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The NHS Integrated Urgent Care Workforce Development Programme was set up jointly between NHS England and Health Education England in April 2015. Running over 3 years, the programme will create a blueprint for the workforce, including standardised job descriptions, core and specific role competencies, training and education development, accreditation, apprenticeships and a career framework. The programme aims to support the development of a sustainable future workforce in Integrated Urgent Care (IUC) / 111 by enabling transformational change within commissioning and frontline services, all of which will help increase patient and service user safety, satisfaction and effectiveness.

This **Workforce Investment Fund Evaluation Report – Phase 1**, highlights the opportunities for development of the diverse IUC / 111 workforce. Enabled by programme investment, nineteen varied pilot projects were run by providers and commissioners to help to identify and evidence new ways of working and best practice across a mix of themes including complicated incidents, enhancing clinical capability, staff attrition and understanding and reporting staff related mental illness.

The outcomes of pilot projects demonstrate the importance of building in opportunities for career progression, staff retention and professionalisation of the workforce. Projects demonstrated the need to maintain staff wellbeing by providing timely mental health support and addressing staff grievances, as well as, the importance of developing a better understanding and response to case-mix and workload issues.

The Workforce Investment Fund – Phase 2, will run in 2017 and is focussed around 8 key themes - integrated urgent care - introduction of Clinical Assessment Service (Clinical Hubs), patient perspective, new workforce models, mental health competencies, recruitment and retention, workforce governance and oversight, integration across Urgent and Emergency Care, and projects which build on pilots from Workforce Investment Fund phase 1.

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NHS Integrated Urgent Care Workforce Development Programme Evaluation Synthesis Report

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Contents

| | |
|--|----|
| Summary | 3 |
| 1 Background..... | 5 |
| 1.1 NHS 111..... | 5 |
| 1.2 The NHS Integrated Urgent Care Workforce Development Programme | 5 |
| 1.3 NHS 111 Competency Framework | 6 |
| 1.4 The NHS 111 Workforce Investment Fund (WIF)..... | 7 |
| 2 The projects in the WIF programme | 8 |
| 3 Evaluation of the projects | 15 |
| 3.1 Evaluation support..... | 15 |
| 3.2 Phase 1: Initial review of proposals..... | 15 |
| 3.3 Phase 2: Support and advice | 16 |
| 3.3 Phase 3: Review of draft project reports | 19 |
| 3.4 Phase 4: Synthesis of project outcomes | 20 |
| 4 Learning from the evaluation..... | 21 |
| 4.1 Profile of projects-..... | 21 |
| 4.2 Learning by theme | 22 |
| Theme 1 Review of complicated incidents | 23 |
| Theme 2 Enhancing clinical capability of the services, including the development of multidisciplinary clinical hubs | 25 |
| Theme 3 Attrition and retention | 27 |
| Theme 4 Understanding and supporting work related mental illness | 29 |
| 4.3 Overall learning from the evaluation | 31 |
| 5 Discussion | 33 |
| 5.1 Key learning points | 33 |
| 5.2 Strengths and Limitations | 34 |
| 5.3 Conclusion..... | 34 |
| Appendices | 36 |
| Appendix 1 | 37 |
| Appendix 2 | 78 |

List of Tables

| |
|--|
| Table 1: NHS 111 Workforce Investment Fund Themes |
| Table 2: NHS 111 Workforce Investment Fund Project Profile |
| Table 3: Workshop Attendees |

List of Abbreviations

| | |
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| CCG | Clinical Commissioning Group |
| HEE | Health Education England |
| LTC | Long term conditions |
| OOH | Out of Hours |
| WIF | Workforce Investment Fund (WIF) |

Summary

The NHS Integrated Urgent Care Workforce Development Programme supports the development of the future NHS Integrated Urgent Care call centre workforce, aiming to improve services for patients across England. A Workforce Investment Fund (WIF) was set up jointly by NHS England and Health Education England (HEE) to facilitate this work. Under the WIF funding scheme, project proposals under four themed topic areas and an 'other' category were invited from provider organisations working in partnership with their local Clinical Commissioning Group (CCG). A total of 19 project proposals from across England were successful.

As part of their funding remit, each project team was required to include an evaluation component within their project and report on this in their final report to funders. In consideration of the complexity involved in evaluating projects, NHS England and HEE contracted Swansea University, in collaboration with Sheffield University, to provide guidance and evaluation support to projects and to produce a synthesis of evaluation findings. Four experienced members of the evaluation support team provided feedback on the evaluation component of each project proposal and arranged two evaluation support workshops. During the workshops project teams were able to share practice and to discuss issues concerning project delivery and evaluation with funders and the support team, who were present at both events. The evaluation support team offered advice to projects on their draft reports; in particular focusing on the evaluation component of each report.

This report is a synthesis of the evaluation component of the reports on the pilot projects, providing an overarching narrative of outcomes and future direction. The findings highlight the challenging time schedule for delivering projects which placed constraints on the range and depth of evaluation that provider organisations were able to undertake. This in turn has placed a limit on the transferability of learning that can be drawn on from each evaluation report. However, there is some learning from these projects which can inform future workforce development initiatives, particularly related to promoting uptake amongst staff and including staff views in the development of courses and other staff support interventions. New data has been drawn together about workload and linkage of data has allowed new understanding of interfaces between NHS 111 and primary care as well as care home workload. Overall the findings from the 19 projects indicate the importance of addressing workforce attrition issues through training and education, building in career progression and professionalisation, and maintaining staff well-being by providing timely mental health support and addressing staff grievances.

Inclusion of a requirement for evaluation in these commissioned projects has allowed the use of methods to gather quantitative and qualitative data and to report these data in a structured manner. Provision of evaluation support to plan and deliver these evaluations has allowed providers to consider their desired outcomes and to collect data in a focused way to address these outcomes. In particular, drawing together projects through evaluation support workshops provided a forum for discussion, development of evaluation skills and for communication between projects and commissioners.

1 Background

1.1 NHS 111

The NHS 111 service is a free 24 hour telephone service available across England that aims to address any urgent medical healthcare needs of the general public which are not a 999 emergency. The service is staffed by trained, non-clinical call handlers (Health Advisors) who are supported by clinical advisors and clinical supervisors who are nurses and paramedics.

A caller to the NHS 111 service may have their enquiry dealt with by a call handler who will assess their symptoms using NHS Pathways Clinical Decision Support Software (CDSS). Once symptoms have been identified the call handler will triage the patient, and so direct the patient onwards to an appropriate local service which can address their needs. Where 'self-care' is advised, then a nurse or paramedic will talk the patient through each step. As and when difficult or complex cases arise, the call handler will pass on information gleaned from the patient to clinicians for further advice and appropriate action.

1.2 The NHS Integrated Urgent Care Workforce Development Programme

The NHS Integrated Urgent Care Workforce Development Programme is a joint programme of work between NHS England and Health Education England (HEE). It was set up in April 2015 aiming to support and develop an optimal NHS 111 / Integrated Urgent Care call centre workforce, and is planned to run for three years. The objectives of the programme were to improve current and future delivery of

urgent care through: a) increasing the clinical capability and support within NHS 111 services for staff; b) managing problems with staff attrition and high turnover; c) decreasing ambulance conveyance to emergency departments; and d) increasing the proportion of calls resolved through 'hear and treat'.

To achieve these objectives, local Clinical Commissioning Groups (CCGs), NHS 111 providers and local education and training groups are being encouraged to work in partnership. The work of the programme includes developing new and innovative training based on best practice, creating a set of workforce competencies for integrated urgent care, and identifying ways to improve quality, patient safety and best practice, whilst supporting the health and wellbeing and career structure of staff working within the services.

1.3 NHS 111 Competency Framework

The NHS 111 Competency Framework supports the move to a new Integrated Urgent Care service, accessed through the 111 telephone number. The framework sets out a clear career structure, highlighting skills levels and competencies for job roles within NHS 111 and future Integrated Urgent Care models of work. In addition, the framework sets out the skills, behaviours and competencies required for both clinical and non-clinical staff, to continually improve the safety and quality of patient care.

To ensure that the NHS 111 Competency Framework is robust and fit for purpose, Effective Workforce Solutions Ltd (EWS), a training company specialising in workforce development in the health and social care sectors, along with HEE have

been working with two NHS 111 providers to support the research and work necessary to successfully develop competencies mapped to the right behaviours and skills needed in a modern NHS 111 / Integrated Urgent Care call centre workforce. In addition, NHS England and HEE have established an NHS 111 Workforce Investment Fund (WIF). The fund has enabled NHS 111 provider organisations to set up a number of projects to test and evaluate initiatives for improving the effectiveness of the NHS 111 workforce.

1.4 The NHS 111 Workforce Investment Fund (WIF)

The NHS 111 WIF was introduced to support workforce improvements within existing NHS 111 provider organisations across England. Clinical commissioners and providers of NHS 111 services were asked to put forward proposals with innovative ideas which would support one or more of the core themes (see Table 1).

Table 1: NHS 111 WIF Themes

| | |
|---------|--|
| Theme 1 | Review of complicated incidents to analyse trends and enhance staff development. This includes getting ‘closure’ for clinical and non-clinical staff around their interactions with patients |
| Theme 2 | Enhancing clinical capability of the services including the development of multi-disciplinary clinical hubs |
| Theme 3 | Staff attrition and retention issues of the workforce – providing benchmarking data to help assess and improve staff turnover rates |
| Theme 4 | Understanding & supporting work related mental health needs of the workforce |

| | |
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| Theme 5 | Other areas not covered by the above four themes |
|---------|--|

The purpose of the WIF programme was to augment the strategic development of the NHS Integrated Urgent Care Workforce Development Programme by providing evidence, information, and examples on ways to enhance practice. In 2015, NHS England and HEE selected 19 projects from 15 CCG areas which were awarded funds from the WIF programme to support project ideas.

Project groups were required to complete their projects within a set timeframe. Funds were released in December 2015 by the fund holders, NHS England, through Clinical Commissioning Groups. The timescale for implementation of project proposals, delivery and evaluation of project outcomes, and presentation of a final report to NHS England and HEE, was four months (December 2015 - April 2016).

2 The projects in the WIF programme

A brief profile of all 19 WIF projects is presented in Table 2, and shows participating CCGs and their partner provider organisations, along with the project topic area, theme, aims and description.

