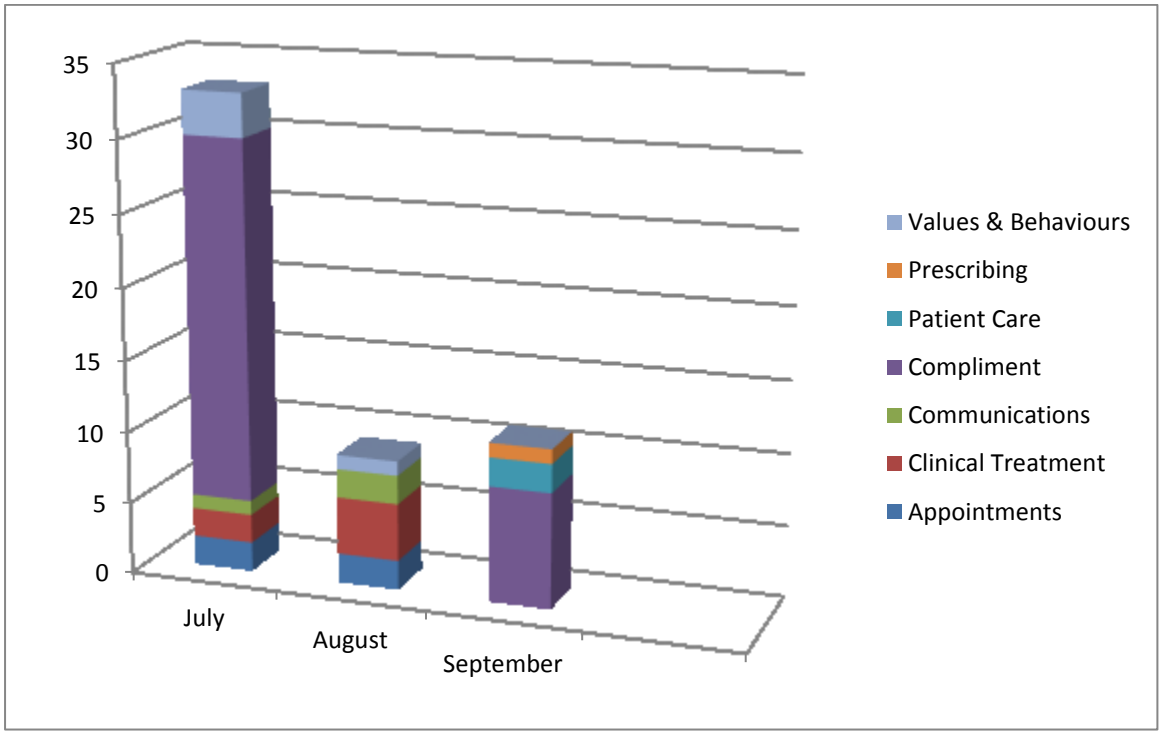
None of the complaints in the OOH service resulted in harm to patients. Most of the complaints in the OOH service (16) relate to

- Delays in telephone call back
- Delays in home visits
- Delays in base appointment

On review, most of the complaints coincided with operational challenges such as staffing gaps due to sickness, leave and hours requiring recruitment which is now in process. As part of the investigations, it is apparent that the Comfort Calling procedure had not been enacted in most of the cases, where delays were anticipated.

Some of the complaints were withdrawn or not upheld following investigation [*paragraph redacted under Section (2) (40) – personal information*].

