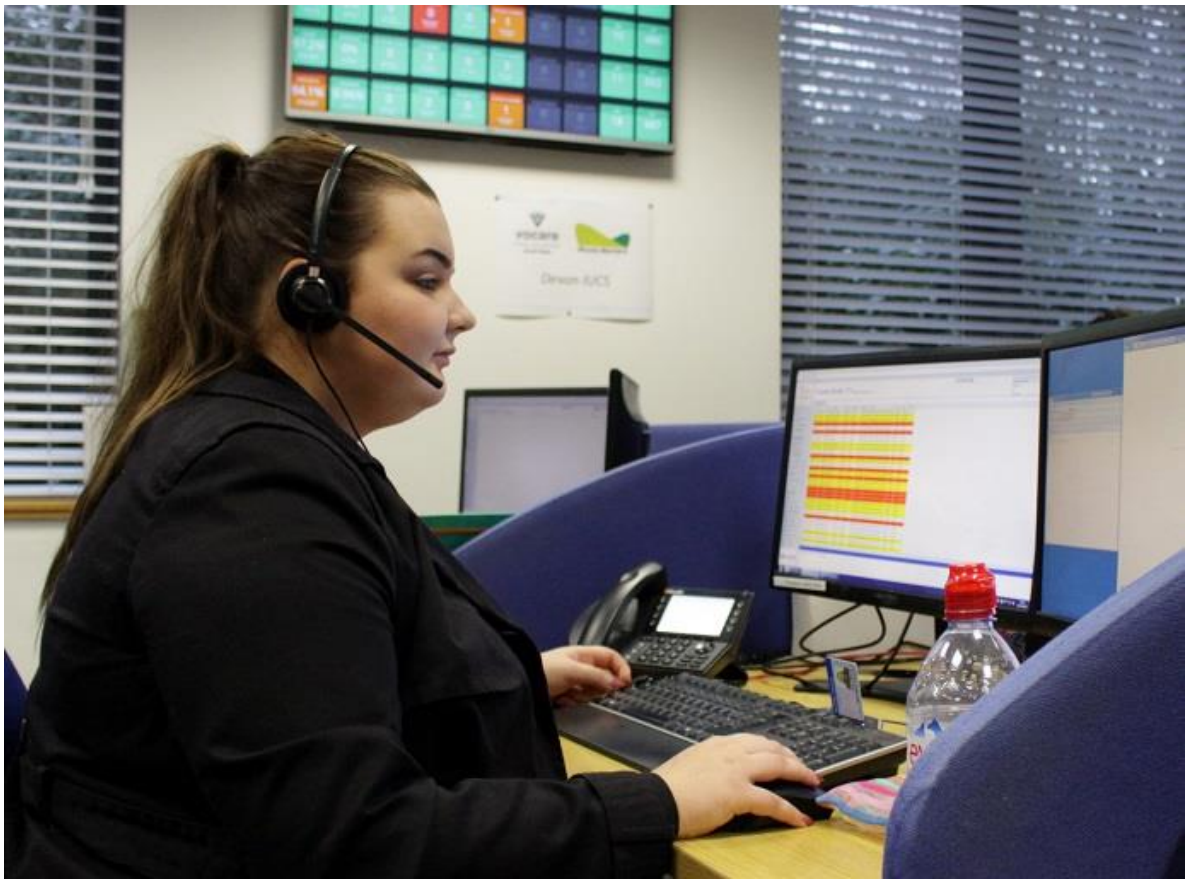
Integrated Urgent Care (IUC) / NHS 111 National Workforce Development Programme

Workforce Investment Fund Phase II Executive Summary & Full Reports 2016-2017



Background

The IUC/NHS111 Workforce Development Programme was established in April 2015 as a joint programme between NHS England (NHSE) and Health Education England (HEE). Informed by the Workforce Report published November 2015, the scope was developed at a point when NHS 111 services were determined by the NHS 111 Commissioning Guidelines. The current commissioning context provides a Service Specification for IUC that sees functional integration of the call handling service, together with Out of Hours services; crucially it introduced a multi-professional Clinical Assessment Service (CAS), comprising senior clinicians driving a Consult and Complete service for patients and the provision of clinical support and shared decision-making for health and care professionals within the community. The development of the IUC specification has seen the three year workforce programme developed to incorporate key components of the original NHS 111 service and the developing IUC services.

The overarching aim of the programme is to enable the development and professionalisation of the optimal NHS 111 / IUC workforce for the future to drive improvements in patient safety and experience within an effective healthcare system.

Programme aims:

- Increase clinical capability & competence
- Decrease un-needed ambulance and ED dispositions
- Increase 'Hear & Treat' / 'Consult & Complete'
- Decrease turnover, increase retention of workforce

Workforce Investment Fund Phase II

This second phase of the Workforce Investment Fund provided further opportunities for the development of the diverse IUC / NHS 111 Workforce. Enabled by programme investment in 2016/17, fourteen pilot projects were funded within NHS 111 healthcare providers and commissioners. Projects were awarded across a number of themes, including;

- introduction of the CAS,
- patient perspective,
- new workforce models,
- mental health competencies,
- recruitment and retention,
- workforce governance and oversight,
- integration across Urgent and Emergency Care, and
- projects which built on pilots from Workforce Investment Fund Phase I.

This report shares the learning and outcomes from the local pilot projects across England, as providers and commissioners sought to drive forward and test approaches to enhance service provision, upskill their workforce to improve recruitment and retention and respond to changes driven through the fast developing Integrated Urgent Care environment.

Key learnings and outcomes

The principal learning from the Workforce Investment Fund Phase II pilot projects indicate the importance of continuing to address IUC /NHS 111 workforce attrition issues; building in opportunities for an accredited telephone triage course for all clinicians working across the IUC care system; further developing remote and rotational working of pharmacist within Integrated Urgent Care and ensuring workforce well-being by providing timely mental health support. In ensuring the development and professionalisation of a well-led and supported multi-professional workforce, there are advantages in terms of patient outcome and system impact, including ensuring only the most appropriate cases result in an emergency department or 999 disposition.

Protecting delivery of care within the context of continued Urgent and Emergency Care (UEC) winter pressures across the health system and the limited timescales for project delivery restricted the depth and breadth of findings related to the impact of interventions. However, there is valuable learning from these pilot projects which can be used to inform future workforce development initiatives.

Table 1 shows the summary and key learnings from each individual pilot project from the Workforce Investment Fund Phase II.

Table 1 - Summary and Key Learnings of Workforce Investment Fund Phase II Pilot Projects

Project	Summary	Key Learning
Project 1 – Care UK – Piloting Work Well Programme with Price Waterhouse Cooper (PwC)	Worked with PwC to pilot the Work Well programme which was an online tool and resources that staff accessed; The project focused on the wellbeing of their staff and indicated ways in which to improve on the impact on quality and outcome of patient care, patient satisfaction, overall staff performance, as well as staff attrition and sickness. Healthier and happier people cost less, produce more and have better relationships	• Programme saw higher staff engagement levels (50%+ vs 36% in engagement survey) than seen previously • Positive correlation between resilience, work-life and stress • Good insight into workplace issues through sentiment analysis • Not enough data to see is improved wellbeing due to time constraints • suggests a correlation between the intervention and improving engagement, wellbeing and performance • Key insights around employee engagement and consideration of rolling-out programme to larger base
Project 2 –NHS Nene & Corby – Introducing independent prescribing pharmacists in Northamptonshire	Project saw introduction of independent prescriber pharmacist (IPP) working remotely from the NHS 111 call centre within an ED department– to manage medication and repeat prescription enquiries. Whilst the inclusion of pharmacists into the IUC NHS 111 CAS has been positively evaluated there remains a challenge to attract prescribing pharmacists to the role and to embed the practice and include it as part of a wider regional foot print has been limited by recruitment.	• Project was successful – IPPs were able to receive and manage the caseload resulting in patients avoiding a GP OOH consultation. • Activity costs decreasing during the course of the project suggests that it will become increasingly cost-effective • Challenges over matching resourcing and demand in staffing the function • Support and IT resilience important for pharmacists, suggesting better placed within the OOH call-centre or hospital pharmacy for supervision/support • 70.92% of outcomes over the 12 week pilot were for self-care • Modelling indicates that each case would cost £17.59 per referral

Project 3 – Derbyshire Health United (DHU) – Health & wellbeing of the workforce to improve recruitment & retention	Rolled out and implemented mini health checks for staff by way of support their health and wellbeing – specifically looking at stress/mental health issues. It recognised the value in support and retaining staff and also looking at the business costs too.	• Provided a valuable employee benefit • Improved the health of staff and improved motivation and morale • Helped to recruit and retain their staff • Helped staff with stress related problems • Helped staff with musculoskeletal problems • Reduced absence by 2% in the proceeding months • Highest absence in year 14.8%
Project 4 – DHU – Mental health nurses, support & upskilling the workforce	The project indicates a straightforward, cost effective way of improving the management of patients presenting with mental health symptoms across NHS 111 providers and ways in reducing the impact on the wider urgent care network from inappropriately urgent onward referrals	• Having a dedicated mental health clinician resource within the 111 service enabled the management of mental health calls more effectively and reduce the number of patients accessing inappropriate services with mental health conditions. • Pre and post surveys showed an obvious benefit of improving the confidence of the generic 111 advisors when managing these calls. • Pre intervention 50% of health advisors felt confident, 60% felt NHSP didn't support them, 82% felt having mental health clinician will be beneficial and 95% though additional training will be useful. Post training the service found the training helpful or very helpful, 60% had improved confidence. Prior to pilot 60% of calls went to an Urgent outcome disposition (Ambulance, ED, Urgent Primary Care) this reduced to 25% after 5 weeks of pilot.

Project 5 – IC24 – Developing remote consultation educational course for all clinicians	Development of a multi-disciplinary remote consultation course for all clinicians working across the integrated urgent care system. The training was aimed at a multi-disciplinary advanced practice level that included General Practitioners, Advanced Nurse Practitioners and Advanced Paramedics.	• Identified the direct benefits of this initiative and the benefits in providing specialised telephony triage skills. • High level of enthusiasm and engagement from clinicians and perceived benefit of learning on practice. • Further / additional insight around patient / clinician impact will be available from the final report due to be produced by the provider organisation in December 2017.
Project 6 – London Ambulance Service (LAS) – Exploring the potential for integration between the 999 and IUC/NHS 111 clinicians	This project looked at the potential for integration between the 999 and NHS 111 Clinicians in three areas: • Clinical Assessment Services (clinical hub); • New Workforce Models • Integration across UEC It embedded the 999 clinical hub staff within the NHS 11 services to look at knowledge, skills, confidence and experience. It looks at multiple handoffs and sought to eliminate this	• Identified a reduction in the number of pass backs between services and individuals at each stage of the patient cycle • Increased job satisfaction for staff as they use additional knowledge and skills leading to effective and efficient use of NHS resources • Patients have received improved care – “right response, first time” • Increased capacity during increased demand across the 999 and NHS111 systems • More patients treated in the community – fewer unnecessary A&E attendances • Demonstrated the possibility of setting-up remote service to bridge across services. • Gained live insight of demand and issues across both services. Need to consider placing the staff from NHS111 into the 999 environment too. • LAS 111 site 26.34% of calls closed by 999 clinical hub. Other providers in London varied from 26.92% to 33.71%.

Project 7 – London Central West (LCW) – Reducing referrals to secondary care including ambulance, ED and Urgent Care Centres (UCC)	Project sought to reduce referrals into secondary care – ambulance, ED, UCC and more widely by providing clinical staff within the NHS111/IUC/OOH with additional training and tools; innovations included: • Enhanced competences of existing clinical workforce • Introduction video conference facilities to aid home visit assessments • Introduction on Advanced Nurse Practitioners (ANP) for home visiting	• There were challenges in accessing necessary information to undertake end to end reviews of cases. • Challenged around establishing appropriate clinical governance around the ANP • Training sessions received very well by staff as was introduction of ANPs • Supports the extension of video/telemedicine and development of associated competences • A challenge with data sharing and information governance issues across system requires addressing.
Project 8 – Solihull CCG – Working with high volume callers and service users to reduce demand via Health Coaching	This ambitious project worked across multiple providers/organisations in a 1.3 million population, including acute, CCG, ambulance, mental health and community providers. It sought to drive the use of health coaching with a view to managing the demand across the system from frequent users It identified.	• Challenges of mobilising against Ambulance Response Programme occurring simultaneously in addition to release of frontline paramedic staff within winter period • Key innovation is around working as an IUC system rather than relying on a single organisation • Project needs to continue before being able to demonstrate outputs/benefits – Dec 2018 next system evaluation due • Data sharing and information governance required substantial planning across the system.