Table 2 NHS 111 Workforce Investment Fund Project Profile

| Project No. | Lead CCG organisation/111 provider | Project topic | Project theme | Aims and description of project |
|-------------|---|---|---|--|
| 1 | North Essex CCG/Integrated Care 24 Ltd | “Professionalization” of the call handler role within the 111 Urgent Care Setting | 1 Complicated incidents and 3 Attrition and retention | To increase the quality and experience of the NHS 111 call handler workforce by nationally accrediting call handling staff. To also identify appropriate distance learning packages for call handlers and to support trainers through training course. |
| 2 | Greater Huddersfield CCG/Yorkshire Ambulance Service NHS Trust | NHS 111 Recruitment and retention – modified induction and support programme | 3 Attrition and retention | To test an amended induction programme extending the training period by two weeks and providing additional support to establish long-term efficiency gains in comparison to the model currently in use. |
| 3 | Greater Huddersfield CCG/ Yorkshire Ambulance Service NHS Trust | Complicated incidents – staff requested end-to-end reviews | 1 Complicated incidents | To test the value of introducing an end-to-end review process that includes frontline staff. Allowing staff to request reviews of specific patient contact in the case of complicated incidents. |

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|---|---|--|---|--|
| 4 | Stafford & Surrounds & Cannock CCG/ Staffordshire Doctors Urgent Care | Improving Health & Wellbeing of NHS 111 Call centre staff at Staffordshire Doctors Urgent Care | 3 Attrition and retention | To improve absence, reduce attrition rates (by 25%) and drive up quality, through activities including: 1) Health and wellbeing drop in sessions for all staff; 2) Resilience, leadership & wellbeing training sessions (managers & all staff); and 3) Incentive scheme to reward attendance and high performance. |
| 5 | Cambridgeshire and Peterborough CCG | Developing an NVQ qualification and career structure for health advisor staff in 111 | 2 Enhancing Clinical Capacity and 3 Attrition and retention | To create a series of development opportunities for 111 clinical and non - clinical staff, including a Diploma/ NVQ for non-clinical staff to address workforce issues such as development/promotion and developing/maintaining skills sets. |
| 6 | Bristol, North Somerset and South Gloucestershire CCG/Care UK | Understanding human and system factors in 111 | 1 Complicated incidents | To use a root cause analysis approach to examine human and system factors within NHS 111 which have contributed to serious incidents, and the potential for improvement |

| | | | | |
|----|--|---|---|---|
| 7 | Somerset CCG/Vocare | Understanding attrition and retention in the workforce | 3 Attrition and retention | To identify those factors which need addressing in order to successfully attract new staff to join the NHS 111 service and retain existing staff. |
| 8 | Somerset CCG/Vocare | Staff training and dispositions | 1 Complicated incidents and 2 Enhancing Clinical Capacity | To identify the training needs of Call and Clinical Advisors in their role for six months or more, with a view to developing training materials to form the basis of a toolkit for all NHS 111 services to increase staff confidence and competence. |
| 9 | North West London CCG/London Central and West Unscheduled Care Collaborative | Use of pharmacists in integrated unscheduled primary care hub (111/OOH) | 2 Enhancing Clinical Capacity | To deploy an independent prescribing pharmacist for a pilot period of 3 months in the integrated out of hours setting to utilise their skills on medication queries, repeat prescription requests and the treatment of a selected cohort of patients with minor mental illness. |
| 10 | New Devon CCG/ South West Ambulance Service Foundation Trust | 111 How Are You? | 4 Mental health needs | To conduct a mental health and wellbeing audit focusing on all staff within NHS 111, to enable interventions to be developed in order to make improvements to staff wellbeing performance and retention rates. |

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|----|---|--|---|--|
| 11 | Richmond CCG/Care UK | The Use of Schwartz Rounds in 111 to support the work-related mental health needs of the staff | 4 Mental Health Needs | To introduce Schwartz rounds into the 111 environment with the aim of reducing attrition and sickness rates amongst 111 staff. |
| 12 | South Worcestershire CCG/Health Education England West Midlands | Training in teamwork and communications skills for NHS111 and OOH clinicians and call handlers | 3 Attrition and retention | To test the concept of a Telephone Consultation and Distance Health Assessment training module. Clinicians / non-clinicians will be offered to take part in one day (two sessions) training with supplementary online eLearning training in telephone consultation skills and peer-to-peer support. |
| 13 | SWALE CCG/South East Coast Ambulance NHS Foundation Trust | Improving NHS 111 clinician skill set and ability to handle calls relating to Mental Health | 1 Complicated incidents and 2 Enhancing Clinical Capacity | To facilitate better quality interactions between 111 Clinical Advisors and patients suffering mental health related issues, by developing a specialist training program to support the 111 Clinical Advisors who do not have mental health as a specialist skill set and to facilitate access to patient care plans when dealing with 'live cases'. |
| 14 | SWALE CCG/ South East Coast Ambulance NHS Foundation Trust | Improving NHS 111 clinician skill set and ability to handle calls relating to the | 1 Complicated incidents, 2 | To refine a training program for 111 clinicians and a 'train the trainer' course respectively in order to improve understanding in the use of toxbase and to up-skill the 111 clinicians, and so improve operational effectiveness, patient safety, pressure on |

| | | | | |
|----|---|---|---|--|
| | | ingestion of poisonous and toxic substances | Enhancing Clinical Capacity and 4 Mental Health Needs | the GP OOH's services and service user satisfaction.. |
| 15 | North Derbyshire CCG/ Derbyshire Health United | Introduction of Pharmacists into the workforce of the NHS 111 & Out of hours Integrated Service | 1 Complicated incidents and 2 Enhancing Clinical Capacity | To demonstrate that pharmacists can be part of the NHS 111 skill mix providing clinical support to the service by increasing closure rate and reducing calls requiring onward referral. |
| 16 | Tower Hamlets CCG/Partnership of East London Co-ops | Improving pathways for patients with long term conditions | 1 Complicated incidents and 2 Enhancing Clinical Capacity | To use clinical modelling to better understand how different patient cohorts with long term conditions (LTC) use 111. To inform the development of a 111 workforce model and the design of improved LTC pathways to deliver appropriate care more quickly. |

| | | | | |
|----|--|--|---|---|
| 17 | Sandwell and West Birmingham CCG/West Midlands Doctors Urgent Care | Residential and Care Homes Pilot Phase 1 | 1 Complicated incidents and 2 Enhancing Clinical Capacity | To analyse the range of calls from Residential Homes (Residential and Care) to NHS 111, using in-depth analysis to identify and plan better models of working with Residential Homes and to test how best to use NHS 111 services to benefit such patients. |
| 18 | East & North Herts CCG | Enhanced teaching and joint call reviews to support 111 staff development | 1 Complicated incidents | To increase the learning of Health Advisors and Clinical Advisors through eight themed weeks of a hands-on learning approach. |
| 19 | East & North Herts CCG | Enhanced review to understand staff retention and attrition issues of the 111 workforce. | 3 Attrition and retention | To analyse factors that affect attrition and retention of NHS 111 Health Advisors and Clinical Advisors. To develop entrance and exit templates for all NHS 111 providers to collect data on staff attrition and retention rates. |

3 Evaluation of the projects

3.1 Evaluation support

Support for project teams in evaluating their work through the WIF programme was provided by Swansea University with support from the University of Sheffield. The team included four qualified and experienced staff members who worked with project leads from January 2016 to April 2016. The evaluation support team aimed to support project partners through the challenges of project evaluation, helping them to focus attention towards important details such as goals, progress and outcomes during key stages of project development, and to encourage continuous discussion and feedback among project team members and stakeholders. All members of the evaluation support team were aware that WIF funded projects were operating within strict time constraints which may have had a bearing on how projects were able to evaluate processes and outcomes.

Evaluation support was provided in three phases. During each phase the team took measures to ensure that projects were provided with timely opportunities to communicate their aims and progress, and to seek guidance when required.

3.2 Phase 1: Initial review of proposals

In January 2016, the evaluation team sent an introductory email to all the 15 CCG project leads covering the 19 commissioned projects, describing how evaluation support would be provided. Project team leads were informed that the evaluation team would carry out an initial critical review of each project proposal focusing on the

evaluation component with the aim of supporting and enhancing the evaluation of each project. Project proposals were reviewed to check that they:

- had clear and relevant objectives
- had detailed appropriate and achievable methods
- included outcomes that match objectives and are feasible to collect within the timescale
- included service user (patient/public) representatives in processes of design and execution
- were in broad alignment with NHS Strategies and direction
- were feasible in terms of resources
- were supported within their organisation

Each project evaluation plan was reviewed by two members of the evaluation team, using a standard reporting form to ensure validity. For each, both reviewers' comments were synthesised and a final version of the review was emailed to the respective project team lead.

3.3 Phase 2: Support and advice

Once the initial review phase was complete, all project leads were offered a telephone discussion with their assigned lead reviewer at a convenient time, to discuss their proposals for evaluation and received tailored support and advice. All but three of the projects took up this offer. During these calls the evaluation team reviewed the methods, findings and interpretation(s) with the lead from each project

team, highlighting any concerns about quality, accuracy and validity. Due to the tight timescale for this work, projects were advised to prioritise quantitative outcomes that are available routinely, rather than needing to collect data specifically for the evaluation. As far as possible, project leads were guided towards common outcomes that could then be combined and compared across projects. Complementary qualitative approaches were also supported where they were clearly defined and focused.

Following the tailored support discussions over the telephone, two regional workshops were arranged, a week apart, in two locations to facilitate attendance. One workshop was held in London in late February and the other in Sheffield in early March. The workshops aimed to bring together members of the project teams in order to:

- provide project teams with guidance on straightforward and achievable approaches to evaluation
- provide a place for project leads/team members to discuss common challenges and opportunities with the evaluation team and funders
- enable projects to link in with project teams in other areas and to build a professional working relationship
- identify key implementation issues with Workforce Investment Fund projects
- share ideas and ways to overcome difficulties in implementation
- discuss the format of their final report to support standardisation across projects

To ensure that the aims of the workshops were met, each project lead was asked to provide in advance a one page summary of their project prior to the workshop, using a template devised by the evaluation team. These project summaries were shared with all the delegates who attended the workshops. In total 16 project summaries were distributed and shared.

Although some project leads/team members were unable to attend the workshops due to prior commitments, the majority of projects were represented at one or other of the meetings. Attendance included team members from CCGs and from provider organisations, as well as from the commissioners of the WIF programme at NHS England and HEE. A breakdown of workshop attendees is provided in Table 3. Both workshops were lively and stimulating, with supportive discussion among delegates, who gave positive feedback on the events.

Following the workshops, feedback was provided to all project teams on the key issues raised by project leads/members. PowerPoint presentations made at each workshop by members of the evaluation team and NHS England and HEE were also shared.

Table 3: Workshop attendees

| NHS 111 Workforce Investment Fund workshops <i>Evaluation support</i> | | | |
|---|---|--|-------|
| | London workshop February 25 th 2016 | Sheffield workshop 3 rd March 2016 | Total |
| Number of CCG project areas represented | 6 | 6 | 12 |
| Number of project team leads/members attending | 10 | 11 | 21 |
| Evaluation team attending: Swansea University and University of Sheffield | 4 | 2 | |
| Funders attending: NHS England/HEE | 6 | 4 | |

Throughout this period the evaluation team continued to provide tailored support and constructive feedback to each CCG project team on revising and delivering their evaluation plans, by email and through telephone calls.