111 Complaints by Category

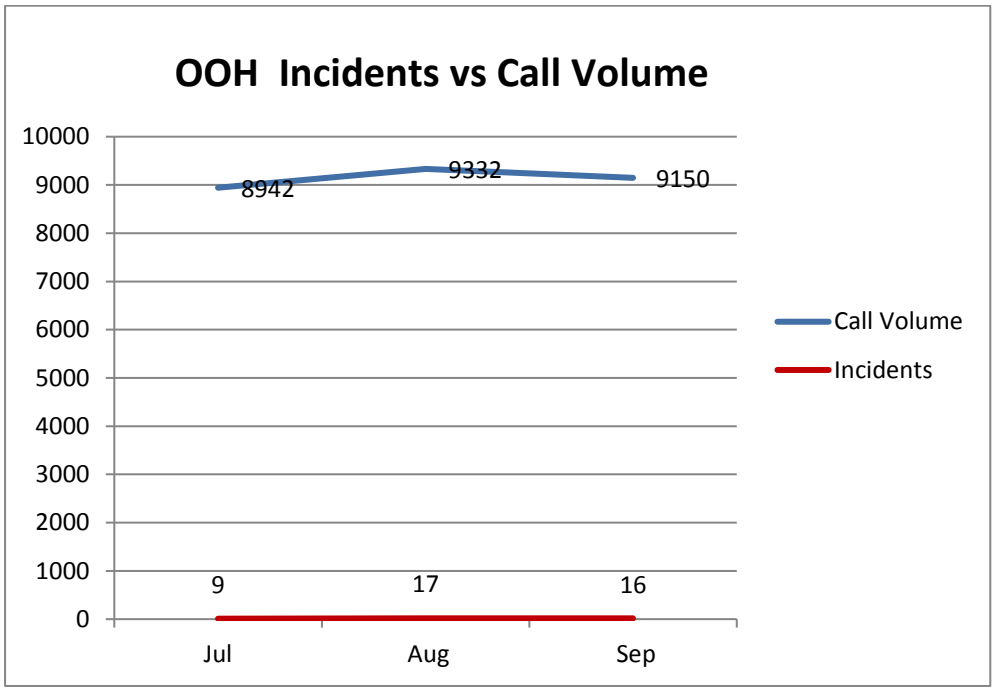


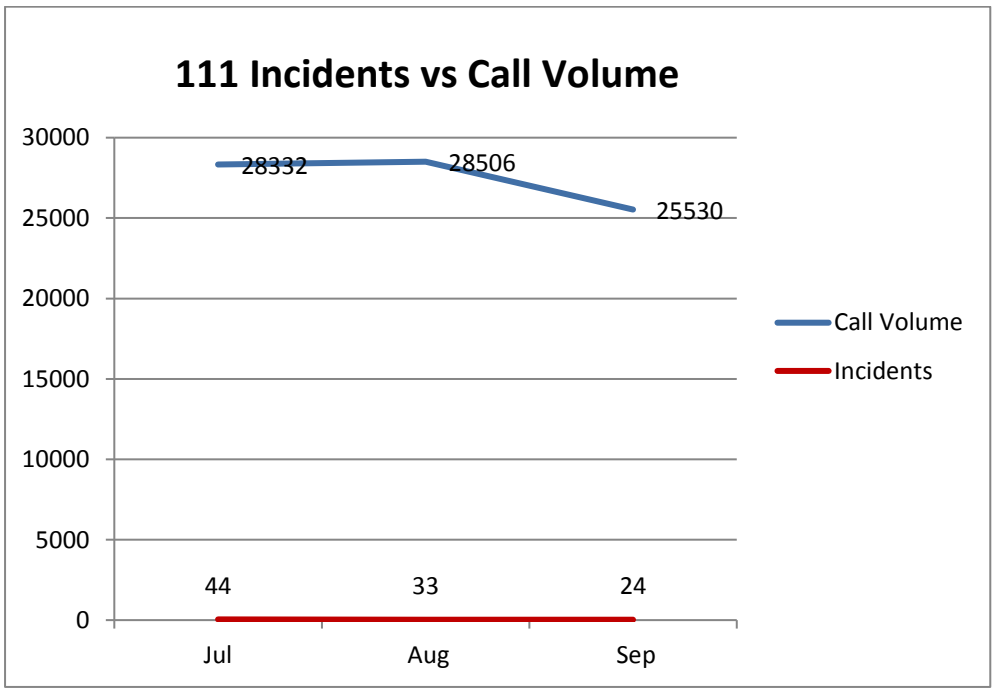
Despite higher call volumes in comparison to OOH service, the NHS 111 service received fewer complaints in the quarter. Most of the complaints were received in July and August with a significant drop in September 2018.