Project 9 – Vocare – Enhancing clinical competences of NHS 111 clinical advisors in Urgent Care	This project sought to develop the clinical advisors through a temporary development role to develop clinical skills together with consolidation of their practice within Urgent Care. It oriented around the development of a Junior Integrated Urgent Care Practitioner role at skills for health level 5/6 in conjunction with Sunderland University. Objectives were around recruitment and retention, development of career pathway, improved satisfaction, increased integration and supporting a career of choice.	• Unable to measure all desired outputs due to timescale of the project • Appetite from staff and organisation to develop clinical staff – addressed issues of confidence in role and perceived lack of training • Future development suggests development of dual job roles, serving to redistribute clinical resource in order to deliver a better patient care service • The project highlighted a number of workforce development opportunities and develop new and attractive role • Significant reduction in average 999 disposition rates from approx. 21% to 14% between Oct 16 and May 2017 and Ed disposition from 18% to 12.5 % in the same period. There was an increase in confidence of 16.9%.
Project 10 – Vocare – Developing & implementing training programme for Clinical Advisors	Development of a training programme for NHS 111 clinicians – focusing on validation of ambulance and ED disposition across multiple sites. This was a continuation of a WIF1 project addressing recommendations to test in a larger group of staff, develop methods for gathering more staff feedback and setting operational targets. It used senior clinicians to review disposition data to determine those with high and low referral rates. Questionnaires and one to one feedback shaped the design of education programme and project. Evaluation looked at rates of dispositions, a self-assessment of competence, costing of episodes and organisation benefit for intervention. Additionally they looked to develop professional and patient feedback rates.	• Benefits in referral rates were noted for all staff, with considerable inter-operator variation though all improved significantly • There was effect due to time of day/night and availability of services, but not evaluated, and some variation between clinical professions, again not evaluated • Significant cost savings to system modelled • There was increased self-reported confidence and competence and this benefited from discussion with consultants • The median improvement for referral rates for ED 32% and 41% for 999 and 67% of clinical staff now move outside NHS pathways to change dispositions

Project 11 – Vocare – Developing competences in mental health for Health Advisors	This project looked to increase the competences of Health Advisors in managing callers/patients presenting with mental health issues. The project that ran across multiple areas with 185 staff, including a supervision model as well as developing an education programme. Training was provided by a number of providers from national charities to local mental health trusts and local support groups i.e. Dementia Friends. Evaluation was considered across a number of areas, including call volumes, rates of referral and self-reported confidence and competence. Analysis also included external organisations' view on the effectiveness and appropriate of management of callers/patients with mental health needs.	• External organisation feedback suggested training, better referral pathways, closer working and information sharing and embedding mental health professionals into the NHS 111 service • Pre-training questionnaires revealed confidence and competence concerns amongst staff • Post-training found training useful and positive, engendering a greater understanding of mental illness and increased empathy • Suggested future training focus on suicidal and distressed patient communication, managing crisis and aggression, role play • 24% of staff trained responded to post education questionnaire, which showed small improvements in confidence • Before training 38% of staff did not feel confident in their management of mental health calls

Project 12 – Vocare – Developing a recruitment & competency framework for Pharmacists in IUC/NHS 111	Identification and development of a recruitment and competency framework for pharmacists working within the IUC / NHS 111 service. The projected introduced a greater number of pharmacists into the services, including OOH services managed by the provider, with a view to understanding the impact of incorporating the new workstream. It included developing competency framework; training programme; governance mechanisms.	• Operational and recruitment challenges were noted, as were competing regional and local agendas across operational areas • Creating uniformity of training was challenged by the variation in cohorts of pharmacists in terms of their experiences and competences Whilst there were obvious cost-savings available by utilising pharmacists there was reluctance from various CCGs and clinical leads – this was mitigated through audit and demonstrated a positive trend within the cohort, ultimately benefiting patient care. • Demonstrated better correlation with patient needs and better outcomes in appropriate cases with reduced costs • Competency framework, training programme and recruitment model were successfully developed and applied in line with an agreed governance framework.
Project 13 – Yorkshire Ambulance Service (YAS) – Creating a supporting and developmental audit culture	Identified ways how the culture that currently exists within the call centres about how people view call audits can be changed, improve staff understanding by building confidence and the feeling of being supported. Objectives included consideration how the existing culture around audits could be positively affected and how to improve staff understanding confidence and foster a supportive environment.	• Staff feedback demonstrated improved perception of audit post-project • Staff perception / view of audits felt to be valuable and useful as is peer/supervisor review • Training includes greater content around audit • There are greater costs (with unknown cost benefits) associated with the implemented model • To maintain this audit system would require an additional £100k annually

Project 14 – YAS – Creating a supportive and developmental culture within the team through supervision	The project looked to identify alternate models of supervision within the workforce and make recommendations to best methods. The project explored the team concept and how/if this can work to benefit staff and the organisation. It suggests ways to involve staff in developing a more meaningful and effective supervision and appraisal process that is valued and will support the improvement of patient care. Interventions included setting-up of pilot teams which were re-structured and re-aligned in terms of rostering; identities were created through colours; feedback was gathered around interventions which would improve effectiveness of the team.	• Additional Team Leaders were deployed across the centres, resulting in reduced management spans with managers able to follow staff shift patterns. Whilst proving beneficial the learning was that this is challenging to deploy fully given the variety of shift patterns and the required increase in Team Leader numbers. • Staff satisfaction and PDR compliance was increased through team alignment and limiting size • Increased support provided a positive impact on staff perception • A further review is required to consider other duties required to be undertaken by team leaders • The percentage of staff who felt they had enough support from their team leader rose to 95% from 74%

Table 2 - Project Themes

The final Workforce Investment Fund Phase II full reports are contained within Appendix A:

This table below shows the spread of projects by themes and a further visual tool can be found in Appendix B.

Project Theme	Project Number	Lead CCG organisation/NHS 111 Healthcare provider
Introduction of the Clinical Assessment Service (CAS)	2, 5, 6, 7, 8, 9, 12	NENE CCG, IC24, LAS, LCW, Solihull CCG, Vocare
Patient perspective	4, 7, 8	DHU, LCW, Solihull CCG
New workforce models	2, 6, 7, 8, 9, 12	NENE CCG, LAS, LCW, Solihull CCG, Vocare
Mental health competencies	4, 8, 11	DHU, Solihull CCG, Vocare
Recruitment and retention	1, 3, 5, 7, 8, 9	Care UK, DHU, IC24, LCW, Solihull CCG, Vocare
Workforce governance and oversight	8, 11, 12, 13, 14	Solihull CCG, Vocare, YAS
Integration across Urgent and Emergency Care	5, 6, 7, 8	IC24, LAS, LCW, Solihull CCG
Projects which built on pilots from Workforce Investment Fund Phase I	2, 5, 10, 11	NENE CCG, IC24, Vocare

The final reports from the Workforce Investment Fund **Phase I** can be found by clicking here.

For more information, please email: england.workforcedevelopment111@nhs.net

Appendix A – Full Project Reports

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Project 1 – Care UK – Piloting Work Well Programme with PwC

Contact details	
Name of Organisation	Care UK
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Date of Report Submission	31 May 2017

Project Summary
Themes: ● The fundamental principle of this project is that healthier people perform better, cost less and cause fewer organisational risks. Work Well is a new programme that has been developed by PwC to improve employee wellbeing and measure the impact on business performance in a meaningful way. ● PwC define Wellbeing as 'being the best version of yourself'. The approach was to be as holistic as possible to help people be at their best both inside and outside of work. This includes looking at areas such as working practices and management alongside the more traditional wellbeing areas such as Nutrition and Exercise. ● The programme delivers interventions at three levels: ○ **Employees** - receive a direct intervention through a Wellbeing Platform 'My Wellbeing' that raises self-awareness and provides tailored support to change a particular behaviour to help even those who are 'healthy' be the best version of themselves. The platform also provides virtual coaching to support the individual in making their habit change stick. Employees also receive pulse questions to help the organisation understand what it can do differently ○ **Managers** - receive a dashboard to track team issues and progress against identified issues. They can join working sessions with peers to agree actions they can implement to improve identified issues.

- **Organisation** - leaders receive a detailed report showing progress against KPIs and outlining key opportunities for further improvements including quick wins to boost productivity, engagement and cost management based on the data driven insights gathered.

Target Group and Geographic Coverage:

- The target population for this pilot was front line staff in the NW London call centre, based in Southall, who service the 111 contract held for Outer North West London (ONWL) and Hillingdon delivering c.300,000 calls per annum. This site is also networked with our other call centres Bristol and Ipswich.

- Total number employed is 176 staff - many of these are part time:
  - Health advisors employed is 135
  - Clinical Advisors employed is 22
  - Operational supervisors: 6
  - Clinical supervisors: 4
  - The team is supported by a Call Centre Manager and a Clinical Lead. In addition there are two Medical Leads, a Regional Training Manager and 4 Administrators

Background

- Care UK have long been interested in improving staff morale, welfare and reducing the incidence of workplace and other stress factors. We abide by a set of values called the “Three Ps”: Patients, Performance, People.

- The My Wellbeing programme neatly ties the three elements together, since improving the wellbeing of front line staff inside and outside of work, will enhance performance and therefore their ability to deliver positive patient outcomes.

- Care UK have previously implemented a number of schemes, including Schwartz Rounds, and approaches which have already had a positive impact on attrition and sickness, and we had the opportunity, working with PwC, to trial another approach.

- Although Care UK offer a number of corporate staff programmes, these have generally not had a lot of engagement from the team in London. We therefore felt a more targeted and personalised programme would be more beneficial.

Challenges

- **Low engagement.** The NW London call centre has typically shown continued signs of low engagement, and in some cases, scepticism of management intentions. Culturally, this impacted the adoption and engagement with the programme.

- **Communication blockers.** Staff are not allowed to use phones while on the floor, receive large volumes of emails on a daily basis, and the vast majority are not able to access emails outside of work hours this made communication of programme updates difficult and daily engagement with some aspect of the programme very challenging to either access or remember to perform.

- **High workload.** Call volume dictates that staff may not be able to engage with the programme while at work.

- **Shift Patterns.** Care UK operates a 24 hour enterprise, with peak hours being outside of typical 'core' hours: 9am - 5pm. While the organisation implements a fair and unbiased approach to the rotas **they can and are seen at times to be quite inflexible**, this undoubtedly impacts on the wellbeing of staff as they may have to spend less time with children, partners, social circles, etc.

- **Poor team dynamics.** Staff rotas are designed, when possible, to minimise the number of people required to work anti-social hours without impacting negatively on patient outcomes. This means that it is difficult, particularly when call volumes are high, for staff to be able to socialise together and build relationships with each other. Strong relationships and networks in work can be an effective tool to deal with difficult and stressful situations and engagement with programmes and initiatives as people can feel isolated and not benefit from the push that others will give to engage with change.

- **Poor team cohesion.** Further to the point above, staffs are often not aligned to teams in the more traditional sense, with staff unlikely to work with the same colleagues shift - to - shift. This impacts the call centre's cohesiveness which may have a further impact on support networks to help in a crisis point as well as a preventative tool.

- **Culture.** For a number of the staff, this is not their sole or even primary job, and a number of staff are students. This makes developing a team culture difficult and has also impacted negatively on reliability. Additionally, this contributes to high staff turnover which is unlikely to be affected by improved wellbeing.

Approach

Programme outline

An integrated web application and behavioural change programme was deployed which included the following:

- A web based wellbeing platform, to help users better understand and improve wellbeing i.e. fitness, sleep, nutrition, stress.
- A 10 week personalised wellbeing programme that uses science, personalised coaching and habit-forming behaviour change techniques.
- PwC helped to ensure the design and deployment of the programme was data-driven and user-centred.
- Programme engagement supported by engagement with supervisors and staff representatives (wellbeing champions).
- Bi-weekly sessions with supervisor and champion groups to update on results and problem-solve any issues that have arisen as a result of the data the programme has produced. To support this, supervisors are provided with weekly dashboards with key metrics including engagement levels of their teams.

Data-centred approach

- Care UK track and monitor baseline data for staff sickness (short and long term), attrition data (including reasons for leaving), and staff engagement from our annual survey. This data is however influenced by various factors and may not be the only indicators of the success of this pilot.
- A baseline measurement of current absence, utilisation, and call audit scores taken at the beginning and end of the programme. Again the data may be influenced by external factors and consideration of this must be applied.
- Measurement of current wellbeing scores is taken at the start of the programme to form the starting baseline. The wellbeing assessment is comprised of 20-30 questions across 8 areas including: Resilience, Exercise, Financial Wellbeing, Healthy Eating, Sleep, Stress, Workplace Environment and Smoking.
- At the end of the programme participants self-evaluate against these areas to determine any improvement from the previous 10 weeks.
- End of programme survey to capture additional feedback.

Intended outcomes
We will be investigating whether the programme has had any positive impact in the following areas: ○ wellbeing scores (new data - provided through platform) ○ staff engagement (existing Care UK data) ○ absence rates (existing Care UK data) ○ call utilisation rate (existing Care UK data) ○ call audit scores (existing Care UK data) Complete analysis is dependent on access to full data for the duration of the programme and historic datasets in order to assess for seasonality. In the Integrated Urgent Care Model, there is a very diverse group of individuals managing various specialist areas including both clinical and operational functions. This programme is sufficiently versatile and personalised to be effective and cater to individuals' preferences in such a dynamic environment.

Intended outputs
Staff ● Improved awareness and the provision of tools and resources to improve staff wellbeing. **Management** ● Increased management awareness, and improved capacity and data to support staff with their wellbeing. **Leadership** ● Greater understanding of the issues having the biggest impact on staff performance and engagement, and ultimately, what actions can be taken to address this. <u>Strengths of project:</u> ● Employee centric. The project aligns well with Care UK's "Three P" values. It focuses on empowering an employee to manage their own wellbeing through scientifically-based lessons, online resources and access a wellbeing coach. ● Outcomes based. The aims of the project are designed to deliver positive, measurable outcomes. These being:

- To help raise awareness of wellbeing management
- To improve the wellbeing levels of call centre staff
- To positively impact on the performance of staff
- To enable management to take a greater role in employees' wellbeing

- Data-centric decision making. The use of a specially designed platform with employee communication methods enables increased levels of employee data to be collected. This allows for PwC to pass anonymous and accurate employee insight to Care UK management that enable better decision making.

Innovation:

- The programme innovatively combines technology and a variety of behavioural change techniques in a 10 week programme in a way that has not been done before. The platform creates a wellbeing journey which starts with a self-assessment that displays the areas of strength and weakness in their current wellbeing. The platform then guides the user to a number of tailored topics for the user to choose from - this forms the basis of their focus for the next 10 weeks. The topic they chose is made up of small online video lessons they can watch on the move, at home or at work. Their wellbeing journey is supplemented with access to lifestyle coaches available on an almost 24/7 basis; onsite sessions with programme managers and a variety of employee communications methods. The benefit of this is that the model can be easily scaled for deployment across other sites/ nationally.

- The use of anonymous daily pulse questions allows employees to feedback to management on potential issues - wellbeing or otherwise -in a near-real time. These are then feedback to management in an accessible dashboard based format providing management with invaluable insight into the population meaning they are then able to make changes in a quicker and more agile way.

Details of resources and any potential partnership
Care UK resources: ● Deputy call centre manager - project manager and main point of contact ● Clinical and operational supervisors - ambassadors of the programme and team leaders ● Staff representatives - allocated as 'wellbeing champions'

- Data analyst - to provide weekly datasets for analysis
- Prayer room - quiet reserved place to take calls with life coaches
- On-site phone - for anonymous calls to coaches

PwC LLP partnership support, provided:

- Access to My Wellbeing platform
- Wellbeing lessons and resources
- Access to Life Coaches via phone
- Template employee communications
- Data analysis via dashboards provided to management and supervisors; including:
    - Engagement leader board - weekly
    - Pulse question responses - bi-weekly
    - Management insight - bi-weekly
- Facilitation of bi-Weekly feedback sessions with supervisors and "wellbeing champions"
- On-site support to assist with minor wellbeing issues, problem solve potential issues act as impartial sounding board for staff / management.