3.3 Phase 3: Review of draft project reports

All projects were required to submit their final report to NHS England and HEE by 30th April 2016. The evaluation team were on hand to review draft reports should project teams require guidance in terms of how they reported on the evaluation component of their project. To support this undertaking, the evaluation team developed a standard reporting template along with guidance notes. The template was relevant for reporting the full project, but primarily concentrated on the

evaluation component of the report. It included a brief outline of project activities, outcomes, and plans for future evaluation, acknowledging that not all evaluation activities would be delivered within the funded timeframe of the project. In total, only four of the nineteen individual project teams sought advice from the evaluation team prior to submitting their final report.

Once draft final reports had been submitted, the evaluation team assessed each CCG's project report against the specification contained in the call for bids, and checked that the teams were reporting on everything which they said they would do in their proposals. The STROBE checklist used for reporting observational studies was used to check reports. The checklist is widely used in health services research (www.strobe-statement.org). The team reviewed the evaluation component of each report looking closely at analysis and reporting plans, for rigour and achievability.

3.4 Phase 4: Synthesis of project outcomes

To share learning from the WIF pilots, the funders commissioned the evaluation support team to write an overarching report, combining and where possible synthesising results from across all projects. The synthesis report summarises methods used and data collected, including a section on strengths and limitations, and draws together conclusions and recommendations from across projects

4 Learning from the evaluation

4.1 Profile of projects-

The WIF-funded projects cover 15 different CCG areas in England; four CCGs were successful in securing two projects each. Most of the WIF projects were located in the south of England (nine). Three projects were located in the north of England and seven in the west of England. On average each project received £36,000 worth of funds (range £15,500 - £65,000) to deliver their project.

The majority of projects have managed to deliver their project objectives within the allocated timeframe. However, many of the project teams have remarked in discussion, and in some cases in their report, that this has proved challenging, especially when any delays to the start of projects were encountered.

In terms of providers, five of the projects were concerned with 111 services delivered by ambulance trusts; nine with services delivered by other not-for-profit providers; and five with services delivered by for-profit providers.

Most projects focused on three thematic areas around managing complicated incidents, enhancing capacity and staff training, and addressing attrition and retention. Many projects responded to more than one theme, emphasising the overlapping nature of the issues. Only two projects focused primarily on improving staff mental health and wellbeing, though one other did refer to this area.

Six of the projects (6,7,8,10,16 and 17) were concerned with carrying out analysis or audit of the current activity of NHS111, in order to support the development of new interventions, either in terms of support for staff or care pathways. Approaches to this included analysis of routine data (in the case of Project 16, through an innovative approach to linked data) and the conduct of surveys. The remaining projects included some element of development or intervention. These included new training programmes (Projects 1,5,12,13,14 and 18); new approaches to review and supervision of staff (Projects 2,3 and 19); new models of support offered either one-to-one or in a group setting (Projects 4 and 11); and new staffing models, bringing pharmacists into the 111 setting (Projects 9 and 15). In all cases, the work carried out during the funded project period represents just one phase of a development programme, with plans in place for continuation, expansion or roll out of the intervention to other sites. This meant that evaluation was generally not concerned with outcomes, but with establishing a baseline against which future change could be measured, and with examining the process and feasibility of the change introduced.

Appendix 1 contains a description of the evaluation undertaken of each project, and the learning produced. In the sections below, we provide an overarching review of the learning by theme, and also reflect on the overall evaluation process.

4.2 Learning by theme

Below, we report key learning points by theme. Some of the projects are reported under more than one theme heading, because they were identified by the relevant project team as addressing more than one theme. Four of the projects had not yet

submitted a final report at the time of writing, so we can report on what they did but not on any evaluation.

Theme 1 Review of complicated incidents

Three projects tackled head-on the question of how an NHS 111 provider organisation and individual staff can best learn from complicated incidents. Project 3 and Project 18 worked directly with staff to deliver end to end reviews of difficult cases as a form of training, while Project 6 addressed the topic at a more organisational level, using root cause analysis to conduct an analysis of adverse incidents.

Learning points: Project 3 End to End Reviews – Yorkshire Ambulance Service

Call handling staff were invited to request a review of a specific patient contact, in order to understand the final outcome.

Staff were invited to attend group end to end review sessions – a total of 22 attended three sessions in the pilot. Sessions were facilitated by the Head of Nursing and QA.

Each session reviewed two cases. Staff listened to a recording of the call, reviewed the outcome, and discussed what happened.

The project team collected anonymous written feedback on the day, then 30 days later. They also observed the sessions and took notes. They found:

- A very positive response from those attending, and high levels of engagement
- Staff produced useful suggestions for how to improve processes
- Staff reported that their confidence had increased
- Staff had improved insight into the patient journey

- The sessions helped create better mutual understanding of the roles of call handlers and clinical advisors

The pilot will be continued for 6 months. The estimated cost of delivering two sessions per month is £8,500 for a full year – mainly to cover the cost of staff time for attending.

Learning points: Project 18 End to End reviews – East and North Hertfordshire

The project team delivered a series of 8 weekly facilitated learning events, each on a particular theme, e.g. mental health calls. Each lasted two hours, and included the presentation of up to 4 recordings of 111 calls, review of best practice guidance, and discussion. Each group consisted of up to 18 call handling staff, along with facilitators from the CCG and the 111 provider.

Staff were invited to book into as many sessions as they were interested in. After the session they were invited to complete anonymous self-scoring feedback via SurveyMonkey.

Interest among staff was high and the programme was oversubscribed. A total of 31 attended – 28% of them going to 4 or more sessions.

The project was very positively received and revealed a strong desire for more in-service training. It also revealed some gaps in call handlers' knowledge.

Other projects addressed the topic of complicated incidents in other ways. Project 1 looked at how training can be improved to help call handlers in their role. Projects 13

and 14 both considered call categories identified in the service as often being complicated to deal with – mental health and substance ingestion respectively. Project 16 examined demand from patients with long term conditions, and found that this group was more likely than others to be referred on to an ambulance or other clinician – though in the majority of cases they do not call for symptoms directly related to their long term condition. Project 17 analysed calls from care homes, and found these were another group which tended to be complicated – in this case, evidenced by the fact that they take 18% longer than a typical NHS 111 call. Project 15 took a different approach, introducing an intervention – community pharmacists working alongside NHS 111 – to take on some of the burden of complicated calls.

Theme 2 Enhancing clinical capability of the services, including the development of multidisciplinary clinical hubs

Some projects addressed this theme by exploring ways to broaden the skill mix of those delivering the 111 services by introducing new professional groups to the service, while others focussed more on training up existing staff.

Projects 9 and 15 both took the former route, introducing prescribing pharmacists into integrated 111/GP OOH clinical hubs with the aim of resolving calls involving medications quickly and safely without having to pass them on to a GP or other service provider, while at the same time meeting patient expectations. In both cases, the providers responded to what they perceived as a ready supply of qualified pharmacists, and brought them into the service at weekends only, to match demand. Project 15 reported encouraging results in their evaluation (see box below). Project 9 was still at an earlier stage of development at the time of reporting, but was still able

to share useful learning about the need for careful, supervised induction of the pharmacists into the service, and the importance of them having access to the medical records. Project 16, in Tower Hamlets, planned to build on their modelling of care pathways for people with long term conditions by looking for ways to expand the staff skill mix to better meet the needs of this patient group.

Learning points Project 15 Introduction of pharmacists into the workforce of NHS 111 and Out of Hours integrated service – Derbyshire Health United

The project aimed to find out how pharmacists based in NHS 111 could increase efficiency by reducing call length and closing more calls without onward referral.

The evaluation looked at both process and outcomes and used mixed methods, based on routine data, an online survey of staff, and questionnaires to patients. It found:

- Pharmacists were able to close calls without onward referral in 93% of cases – much higher than usual practice
- There was a reduction in the length of calls about medications
- Other NHS 111 staff appreciated having the pharmacists in the team
- Those patients who responded to the questionnaire were satisfied with the service.
- Clinical audit suggested that the quality of the pharmacists response to calls was good.

The service plans to continue with using pharmacists, and to add non-prescribing pharmacists to the workforce, in addition to those with prescribing qualifications.

Other projects addressed this theme through training initiatives. Project 5 in Cambridgeshire and Peterborough aimed to develop a new NVQ qualification for health advisor staff, with the aim of improving turnover rates and supporting career progression, though identified challenges in terms of accommodating the range of clinical backgrounds of health advisors. Project 8 assessed the training needs of clinical and call-handling staff in Somerset, to provide the basis for devising CPD sessions to be delivered by a local college and developing a toolkit, which could then

be applied there and in other services managed by the provider, Vocare. Staff reported generally feeling competent and confident, though particular training needs were identified around mental health and neonates. Projects 13 and 14 both had a more specific focus – the first on training up clinicians in their ability to handle calls around mental health, and the second providing skills and resources in dealing with ingestions of toxic substances. At the time of reporting, none of the projects focused on training had yet reached the point where they could show an impact on operational aspects of the NHS 111 service or patient outcomes

Theme 3 Attrition and retention

Seven of the projects addressed the theme of attrition and retention. Though the focus was on understanding how to attract and retain staff, there were overlaps with other themes, particularly with the issues of training and the management of stress to maintain the wellbeing of the workforce.

Project 7 (described below) and Project 19 both aimed to find out more about what encouraged recruitment and retention among 111 staff. Project 19 carried out an employee engagement survey in East and North Herts, and conducted face to face interviews with selected staff members: they found that the main reasons people were attracted to the role were the inherent interest of the job, and the working hours which fitted well around childcare, but that there was no clear or consistent message around why they left.

Learning points Project 7 Understanding attrition and retention – Vocare in Somerset/Staffordshire

The project aimed to identify what makes people want to join the 111 service and stay working there.

A mixed methods evaluation included a postal survey; interviews on the phone and face to face; and collation and analysis of routine data on attrition, attendance rates and recruitment costs

The different parts of the study supported each other, and were consistent in their findings:

- Staff were most likely to leave within the first four weeks
- Staff had concerns about shift patterns and breaks, communication, and pay, particularly for unsocial hours
- Some people recruited might just not be the right 'fit'

Projects 1, 2, 5 and 12 all put the emphasis on training up staff, with the view to creating a more professionalised workforce which would look on work for 111 as a career with scope for progression rather than simply a job. A consistent theme was the importance of having training externally accredited (as an NVQ, in the case of Project 5) to ensure that it was of high value and transferable across 111 services. In Project 1, a training programme was developed at a core level, for all staff, with a higher level of training in specific skills, such as handling mental health calls, for staff identified as 'champions'. Project 2 modified the training and induction programme for new call handling staff, to give them a more phased and supported introduction to handling calls. Project 12 developed a new two-day training module and e-learning in telephone consultation and distance health assessment, which was aimed at all staff working the 111/OOH service, including clinicians. While these projects collected baseline data and reflected on the process of developing and implementing training, none was yet in a position to report on any impact on staff turnover or satisfaction.