[*paragraph redacted under Section (2) (40) – personal information*].

Some of the clinical treatment complaints related to dental cases where patients were not happy that the service could not address their dental concerns. On review of the complaint, this was not upheld as the advice given was in line with current arrangements for dental calls. Similar dental complaints were also logged as perceived staff attitude. Where staff attitude has been of concern following review of telephone recording, one to one and feedback conversations have taken place.

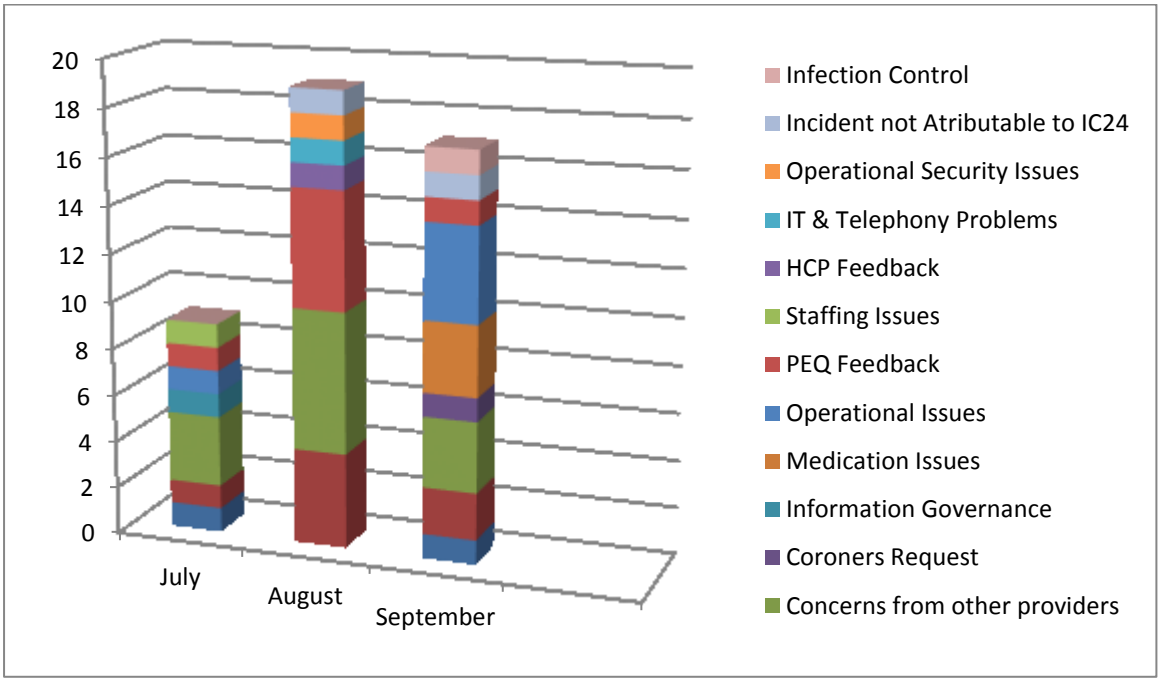
2. Patient Safety (111 and OOH)