Obstacles and issues

- **CQC Inspection.** The contact centre's CQC inspection coincided with programme launch, requiring significant focus and resource commitment and placing pressure on staff. As Care UK was not able to devote the resource needed to implement a management lead wellbeing programme, this problem was overcome by increasing the involvement of PwC.

- **IT issues.** Care UK's IT security system unexpectedly blocked crucial parts of the website for a number of weeks that wasn't picked up during testing. This was resolved but had a significant impact on user engagement.

- **Limited access channels.** Staff struggled to engage with the programme during work hours, and found it difficult to access the platform outside of work due to lack of work-issued mobile device. We attempted to resolve this by providing 15 minutes of paid time every week at the beginning or end of a person's shift to use the platform and engage with their coach, however this did not receive strong take-up.

- **Shift rotation.** We struggled to find an effective method to communicate regularly with Staff, Managers and Staff Reps (Wellbeing Champions) due to shift patterns and inconsistent attendance at meetings that PwC needed to hold with these groups. This slowed and neutralised effectiveness of employee communications, implementation of the programme and impeded ongoing engagement of supervisors and staff reps. Different approaches were taken by both Care UK leadership and PwC to engage different groups of employees, including shutting down the centre for 60mins to address staff, holding multiple versions of the same meeting with Supervisors and Staff Reps and asking people to dial in when out of shift.

- **Team structure.** The lack of "teams" may have meant that staff were not engaging with the programme due to low inclination to do so for the benefit of their colleagues. We therefore organised staff into teams under a particular supervisor and set up a team challenge, offering personal and team incentives. We further supported supervisors with leader-boards so they could keep track of team issues and progress during the challenge.

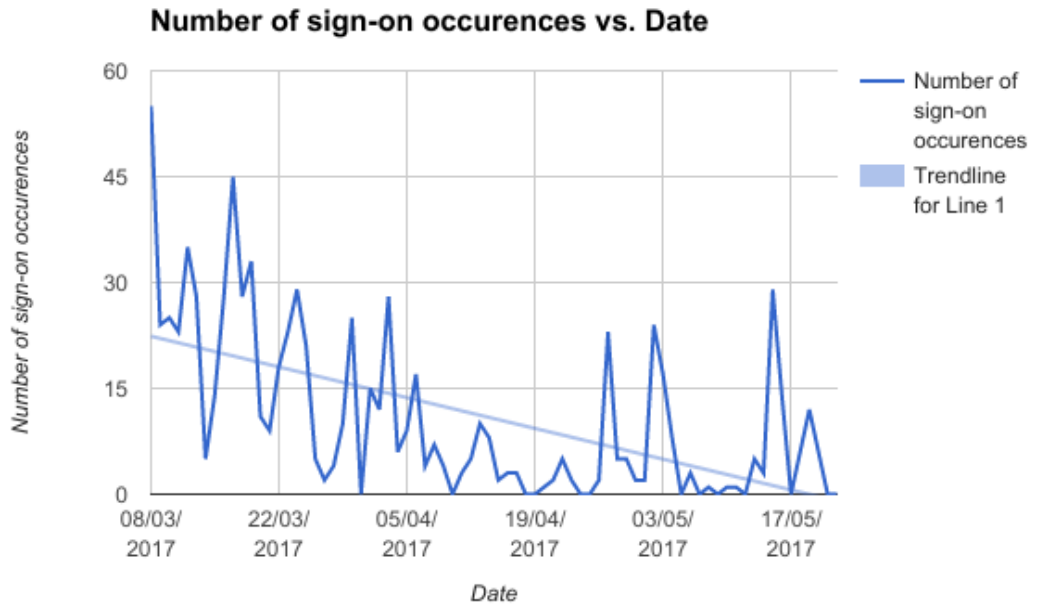
- **Wellbeing Champions.** The programme is designed to take a bottom up approach, especially in environments where there is low engagement (as typically anything coming from management is regarded with a high level of scepticism). In this case the Staff Reps were identified as the ideal Wellbeing Champions, however despite engaging with Reps specifically before kick-off, they did not contribute significantly to the programme and encourage their peers to engage.

- **High Scepticism.** There was large-scale initial and ongoing minor scepticism of the intention of the programme. Further feedback received suggested that this approach by management was an attempt to "place blame" for and / or "cover up" underlying and fundamental issues with the contact centre. We attempted to alleviate this by running sessions and having PwC consultants on the group to raise awareness of the background of the project. The messaging around engagement with the platform was also adjusted to reduce some of these misgivings to make it less "pushy", based on feedback received.

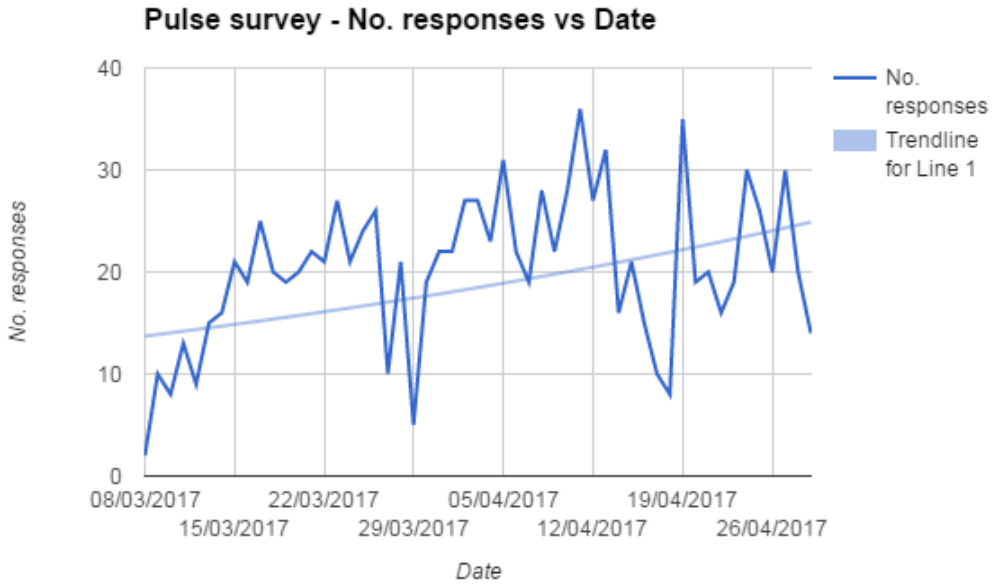
- **Data collection.** Anticipated data was difficult to provide due to Care UK resource constraints

Actual outcomes

1. **Comparatively high engagement.** Overall the programme saw higher engagement levels (50%+) than seen previously (e.g. higher response rate than the engagement survey c.36%). Due to IT issues, the key components that were expected to maintain enthusiasm (such as the e-learns) were not operating properly, this saw a strong decline in continued platform usage after 4 weeks as evidenced by the chart below:



   - We did however see an upwards trend in response to daily pulse questions. This feature was not affected by the IT challenges in the same way, and was more readily accessible (via email) indicating that if the IT issues had been sorted and some of the access challenges (see above) been resolved we might have seen a stronger pull through of platform usage over the 10 week period.



2. Wellbeing insights

The platform did deliver some data insights regarding the wellbeing factors that are most closely related (e.g. which factors affect each other the most). The highest correlations we found were between resilience, work-life and stress - all of which were positively correlated. We've illustrated the detailed results below.

The above scatter plots, with a trend line added, demonstrate the correlation between these wellbeing areas. This shows that people who scored higher on resilience, also tended to score higher on worklife and stress. Therefore, greater resilience indicates better worklife and lower stress.

The chart below illustrates that those who are less stressed, typically report higher worklife satisfaction.

These findings indicate congruence with current research and help to validate the authenticity of the findings and responses received.

3. **Sentiment analysis.**

We were able to gather greater insight into workplace-related issues. Based on responses to pulse questions, the trends we found were:

- Overall, respondents appeared to be positive about their team and supervisor.
- There were less positive responses in relation to leadership and the organisation as a whole - indicating one of the biggest areas of opportunity to focus on improving Workplace productivity and Wellbeing
- There were polarised opinions regarding the value of the job, people's workstation and whether people were getting enough exercise - this allows us to focus on the areas of the business where there are job related issues.
- The most negative responses related to personal aspects of people's life and wellbeing. These include whether people have enough sleep, exercise, energy levels, back pain and time & energy for friends and

family. Back pain in particular was an issue, with 78% of respondents citing this as an issue.

4. Trust

Qualitative and quantitative feedback suggests that the relationship between leadership and staff requires improvement. The programme has catalysed a rebuilding of trust and greater two-way transparency. For instance, the use of fortnightly briefings and daily pulse questions enabled management to gather employee insight which resulted in a rapid and public response to issues:

- *Example 1:* After discussions with staff, it became clear that some would like to take “time out” after a stressful call. Leadership were able to reiterate to all staff that this was always available and supervisors actively encouraged staff to take 5 minute breaks after difficult calls to avoid the negative impacts that this has on wellbeing and productivity.

- *Example 2:* One of the pulse questions indicated there was an instance of physical threat / harm outside of work. Management quickly notified staff that they are able to assist and provide support where this happens.

Actual outputs

1. **Wellbeing Improvements**

The table below shows the average scores for the wellbeing categories included in the Wellbeing Self-Assessment. You can see that there is a dip in April and an upswing in May, however the May figures aren't significant as based on two responses at most.

Average Wellbeing Scores (%)	March	April	May
Sleep	20	26	65
Financial Wellbeing	67	59	77
Nutrition	59	48	75
Resilience	56	33	64
Smoking	82	54	38
Exercise	52	43	50
Worklife	68	32	90
Stress	50	25	63
Overall	57	40	65

2. **Performance Improvements**

In the analysis of absenteeism and call audit performance, there was a possible indication that those who actively engaged with the programme were more likely to take less sick days and achieve higher call audit scores. This is a promising sign that suggests a correlation between the intervention and improving engagement, wellbeing and performance.

Comparison of programme engagement level against audit performance.

		Month					
Bucket	**Audit score**	**1**	**2**	**3**	**4**	**5**	**Count**
No engagement	92	91.9	93	92.2	81.7	88	105
Signed on with no participation	94	94.1	94.8	93.8	83.9	82	64
Minimal participation	95	93.9	95.6	94	96.7	97.5	21
Full participation	94	94.9	94.6	96.4	n/a	73	4
Overall	**93**	**93**	**94**	**93**	**84**	**87**	**194**

There are insufficient data points in the table above to draw any statistically significant findings. However, a general trend that can be identified is that those with no engagement typically have lower audit (job performance) scores than those who have shown an interest.

We found an inconclusive impact on utilisation due to engagement with the programme, primarily due to insufficient data.

3. **Sickness Trends.**
   Comparison of programme engagement level against sickness days taken

   The table below shows the percentage of people in each bucket who took at least one Sickness Absence Unpaid day in each month.

		Month					
Bucket	**Overall**	**1**	**2**	**3**	**4**	**5**	**Count**
No engagement	45%	n/a	n/a	18%	29%	14%	105
Signed on with no participation	39%	n/a	n/a	20%	19%	13%	64
Minimal participation	24%	n/a	n/a	19%	10%	5%	21

Full participation	25%	n/a	n/a	25%	0%	25%	4
Overall	**41%**	**n/a**	**n/a**	**21%**	**24%**	**14%**	**194**

As can be seen above, there is no clear trend in sickness days taken over time and between the different buckets. We note that due to the seasonal nature of sickness days, it is difficult to draw a conclusion based on 3 months' worth of data. Seasonal data was not available against which to make the comparison more fully.

Lessons learned

We have learnt significantly from this pilot and will be leveraging these lessons for future pilots or programme rollouts. Key lessons include:

- **Employee engagement.** Low engagement and scepticism within the call centre of 'another initiative' was more aggressive than anticipated.
    - The CQC inspection coinciding with launch could not have been prevented, however we would in future seek to better clarify that the two events were mutually exclusive, in order to ward off any feeling of scepticism.
    - Any future programme should focus on spending more time with staff prior to the launch in order to co-produce more elements of the programme with them. This was particularly apparent with the 'staff rep' population who had the potential to be ambassadors for the programme but did not engage.
    - Multiple launch events, including site shut downs, would have enabled us to reach more staff.

- **Management and Wellbeing Champion engagement.** Despite incentivising supervisors and Wellbeing Champions to engage with their staff, they were not as engaged as expected. Some of the reasons for this were endemic i.e. it is difficult to get all supervisors / wellbeing champions together at once due to varying shift pattern. However, any future programme would benefit from a smaller, more intense pilot for management to help identify and encourage early adopters and promote leadership by example.

- **In-person coaching.** We were surprised that take-up of the provision of a wellbeing coach was low - especially given their 24 hour availability, zero cost and plenty of on-site marketing and an onsite room dedicated to confidential conversations.
    - We discovered that following a site visit from one of the coaches, and a handful of one-to-one sessions with staff, this was very positively received. If resource and costs allowed, more of these face to face sessions would have been desirable.
    - Additionally, after discovering a latent bias towards the word 'coach', we transitioned to using the language of 'life coach' instead. This is would be recommended for any future programme.
    - There was perhaps some scepticism about taking a coaching call in a room and on a phone owned by the organisation. While this should still be offered, the key would be to encourage people to do it via their personal phones in a space that works for them.

- **Business as usual.** Resource constraints & external factors impacted on

adoption more than anticipated. While there was little to be done to impact the timing of these external stimuli, additional contingency resource would have improved management oversight, especially during the particularly stressful periods.

Next Steps

- **Review and evaluation.** The programme has provided many insights related to employee engagement, wellbeing and operations that will that will help us to make improvements. We have asked PwC to facilitate a session with us so we can better explore these results and test themes with key stakeholders.

- **Develop plan of action.** Based on the findings of this report and our playback session we will be developing a plan of action. Any agreed upon tasks will have been evaluated based on feasibility and assigned an owner to ensure accountability.

- **Further deployment.** Based on the outcome of this programme, and building on the feedback and rich lessons learnt, consideration will be given to a possible rollout of this programme to a wider population.