Project 4 took a slightly different approach to understanding retention and attrition in the 111 workforce in Staffordshire. The project aimed to improve absence and

attrition in three ways: through drop in health and wellbeing sessions; training in resilience; and gift vouchers to reward attendance and performance. Through examination of routine data and staff surveys, the project team found that the training was positively received, sickness absence rates went down, but there were mixed messages about staff satisfaction – though the work was carried out against a backdrop of poor publicity nationally for the 111 service.

Theme 4 Understanding and supporting work related mental illness

Two projects focussed specifically on the mental health needs of 111 staff. In the South West, Project 10 (below) worked with staff to find out more about what affected their mental health in the workplace, and to identify ways to support improvements to it. In Richmond upon Thames, the Point of Care Foundation partnered with Project 11 to provide Schwartz Rounds, structured opportunities for staff to reflect on their work and the challenges it presents.

Learning points Project 10 111 How are you? – South West Ambulance Service

The aim of the project was to get a better understanding of the mental health and wellbeing of NHS 111 and 999 staff working in the South West Ambulance Service, and of what workplace factors affected it. External expertise was brought in, in the form of an organisational psychology consultancy firm.

An audit of all staff was carried out, using online and paper forms. Three key areas of concern among staff were:

- Job satisfaction (111 staff)
- Burnout (999 staff)
- Confidence in patient care (111 and 999 staff)

Initial findings were fed back to staff for discussion. A set of twenty recommendations were developed, to be implemented through staff-led working groups. These include:

- Addressing the support provided by managers
- Reviewing training
- Providing better positive feedback to staff
- Review opportunities for career progression

- Explore how to increase control and decision latitude in relation to work tasks

4.3 Overall learning from the evaluation

Though the themes of the Workforce Investment Fund projects provided a useful framework, the projects did not always fit neatly into themes, and any one project may have achieved a range of linked objectives running across the themes. Although not identified as a theme in the programme, staff training was a topic which featured very consistently across it, as a way of learning from complicated incidents, increasing clinical capability, promoting retention, and (to a lesser extent) dealing with mental health issues. There was learning from across the programme in relation to how training could be developed in response to staff needs and in partnership with staff, and could be supported by initiatives such as enhanced feedback.

In terms of the project evaluations themselves, a range of approaches were taken, including the use of routine data, focus groups and questionnaires. There was a wide variation in the thoroughness and detail shown in projects' own evaluation reports, which raises some questions about how transferable any learning might be.

The majority of projects have managed to deliver their project objectives within the allocated timeframe. However, many of the project teams have remarked in discussion, and in some cases in their report, that this has proved challenging, especially when any delays to the start of projects were encountered.

The rapid timescale for implementing and evaluating the projects meant that it was almost impossible to get any data on the impact of changes within this project period. In all cases, the work carried out during the funded project period represents just one phase of a development programme, with plans in place for continuation, expansion or roll out of the intervention to other sites. This meant that evaluation was generally

not concerned with outcomes, but with establishing a baseline against which future change could be measured, and with examining the process and feasibility of the change introduced.

A number of projects were concerned with collecting baseline data/audit of existing situation – and plans need to be in place to get value from this data through future evaluation. While some projects presented outline plans for future evaluation, support will be needed for more consistent, detailed and costed evaluation plans.

5 Discussion

Projects used a range of methods to carry out evaluation, including both quantitative and qualitative approaches. Routine data sources were used heavily to draw together information related to uptake of interventions. Many projects used survey methods (staff and patients) often combined with interviews with staff. Other methods included observation and call review.

5.1 Key learning points

Use of a range of methods allowed projects to gather and report data related to implementation and staff views which could be used to further develop or refine initiatives. For instance, results helped to:

- develop courses in call handling skills;
- identify areas of need in call handling;
- consider issues and highlight opportunities related to collaboration across sectors;
- provide new clinical understanding of the interface between NHS 111 and primary care, and NHS 111 and care homes

As would be expected, there was some inconsistency between results related to similar initiatives e.g. uptake of training and review opportunities; experience of closer working with prescribing pharmacists.

It was not always clear how evaluation results would be used to develop practice e.g. Unexpected findings related to an increase in negative comments following the

introduction of a poorly attended occupational health initiative for improving staff wellbeing.

5.2 Strengths and Limitations

The timescale was a considerable challenge to the delivery of projects and evaluations. Evaluation plans were over optimistic, with outcome data almost impossible to deliver within the available timescale. Nevertheless, most projects did produce a final report with a section detailing their evaluation methods and results related to processes of care/delivery. Transferability of findings was limited by timescale and specific contextual matters related to service or population features.

5.3 Conclusion

Inclusion of a requirement for evaluation in these commissioned projects has allowed the use of methods to gather quantitative and qualitative data and to report these data in a structured manner. Provision of evaluation support to plan and deliver these evaluations has allowed providers to consider their desired outcomes and to collect data in a focused way to address these outcomes. In particular, drawing together projects through evaluation support workshops provided a forum for discussion, development of evaluation skills and for communication between projects and commissioners.

Although short timescales for commissioning limited the delivery of findings related to impact of interventions, there is some learning from these projects which can inform future workforce development initiatives, particularly related to promoting uptake amongst staff and including staff views in the development of courses and

other staff support interventions. New data has been drawn together about workload and linkage of data has allowed new understanding of interfaces between NHS 111 and primary care as well as care home workload.

Overall the findings from the 19 projects indicate the importance of addressing workforce attrition issues through training and education; building in opportunities for career progression and professionalisation; maintaining staff well-being by providing timely mental health support and addressing staff grievances; and better understanding and response to casemix and workload issues.

Appendices

Appendix 1

Project Summary 1

Lead organisation/CCG: Integrated Care 24 Limited/North Essex

Project Title: “Professionalization” of the call handler role within the 111 Urgent Care Setting

Themes: 1 Complicated Incidents & 3 Staff Attrition

Project aims: To increase the quality and experience of the NHS call handler workforce by nationally accrediting call handling staff. To also identify appropriate distance learning packages for call handlers and to support trainers through a training course. This pilot project sought to develop a clear career pathway for call handlers, linked to training and performance, as is the case for other health care professions.

Project outline: During the initial pilot phase the training programme was fully accredited by NCFE in partnership with a Higher Education provider; Canterbury College. In addition to the formal accreditation of the training programme, the project team worked closely with the college to embed their distance learning packages in line with patients presenting symptoms/ conditions. By completing trend analysis and reviewing themes of what presenting symptoms or conditions are causing inappropriate high end dispositions such as 999/ A&E or early exits, the project aimed to identify appropriate distance learning packages from the college.

The pilot project also supported trainers and coaches through the NCFE assessor’s course, which will enable both standardisation of this group and give them the ability to assess call handlers through the distance learning packages.

The initial three months between January – March 2016 were used to set up the courses and accreditation in readiness for commencement of training.

Project evaluation design: Baseline data has been collated to support a final evaluation, which will be presented once the pilot project has been delivered fully over the next 12 months. As the first stage in evaluating the project, the team

collated baseline data using questionnaires via email and Survey Monkey to gather the views of both call handling staff and those staff involved in training and assessment on the topic of training needs and opportunities.

There will be two main streams to the evaluation over the 12 month period. Firstly, as new call handlers are trained through the accredited training programme, data will be collated to evaluate call handlers outcomes by type, productivity and audit outcomes, as well as overall attrition rates. Secondly, the three contact centres 'champion' a distance learning module for already trained staff in a particular field such as mental health, which is bespoke to the call centre environment. Each of these call centres can be evaluated in terms of improved outcomes in relation to a particular group of patients based on the learning undertaken by this group of staff.

Key findings from project evaluation:

- Surveys revealed a strong appetite among call handlers for additional training in call handling skills . Coaches and quality assessors were keen to gain new assessment skills.
- A new Level 2 course in call handling skills has been developed, covering customer support and assessment, life support skills, and safeguarding vulnerable adults. Feedback from the IC24 coaches indicate that the qualification developed via NCFE, the level 2 Certificate in Developing Skills for Telephone Triage is pitched at the right level for learners, with meaningful learning and assessment opportunities.

Strengths and limitations of project evaluation:

Strengths: the project is using an accredited qualification

Limitations: details of plans for measuring impact (on staff attrition and patient experience) have not been outlined in the project report.

Progress against key targets: The pilot is covering a period of 12 months; reporting is on the baseline phase. The new training programme was prepared by April 2016. As the project is at the initial phase, meaningful evaluation of impact is not possible until call handlers have completed their training.

Project Summary 2

Lead Organisation/CCG: Yorkshire Ambulance Service/Greater Huddersfield CCG

Project Title: NHS 111 Recruitment and Retention – modified induction and support programme

Theme: 3 Staff attrition and retention

Project aims: The project aimed to test whether an amended induction programme for staff helped to support and improve retention rates within NHS 111 call centres in comparison to the model currently in use, and reduce the current attrition rate of 40%.

Project outline: The project extended the current 4-week training programme to 10 weeks, and incorporated the one-week sessions in order to more gradually phase call handling staff. A more supportive 'nursery' was introduced, with dedicated reflective practice sessions and trainer support than is currently available within the existing service model, to ease new staff into their role.

Project evaluation design:

Baseline data was gathered on attrition rates during the pilot phase and retrospectively to the launch of the service in March 2013. Attrition rates and data were assessed and reviewed. Outcome of staff engagement sessions was assessed through focus groups with staff and training evaluation surveys. Call audit data (local Sharepoint) was also analysed to assess any quality differences between the new trainees in the pilot induction programme against other recruits (control). Interviews were conducted with key officers to explore pilot outcomes.

Key findings from project evaluation:

- New call handlers in the pilot group were more confident in taking out-of-hours calls when they 'went live' and in seeking clinical advice.
- The trainees supported each other well during the amended induction and this seemed to help build the confidence of some who felt unsure at times.

- They valued the ability to re-emphasise elements during the amended induction, for example warm transfers.
- the induction programme helped to more effectively prepare staff for the role.
- Higher NHS Pathways audit scores were also recorded for those taking part in the pilot as compared to other new starters over the same period, and fewer minor errors were made by those in the pilot cohort.