2.1 Incident Themes

OOH Incidents by Cause

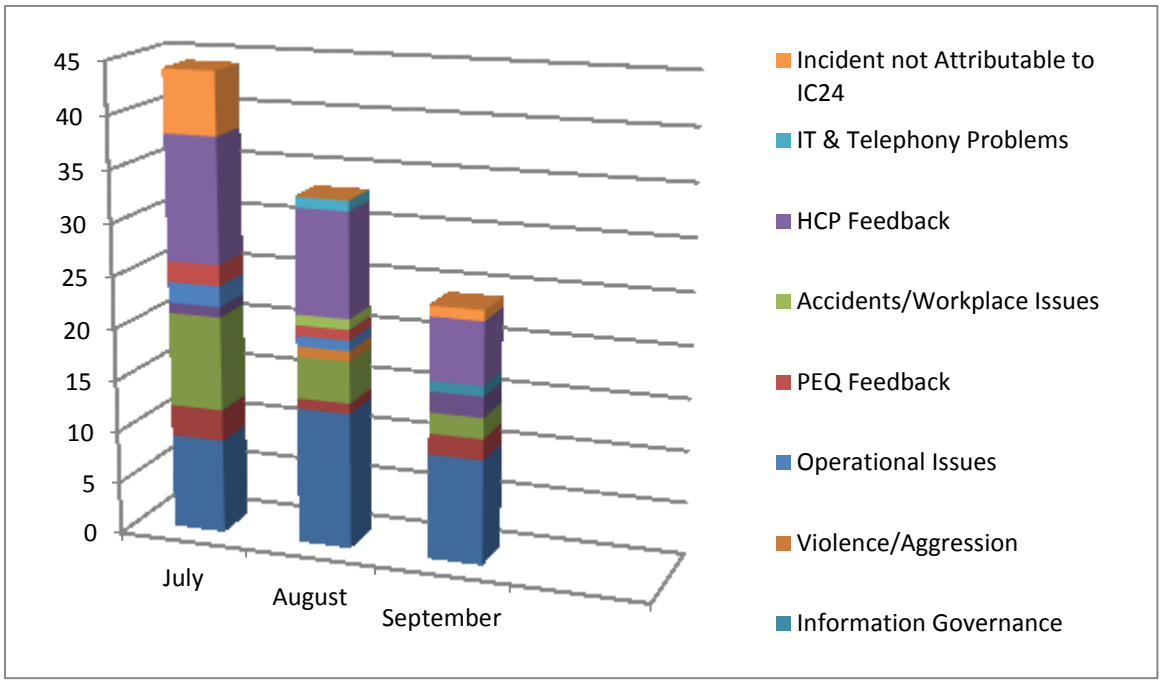


A total of 42 incidents were reported in the OOH service in the quarter. Therefore the number of incidents remained static as 42 incidents were reported in the period April to June also. The above includes incidents not attributable to IC24 which were forwarded to the relevant services in line with the healthcare professional feedback process. None of the incidents resulted in a serious incident. Concerns from other providers include:

- Reported incident regarding medicines cupboard found unlocked at one of the primary care centres (duplicate incident in operational issues)
- Delays in verification of death
- Delays in call back by GP when paramedics seeking advice via the HCP line

The majority of operational issues in the quarter relate to gaps in vehicle checks which were reported from one base and this is now a standing agenda item on base meetings as well as daily vehicle checks which are audited by Service Delivery Managers monthly.

111 Incidents by Cause



A total of 101 incidents were reported in Q2 against 82368 contacts with the NHS 111 service (less than 0.1%). One of the incidents resulted in a Serious Incident (SI) as noted under the SI section.

Most of the incidents were health care professional feedback, which includes DOS issues for patients on the Thetford border (as reported by Care UK). This was escalated to the DOS Lead for investigation. Concerns from other providers include incidents raised by other services such as EEAST requesting a review of the pathways selected (in one incident, the wrong pathway had been selected therefore concern upheld).

Majority of the NHS 111 service issues relate to incorrect Pathways being selected by Pathways Advisors. These are picked up during audit and feedback is provided to Pathways Advisors. Where patient outcome is not known, contact is made with the patient to ensure correct level of investigation is undertaken. Pathway Advisor scores are also shared in the monthly Call Review meeting and actions taken to address these issues are shared with the Commissioners. This includes over-audit, support plans and return to the graduation bay when required.

All incidents not attributable to IC24 were forwarded to relevant organisations for investigation and response.