Project 2 – NHS Nene & Corby – Introducing independent prescribing pharmacists in Northamptonshire

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Project Summary

The model for the Northamptonshire pilot was designed to enable a prescribing pharmacist to work remotely and to assess medication enquiries and issue urgent repeat prescriptions if necessary. This should reduce a significant proportion of work for NHS111 and OoH during bank holidays and weekends. The proposal in Northamptonshire is that 'Medication Advice Dx82' and 'Repeat Prescriptions Dx85,86,87' will be routed via the Directory of Services into the Adastra integrated system and managed by prescribing pharmacist, rather than going to nurse advisors.

The calls will be identified for the attention of the pharmacist and the pharmacist will call the patient back. The pharmacist will assess the reason for the call and provide appropriate advice. If the pharmacist identifies that the patient still requires a doctor then the pharmacist will have the ability to forward the call via the normal routes on Adastra for an appointment, clinical advice or, if necessary, a home visit.

This pilot should remove the need for medication enquiries to be directed to a nurse advisor and ensures that the most relevant skill mix/professional interacts with the patient, thus avoiding duplication.

The pharmacists will work from within the Northampton General Hospital Emergency Department and utilise remote access to the Adastra system. Access to summary care records will be available to ensure that accurate medication advice can be provided and urgent care repeat prescriptions can be arranged. Regular auditing of pharmacist calls will take place using the RCGP toolkit audit process and these results will be reviewed by the audit team. Quality teams within the CCG will support the call review process in line with current practice. In addition, patient satisfaction questionnaires will be sent to

these patients and will be used to compare the levels of satisfaction with other cohorts.

The pharmacist will provide the added benefit of giving support and guidance to the clinicians within the Emergency Department. The pharmacists will be fully trained in Information Governance and they will work under the IG and clinical governance procedures of Derbyshire Health United. There will be an information sharing agreement in place and confidentiality agreements signed. The pharmacists will receive induction into the service, specific training on the use of Adastra, NHS Pathways awareness and clinical telephone assessment skills if required.

The pilot will provide countywide coverage for patients across Northamptonshire.

Background

Previous pilot schemes introducing pharmacists into the call centres have shown that the call length for medication related enquiries reduced by 46% and a closure rate of 93%. It was anticipated that the project would reduce a significant proportion of work for NHS111 and OoH during bank holidays and weekends.

Whilst there had already been successful integration of pharmacists within the 111 call centre's there remained a challenge to attract prescribing pharmacists to the role. This project explored the ability for pharmacists to work remotely to receive warm transfers for advice and repeat prescriptions.

Challenges

The main challenges identified prior to commencement of the project were the recruitment and availability of pharmacists to support the project, the operational elements associated with the recruitment process and the time that this takes and the identification of a clear picture of anticipated outcomes.

Approach

The project followed a clear timescale; the key project activities and tasks are below with a summary of how these were delivered:

- **Project group to be set up to plan and agree the scope and implementation of the pilot.** The initial project group met during late December 2016 and identified the requirements for commencing the project.
- **Outcome measures to be agreed and circulated to the recruited pharmacists to ensure that they record these.** The project group agreed the outcome measures and some specific KPI's. Most of this is addressed within the DHU data and additional ED activity undertaken by the pharmacists was manually recorded.
- **Prescribing codes to be sourced and allocated for the pharmacists to enable them to issue repeat prescriptions as part of the project.** This information was requested of the Pharmacy team at the CCG and registered on the Adastra system at DHU.
- **Recruitment process.** Northampton General Hospital expressed an interest in supporting this pilot and offered to identify any pharmacists that would be keen to support; they identified 2. Derbyshire Health United were tasked with recruiting an additional 2 pharmacists to support the pilot; these staff remain on the books with DHU following the pilot and are now providing some support for other areas and medication enquiry calls.
- **DHU to source and provide the relevant equipment for the project.** A member of the DHU IT support team was tasked with sourcing this. There was some delay in the adequate provision of equipment due to time-constraints on behalf of the allocated person however this did not impact go-live date.
- **Rotas to be collated and shared with pharmacists.** DHU led on the collation of rotas for the staff members. There was regular contact between the HR team and the pharmacists to ensure that they were working shifts that were suitable.
- **Honorary contracts to be requested and implemented from both DHU and NGH for the 4 recruited pharmacists.** There were some delays associated with awaiting references for the newly recruited staff members. Honorary contracts were completed for all pharmacists prior to go-live date following regular update requests from the CCG. The CCG facilitated many conversations with partners involved to ensure that the relevant documentation was being shared in a timely manner between partners.
- **Inductions to be scheduled at both DHU and NGH (locational only).** Due to the other commitments of the pharmacists, induction sessions at DHU had to be scheduled across 4 separate days. There was a noticeable challenge for one of the pharmacists in physically getting to DHU due to personal travel restrictions. The CCG regularly contacted DHU colleagues and pharmacists individually to arrange induction sessions and ensure that each pharmacist was fully inducted before the go-live date.

- **Agreement of a go-live date for the pilot.** The CCG and DHU collectively agreed for a soft-launch go-live date for the pilot of Saturday 25th February. This was agreed as the equipment was unavailable to support the Emergency Department base for the first shift; the pharmacist working this weekend was based within the NHS111 Call Centre.
- **Call recording**. The project group wanted DHU to implement a method for the calls to be recorded once passed to the pharmacist. DHU IT support attended the ED and ensured that the phone system was able to record the cases for the duration of the patient pathway. This provided assurance that any case could be reviewed at a later date if necessary as part of the monthly end to end call review sessions led by the CCG.
- **Prescription pads.** There was some confusion initially as to whether the project would require specific pads. After discussion with DHU, confirmation was delivered that DHU would provide some of the specific prescription paper and that the pharmacists would have the ability to print directly from Adastra.
- **Evaluation in relation to KPI's.** Survey to pharmacists, data collation from DHU including patient satisfaction surveys, data re call length, number of cases picked up, reduction in OoH activity. Surveys circulated to pharmacists on 3rd May; as of 22nd May, 3 returned (below). The surveys outline a mixed combination of feedback outlining some learning points moving forward. The pharmacists also provided feedback on what they felt went well and what would require some additional work in order for the pilot to be more successful in future. Surveys were also circulated by DHU to some of the patients that participated in the pilot; as of 22nd May, there is limited data available due to a lack of returns; additional surveys will be distributed for review at a later date. Initial data collection available from DHU evidences the number of cases picked up by each of the pharmacists with a large data dump providing details of each individual case (time of call, length of episode and whether there were dealt with or forwarded onto another service).

Intended outcomes

The project links with the national Integrated Urgent Care Workforce Programme agenda via the following themes:

- Clinical Assessment Services (Clinical Hubs)
- New Workforce Models
- Projects specifically building on from WIF Phase 1 pilot

The measurement framework and anticipated impact of the pilot considered the elements below:

- The length of a patient's episode of care from end to end when presenting to the NHS 111 service will be compared pre and post the intervention. It is anticipated that this will reduce. It was anticipated that

this could be measured via the available DHU reporting function to outline case length for patients going through OoH for their repeat prescriptions versus the call length for cases utilising the pilot.

- The impact of a prescribing pharmacist working remotely versus a non-prescribing pharmacist within the call centre will be measured in terms of performance and outputs. This will be picked up via the relevant qualitative data collection (surveys).
- Level of satisfaction will be a measurement as part of the normal process of patient satisfaction but the patients on these dx codes will have a targeted patient satisfaction survey circulated by DHU.
- Qualitative data will be obtained from pharmacists, out of hour's clinicians and NHS 111 nurse advisors via discussions and surveys.
- The reporting will be from the Adastra software and within the normal parameters. A summary will be provided of the main reasons for contact requests.
- The project team will be established with leads from DHU, Lead commissioners and Nene CCG.
- Weekly project planning / implementation meetings with all members of the project team will take place.

Intended outputs

The main strength of the project is the ability for pharmacists to work from a remote location to provide repeat prescriptions for patients in emergency situations. This means that it is possible for a pharmacist to work from a location other than the DHU call centre to do this, enabling pharmacists more freedom to work from a location closer to home allowing more time to be spent undertaking the role. It was anticipated that the number of cases sent through to the remote pharmacist would help to reduce pressure on OoH services for repeat prescription requests during weekends and bank holidays. Feedback from OoH partners was positive and they felt that the project was helping to reduce pressure on their services. The project was anticipated to deliver a smooth pathway for patients allowing them to easily access a repeat prescription from their local pharmacy without the requirement to see a GP.

Details of resources and any potential partnership

The project required partnership working between the CCG, DHU (NHS111 provider) and Northampton General Hospital to ensure a seamless operational model. The model required several pharmacists to support it in order to cover shifts each Saturday and Sunday and Bank Holiday from 8am-8pm. 2x pharmacists already employed by Northampton General Hospital offered their support for this. Derbyshire Health United recruited an additional 2x pharmacists to provide adequate cover. Derbyshire Health United also provided IT support for this project.

In addition to staffing resources, the pilot required some equipment (a laptop, a printer) to ensure that the pharmacists would be able to adequately complete cases. All equipment was provided by DHU.

Obstacles and issues

- Honorary Contracts

One of the initial challenges was the arrangements for honorary contracts for the pharmacists to enable them to work as part of the pilot. There were some challenges with this as the 2 NGH pharmacists' required honorary contracts with DHU to enable them to access the Adastra system and to undertake an induction. Similarly, the 2 DHU recruited pharmacists required a locational induction at NGH to ensure that they were aware of the department layout, facilities etc. They also required honorary contracts with NGH. This process was time-consuming as each partner requested different information and there were delays in receiving the appropriate documentation from the pharmacists. Honorary contracts were provided for all pharmacists before go-live. Inductions at DHU were held in the 2 weeks before go-live; pharmacists all attended for their inductions at different times due to their other commitments and it was noted that DHU is geographically challenging for some of the pharmacists to attend. Despite this, all pharmacists completed the appropriate induction.

- Utilisation of support within ED

Another issue noted was the utilisation of the pharmacists by the ED department for support. It was agreed as part of the initial project plan that pharmacists would be able to provide support to the ED department for pharmacy-related queries however this was not well utilised. Some of this was in relation to the A&E department being unaware that the pharmacist was there to help. Initial contact was made with the A&E Lead Consultant before the pilot began to inform them that the pharmacist would be there during weekends for the next 12 weeks and a reminder was sent to the pharmacists part way through the pilot to request they introduce themselves at the A&E Desk on arrival for their shift to ensure increased awareness. Attached below is a breakdown of the additional work done to support ED recorded by the pharmacists.

As an aside it is important to note that capacity issues within the staff rota for the pilot were such that, had the ED department wished to utilise the pharmacists more, it may not have been possible for the pharmacists to provide support due to the intensity of their work load.

- Availability of local pharmacies

Another issue which was pointed out by the pharmacists was that there is a distinct shortage of pharmacies within the county that are open during weekends and bank holidays. This was also picked up by the DoS Lead and Urgent Care Team on a separate occasion and has been flagged to NHS England. This made it challenging for the pharmacists to identify an open pharmacy for patients living in certain areas of the county.

- Information Technology

a) Connectivity – there were some issues with the connectivity between the laptop connected to the NGH Wi-Fi and getting access into Adastra before go-live. The problem was resolved following several calls between the DHU and NGH IT service teams to fix the issue. This was in relation to the NGH firewalls in situ which were not allowing the pharmacists to access the system.

b) Printer – It was agreed that a laptop and printer would be sourced and provided by DHU however a printer was not provided in time for the go-live weekend of 25th/26th February. A DHU colleague urgently resolved this issue and the printer and laptop were transported to NGH via one of the pharmacists after attending their induction at DHU, ensuring that the equipment was available for 4th/5th March. Good support was provided by the pharmacist in question to ensure that the printer and laptop were ready for use.

c) Onward referral – During the first 3 weekends of the pilot there were issues within Adastra in relation to the onward referral of cases from the pharmacist to the OoH service. The pharmacists were regularly reporting that the button to forward a case was not showing on the system and therefore cases were manually handed over to OoH via a telephone call. The DHU IT service department reviewed this and informed all partners that the issues were resolved. Some of the pharmacists were then able to forward referrals on however others noted all the way through the pilot that they had to continue to manually hand cases over. This was an acceptable work-around however usage of a forward button option would have saved time for the pharmacists; they needed to contact the relevant shift manager at DHU to request that they forward the case onto the Northants OoH service through Adastra and then make a telephone call to OoH to ensure that the referral had been received successfully.

Actual outcomes

- Progress was reviewed regularly throughout the 12 week pilot via both individual discussions with partners involved asking for feedback/updates as well as scheduled teleconferences with NGH, DHU and CCG representation to address any potential issues and gather positive feedback.
- The 12 week pilot was able to identify that technically remote-working to support NHS111 is achievable.
- Evidence gathered throughout the pilot (the monitoring of work done to support ED) showed that the location of the service created isolation for the pharmacists. This meant that they struggled to be able to gain any clinical support for any cases, which would have been available had it been based within DHU, OOH or within a Pharmacy. It also meant that the ED department were unable to utilise the pharmacist expert knowledge to assist them with patients in the department, as originally anticipated.
- The available data showing the number of referrals being picked up by the pilot proves that the service took some time to establish – an increase in the number of cases was evidenced from week 4 onwards.

Pilot Activity	Repeat Prescriptions	Medication Advice	Total
20/02/2017	3	0	**3**
27/02/2017	7	0	**7**
06/03/2017	8	0	**8**
13/03/2017	21	0	**21**
20/03/2017	10	0	**10**
27/03/2017	12	0	**12**
03/04/2017	22	8	**30**
10/04/2017	125	8	**133**
17/04/2017	50	12	**62**
24/04/2017	40	1	**41**
01/05/2017	41	5	**46**

As per intended outcomes:

- **The length of a patient's episode of care from end to end when presenting to the NHS 111 service will be compared pre and post the intervention.** It was noted part way through the pilot that it would not be possible to measure the length of time a pathway would take when referred to OoH for a repeat prescription as, once the case is passed on, it is not possible for DHU to record the length of the case. Despite this, data was collected for each case that went through to the remote working pharmacist. Average call handling time for cases in Northamptonshire was 8 mins 32 seconds based on the data collected across 111 calls for Northants in total. In comparison, the average case length for a patient going through the remote working pharmacist was around 30 minutes but it should be remembered that the process for repeat prescriptions entails

first a discussion with a 111 call handler before being passed to a pharmacist for a clinical discussion, which is more time consuming.