Interim findings also suggest lower attrition rates and the delayed introduction to the peak out of hours period allowed trainees to build their competence. An additional 2 weeks of full time training was an issue for some staff. Additional workload for trainers: on average those who were supported achieved an audit score of 95%, whilst the non-pilot cohorts achieved 89%, but other cohorts of new starters ranged from 89 to 94 %.

Strengths and limitations of project evaluation:

Strengths: Range of methods used to assess effects of pilot in both the group undergoing new induction package and a contemporary control cohort. Views were sought from both trainee groups and established clinical and training staff.

Limitations: Whilst the interim findings appear positive it was acknowledged that the sample size and timeframe to assess was relatively small, and therefore made it difficult to reach any definitive conclusions.

It is too early to confirm whether this will affect attrition rates, so a plan is in place to re-evaluate at six and 13 months.

Progress against key targets: A cohort of 13 trainee staff took part in the pilot modified training programme, which was implemented from 8th February 2016 to March 2016. Formative evaluation was carried out at the end of training (six weeks). The pilot project will continue to be assessed again in six months and then in 12 months, to look at whether attrition from the pilot group and then subsequent groups has reduced, to allow for a fuller evaluation, including longer term analysis of attrition rates.

Based on the findings from the pilot, the amended induction has been implemented for all new starters.

Project summary 3

Project Title: Complicated incidents – staff requested end-to-end reviews

Lead Organisation/CCG: Yorkshire Ambulance Service/Greater Huddersfield

Theme: 1 Complicated incidents

Project aims: The pilot project aimed to test the value of introducing an end-to-end review process for staff. It was believed that participation in the review sessions would enhance job satisfaction and improve staff members' sense of value to the service by providing visibility of their role in the patient journey and outcome.

Project outline: Those participating in the end-to-end review included both call handlers and clinicians, with the caveat that they were not new to the service. This was done to ensure participants had a level of experience that would allow for insight into shaping the process. They were invited to:

- request a review of a specific patient contact in order to understand their final outcome, thus providing a means of closure for complicated incidents
- identify potential improvements on how the call could have been triaged through NHS Pathways, following confirmation of their final clinical outcome
- reflect on the handling of the call, based on the known patient outcome and to establish the potential for wider service / system learning

Project evaluation design: Both formative and summative evaluation was undertaken. Items measured include the cost of the initiative, staff participation, and staff satisfaction with the sessions in relation to their personal development, any system-wide learning identified, and whether or not staff felt it was of value. Data collection was done through internally developed feedback forms, delivered at the end of each session and approximately four weeks later. These were completed anonymously by all staff attending. A follow-up feedback form was sent to participants 30 days after each session, and a feedback form was sent to staff who did not submit a call synopsis or attend a session. These were also anonymous and

were done through an internet link. As this feedback was collated after the submission of the evaluation report, results are not available at present. Additional data collection was done through observation of the meetings by an NHS 111 Non-Clinical Duty Manager who was a member of the Governance team and assisted with the preparation of cases.

Key findings from project evaluation:

- The sessions proved to be an effective forum for open discussion. The level of support received and the level of relief and assurance that staff felt when going through the process was an unexpected benefit.
- Early outcomes have evidenced a positive uptake in staff engagement, a sense of feeling valued, and a better understanding of the patient journey.
- Staff feedback about the pilot was positive. And increased a sense of staff engagement and sense of value to the service and a belief from participants that all staff should attend an end-to-end review.
- Increased appreciation between, and understanding of, the roles of call handlers and clinicians.
- Improved confidence level for those submitting calls. Support and suggestions from those in attendance provided assurance, which in turn, improved the confidence level of the call handler.

A potential improvement to the training process was identified, as staff suggested listening to real calls which should be included in training. The total cost to implement 2 sessions per month = £8,562 per year.

Strengths and limitations of project evaluation:

Strengths: Three sessions were held during the pilot. There was comprehensive follow up with feedback forms and observer insights. Associated costs were calculated. The project team used findings to develop recommendations and further improvements to end to end review process.

Limitations: Limited by short timescales and therefore no further 30 day follow up results or results from staff involved in usual process (i.e. without frontline staff present)

Progress against key targets:

Three month timescale for project: Unable to complete 30 day follow up within the timescale of this project. Key targets were met other than feedback at 30 days and additional feedback from staff not involved at this stage of the project.

Based on the outcome of the pilot programme, it is recommended that the service continue conducting end-to-end review sessions for an additional six months, providing an opportunity for more staff to attend and additional feedback to be gathered.

Project summary 4

Project Title: Improving the Health & Wellbeing of NHS 111 Call Centre Staff

Lead organisation/CCG: Staffordshire Doctors Urgent Care (SDUC)/ Stafford & Surrounds & Cannock CCG

Theme: 3 Staff Attrition

Project aims: The purpose of this project was to understand attrition and retention issues of the SDUC 111 workforce, both quantitatively and qualitatively. Interventions were put in place to raise staff morale, improve attendance and delivery of the quality of the service, with an aim to reduce attrition by 25%.

The project addressed three key motivators: Reward, Recognition, and Real-time feedback, by a combination of interrelated interventions delivered over a 12 week period. This included:

- Health and wellbeing drop in sessions for all staff
- Resilience, leadership & wellbeing training sessions (managers & all staff)
- Incentive schemes to reward attendance and high performance

Project evaluation design: The aim was to measure the success of the interventions during each stage of delivery to benchmark as well as evaluate the overall outcome and level of success. Quantitative data were collected using pre- and post- intervention staff survey of staff morale and job satisfaction, up take of health and wellbeing clinics, attendance at health and wellbeing/ resilience/ leadership courses, evaluation of incentive scheme, attrition, absence and sickness rates, and call audit results.

Key findings from project evaluation:

- Overall, the results were mixed. After the intervention, fewer Call Advisors looked forward to returning to work; however, clinicians felt their role made more of a difference to patients.

- The training sessions were well received, with 100% of staff who attended the session stating that it was beneficial and useful to their work.
- The health and wellbeing drop in days offered to staff were not as successful as anticipated due to lower attendance than expected, as only 25.5% of staff attended. This was potentially due to the health drop in clinics taking place during the day and therefore night staff would not have been able to attend.
- There was some evidence of a reduction in staff sickness after the introduction of the staff incentive scheme but there were indications of rising sickness levels towards the end.

Strengths and limitations of project evaluation:

Strengths: A range of initiatives were explored in the package with mixed results.

Outputs from the evaluation have provided other new insights into staff morale that can be used to help develop further initiatives.

Limitations: Intervention period included Christmas and New Year which will have been busy and high pressure for staff.

Progress against key targets: The project was conducted within intended timescales.

There was low uptake of drop in sessions, so it is difficult to assess their true effectiveness in the 12 week intervention period, and there would not have been sufficient time to change culture and perceptions. Staff may have reacted negatively to the intervention due to perceptions that the interventions were short term measures; or these interventions would not necessarily be the ones that they would have chosen to improve their workplace experience. The pilot was useful for the company as it identified where the concerns and problems lie within the workforce. Changes to work conditions are being put in place in light of these findings. Although sickness and absence variables were collected there was no control to compare against.

Project summary 5

Project Title: Understanding attrition and retention issues of the NHS 111 workforce

Lead organisation: Herts Urgent Care/ Cambridgeshire and Peterborough CCG

Themes: 2 & 3 - Enhancing clinical capability and staff attrition

Project aims: The project aimed to create a new qualification for health advisor staff, in order to improve turnover rates, as well as supporting career progression and developing new skill sets.

Project outline: The project was to create a series of development opportunities for 111 clinical and non-clinical staff to assist with recruitment and retention, including the creation of a Diploma/ NVQ for non-clinical staff.

Method of evaluation: Project evaluation will use both quantitative and qualitative methods. Qualitative data will be gathered directly from participants in the Diploma / NVQ Level 3 programme on levels of engagement with the ambitions of the service; personal ambition to progress; a sense of value for the work that they do; factors known to support good service retention figures. Quantitative data will be gathered by monitoring the monthly turnover rates for Health Advisors. Career progression for Health Advisors will also be reported on and monitored.

Key findings from project evaluation: The project has yet to report, but expected outcomes to improve workforce issues; include identifying opportunities for learning and trying new things; addressing issues of developing and promoting new professional identities; maintain existing skill sets and developing new ones

Strengths and limitations of project evaluation: *Limitations* to date include variation in the educational background of staff. Mature staff often have other commitments which reduce the opportunity for them to participate, and surveys for evaluation purposes are not always returned

Progress against key targets: The project is still ongoing and has yet to report. However, a number of challenges have been identified. The geographical spread of Cambridgeshire and Peterborough indicates that local level educational support will be required. Not all Health Advisor staff in 111 are currently educated to the same

basic level, and mature learners often have other commitments at home, so learning needs to be flexible in terms of content and timescales. Finally surveys are not always returned. Future evaluation may aim to collect data “in person”.

Project summary 6

Project Title: Understanding attrition and retention issues of the NHS 111 workforce

Lead organisation: Care UK/ Bristol CCG

Themes: 1 Complicated incidents

Project aims: The project aims to understand how cognition is distributed in NHS 111 system. This will allow recommendations for future improvements to the design of the system based on such an understanding, without making value judgments with regards to patients, staff, or NHS Pathway designers. It is anticipated that learning from this study will benefit all staff who take calls for patients through NHS 111. The patient group who stand to gain most from this are those with complex presentations or potentially serious underlying conditions.

Project outline: For the purposes of this pilot study, the distributed cognition model to be focused upon is Information Flow - specifically, the communication between the participating members, what their roles are, and the sequence of events, which defines the mechanics of the system. Researchers have represented communication links between agents in a similar way using social network theory applied to emergency service operations.

Project evaluation design: The study will use anonymised voice recordings for transcription, anonymised full triage assessment reports and will require access to the appropriate version (in use at the time the call was taken) of the triage tool itself (training version, not live system). All patient identifiable information will be excluded from the data required. Data will be extracted from the voice recordings held in archive on the Avaya telephone system and Adastra platform which hosts the NHS Pathways triage record. Care UK will collect the required data and supply it securely and directly to the academic contact. To facilitate the project it is proposed that this work of the study is performed at the academic institution commissioned and the project proposal will be reviewed by the appropriate panel within that institution to meet relevant criteria.

Key findings from project evaluation: None yet reported

Strengths and limitations of project evaluation: None yet reported

Progress against key targets: The project has yet to report on findings. Any suggested improvements for NHS 111 systems, if implemented, should result in fewer serious incidents and near misses for patients. Variability in identifying and/or reporting of such incidents may confound the measurement of this outcome. Advisors handling calls should find greater system support for challenging areas of their role. This may be evident in call audits or feedback. It is possible that with greater recognition of case complexity the proportion of cases which Health Advisors seek Clinical Advisor input may rise, affecting the clinical resourcing within NHS 111 and case queuing.