2.2 Serious Incidents/Never Events

111

Month	Serious Incidents	Never Event
July	1	0
August	0	0
September	0	0

OOH

Month	Serious Incidents	Never Event
July	0	0
August	0	0
September	0	0

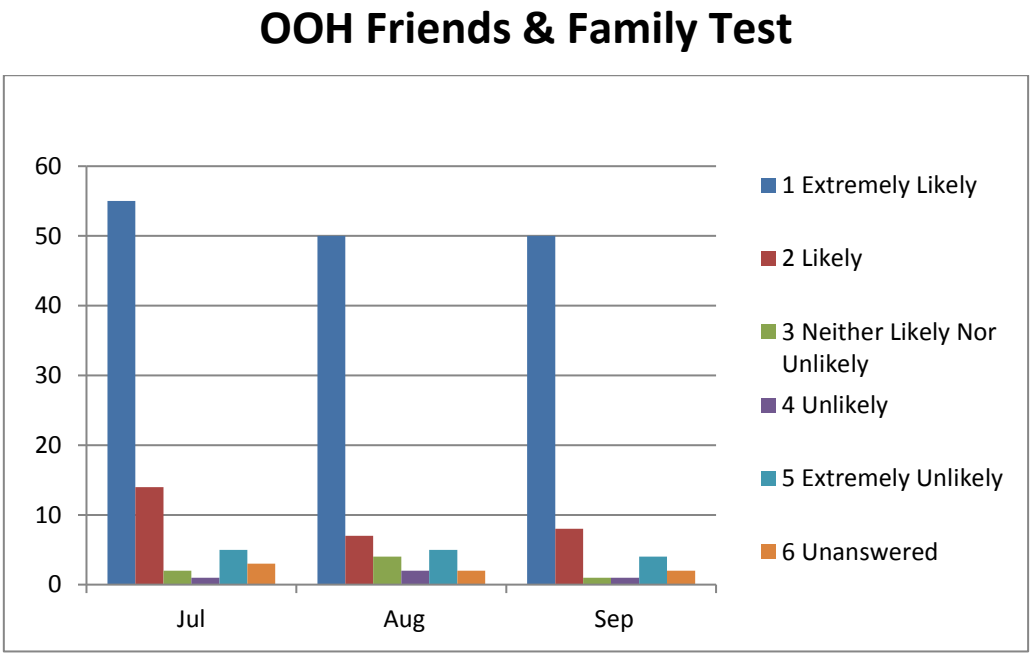
There was one serious incident reported in July [*paragraph redacted under Section (2) (40) – personal information*]. The key learning from this serious incident was to change policy such that Pathway Advisors and get the caller to confirm their address instead of them reading out the caller's address prior to ambulance despatch. A case study was also developed around this case to be incorporated in Pathways Advisors Training sessions.

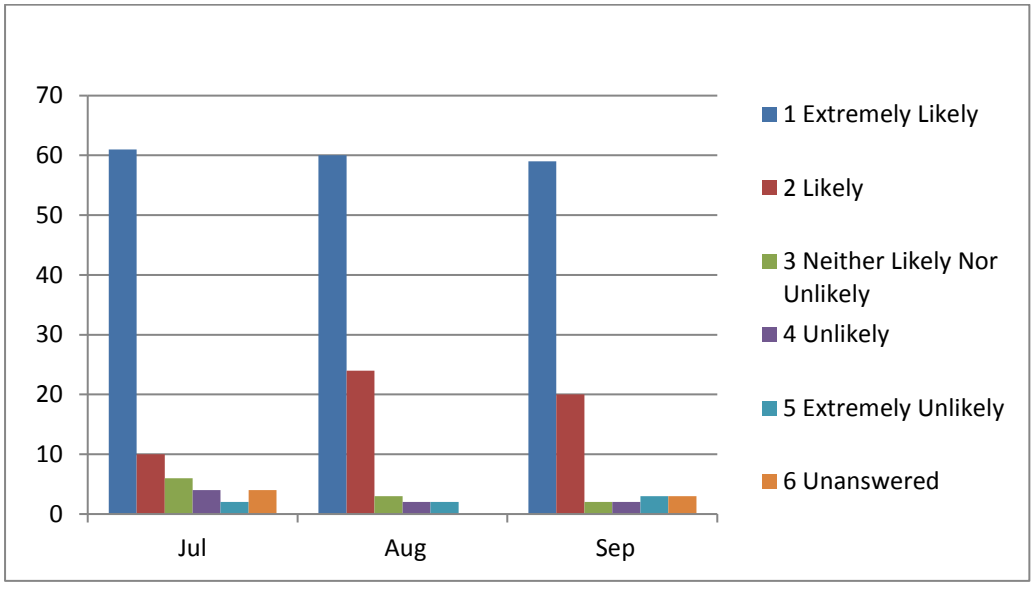
3. Compliments (111 and OOH)