- **The impact of a prescribing pharmacist working remotely versus a non-prescribing pharmacist within the call centre will be measured in terms of performance and outputs.** This was addressed via the questionnaire feedback from each of the pharmacists who reported that they did not feel that they had enough clinical and operational support available to them during the pilot. This potentially created delays in the pathway for patients whilst clinical advice/support was sought by the pharmacist contacting DHU. The questionnaires outlined that the pharmacists felt that the overarching notion of remote-working was positive and that this would have been more successful if based in an alternative environment e.g. OoH or the pharmacy department with some professional support.
- **Level of satisfaction will be a measurement as part of the normal process of patient satisfaction but these patients on these dx codes will have a targeted patient satisfaction survey circulated by DHU.** The following number of questionnaires were circulated;

  7th-13th April – 14 surveys
  14th – 20th April – 36 surveys
  21st – 27th April – 14 surveys
  28th – 4th May – 17 surveys
  5th – 11th May – 15 surveys

  At the time of writing this report, only 6 questionnaires had been returned by patients, as per below. The data will be refreshed again once additional questionnaires have been returned. As per the report below, feedback from patients was positive and all patients reported being extremely satisfied with the service they received as part of the pilot.

- **Qualitative data will be obtained from pharmacists, out of hour's clinicians and NHS 111 nurse advisors via discussions and surveys.** Qualitative data was collected from the pharmacists as per the questionnaires. Verbal feedback was provided by OoH managers that they felt that the pilot had an extremely positive impact on reducing the number of repeat prescription cases being sent to their service.

- **The reporting will be from the Adastra software and within the normal parameters. A summary will be provided of the main reasons for contact requests (below).**

  The main reasons for contact to the service were;
- Run out of medication- the main being antidepressants.
- Pharmacy attached to GP practice is usual pharmacy and is shut at weekends.
- Usual pharmacy has no stock of drug.

Data was collected by DHU for the duration of the 12 week pilot, as per above. This shows the number of cases resolved by each of the individual pharmacists plus a summary of the outcomes; 70.92% of outcomes were for self-care.

A summary of the drugs prescribed as part of the pilot is also embedded above; this evidences that antidepressants were the most prescribed drug type.

- **Weekly project planning / implementation meetings with all members of the project team will take place.** Unfortunately, this was not delivered due to capacity issues across all partners however the CCG Lead regularly kept in contact with partners involved virtually on a weekly basis and would regularly chase up issues for resolution.

Actual outputs

The available data evidences that the pilot was successful in its function of providing an easy repeat prescription service for patients during weekends and bank holidays, as a total of 194 medications (out of a total 306 cases) were prescribed during the course of the 12 weeks. This meant that these patients did not have to make an appointment to see a GP at an Out of Hours base for their prescription request to be completed hence improving their pathway and allowing them to visit a local pharmacy to their home to collect their prescription.

Cost benefit analysis

The full funding allowance allocated for the project was £39,470. The agreed funding breakdown is below.

The activity cost for each case closed as part of the pilot was therefore £128.98. As the activity levels during the pilot were increasing week by week, it is likely that the cost per episode would continually decrease over time.

The cost when splitting the funding out to just the wages for the working pharmacists reduces this even further:

£15,384/306 episodes = £17.59 per referral.

This would be the case if the project was to continue in future as the majority of the additional funds allocated were for initial set-up costs i.e. equipment and project support, which would not need to be continually paid for on a long-term basis.

Pharmacist	Activity (cases)	Hours worked	Productivity Cost per patient
Pharmacist 1	32	36	£64.04
Pharmacist 2	97	84	£49.29
Pharmacist 3	86	72	£47.65
Pharmacist 4	91	78.25	£48.94

It was intended that there would be 12 weeks of Saturday and Sunday plus any bank holidays shifts covered as part of the pilot. This meant cover of 27 shifts at 12 hours= 324 hours of service provision. Confirmation was received from DHU that cover was provided by the pharmacists for 270.25 hours (83% of planned hours) for the pilot due to some shifts being uncovered; this was due to prior commitments of the pharmacists.

Lessons learned

Some key lessons learnt noted by the pharmacists involved include the following:

- Case levels during the Bank Holidays were much higher than other shifts which meant that one pharmacist struggled to deal with all of the cases. This could be avoided by amending the rota to ensure that there is more than one staff member available for the duration of the shift during a bank holiday.
- It was felt that the initial set-up of the project felt rushed and not completely considered due to a lack of equipment and a lack of clear leadership. It is worth noting that the original project lead from the CCG left the organisation before go-live meaning that there were some organisational challenges in locating a lead for the project. In addition, there were some issues with equipment availability from DHU. There was not a laptop or printer available in enough time before the agreed go-live date to enable issues to be resolved hence when the laptop was available w/c 20th February, there were some problems connecting to Adastra and then it was not possible for these to be resolved before the first shift, hence the first shift being run from the DHU call centre. This could be avoided on a future project by ensuring the equipment is available and tested at least a fortnight before the agreed go-live date.
- Locational issues in relation to the service being based in ED. The pharmacists noted that they were unable to spend a lot of time assisting in ED due to the high number of cases they were already dealing with, rendering it unnecessary for them to be based within the ED department. It was suggested by one that the service could be based within Out of Hours or the Pharmacy department to ensure adequate support for challenging cases. Feedback received from the ED manager was that ED staff did not have a great deal of interaction with the pharmacists. It was also noted that the physical set up within the department was not beneficial. This could be avoided moving forward by setting up the area to support a simple way of working for the pharmacists. For a future project, alternative locations could be considered, for example pharmacy or OoH as these would provide professional support to the pharmacists.
- Some of the coding combinations were felt to be inappropriate, for example, failed contraception and controlled drugs, as the pharmacists were unable to deal with these queries, hence making the pathway more complex for the patient. This could easily be addressed by reviewing the

coding combinations within Pathways or adding dispositional instructions for the call advisor to not send cases to the queue for this type of query.

- Providing support to other areas in the East Midlands. The decision was made by the CCG and DHU Project Leads that the pilot would be able to accept cases from other areas in the East Midlands during busy periods for NHS111 but this was not acknowledged in terms of support for Northamptonshire when local activity levels were high. This could be addressed in a future model by live activity monitoring and allocation to create clear focus and should be considered as a potential option for any future remote-working model.
- Following on from the point above regarding support for other areas within the East Midlands, the pharmacists were concerned that they did not have a paper version of all opening hours for pharmacies in other areas. They were informed that they could utilise the Mobile DoS for this purpose however noted in their questionnaire that they were using Google to search which was time consuming and not always correct. The Northamptonshire DoS Lead provided all pharmacists with access to the DoS and a step by step guide of how to utilise the service for searching but pharmacists either did not feel confident in using it or did not consider it as an option. This could be addressed by ensuring that pharmacists are confident in using the Mobile Directory to access service information and also providing them with a paper DoS version of this information as a backup. A paper version was provided to each pharmacist by the Northamptonshire DoS Lead for pharmacies in Northants.
- A recurrent theme across all questionnaire feedback was that the level of support available to the pharmacist whilst working in ED was limited. The clinical support was an important factor for pharmacists to enable them to manage demand at peak periods.
- IT issues continued throughout the pilot; there was a failure with the forward button on Adastra to forward cases onto the OoH service. This should be resolved before any further pilots; therefore dedicated IT support should be available to fix these kinds of issues.
- One of the pharmacists felt that she was inappropriately allocated the 'lead' pharmacist for the duration of the pilot. This was one of the pharmacists already employed by NGH; the pharmacists and project team utilised her knowledge of local environments and processes. There were several occasions when senior team members devolved actions to this pharmacist who felt increasingly put upon. The same pharmacist also felt that there was limited organisation and leadership involved throughout the project and requested that the pharmacists be involved earlier in future pilots. This was despite the Pharmacy Lead for the county, the CCG Pharmacy Lead and the Head of the acute trust Pharmacy Teams being involved in the planning and set-up of the project.
- A summary of the impact on OoH based on the number of cases sent over for repeat prescription and medication enquiries has been collated as per the attachment below. This evidences an increase in repeat

medication requests during bank holiday periods for both OoH and the pilot. The data shows that the pilot was initially slow to pick up but the number of cases dramatically increased as the pilot progressed through its 12 weeks, evidencing its success. Despite this, there were still a significant number of cases being sent to OoH throughout the time period. This may be due to the fact that there were simply more cases for repeat medication throughout the period of the 12 week pilot. No data is available for the final weekend of the pilot currently due to the Cyber Attack.

The above were all key learning points noted from the Pharmacy Pilot and have been discussed and reviewed on an individual basis. Each point could be easily addressed for any future projects.

Next Steps

The project ceased from Sunday 14th May 2017. Questionnaires were submitted to the pharmacists for review of the project as a whole. Key learning points have been picked up and will be considered for any future projects.

Recommendations

This proves that the project was extremely beneficial to patients to provide advice and repeat prescriptions however the staffing model would need to be resourced appropriately for any future projects.

The feedback from the pharmacists involved in the pilot was extremely useful in gathering some learning points for future projects. It also evidenced some issues in relation to the operational running of the project initially, issues which were resolved during the first few weekends causing time constraints and problems in forwarding referrals onto other services. The overall feedback from the pharmacists involved was that the idea behind the project was good and beneficial to patients however the actual implementation could have been improved to ensure the most appropriate use of pharmacist's time and to address a supporting structure for the pharmacists to enable them to deal with cases appropriately.

Based on all of the data available following the completion of the pilot, it is agreed that the idea of remote working does work in practice but with increased clinical support; therefore any future models would be co-located with easily accessible professional support. IT infrastructure is a key part of this for future plans and robust arrangements would be agreed prior to go-live as part of the project group discussions.

Currently there are no further plans to extend this pilot into a permanent arrangement. This is due to the NUMSAS initiative which Northants is due to commence with during w/c 22nd May 2017; this should pick up a large proportion of the repeat prescription requests via NHS111 and therefore is very similar in model to this pilot. Although the pilot worked well overall, there is some cross-over between the local pilot and the national pilot.

Survey for Pharmacists taking part in the WIF Phase 2 Northamptonshire Pharmacy Pilot

1. Role/Function: Did the initial scope of the role accurately reflect the activity undertaken? If no, please provide us with some narrative to explain why.

111 pharmacists were expected to have calls regarding to medicines queries and repeat prescription requests. Induction training in Derby was useful. There was no estimation of number of cases in general so the workload could be spontaneous. Bank holiday cases were ten times higher than normal weekends, which was impossible for a single pharmacist to handle all the cases. There was confusion in referring cases to OOH. Instructions from different shift managers were not consistent.

2. Technology: Was the technology available to you able to support decision making and provide effective outcomes? Please provide comments below.

Adastra did not always connect properly. Several times I had to log out and log back into Adastra. Initially prescribe button was not working, so cannot undertake prescribing role. Button for out of hour service referral not function during the whole pilot; pharmacist had to contact shift manager each time to refer a case. There were several times the calls came back to pharmacist queue instead of directing to OOH. SCR did not work for several times. My username for the Adastra was incorrect. It ended up my middlename was shown on the prescription template instead of my surname.

3. Do you feel that you were provided with adequate support to enable you to undertake the role that you were asked to do? If yes, please explain what you feel went well. If no, please provide comments regarding what you feel could have been improved.

Working in very isolated environment with no other support. Unlike in Derbyshire where they have clinicians, nurses and pharmacists working in same area to seek for advice, NGH pharmacists have to work isolated. During the bank holiday, when there were high demands of cases in Northampton area, no support was given to the pharmacist who had worked nonstop for 12 hours straight. Shift manager should have monitor the number of calls and redirect calls to out of hour and the responsibility of directing cases should not rely on the trial 111 pharmacist. When pharmacist stated there was already high number of calls in the morning, there were messages from mallard house informing Derbyshire team not needed to answer the pharmacists' cases in Northampton. There seems to be no consideration that there was only one pharmacist working in Northampton to deal with all repeat prescription calls comparing to in Derbyshire Mallard house there were few pharmacists working at the same time to answer cases. Average time to arrange a prescription including time to call patient, community pharmacy, faxing prescription, completing the case in Adastra could take over half an hour per patient. Shift manager should have consider the number of cases in the queue for repeat prescription and considered whether the workload is manageable for the 111 pharmacist and consider to redirect cases after discussing with 111 pharmacist.

There was no early warning to 111 pharmacist that workload during bank holiday would be in extreme workload, and did not consider to have extra support for the 111 pharmacist. Considering there were still 30 cases left at 8pm shift, it needed to have at least three 111 pharmacists to complete the cases.

4. Do you feel that the pilot was able to deliver an effective way to manage the needs of the patients? Please provide some commentary.

For normal weekends, the workload was manageable and pharmacist was able to have the time to deal with patients' queries in an effective way. Patients were appreciated when pharmacist was able to deal with the query and provide them with pharmaceutical advice or manage their repeat prescriptions.

For bank holiday, the workload was beyond the one pharmacist's capacity to handle with no support. There was huge delay for patients to wait for pharmacist to call back. It took several attempts to be able to contact the community pharmacies as they were too preoccupied for their work and a lot of the time wasted to wait for their staff to pick up the phone. Shift managers were able to see the growing number of cases but did not provide advice or solution to reduce the workload. Some calls were not beneficial to be directed to 111 pharmacists e.g. controlled drug request (issue with legality of faxed prescription); failed contraception; and patients who could not go to pharmacies to collect their medicines.

5. If we were to undertake the project again, what do you feel could have been done differently to enhance the service?

The initial pilot was too rushing which had omitted a lot of consideration of the practicality of the service such as setting up laptop, printer, posting prescription. Fax machine was not at the same room where pharmacist was working. The 111 service did not provide A&E as much benefit as pharmacist could not spare too long time to help A&E whilst checking for cases simultaneously. The 111 service could be set in pharmacy or out of hours service so the pharmacists can have extra support from other HCPs.

Some calls would not be beneficial to direct to 111 pharmacists by the call advisors. Such as request for controlled drug as community pharmacies do not normally accept faxed prescription with controlled drug. Such as failed contraception calls, 111 pharmacists do not have the face to face assessment and are not trained to deal with this type of query.