Project summary 7

Project Title: Understanding Attrition and Retention on the Workforce

Lead organisation: Somerset Doctors Urgent Care (Vocare)/ Somerset CCG

Theme: 3 Staff Attrition

Project aims: The project aims to reduce attrition and identify those factors which need addressing, in order to successfully attract new staff to join the 111 service and most importantly to stay within it - identifying the right 'fit' for the type of work being provided. Call Advisors and Clinical Advisors from both Staffordshire and Somerset were involved in the project.

Project outline: The project entailed collecting qualitative data to inform proposals to improve retention. Data was collected from staff (clinical and non-clinical) through use of postal surveys (n=99), telephone interviews and face to face interviews (n=20), to aid the understanding of attrition and determine current levels of staff satisfaction.

Method of evaluation: The evaluation drew on the qualitative data and also entailed collecting baseline data, against which any future change could be measured, and comparison made between sites. Baseline data involving attrition rates, attendance rates and recruitment costs were collated and analysed.

Key findings from project evaluation:

The findings suggest that maybe the wrong 'fit' of candidates were being identified during recruitment. Quantitative data collected through staff surveys was very strongly supported by documented and qualitative data, adding overall value and reliability.

Baseline data indicated that the majority of staff leaving the workforce were doing so during the initial training period (first four weeks). Staff concerns centred on breaks, shift patterns, communication, recognition and pay enhancements, particularly for unsocial hours.

Staff reported feeling supported by colleagues.

Recommendations for change include exit interviews; a profiling exercise for staff who remain in the service; and mock 111 calls as part of the recruitment process to ensure that new recruits are the 'best fit' for the job.

Strengths and limitations of project evaluation:

Strengths:

The mixed methods approach allowed triangulation of results.

Limitations:

The survey and interview questions were not validated.

Approach to analysis of Likert scale data concealed the range of responses.

Low participation in interviews, especially in Somerset.

Progress against key targets:

The collection of baseline data has been completed and work is underway to apply the learning from it. Routine data covered the period Oct 2015 to Feb 2016. Survey and interviews carried out and written up during 3 month project period.

To improve attrition rates, an additional profiling exercise has been implemented as a quick guide to skills and experiences possessed by staff that are retained within the service for longer than six months. It is recommended that potential employees undergo an assessment during interview to evaluate key skills vital to the role. Other recommendations include re-directing focus on the strengths of the organisation, review of break and shift policies and launching a Problem Solving Matrix. Since the launch of the project pay enhancements have been reviewed and improved. It is anticipated that after implementing these changes, new data will indicate an increase in staff satisfaction and a reduction in attrition issues.

Project summary 8

Project Title: Staff Training Needs

Lead organisation: Somerset Doctors Urgent Care (Vocare) /Somerset CCG

Themes: 1 & 2 Complicated Incidents and Enhancing Clinical Capability

Project aims: The project aimed to identify the training needs of Call Advisors and Clinical Advisors with a view to developing training material which can form the basis of a toolkit for all 111 Services.

Project outline: The intervention focused on improving staff confidence and competence in the handling of calls that frequently result in Ambulance, ED, Speak to 1 hour and Contact 2 hour dispositions. The intervention is targeted at staff (n=11) who have been in their role for six months or more.

Project evaluation design: Routine baseline data from Agent Scorecards through the local Report Manager was collated prior and after the delivery of the new training initiative, to detect changes in the 1 and 2 hour PCS dispositions as recorded on Agent Scorecards. Outcomes were also assessed through one to one staff performance reviews and through self-assessment of confidence and competence with a range of calls.

Key findings from project evaluation:

9 Call Advisors and 2 Clinical Advisors took part in the performance reviews.

The results from this small pilot project indicate that Call Advisors were achieving current targets in regards to Ambulance and ED dispositions; however Clinical Advisors did not quite meet the target. It was clear that for Clinical Advisors, a benchmark for Speak to 1 hour and Contact 2 hour PCS dispositions needed to be clarified.

Staff highlighted training gaps during the course of this pilot project. Confidence and competence with Mental Health calls was rated lowest, therefore additional training has been arranged to address this issue in collaboration with the local college.

Lack of feedback was also emphasised as an issue of concern for both Call Advisors and Clinical Advisors. To address this issue Clinical Advisors are required to provide regular feedback to Call Advisors, which is hoped, will improve confidence and good practice. To ensure Clinical Advisors also receive feedback, there is on-going discussion with Somerset 111's local Hospitals and Ambulance Service to set up a feedback system. Once all suggested recommendations are in place, it is anticipated that a repeat of data collection will demonstrate an improvement in competence and confidence for both the individual and the organisation.

Several themes which emerged during the performance reviews were so diverse that they do not lend themselves to an intervention.

Strengths and limitations of project evaluation:

Strengths:

The project has been considered as a pilot before roll-out to other sites.

Limitations:

The report does not make a clear distinction between the intervention and the evaluation

Progress against key targets:

The initial work has taken place. Data will be collected to measure the success of the intervention in terms of patient disposition (from the Agent Scorecard), clinician feedback, and GPOOH data. Currently, there is no target in place for 1 and 2 hour dispositions. Somerset Doctors Urgent Care will introduce a larger study targeted towards more staff members across all VOCARE sites alongside Local Clinical Directors. As Somerset 111 integrates with Somerset Out of Hours Service, this work will take place across the two services and enable the use of additional data from the Out of Hours Service to inform further evaluation of the exercise.

Project summary 9

Project Title: Use of pharmacists in integrated unscheduled primary care hub (111/OOH)

Lead organisation: London Central & West- Unscheduled Care Collaborative

Theme: 2 Enhancing Clinical Capability

Project aims and goals: The project aim is to deploy an independent prescribing pharmacist in the integrated 111/Out Of Hours (OOH) call centre to increase the proportion of calls to be closed within 111 without referral to a GP or other provider, while continuing to provide a safe and effective service which meets patient expectations.

Project outline: The project will augment the existing GP workforce and utilise the pharmacist's enhanced skills in relation to medication queries which can't be closed in 111, repeat prescribing requests which can't be closed using PURM and the assessment and treatment of an identified cohort of patients with minor illnesses. The pharmacist has been placed in the setting for a pilot period of three months during weekend hours (9am-9pm Saturday and Sunday). A suitable cohort of patients whose needs would by default be met by a prescribing pharmacist working in integrated primary care was identified to take part in the pilot.

The integrated OOH/111 pilot pharmacist was governed under the mature and tested processes in place for OOH GPs.

The pilot project is supported by a Patient Public Engagement (PPE) panel who have the opportunity to co-produce and be involved in the evaluation process.

Project evaluation design: Reflection and observation by the medical director took place during the development stages. Evaluation of outcomes will be measured by objective audit criteria of records on the proportion of patient episodes that are definitively managed (without any downstream referral or to other skill set in OOH) by the pharmacist with or without a prescription. Audit data will be supported by qualitative analysis of consultations triangulated by patient satisfaction

questionnaires to identify the impact of this scheme in reducing reliance on GPs in phone triage.

Key findings from project evaluation: Pharmacists need further development of their confidence and clinical skills. Initially, pharmacists require a significant period of supervised practice within the OOH/Integrated primary care hub setting. The lack of access to full medical record may significantly inhibit the range of patients within the cohort who can be treated in confidence.

Strengths and limitations of project evaluation:

Strengths

Proposed outcome measures cover both operational aspects of the service and patient experience.

Limitations

It is unclear how the WIF project relates to an earlier pilot.

Progress against key targets: So far, findings are based just on the observation and reflections on the development process. A full evaluation of the pilot has not been possible within the limited timeframe. Progress was delayed due to the availability of suitably qualified pharmacists to work the hours of operation. Nevertheless, a number of issues were identified as the service was rolled out. Initially pharmacists even those with a prescribing qualification require a significant period of supervised practice with the OOH/Integrated Primary Care hub setting. The lack of access to full medical records reduced the number of potential patients within the pilot cohort who could have been managed by the service.

Project summary 10

Project Title: 111How are you?

Lead organisation: New Devon CCG/South Western Ambulance Service NHS Foundation Trust

Theme 4: Understanding and supporting work related mental illness

Project aims: The aim of this research was to enable the Trust to have a clear understanding of the work-related mental health needs of the 111 workforce and enable targeted interventions to be developed in order to enhance workforce wellbeing, improve performance and increase staff retention rates.

Project outline: The Trust worked with Zeal Solutions Ltd who specialise in organisational psychology to develop a tailored survey aimed at assessing the impact of a number of workplace factors and health and wellbeing.

Method of evaluation: A mental health and well-being audit of all NHS 111 staff was collated through anonymised questionnaires. Feedback from the survey was delivered to staff through two focus groups. Throughout the process staff were encouraged to make recommendations on the changes that they would like to see put in place.

The audit also included a group of staff from the 999 Clinical Hub in order to compare and contrast any differences between the mental health needs of these staff groups.

Key findings from project evaluation: The results of the survey indicate three key areas of concern among staff: job satisfaction (111 staff), burnout (999 staff) and patient care confidence (999 and 111). Workplace features that have a beneficial impact upon individual and organisational wellbeing include a supportive workplace environment, positive work experience and continued professional development, and the feeling that staff are valued and kept informed of developments.

The results of the audit and focus group meetings have been used by Human Resources to inform the 111 Development Plan and have ensured that the feedback features in the action plan for current staff survey.

A set of twenty recommendations were developed, to be implemented through staff-led working groups.

Strengths and limitations of project evaluation:

Strengths

The project used external expertise.

Limitations

SWASFT is planning to transfer the NHS111 service to a new provider from October 2016, which may have an impact on continued evaluation.

Progress against key targets:

Mental health audit, feedback and development of an action strategy completed by March 2016.

A follow-up assessment in 12 months' time would indicate if any change can be detected in the mental/psychological health of staff, as well as, establish an accurate set of norms to enable benchmarking of the health and well-being of SWASFT 111 and 999 hub staff.

Project summary 11

Project Title: The Use of Schwartz Rounds in 111 to support the work-related mental health needs of the staff in order to enhance their wellbeing

Lead organisation: Care UK

Theme: 4 Understanding and supporting work related mental illness

Project aims and goals: With the aim to address high rates of staff attrition and sickness within the 111 workforce, the project introduced Schwartz Rounds: a structured monthly one-hour forum for staff from all disciplines to discuss difficult emotional and social issues that arise in caring for patients.

Project outline:

All Schwartz Round sessions were held off site, in the evening. Each session ran for a total of 90 minutes (an initial 30 minutes for staff to have an opportunity to socialise, followed by 60 minutes for the Schwartz Round itself). All staff were remunerated separately for the time involved in attending the Schwartz Round and food and refreshments were provided on site. The themes for the sessions held on 23/02/16 centred around 'a patient I will never forget' and on 29/03/16 it was 'I felt I made a difference'.