Examples of compliments received for both the 111 and OOH service

111	*"I have the utmost confidence in this service and also the NHS in dealing with my sickness"*
111	*"The person I spoke to over the phone was very kind and reassuring. I was upset and she was lovely, also patient with me while I composed myself, thank you!"*
111	*"The call handler who took my initial call was absolutely lovely, empathetic and Kind - a real credit to the service".*
111	*"Very good and reassuring attitude of all staff members and I rate you all 10 out of 10"*
111	*"Fantastic service. I've used for [paragraph redacted under Section (2) (40) – personal information] several times - would recommend and hope it continues"*
OOH	*"Very happy with the service received. The clinician that visited was very good and kind"*
OOH	*"The clinician that saw my daughter was polite and professional. He had a lovely manner and provided a very thorough examination"*
OOH	*"I was seen very quickly and dealt with kindly and professionally".*
OOH	*"I got given an appointment and was seen really quickly. The prescription was written up and given with minimal waiting time"*
OOH	*"I was very happy with the service received from OOH. The Doctor attended my home address within half an hour and spent an hour with me. Thank you".*

3.1 Friends and Family Test





Whilst the number of Friends and Family test is low compared to the volumes of calls, it is reassuring that most of the returns show that most of the patients will be happy to use the NHS 111 and OOH service again. Continued efforts are made to improve the service provision so that we reduce the number of patients who are unlikely to use our service again.

Patient Experience (111 and OOH)

3.2 PEQ Scoring

111 PEQ			
Month	**Call Volume**	**Number Sent**	**%**
July	28332	354	1.25%
August	28506	348	1.22%
September	25530	354	1.39 %

OOH PEQ			
Month	**Call Volume**	**Number Sent**	**%**
July	8942	275	3.08%
August	9332	240	2.57%
September	9150	255	2.79%

4. Audits

All Clinicians	Norfolk and Waveney	Total
All Questions	**92.06 %**	**92.08 %**
Q1 - Reason	98.65 %	98.66 %
Q2 - Emergency	85.83 %	85.86 %
Q3 - History	85.68 %	85.70 %
Q4 - Assessment	94.46 %	94.46 %
Q5 - Conclusions	96.69 %	96.70 %
Q6 - Empowering	96.88 %	97.06 %
Q7 - Management	95.73 %	95.74 %
Q8 - Prescribing	93.52 %	93.52 %
Q9 - Safety Netting	79.94 %	79.98 %
Q10 - Rapport	95.83 %	96.00 %
Q11 - IT	98.03 %	98.04 %

All staff have received their audit feedback for the months of July to September. Each member of staff has at least one case audited per month and the results are discussed at Call Review. Where audit is below the threshold of 80%, clinicians are over-audited; however, no clinician scored under 80% in this quarter. Staff are

reminded to provide full safety netting advice to patients that includes calling NHS111, 999 or contacting own GP if symptoms worsen, and not to generalise.