More support for the 111 pharmacists is essential to be able to run the service effectively. Northampton pharmacists were asked if there were no cases, then to help answer calls from other regions e.g. Derbyshire, Nottinghamshire, and Milton Keynes. However, when there were calls from Northampton, there were no other staffs helping to complete high number of cases.

A list of community pharmacies opening time and contact number during bank holiday for all regions would be helpful to provide repeat prescription service. When asked for the resource, it was expected to use google to search for opening pharmacies. The task was difficult and time consuming especially when pharmacists were not familiar with other region.

6. If you have worked in both the DHU call centre and the A&E Department, please provide an outline of advantages and disadvantages to both of these options?

7. Do you feel that you would be keen to support a project such as this in future?

It was very rewarding when patients were appreciated of the 111 pharmacists' service and were able to provide their needs in a timely and effective manner. It was a challenging task when workload was high, but not as challenging when workload was very low. I enjoyed being able to use pharmacist's clinical knowledge and independent prescribing skill to provide patient's care. If there was right support and right resource, I would be keen to work with NHS111 in future. Remote service works fine when IT resource and other equipment e.g. laptop, printer, fax machine are in place. Instead of working in a room in A&E, location can be relocated to Pharmacy or GP out of hour service to have the support from other colleagues.

Survey for Pharmacists taking part in the WIF Phase 2 Northamptonshire Pharmacy Pilot

1. Role/Function: Did the initial scope of the role accurately reflect the activity undertaken? If no, please provide us with some narrative to explain why.

Yes – dealing with 111 calls, covering medication advice, toxic ingestion queries and repeat prescription

requests.

A&E – I received a very small number of medicine queries from the A&E.

2. Technology: Was the technology available to you able to support decision making and provide effective outcomes? Please provide comments below.

Yes – laptop and telephone.

Initially had IT issues with Adastra, but most of them now resolved with the exception of referrals to OOH.

3. Do you feel that you were provided with adequate support to enable you to undertake the role that you were asked to do? If yes, please explain what you feel went well. If no, please provide comments regarding what you feel could have been improved.

Yes – I have received support from Jenny Doxey, pharmacist colleagues at Mallard House, clinical shift managersand the Ops team. I am able to call Mallard House and get help/advice.

The Clinical Leads/GPs are usually busy with calls and it's not easy to get to speak to them quickly. At NGH, we don't have the advantage to speak to the Clinical Lead face to face (like at Mallard House and Ashgate).

4. Do you feel that the pilot was able to deliver an effective way to manage the needs of the patients? Please provide some commentary.

With additional pharmacists recruited for the pilot, there is good support for the OOH service as we are able to deal with medication related queries, toxic ingestion queries and repeat prescription requests. This takes off some pressure from the OOH services and the pharmacist skills are put to good use.

5. If we were to undertake the project again, what do you feel could have been done differently to enhance the service?

A well set up base, with integrated IT and faxing facilities.

I have had limited queries from the A&E. However if we are to provide more support to the A&E team, would be ideal to have allocated time for the A&E work due to the number of calls coming through. It has got busier over the weeks with the calls.

6. If you have worked in both the DHU call centre and the A&E Department, please provide an outline of advantages and disadvantages to both of these options?

I have only worked once at Mallard House. Enjoyed the easy access (face to face) to the clinical team and other relevant personnel. Working at the A&E, you can feel isolated. More time is spent on queries when additional support is required from Mallard House. It is quicker to deal with things at Mallard House/Ashgate due to easy access to relevant personnel.

7. Do you feel that you would be keen to support a project such as this in future?

I would be happy to consider supporting any project.

Survey for Pharmacists taking part in the WIF Phase 2 Northamptonshire Pharmacy Pilot

1. Role/Function: Did the initial scope of the role accurately reflect the activity undertaken? If no, please provide us with some narrative to explain why.

No – was led to believe that there would be a large number of patients/queries. Apart from the bank holiday weekends the patient/query number was very low. We were told that NGH would just need to provide a space to work and nothing else whereas I had to spend a considerable amount of time on this project, including security of the laptop and FP10s.

2. Technology: Was the technology available to you able to support decision making and provide effective outcomes? Please provide comments below.

Numerous problems with IT. As the base pharmacist I was being asked to dial in during my normal working day to sort out queries which was unacceptable. Some issues were sorted out and then the next time you worked it would be another issue. I had to ask for a printer as it was assumed that NGH would supply one. I delivered this in my car from Derby.

3. Do you feel that you were provided with adequate support to enable you to undertake the role that you were asked to do? If yes, please explain what you feel went well. If no, please provide comments regarding what you feel could have been improved.

No – I made a complaint about one of the sessions where the support at Derby was very rude and unhelpful. For the rest of that session I just contacted the normal staff there rather than the co-ordinator. Felt very isolated as difficult to get extra support. The co-ordinators did not seem to be aware of our role and limitation ie not being able to use the button to refer to OOH.

4. Do you feel that the pilot was able to deliver an effective way to manage the needs of the patients? Please provide some commentary.

No – patients were going to their regular pharmacy where they were being turned away if the script had not arrived. They were then asked to call 111 to get us to provide a script and then had to wait for a call back from us to then go back to the original pharmacy in the first place. Expensive service for little patient benefit.

A number of queries came through which were for CDs and so we were not able to provide the script. The question had not been asked about the specific medication e.g. info was 'sleeping tablets' rather than temazepam. This then involved getting the info from the patient and then having to tell them you would not be able to help and that the doctors would have to contact them back.

Had a query about a catheter supply which took a long time to resolve and should not have been sent through as a pharmacy query.

There was no advantage for Northampton patients to having the 111 service based at NGH rather than Derby.

5. If we were to undertake the project again, what do you feel could have been done differently to enhance the service?

It would need to be organised properly from start to finish, with all stakeholders involved. I was the last person to be trained in Derby for the project and it was only with prompting from me that I was able to secure a printer and the actual FP10s as nobody had thought about those. It was left up to me to work out the logistics of the project including the laptop and FP10 security. The other staff saw me as a 'lead' for the project, sending me numerous queries, which was not true as I was being paid the same as them.

6. If you have worked in both the DHU call centre and the A&E Department, please provide an outline of advantages and disadvantages to both of these options?

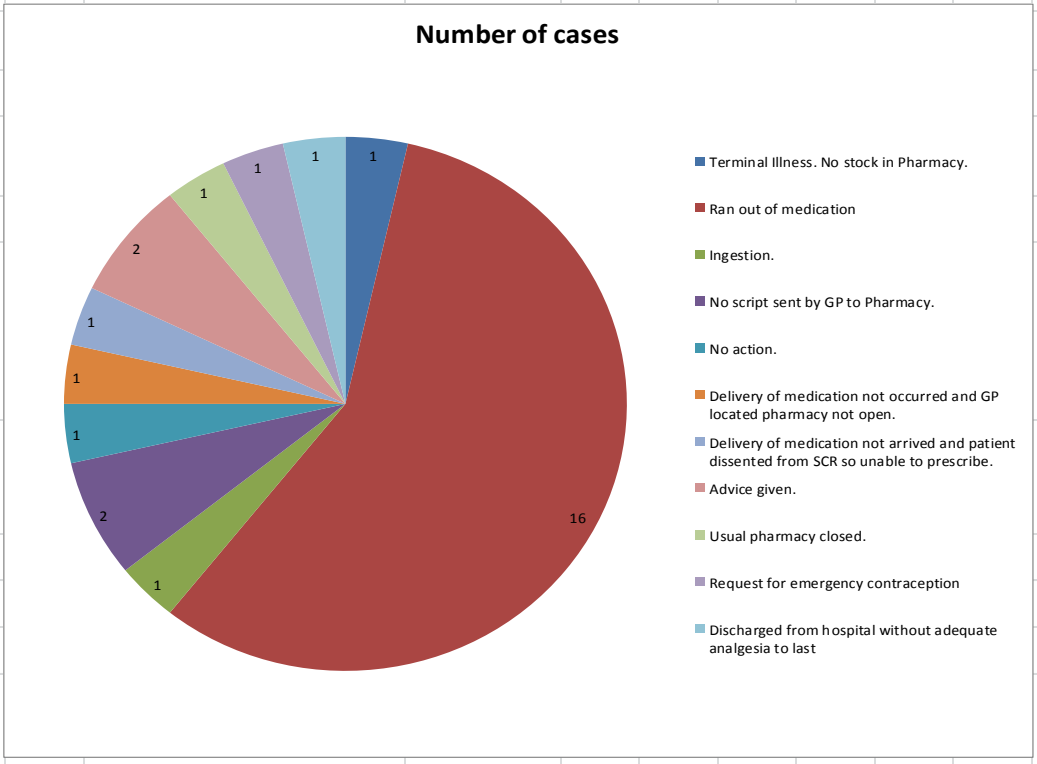
n/a

7. Do you feel that you would be keen to support a project such as this in future?

Not in the current format. I do not believe that there was any benefit for our hospital from having the project based in A&E at NGH and so we would need to weigh this up for future projects. The hospital already has support systems in place for our staff and patients and the advice was only needed from me as it is my usual place of work. The query handled in the first week by one of the other pharmacists may have been technically correct, however it was an inappropriate answer for an acute urgent care setting ie they were answering as a community pharmacist with no understanding of the immediacy of the A&E environment. It may also have been more appropriate to base the prescribing pharmacist with the OOH service so that they could have another colleague to discuss any issues with rather than having to phone. This would also give the OOH GP clinical pharmacy support. I would be happy to look at any other projects but would want to be involved at an earlier stage, to ensure that all the logistics are in place and key people are kept informed.

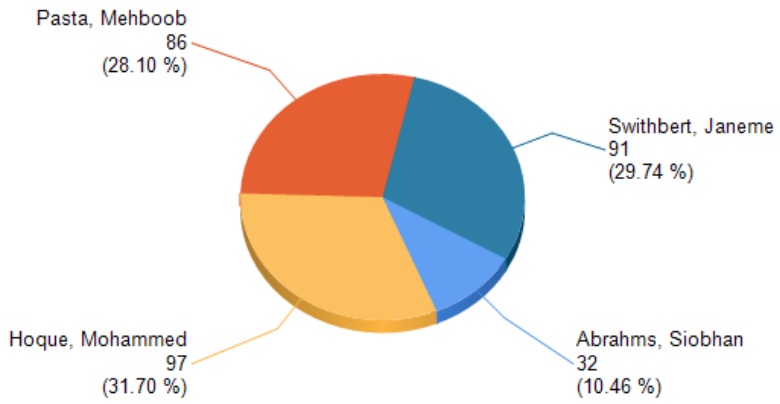
Summarised Reasons for prescription requests

Break down of reasons	
Reason	**Number of cases**
Terminal Illness. No stock in Pharmacy.	1
Ran out of medication	16
Ingestion.	1
No script sent by GP to Pharmacy.	2
No action.	1
Delivery of medication not occurred and GP located pharmacy not open.	1
Delivery of medication not arrived and patient dissented from SCR so unable to prescribe.	1
Advice given.	2
Usual pharmacy closed.	1
Request for emergency contraception	1
Discharged from hospital without adequate analgesia to last	1