Project evaluation design: Prior to each Round all staff in the call centre were provided with a quality of work life questionnaire to complete. This was repeated throughout the assessment cycle. The aim of these forms was to assess if there had been any change or impact following the introduction of Schwartz Rounds. At the Round itself staff were asked to complete a standardised proforma (provided by the Point of Care Foundation) to assess their views of how they felt the Round was conducted, its impact and value to them.

Key findings from project evaluation: The Schwartz Rounds were well received by those members of staff who attended and the overall feedback was universally positive. The Rounds were felt to be relevant, helpful and the majority of respondents would both attend again and recommend them to another work colleague. Staff found the opportunity to share and reflect invaluable and many themes were

generated for the operations team to reflect upon and action which will certainly have a beneficial effect both in terms of operational efficiency, staff moral and well-being, as well as patient care.

Achieving high staff attendance and participation in the Rounds was challenging and often confounded by work patterns and the large numbers of staff employed within the call centre. If the Schwartz Rounds could be held on site and embedded as business as usual within shift patterns and led by Clinical & Operational Supervisor Teams we believe attendance may be improved.

Strengths and limitations of project evaluation:

Strengths:

The staged evaluation design involved first checking feasibility, then planning to evaluate impact, before rolling the intervention out to other sites.

Standardised intervention and pro forma for evaluation were designed by the Point of Care Foundation.

Limitations:

Low rate of participation limits scope to evaluate impact, though it provided useful learning re: process of implementation

It was not possible to draw statistical significance regarding absence and sickness rates among staff from this short intervention.

Progress against key targets:

Schwartz Rounds held in late February and late March 2016.

Plans to repeat the staff wellbeing survey at the end of April 2016.

To obtain results on the impact of the intervention on absence and sickness rates will require a further evaluation over the next six months to a year. Other UK studies of Schwartz Rounds conducted over a longer period have demonstrated improvement in these metrics (Kings Fund).

Project summary 12

Project Title: Team working and Communication Skills Training for NHS 111 and Out of Hours Clinicians and Call Handlers. Double Module Class-Based sessions, supported by bespoke E-Learning

Lead organisation: South Worcestershire CCG/Health Education England West Midlands

Theme: 3 Staff Attrition

Project aims: The aim will be to provide targeted skills training to clinicians involved in 111 and OOH service delivery; addressing an identified training need and satisfying national policy to enhance the development of “tele-competencies” in the clinical workforce. It is anticipated that a creation of a robust training module, with capacity for evaluation and regular quality assurance, would add a previously unseen level of governance and reassurance to participating clinicians, employers and ultimately patients; that standards of telecommunication and patient outcomes are safe, proportionate and confident.

Project outline: To develop and, through a pilot study test, a bespoke training module in Telephone Consultation and Distance Health Assessment. The specific output is a single day (two session) training module, supported by a bespoke E-Learning module. The programme is versatile enough to be aligned to existing training pathways (eg. Post-CCT GP Fellowships / Advanced Practice / Physician Associate / NHS Pathways) and / or be offered as a stand-alone module. The training is aimed at all staff who handle calls, including clinical staff.

Method of evaluation: The initial phase of this project concentrated on developing learning materials only. An Action Learning Set approach was taken to developing modules. It is recommended that retrospective evaluation take place at key milestones and end-project phases, while the training programme is being delivered to NHS 111 staff.

Key findings from project evaluation:

Two training modules were developed, equivalent to two clinical sessions plus 2-3 hours of e-learning.

Challenges to delivery within timescale encountered, particularly in relation to use of e-learning portal.

Using an experienced and professional elearning developer with experience of integration into NHS Learning and workforce was essential

The project team questioned the need / requirement for CCGs to be budget holders for the project.

Negotiating contracts and finance was lengthy.

External support from the NHS 111 team was valued.

Strengths and limitations

Strengths: Commitment from a cross-organisation team.

Limitations: Slippage in timescale meant that no evaluation of project delivery or impact yet completed.

Progress against key targets: Initially, a six month pilot was proposed. By May 2016, all teaching and facilitator materials were available for testing / piloting by training facilitators. A West Midlands clinical Call Centre (South Worcestershire Healthcare GP Access Fund - not an NHS 111 organisation) has been identified as a pilot site to test the teaching material. This will be offered as part of the agreed project site delivery and will be delivered by the existing team. It is suggested that the training module, if appropriate, is incorporated into NHS 111 to integrate this learning into strategic workforce planning. If considered appropriate the project team will commit to an initial round of "train the trainers."

External evaluation of impact is proposed.

Project summary 13

Project Title: Improving NHS 111 clinician skill set and ability to handle calls relating to Mental Health

Lead organisation: SECamb NHS Foundation Trust, in conjunction with CareUK/SWALE CCG

Themes: 1 Complicated incidents; 2: Enhancing clinical capability; 4: Understanding & supporting work related mental illness

Project aims: The project aims to facilitate better quality interactions between 111 Clinical Advisors and patients suffering mental health related issues.

Project outline: The project entails developing a specialist training program to support the 111 Clinical Advisors who do not have mental health as a specialist skill set. The project will also address issues around enabling Clinical Advisors access to Patient Care Plans within the KMPT RiO platform which will provide additional clinical information when dealing with a 'live' case, providing a more integrated response to patient needs.

Method of evaluation: The project evaluation will include approaches to measure improved patient experience and quality through audit and improved clinician confidence through pre and post project survey. The main outcome measures from the project will be:

- a reduction in frequent/repeat calling
- a reduction in average handling time
- reduced referrals to ED and Ambulance
- increased referrals from KMSS 111 Clinical Advisors to KMPT for those patients without a current Care Plan for better case management

Key findings from project evaluation: Issues around information governance and IT have been the main two challenges along with workforce availability - due to service delivery demands which have delayed the project.

Strengths and limitations of project evaluation: Not yet assessed.

Progress against key targets: As the project is still at the implementation phase reports on outcomes are delayed.

Project summary 14

Project Title: Improving NHS 111 clinician skill set and ability to handle calls relating to Mental Health

Lead organisation: SECamb NHS Foundation Trust, in conjunction with CareUK/SWALE CCG

Theme: 1 Complicated incidents; 2 Enhancing clinical capability

Project aims: The aim will be to upskill the 111 clinicians, ensuring a greater operational effectiveness whilst improving patient safety, alleviating pressure on the GP OOH's services whilst increasing overall service user satisfaction. Anticipated outcomes from the project include:

- Improved patient experience and quality due to more effective access of NPIS and Toxbase
- Reduced necessity to refer service users to other parts of the wider health economy i.e. to GP OOH's services, A&E, ambulance etc.
- Improved clinician understanding and CPD – measured through clinician peer to peer feedback
- Reduction in Average Handling Time as the CA's will be able to access and provide the correct information to patients more promptly, leading to improved clinical effectiveness and operational efficiency.

Project outline: This project will build upon the initial success with the NPIS Learning and Development team to refine a training program for 111 clinicians and a “train the trainer” course respectively to allow a better understanding in the use of Toxbase. In addition to develop a greater understanding in the use of Medicines Complete as well as other suitable references by working with the Royal Pharmaceutical Society.

Method of evaluation: The project will aim to collate data in several ways.

- Improved clinician understanding and CPD – measured through clinician peer to peer feedback

- Audit will be used to continually monitor effectiveness, outcomes and patient safety
- Patient feedback will be measured through the 111 patient telephone questionnaires
- Success of NPIS HCP feedback and effective communication evaluated through continued working groups.

Key findings from project evaluation: Project has yet to report on findings

Strengths and limitations of project evaluation:

Progress against key targets: Project has yet to report on findings.

Project summary 15

Project Title: Introduction of Pharmacists into the workforce of the NHS111 & Out of Hours Integrated Service

Lead organisation: Derbyshire Health United (DHU)

Themes: 2 Enhancing clinical capability ; 3 Staff attrition

Project aims and goals: The project aims to demonstrate that pharmacists can be part of the NHS 111 skills mix to increase efficiency by reducing call length and increasing closure rate of calls without onward referral. The use of Pharmacist Independent Prescribers and Non-Prescribers in the NHS 111 care provision could facilitate enhancements in clinical effectiveness, safety and improvements to patient care and experience, ensuring patients speak to the right person at the right time with the appropriate skill set/knowledge.

Project outline: Prescribing pharmacists were recruited to work in the 111 service at the weekends, in line with demand. They were trained in Pathways and Aadastra, and could access patients' summary car records.

Method of evaluation: Both summative and formative evaluation methods have been utilised to evaluate this project. Data analysis has been based on data collated mainly during the Easter period after the pharmacists have had a few weeks of embedding within the service. Comparisons were made between the number of contacts patients have had during an episode of care for medication enquiries pre and post intervention, and the length of episodes of care from contacting the service to the final outcome measurements – pre-project and during the project. The impact of a prescribing pharmacist versus a non-prescribing pharmacist was also measured by clinical auditors who have audited calls using the traditional RCGP audit tool kit.

Qualitative data was obtained using Survey Monkey for the survey of both NHS 111 staff and pharmacists. Patient satisfaction was measured through written questionnaires which were sent to patients who had accessed the service and spoken to the pharmacists. Due to the short timeframe for delivering this evaluation it was not possible to survey larger numbers of patients.

Key findings from project evaluation: The introduction of pharmacists within the 111 service improved efficiency and patient experience by reducing overall average call length of medication related enquiries, without onward referral compared to the non-pharmacist Pathway's Clinicians. Pharmacists were able to close calls without onward referral in 93% of cases – a considerably higher rate than previously. The patient satisfaction survey generated a high level of satisfaction. Further surveys are planned to include a larger sample size.

The staff surveys have shown that the pharmacists are appreciated by all members of the NHS 111 and Out of hour's team, who have quickly recognised their skills. The RCGP audits found a very high standard of professional care from pharmacists.

Strengths and limitations of project evaluation:

Strengths

Well thought out and sensible focus on the right type of calls.

Comprehensive preparation for pharmacists. Both qualitative and quantitative aspects explored. Short period of operation but have used the experience to generate a set of recommendations for further development.

Limitations

Only 3 pharmacists and 6 patient surveys to provide feedback so small number. Recognise need for further follow-up surveys.

Progress against key targets: The project was completed within the planned 3 month timescale. Most of the time used recruiting and training so there was just a short period of operation, with an evaluation of impact after a few weeks. The project used prescribing pharmacists, and next steps may entail extending the model to non-prescribing pharmacists.

Project summary 16

Project Title: Improving pathways for patients with Long Term Conditions

Lead organisation: Tower Hamlets CCG / PELC

Themes: 1 Complicated incidents; 2 Enhancing clinical capability

Project aims : The project aimed to:

- support the integration of the NHS 111 / integrated urgent care service into Long Term Conditions (LTC) pathways.
- support the development of the professional skill mix of the clinical hub of the 111 service for Tower Hamlets.