5. Mandatory Training

Course	NHS 111 Conical	NHS 111 non Clinical	OOH Clinical	OOH Non Clinical
Violence and aggression	83.8%	85%	77.6%	67%
Equality & Diversity	89.7%	85.9%	75.5%	73.8%
Infection Control	89.7%	84%	71.4%	70.2%
Information Governance	76.5%	84%	59.2%	76.2%
Health and Safety	91.2%	85.4%	83.7%	72.6%
Safeguarding Adults	94.1%	94.4%	77.6%	83.3%
Safeguarding Children	92.6%	93.9%	77.6%	85.7%
Manual Handling	91.2%	85.4%	81.6%	72.6%
Fire Safety	91.2%	84.5%	81.6%	72.6%
Fraud Prevention	94.1%	93.4%	79.6%	89.3%

IC24 introduced a new learning portal: Learn24, therefore all staff training records were transferred from the previously utilised ATF records. There are ongoing issues to address some discrepancies in the data transferred to reflect actual position. We are working closely with the corporate learning and development team to ensure that this is accurate. A report has been run to check staff who have never logged on to the new portal so that targeted contact is made to improve compliance and ultimately support safe practice.

6. Other Quality Matters

IUC staff engagement workshops

Staff engagement workshops were held throughout the month of July to raise awareness among staff on the IUC model and National Workforce Blueprint. This was also an opportunity for staff to ask any questions and get them involved in the future of urgent care delivery in Norfolk. Clinical and non-clinical staff from NHS 111 and OOH attended the four sessions led by the Senior Management Team. Feedback was sought from staff via Survey Monkey and this was very positive.

Base Meetings

Clinical and non-clinical staff were invited and attended five base meetings held in September. These meetings were held at Thetford, Kings Lynn, North Walsham, Norwich and Lowestoft bases. This was an opportunity to thank staff for their contributions during the difficult summer and also reinforce some of the key lessons identified from complaints and incidents.

Quality Champions Programme (QCP)

IC24 Quality Champions programme commenced in September and Clinical and non-clinical staff registered to join the cohort. The QCP equips staff to influence change within the work place. Staff will attend four one-day workshops that focus on quality improvement and give them the tools, understanding and support to make changes. Staff will also design a quality improvement project on a topic of your choice that will benefit the locality.

7. Key Learning and Actions Taken

Comfort calls need to be made to patients when demand on service is unexpectedly high and resource cannot meet expected timeframes.

- *Reception staff involved have received direct feedback and this is now a standing agenda item on the Base meetings for continued emphasis on the matter*.

There were gaps in the rota attributed to hours that needed recruiting into.

- *Recruitment has taken place for 5 Urgent Care Practitioners and more bank ANPs*

Perceived lack of empathy when Pathway Advisors and clinicians are speaking to patients over the phone.

- *Individual feedback provided to staff involved to be more empathetic when speaking to patients, with emphasis on active listening.*

Pathway Advisors not always selecting the correct pathway due to deficiencies in skilled questioning and other elements of telephone assessment skills– picked up from audits.

- *Individual feedback given to staff and audit feedback given to the training team proactively for training purposes.*

Staff need to take collective responsibility in medicines management following the incidents raised by other providers on cupboards found unlocked.

- *Direct feedback given to staff involved as well as discussed at base meetings.*
- *Communication sent to all staff to ensure that cupboards are locked when not in use and compliance will be monitored via monthly audits.*

Drivers need to ensure that they check vehicles at the start of their shift to ensure they have all the equipment required when out on home visits.

- *Individual feedback given and now standing agenda item for base meetings.*
- *Escalated concern for consideration regarding number of oxygen cylinders to be carried in home visiting cars corporately. Working group for medical devices now active to review this.*

Staff mandatory training compliance figures are very low and this is a combination of data transfer issues and staff not using the new Learn24 portal.

- *Communication has gone to all staff on how to log onto Learn24.*
- *Mandatory training forms part of the standing agenda items for base meetings, Executive meetings and staff PDR process.*
- *To support learning for clinicians, we will be starting some evening educational sessions with experienced GPs once a month on primary care cases*
- *Work with the Learning and Development Team to ensure that data provided is accurate and reflects a true position of staff mandatory training for internal and external assurance purposes*