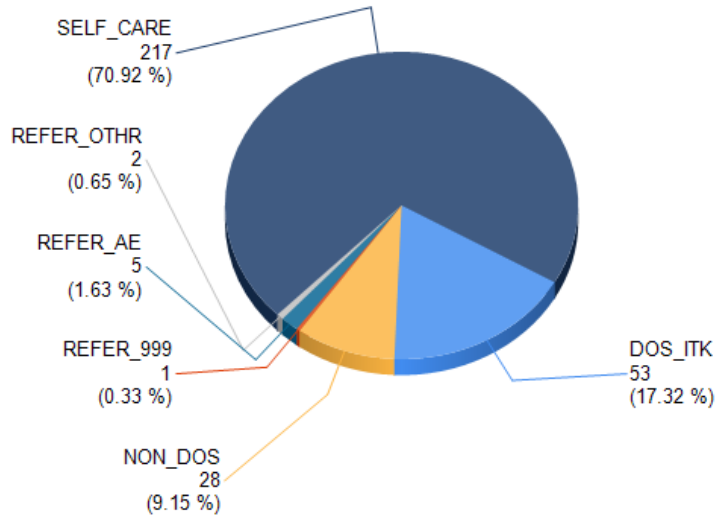


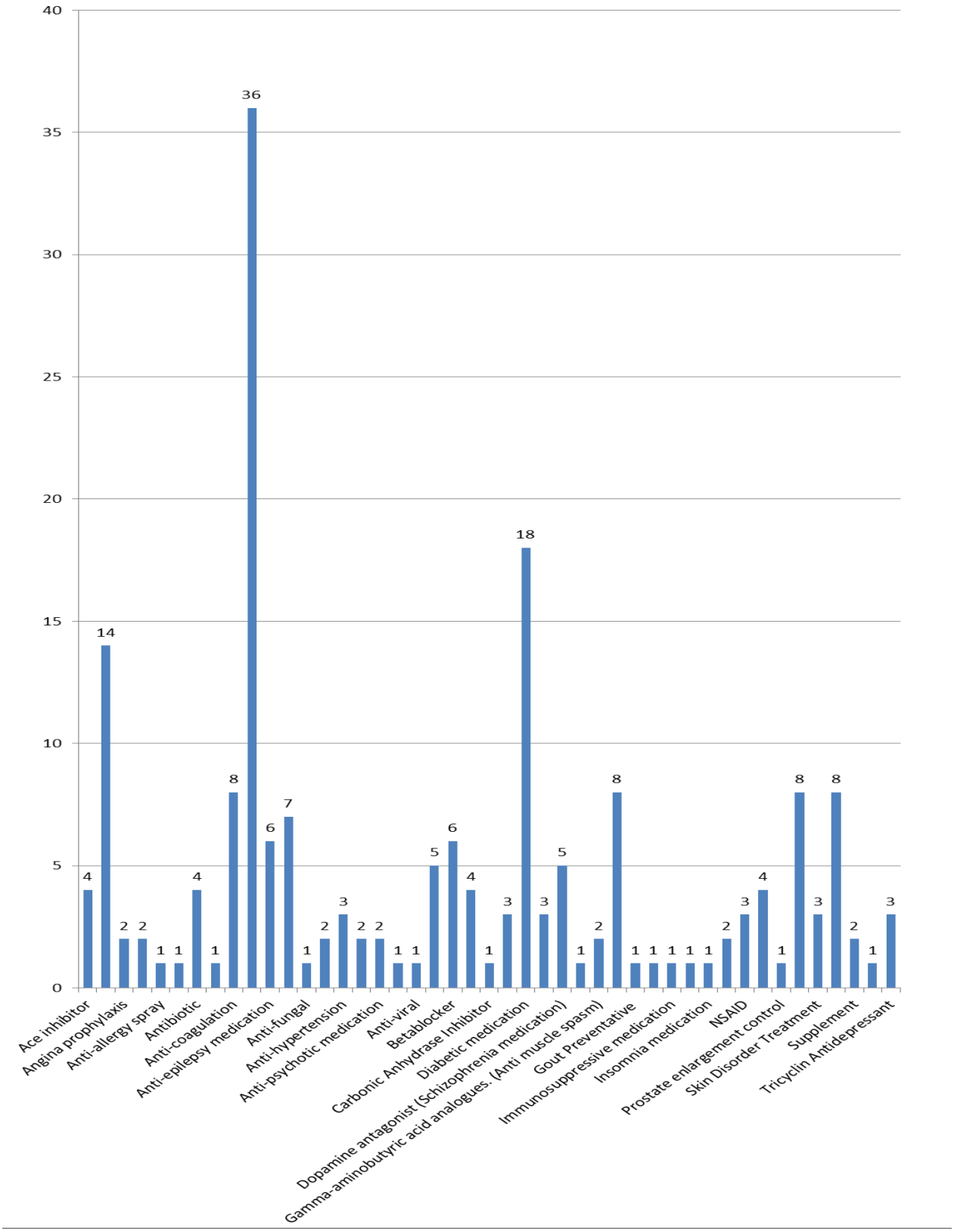
Northants Pharmacists Pilot									
04/03/2017 to 07/05/2017									
Pharmacist	**Volume**	**Avg. Consultation Length**	**Avg. Episode of Care Length**	**DOS_ITK**	**NON_DOS**	**REFER_999**	**REFER_AE**	**REFER_OTHR**	**SELF_CARE**
Abrahms, Siobhan	32	00:21:05	02:04:59	6	4	0	0	1	21
Hoque, Mohammed	97	00:34:45	02:16:10	13	15	0	4	0	65
Pasta, Mehboob	86	00:35:20	01:53:13	26	9	1	1	0	49
Swithbert, Janeme	91	00:25:43	02:11:57	8	0	0	0	1	82
Total	306	00:30:54	02:07:41	53	28	1	5	2	217

Total Consultations per Pharmacist



Total Consultations per Outcome Code

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Ace inhibitor
Angina prophylaxis
Anti-allergy spray
Antibiotic
Anti-coagulation
Anti-epilepsy medication
Anti-fungal
Anti-hypertension
Anti-psychotic medication
Anti-viral
Betablocker
Carbonic Anhydrase Inhibitor
Diabetic medication
Dopamine antagonist (Schizophrenia medication)
Gamma-aminobutyric acid analogues. (Anti muscle spasm)
Gout Preventative
Immunosuppressive medication
Insomnia medication
NSAID
Prostate enlargement control
Skin Disorder Treatment
Supplement
Tricyclin Antidepressant

Workforce Development Programme
Hampstead Road
London
19 December 2016
Nene Clinical Commissioning Group
Francis Crick House
Summerhouse Road
Northampton, NN3 6BF
Our Ref: 3.6

Dear Jane,

NHS INTEGRATED URGENT CARE WORKFORCE INVESTMENT FUND PHASE 2 - PANEL OUTCOME - CONDITIONAL - REMOTE WORKING FOR 111 PHARMACISTS

Thank you for your application to request funding from the NHS Integrated Urgent Care Workforce Investment Fund Phase 2 to support your pilot project focused on the thematic areas identified above.

The evaluation panel comprising of clinical leads, academics, NHS managers and a patient representative, met on Tuesday 22nd November 2016 to evaluate the applications received.

Each application was considered against the assessment criteria outlined within the expressions of interest.

We are pleased to confirm the panel would like to support your application. If you have not already provided as part of your original application, please can you submit a detailed breakdown on the total amount requested for backfill, up to the value of **£75,000.** Please find attached (Appendix 1) a signature sheet which the Project Sponsor, Clinical Commissioning Group (CCG) Lead and CCG Finance Lead are required to sign and return to us via email at england.workforcedevelopment111@nhs.net by **noon Wednesday 21 December 2016** to enable the transfer of funds. Additionally, you will also need to make arrangements for transfer of these funds directly with your nominated CCG. The CCG will advise you when funds are transferred from central allocation.

All successful applicants will be supported by the Integrated Urgent Care Workforce Development Programme and will be required to share learning and attend joint workshop(s) to present these findings on their project(s). Applicants will also commit to producing a final report evidencing the learnings and outcomes via NHS England and Health Education England on completion of the project for onward and unrestricted sharing.

Your commitment, and indeed that of all those organisations which made applications to the NHS Integrated Urgent Care Workforce Investment Fund Phase 2, to develop and enhance the workforce, as well as support the NHS Integrated Urgent Care Workforce Development Programme is greatly valued. Together with Health Education England, we look forward to working with you over the coming months.
If you have any questions please, please do not hesitate to contact us via email at england.workforcedevelopment111@nhs.net and a member of the team will respond at the earliest opportunity.

Once again, thank you for your interest and application; we look forward to speaking with you soon.

Yours sincerely,

David Davis *FCPara*
National Clinical Lead
NHS England

Dr Sharon Harrison
National Programmes Manager
Health Education England

NHS Integrated Urgent Care Workforce Development Programme

APPENDIX 1
CONFIRMATION TO DELIVER PILOT PROJECT(S) AND AGREE TO TERMS OUTLINED IN THE COMPLETED APPLICATION FORM AND DOCUMENTATION - NHS INTEGRATED URGENT CARE WORKFORCE INVESTMENT FUND PHASE 2
Please detail below amount of funding requested up to the value of **£75,000**. Funding can only be requested
for the backfill of core staff to protect frontline services and staff required to support the project.

Breakdown of Budget

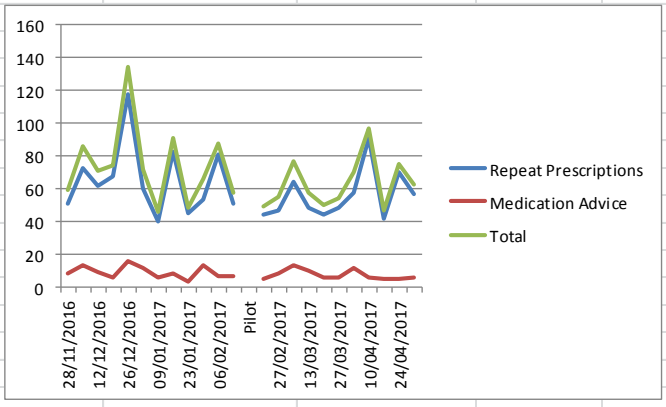
I hereby agree to the Terms outlined in the completed application form and documentation. **Activity**	**Total**
Project management & administrative support	3,500
Project analytics & IT support	3,700
Clinical leadership – Nene CCG & DHU	9,385
IT hardware, software and testing	7,500
Pharmacists for 10 week–ends @ 12 hours per day	15,384
Total £39,470	

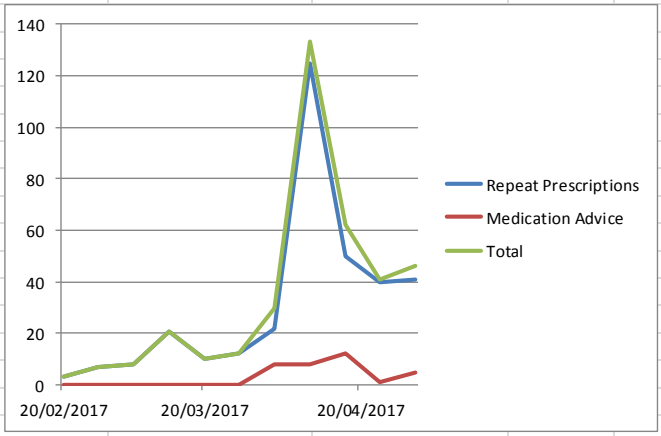
OoH Activity vs Pharmacy Pilot Activity

Week	Repeat Prescriptions	Medication Advice	Total
28/11/2016	51	8	**59**
05/12/2016	73	13	**86**
12/12/2016	62	9	**71**
19/12/2016	68	6	**74**
26/12/2016	118	16	**134**
02/01/2017	60	12	**72**
09/01/2017	40	6	**46**
16/01/2017	83	8	**91**
23/01/2017	45	3	**48**
30/01/2017	53	13	**66**
06/02/2017	81	7	**88**
13/02/2017	51	7	**58**
Pilot			
20/02/2017	44	5	**49**
27/02/2017	47	8	**55**
06/03/2017	64	13	**77**
13/03/2017	48	10	**58**
20/03/2017	44	6	**50**
27/03/2017	48	6	**54**
03/04/2017	58	12	**70**
10/04/2017	91	6	**97**
17/04/2017	42	5	**47**
24/04/2017	70	5	**75**
01/05/2017	57	6	**63**
08/05/2017			

Dx codes: Dx 28 Contact Pharmacist within 12 hours, Dx80 Repeat Prescription required within 6 hours, Dx82 Medication Enquiry, Dx85 Repeat Prescription required within 2 hours, Dx86 Repeat Prescription required within 12 hours, Dx87 Repeat Prescription required within 24 hours .

Pilot Activity	Repeat Prescriptions	Medication Advice	Total
20/02/2017	3	0	**3**
27/02/2017	7	0	**7**
06/03/2017	8	0	**8**
13/03/2017	21	0	**21**
20/03/2017	10	0	**10**
27/03/2017	12	0	**12**
03/04/2017	22	8	**30**
10/04/2017	125	8	**133**
17/04/2017	50	12	**62**
24/04/2017	40	1	**41**
01/05/2017	41	5	**46**
08/05/2017			





WIF Phase 2 - Northamptonshire Pharmacy Pilot

Additional work done to support ED

Date	Time	Pharmacist	Query raised by	Type of query: supply issue, medical history, clinical e.g. interaction/dosing/renal/prescribing	Medicine involved	Action Taken	Time taken
04/03/2017	14:33	Mehboob Pasta	Dr Emmanuelle Molmer	Patient with swallowing difficulties/dysphasia	Amlodipine	As per NEWT guidelines, suggested oral solution. Dr to contact on-call pharmacist for stock availability.	10 minutes
04/03/2017	13:30	Siobhan Abrahams	Dr Fiona Poyner	Alterted that GP had used A&E FP10's and had left pad unattended	N/A	FP10's locked away at time by Dr Poyner - email sent to GP Lead to ensure doesn't happen again.	5 minutes
04/03/2017	17:30	Siobhan Abrahams	Sarah Cross - A&E Matron	Medication timings for tazocin for oncology patient - ICT could not get	Tazocin	Patient to return to ED for doses at 23:30 tonight and 09:30 tomorrow. Chart annotated.	15 minutes
04/03/2017	17:55	Siobhan Abrahams	SN/ICT Nurse	Medication timings for tazocin for oncology patient - ICT could not get	Tazocin	Advised to speak to Sarah - explained plan for patient.	5 minutes
11/03/2017	09:05	Mehboob Pasta	A&E Nurse	Requesting additional medicine labels.	N/A	Referred the nurse to the pharmacy department within the trust.	2 minutes
19/03/2017	N/A	Siobhan Abrahams	Normal A&E work	Triage 6x patients. Change meroperem dose - renal dose not necessary. Confirmed MH meds with Berrywood including methadone - handover to Drs.	Meroperem & Methadone		30 minutes
01/04/2017	14:30	Mehboob Pasta	Sister Flanagan	Sister asking whether sertraline could cause vomiting when newly started.	Sertriline	Advice provided.	2 minutes
01/04/2017	18:00	Mehboob Pasta	Sister Flanagan	Query about TTO for Oromorph.	Oromorph	Advice provided.	5 minutes
01/04/2017	13:45	Mehboob Pasta	Sister Flanagan	Sister asking for advice regarding a forged script (opthalmic with tramadol added).	Tramadol	Advice provided.	5 minutes
08/04/2017	17:45	Mehboob Pasta	N/A	Run out of FP10's in the department.	N/A	Advised to use GP pad	N/A
09/04/2017	N/A	Janeme Lam	A&E Nurse	Query whether pharmacy was open to complete an FP10.	N/A	Advised to refer patient to community pharmacy.	5 minutes
09/04/2017	N/A	Janeme Lam	A&E Doctor	How to request oromorph on FP10.	Oromorph	Advised of frequency and quantity.	5 minutes
14/04/2017	N/A	Janeme Lam	A&E Nurse	Nurse asked how to request oromorph on an FP10. Nurse also queried which pharmacies were open in Northampton town.	Oromorph	Relevant information provided.	10 minutes
16/04/2017	N/A	Janeme Lam	A&E Nurse and A&E GP	Nurse querying EPMA. GP asks for insulin prescription for patient.	Insulin	Relevant information provided.	N/A
17/04/2017	N/A	Janeme Lam	A&E GP, A&E Nurse.	Dr requesting oromorph FP10. Nurse requesting information on pharmacies open in Northampton. Nurse asking for gentamicin IV administration. Dr requesting support for 2x TTO's in A&E.	Gentamicin	Relevant information provided.	N/A
23/04/2017	N/A	Janeme Lam	A&E Nurse	Support requested with a mental health patient in A&E.	Nicotine	Relevant information provided.	N/A

Project 3 – DHU – Health & wellbeing of the workforce to improve recruitment & retention

Contact details	
Name of Organisation	DHU Health Care CIC
Postal Address	Charlotte House Stanier Way Wyvern Business Park Chaddesden Derby Derbyshire DE21 6BF
Contact Lead (s)	David Walsh
Email Address	david.walsh@derbyshirehealthunited.nhs.uk
Contact Number (Mobile / Landline)	03001 000 404 x 6201 07702 909977
Date of Report Submission	June 2017

Project Summary

DHU introduced health and wellbeing initiatives under the "Recruitment and Retention" heading in order to improve the health, motivation and attendance of our NHS111 workforce. It also provides a valuable employee benefit that will help us to attract, recruit, and retain staff across East Midlands.