Project outline: The project was established to identify current pathways for Tower Hamlets patients with Long Term Conditions (LTC) who are calling the PELC 111 service and assess whether there are any changes that can be made to improve those pathways and develop the professional skillmix. The project team carried out clinical modelling of patient use of the 111.

Method of evaluation: The measurement framework for making improvements in pathways includes the auditing of the following outcomes:

- reduction of minor attendances in A&E by patients with one or more long term conditions (audit of A&E attendances)
- reduction of minor attendances in UCC by patients with one or more long term conditions (audit of UCC attendances)
- increase in usage of NHS 111 by patients with long term conditions (repeat of clinical modelling exercise)
- reduction in ambulance dispatches and conveyances (LAS performance data)

The measurement framework for having the right skill mix of professionals in the clinical hub will include:

- Increase in number of calls 'closed' by NHS 111 service (111 activity data)
- increase in range of calls 'closed' by 111 service (111 activity data)

- improved wellbeing of 111 staff (staff satisfaction surveys)
- increase in calls to 111 (111 activity data)

Key findings from project evaluation: Linking of primary care and 111 data was found to be feasible, and produced a number of useful analyses, eg.

- The symptoms that patients are presenting to NHS 111, in the majority of cases, do not appear to be related to their LTC.
- The percentage of callers within the LTC call group referred to an ambulance or passed to an in-house clinician is notably higher than in the non LTC call group.
- A high number of asthma patients calling 111 with breathing problems, are being referred to emergency ambulances.

Information governance challenges meant that initial approaches yielded matched data for only 65% of cases, but modifications to the method used boosted this to 75%.

The exercise undertaken to link data between primary care and 111 has been extremely useful in gaining a better understanding of who is calling 111 with what symptoms, how frequently, what the most common LTCs are and what advice / referrals are assigned to them. In order for findings to be used in support of decision making around workforce configuration and pathway design, a number of recommendations have been put forward, including a recommendation for bespoke training for call handlers.

Understanding and ensuring compliance with information governance was initially a challenge, but this has not hindered the process. It may do in the future if more interrogation of data is required such as analysing activity 'downstream'.

Strengths and limitations of project evaluation:

Strengths

Innovative use of linked data written up in a full and thorough report.

The project was overseen by a joint project board, bringing together providers and commissioners.

Limitations

Mental health related long term conditions were not included in the analysis.

Progress against key targets: Tower Hamlets CCG and PELC propose to extend the project until mid-May in order to carry out the recommendations. In doing so, the project objectives can be fully realised over and above the original remit detailed in the project bid.

Project summary 17

Project Title: Residential and Care Homes Pilot Phase 1

Lead organisation: Sandwell and West Birmingham CCG/ West Midlands Doctors Urgent Care

Themes: 1 Complicated incidents; 2 Enhancing clinical capability

Project aims: This pilot aimed to investigate the activity and case mix profile of NHS 111 calls from care homes, compared to all other calls. The project aimed to investigate if this cohort is appropriate for potential intervention to better improve the patient journey, highlighting where using NHS 111 in its traditional form does not add value, and testing how best to utilise NHS 111 to benefit the patient.

Project outline: A call audit was undertaken to identify those homes that call frequently and the characteristics of each call was noted. End to end reviews and local knowledge was also captured to better understand the reasons for the calls and the response from 111. A questionnaire was sent to a sample of care homes from across the region to understand reasons and needs of the calls to 111.

Method of evaluation: Both formative and summative evaluation methods were used to explore how care homes were using the NHS 111 service.

Key findings from project evaluation: The results indicate that care homes make 21% more of their NHS 111 calls within the Out of Hours period on weekdays, calls from care home are taking 18% longer than a regular NHS 111 call to handle, therefore using more resources than a regular call would. The majority of these cases (74%) are referred to primary care.

Strengths and limitations of project evaluation:

Strengths

Communication work within care homes in Worcestershire has had a positive outcome in many of the calls (i.e. being clear on what the home wants/needs, have patient information to hand etc.)

Progress against key targets: Phase one of the project has been completed and a case for change has been evidenced. Although the pilot study was undertaken in a fairly short timescale, it has provided the project team with evidence to devise approaches to make better use of the service.

Future recommendations include:

- Further analysis of 999 workload and timing to gauge scope for reducing 999 workload but increasing NHS 111
- Analysis of potential demand on NHS 111 Clinical staff i.e. how many calls moved from NHS 111 to 999 because could not access a clinician in 2 minutes

Project summary 18

Project Title: Enhanced teaching & joint call reviews to support 111 staff development

Lead organisation: East and North Hertfordshire CCG/Herts Urgent Care

Theme: 1 Complicated incidents

Project aims: The aim of the pilot study was to increase the learning of Health Advisors and Clinical Advisors.

Project outline: The project delivered eight themed weeks of classroom based training and through an IT platform where slides of the sessions and a video of the sessions would be made available for participants to view in their own time. The themed teaching programme also incorporated enhanced call reviews and end to end case reviews of NHS 111 calls. The approach taken is based on medical student education, moving away from a lecture style approach to a more hands on, patient reviews style approach

Method of evaluation: The evaluation of the pilot focused on a formative evaluation of the process in the form of qualitative feedback and reflection from participants attending the sessions, and from those who viewed the content through the IT platform. Following each session of training, all attendees were sent a Survey Monkey link to complete specific feedback on the session they attended. The analysis of the feedback focused on whether the teaching programme had met participant's learning needs and how the sessions could be developed going forward.

Key findings from project evaluation: The key overriding theme from both the formal evaluation of the questionnaires and informal verbal feedback was the need and desire for Health Advisors and Clinical Advisors to have regular teaching schedules built into their training and audit programmes, particularly with respect to call reviews.

A number of additional themed sessions were identified for future development.

Strengths and limitations of project evaluation:

Strengths

The training course was oversubscribed. Capacity was increased from 8-10 participants to 18. 28% of the participants (9) attended 4 or more sessions, and one participant took part in all 8 sessions.

Limitations

It was not possible to monitor and report on access to the video and power point presentation material due to the lack of an online learning portal.

Utilisation of an electronic learning journal for participants to record and reflect on their learning was dropped due to short timescale for development.

Progress against key targets: Although a large proportion of the planned activities were successfully achieved, there were some challenges during the planning and delivery phases and some changes were required to the initial proposed pilot design. The initial budget for the pilot did not factor in the time required for video recording and basic editing. NHS England approved additional funding to support this process.

There was a high response rate to the staff feedback survey, but a small number of attendees failed to complete the feedback citing relevance of its purpose. Given a longer timeframe, it would have been possible to assess any change in quantitative outcomes such as reduced call lengths, a higher rate of appropriate end dispositions and improved staff retention with reduced attrition rates; and an improvement in qualitative outcomes such as a higher confidence in managing specific clinical conditions, improved patient safety and increased job satisfaction. The study findings suggest that NHS England should urgently consider a standardised online learning portal to aid staff development and continued investment in service delivery.

Project summary 19

Project Title: Understanding attrition and retention issues of the NHS 111 workforce

Lead organisation: East and North Hertfordshire CCG/Herts Urgent Care

Theme: 3 Staff Attrition

Project aims and goals: The project aimed to help understand the factors affecting attrition and retention rates, and to gather benchmarking data to support improvements to staff turnover rates for the 111 workforce.

Project outline: The project sought to inform and start the development of templates for entrance and exit questionnaires, and workforce surveys which could be used as a standard template for all NHS 111 providers, so local and national data regarding Health Advisor and Clinical Advisor attrition and retention can be collated in a standardised format going forward.

Project evaluation design: A mixed methods approach using both quantitative and qualitative methods was utilised. Quantitative analysis of Health Advisor and Clinical Advisor retention and attrition rates were analysed since the NHS 111 Hertfordshire service went live in 2012. Qualitative information included both entrance and exit interviews with Health Advisors and Clinical Advisors to understand reasons for joining and leaving their roles. Further data was collated through a survey which was sent to all Health and Clinical Advisors using a written / online questionnaire to understand the issues affecting their roles. Administration of the staff survey achieved a 52% response rate. In total just under 26% of the combined Clinical and Health Advisor HUC NHS 111 workforce were interviewed. Of the 38 interviews conducted, 12 were with Clinical Advisors and 22 were with Health Advisors (totalling 89% of the interviews).

Key findings from the project evaluation: The quantitative and qualitative results from the survey covered the key areas for review and informed project outcomes such as job satisfaction, training and support, pay rates, opportunities for development, working hours and relationship with the provider (i.e. HUC). The overall findings from the study indicate that 42% of staff applied for NHS 111 positions through a recruitment website and 26% applied for 111 posts on the

recommendation of colleagues. Many reported that they did not fully appreciate the work role and environment before applying. When asked why they were attracted to the role, the two biggest responses were the inherent interest of the job, and the flexible work patterns. Staff favoured the set rotas which offered stability and flexibility as it suited childcare arrangements or study periods. However, many referred to the emotional pressure of having to work during school holidays or the Christmas period. Staff were happy to work over Christmas if they had the following year off, but this was rarely the case. Analysis of staff attrition rates indicate improvements in staff retention between 2014 and 2015 when new pay and work conditions were introduced. In 2014, 54% of staff had left the service and this figure had dropped to 35% in 2015. When data is compared between Clinical Advisors and Health Advisors the picture is mixed. Staff turnover among Health Advisors remains high. 29% of staff have been with NHS 111 for 3 years or more. There was no consistent message on reasons for leaving.

Strengths and limitations of the project evaluation:

Strengths

The study used a number of methods to engage with staff to identify a range of issues concerning staff attrition and retention.

Limitations

Progress against key targets

The study completed data collection and analysis within the given time period.

Appendix 2

Key points from workshops

Implementation issues

Timescale

- Evaluation and timescale – what can you do within the time?
- Timescale for impact
- Timescale does not allow evaluations to capture impact
- Limited timescale does not allow time to see the impact of actions
- Delivering project – staff availability

Data

- Retrieving data across services
- Being able to collect good baseline data
- Due to short timescale only baseline data is available
- How to define/measure patient satisfaction
- Getting enough data – response rate and robustness of sample
- Making the best use of available data – is there evidence to support subjective judgements?
- Governance – sharing data
- Currently only 'soft' data available – such as staff experience

Transferability

- Implementing project- recruitment issues, lack of IT support,
- How do you identify/define callers with mental health issues?

- Unique geography – questionable whether transferability of outcomes to other settings is possible

Future

- What next? Is this just a one-off exercise?
- Training affects the service and team can assess staff response
- Learning so far is about process-not yet impact
- Timescale- baseline data only available at present