Background

Health and wellbeing is becoming increasingly important to the HR strategy of our business as we strive to improve the health and attendance of staff and offer benefits that will increase employee engagement.

Around 140 million working days are lost in the UK each year because of sickness and 300,000 employees a year quit work due to ill-health, according to non-profit research firm Rand, while the Financial Times calculated that stress costs the UK £70bn annually.

DHU also suffer from attendance issues with absence in some months running at 14% and costing over £600k per annum. We offered employees a 'mini health check' via Arden & Gem and access to medical advice via Westfield Health. The aims of this is to:

- Involve DHU staff in Health Checks
- Generate a significant contribution to overall health outcomes for DHU staff
- Provide lifestyle analysis and advice after each Mini Health Check
- To present the damages caused by stress and how to combat stress/mental health in an informative manner
- Provide relevant health information for staff to take back to work/home and incorporate into their lifestyle
- Health reports 2-weeks after event for all taking part
- 'Mini Health' Checks to include height and weight to determine individual Body Mass Index (BMI) measures, Blood Pressure and lifestyle advice
- All staff attending will be given a quick interactive lifestyle check

- Advice on picking up signs early and lifestyle changes to prevent stress
- Information to take away and action
- Provide access to expert medical advice and get people back to work as quickly as possible

Both pilot projects aim to change our health and wellbeing culture in order to change with the times. Keeping people productive and not exhausted is what brings benefit, reduce our costs and improve our service to the NHS.
The more of our employees we can keep at work in a fit and healthy state the more we can continue to provide an excellent service to our millions of people in the East Midlands.

Challenges

The only challenge was providing excellent communication with employees, liaison with providers such as Arden & Gem and Westfield Health.

Approach

We rolled out this project out in December 2016 to March 2017. The aims of the Mini Health Checks event were to provide lifestyle analysis and advice after each Mini Health Check to each of our employees. To help them understand how they can combat the causes of stress/mental health issues in a safe and informative manner. It will also provide health information for staff to take back to work/home and incorporate into their lifestyle. The project is aiming to change our health and wellbeing culture to change with the times. Keeping people productive and not exhausted is what brings benefit, reduce our costs and improve our service to the NHS.

Intended outcomes

The benefits of this project for our business:

- Provides a valuable employee benefit
- Improves staff health, motivation and morale
- Helps to recruit and retain our staff
- May help staff with stress related problems
- May help staff with musculoskeletal problems
- May help reduce absence

We needed to address absence, in one month this year it was 14.8%. Absence is costing us nearly £600,000 per year. By introducing mini health checks for staff we expect to see improvements in attendance. We can measure this over the project pilot period and compare it with the same period last year. Improving attendance will have a positive impact on patients and will ensure that DHU are able to hit their performance targets as planned during the winter period. This should take pressure off other parts of the NHS system.
We will measure the success of our pilot project, by looking at attendance metrics each month at our Board Meetings. We will also look at our Operating performance against the key SLA's to ensure that we are hitting targets or making improvement.

Intended outputs
Improved employee engagement and improved attendance.

Details of resources and any potential partnership
In order to deliver this project we engaged with Arden & Greater East Midlands Commissioning Support Group (GEM) and Westfield Health (not for profit social enterprise). Their services are built on a strong foundation of experienced people who build great relationships and a commitment to NHS values. NHS Arden & GEM CSU and Westfield Health team provided NHS Health Checks for our staff and provided additional support in tackling stress and mental health. The Health Check is a key tool in identifying lifestyle traits that could cause health problems in later life, as well as detecting certain medical conditions earlier so they can be identified, managed and treated. Employees were supported by an Arden and GEM Nurse Practitioner at a one to one workshop. They completed a paper based quick lifestyle health check, then undertook a health check that included Body Mass Index (BMI) and Blood Pressure check. The lifestyle advice in one to one or group talk highlighted different types of stress/mental health picking up signs early and lifestyle changes to prevent stress/mental health. Employees were given information to take away on stress/mental health. The meetings took 25 minutes per employee. The pilot covered 288 Health (Call) Advisors and 79 Clinical Advisors.

Obstacles and issues
We had no obstacles or issues. The mini health checks were well received.

Actual outcomes
The Mini Health Events generated a significant contribution to the overall health outcomes for our staff. Feedback from employees was positive. We will provided Health Check reports two weeks after the event for all staff who take the Health Checks

We even saved the life of one employee who had signs of carbon monoxide poisoning. When challenged about his smoking habits he declared the he did not smoke. It turned he had a faulty boiler at home. He would never have known this if he had not attended a health check at DHU.

Actual outputs

The benefits of this project for our business:

- Provided a valuable employee benefit
- Improved the health of staff and improved motivation and morale
- Helped us to recruit and retain our staff
- Helped staff with stress related problems
- Helped staff with musculoskeletal problems
- Did reduce absence by 2% in the proceeding months
-

Lessons learned

Lessons learned were that we should communicate the offer of mini health checks and the benefits of such to a wider population of staff. We should encourage all to take part in many more of our health and wellbeing initiatives.

See supporting documentation.

Next Steps

We will continue to provide employees with health and wellbeing initiatives including the mini health checks.

See supporting documents for further information.

Health & Wellbeing at DHU Health Care CIC

"YOUR Health Matters, YOU Matter, We CARE"

DHU Health Care CIC is a Community Interest Company and a not for profit company, known locally as DHU. The company was established in 1989 and in April 2007 became known as Derbyshire Health United. This year we have become DHU Health Care CIC. Our operations provide for the East Midlands area covering a population of over 5 million. We currently have 1,350 employees consisting of Salaried GP's, Advanced Nurse Practitioners, Community District Nurses, Clinical Pharmacists, HCAs, NHS111 Advisors, NHS111 Clinicians (including Dental Nurses / Paramedics), Drivers, Support Staff and Sessional GP's.

DHU provide the highest quality of clinical services and have a reputation for working in partnership with other service providers. We have significant experience across the following contracts covering:

Our Out of Hours (OOH) primary healthcare services are provided to over 1 million people across Derbyshire and North Nottinghamshire.

The Derbyshire OOH Primary Care Service is accessed via telephoning our 111 call centres and referred to provide:

- Clinician Advice telephone triage
- Home visiting
- GP/ANP Consultation (booked appointments) in one of our 12 Primary Care Centres.
- c. 226,000 patient contacts per annum
- Quarterly Contract Management
- Quarterly Quality Assurance Group
- Contract awarded caretaking LLR Urgent Care & Home Visiting Services
- LLR Out of Hours - c158,000 per annum
- Loughborough Urgent Care open 24/7 – c.50,000 contacts per annum

The Community Nursing Service at DHU operates from 6pm-8am in Derbyshire County and 10pm-8am in Derby City 7 days a week. We employ Community Nursing Sisters, Community Staff Nurses and trained Health Care Assistants. We have a number of bases across the county (Buxton, Matlock, Chesterfield and Derby) with nurses going out to visit housebound patients in their own homes. We have an increasing patient demand with circa 20,000 patient contacts per annum. DHU have recently awarded the overnight LLR Community Nursing contract by LLR commissioners

DHU have a subsidiary company, **DHU 111 (East Midlands) Community Interest Company**, which has its own in house call centres providing a high quality NHS 111 service. Working across the East Midland covering patients in Derbyshire, Nottinghamshire, Leicester, Leicestershire, Rutland, Northamptonshire, Milton Keynes and Lincolnshire we offer a completely integrated solution with state-of-the-art technology delivered by highly trained employees.

NHS 111 can be accessed 24/7/365 (non-life threatening). This covers circa 5m Population across six counties and takes over 1.3m patient calls per annum. This has grown by 36% over 3 years.

Our Urgent Care Centres ensure that we can provide the most appropriate care in the most appropriate location for our patients. These local centres offer face to face consultations with a clinician. This ensures that patients can visit convenient sites for accessing healthcare.

Other Healthcare Services

DHU provide A&E Primary Care Streaming for Chesterfield Royal Hospital and Royal Derby Hospital. We are involved in the Erewash MCP Vanguard, Erewash Clinical Hubs, Erewash Acute Home Visiting Service, Greater Nottingham & LLR UEC Vanguards and the Health & Social Care Summary Plan.

DHU OOH also cover for the community hospitals across Derbyshire, Quest GP cover, GP crisis cover, Prison OOH cover in our location and a Phlebotomy service.

Health and Wellbeing Initiatives

DHU have introduced health and wellbeing initiatives in order to improve the health, motivation and attendance of our workforce. It also provides a valuable employee benefit that will help us to attract, recruit, and retain staff.

Health and wellbeing is becoming increasingly important to the HR strategy of our business as we strive to improve the health and attendance of staff and offer benefits that will increase employee engagement.

Around 140 million working days are lost in the UK each year because of sickness and 300,000 employees a year quit work due to ill-health, according to non-profit research firm Rand, while the Financial Times calculated that stress costs the UK £70bn annually.

DHU also suffer from attendance issues with absence which is costing the business over £600k per annum. We have offered employees a ‘mini health check’ via Arden & Gem and access to medical advice via Westfield Health.

Mini Health Checks

The aims of Mini Health Checks are as follows:

- Involve DHU staff in Health Checks
- Generate a significant contribution to overall health outcomes for DHU staff
- Provide lifestyle analysis and advice after each Mini Health Check
- To present the damages caused by stress and how to combat stress/mental health in an informative manner
- Provide relevant health information for staff to take back to work/home and incorporate into their lifestyle
- Health reports 2-weeks after event for all taking part
- 'Mini Health' Checks to include height and weight to determine individual Body Mass Index (BMI) measures, Blood Pressure and lifestyle advice
- All staff attending will be given a quick interactive lifestyle check
- Advice on picking up signs early and lifestyle changes to prevent stress
- Information to take away and action
- Provide access to expert medical advice and get people back to work as quickly as possible

The Mini Health Check event is to provide lifestyle analysis and advice after each Mini Health Check to each of our employees. To help them understand how they can combat the causes of stress/mental health issues in a safe and informative manner. It will also provide health information for staff to take back to work/home and incorporate into their lifestyle. The project is aiming to change our health and wellbeing culture to change with the times. Keeping people productive and not exhausted is what brings benefit, reduce our costs and improve our service to the NHS.

We started the project covering our NHS111 staff as a pilot. This proved to be a success and we decided to run this programme across the rest of our organisation and share it with our partners in the NHS.

Company Doctor

We are also working with Westfield Health (a 'not for profit' social enterprise) on a second initiative to improve the health and wellbeing of our staff. They offer access to the following:

By joining this scheme our staff can pick up the phone and arrange a call back from a practising UK GP, to discuss any health issues and receive advice or a diagnosis from anywhere in the world, 24 hours a day. It's the closest thing to a surgery appointment, but without the wait. We may also have staff at home that are sick but won't call 111 because they won't run the risk of having to speak to a work colleague. Also working 24/7 shift patterns make it difficult to secure a GP

appointment. They even have an App to give people instant access. Common ailments, musculoskeletal injuries, back pain and stress account for the majority of our short term absence, so fast access to a GP for early referral and intervention, particularly in relation to mental health and musculoskeletal disorders, is invaluable and might help prevent short term absence becoming long term.

Big White Wall

Feedback tells us that there is still a stigma when it comes to talking about our feelings. Research also tells us that 93% of people will give a different reason for absence in the first instance. This is a safe online community of people who are anxious, down or not coping who support and help each other by sharing what's troubling them, guided by trained professionals. Available 24/7, Big White Wall is completely anonymous so you can express yourself freely and openly. Professionally trained Wall Guides ensure the safety and anonymity of all members. Big White Wall can help people to start to take control and get the support they need to feel better.

24/7 Access to Emotional Support

Depression, family, bereavements, relationships, and money management can all have a debilitating effect and impact on home and work life. Staff sometimes do not feel comfortable opening up to their manager at work about the real reason for absence or reduced productivity. This benefit offers a 24/7 counselling service helpline to help Staff face up to these problems and ensures they are not alone.

Physiotherapy Assessment

Evidence shows that speedy assessment by a physiotherapist can reduce recovery time. There is no need to obtain a GP referral. Staff experiencing a musculoskeletal issue can call on this service to book a telephone assessment with a qualified physiotherapist.

The key with Company Doctor is about putting the intervention in the hands of our team making access to services earlier in the journey before they are off work. Tackling head on the big issues of (1) Access to a GP (2) Mental health and (3) Musculoskeletal expertise to help our workforce to stay at work.

Occupational Health Managers' Helpline

This helpline will give us the opportunity to talk through situations you are experiencing with staff that may relate to their physical or mental wellbeing.

Both pilot projects aim to change our health and wellbeing culture in order to change with the times. Keeping people productive and not exhausted is what brings benefit, reduce our costs and improve our service to the NHS.

The more of our employees we can keep at work in a fit and healthy state the more we can continue to provide an excellent service to our millions of people in the East Midlands.

We rolled this project out between December 2016 to March 2017 and provided-management information on the usage and compare the attendance and retention of staff during this period with the same period last year.

Benefits for our business:

- Provides a valuable employee benefit package
- Improves staff productivity, motivation and morale
- Helps to recruit, retain and reward our staff
- Helps as part of pay reviews
- May help employees with stress related problems
- Can support our duty of care obligations

By introducing mini health checks and company doctor for staff we expect to see improvements in attendance. We can measure this over the project pilot period and compare it with the same period last year. Improving attendance will have a positive impact on patients and will ensure that DHU are able to hit their performance targets as planned during the winter period. This should take pressure off other parts of the NHS system.

We will measure the success of our pilot projects, by looking at attendance metrics each month at our Divisional and Corporate Board Meetings. We will also look at our Operating performance against the key SLA's to ensure that we are hitting targets or making improvement.

In order to deliver this project we are going to engage with Arden & Greater East Midlands Commissioning Support Group (GEM) and Westfield Health (not for profit social enterprise).

Their services are built on a strong foundation of experienced people who build great relationships and a commitment to NHS values.

Health & Wellbeing Measures

Our Health & Wellbeing Events generate a significant contribution to the overall health outcomes for our staff.

The pilot covered 288 Health (Call) Advisors and 79 Clinical Advisors providing the following:

- Health Check reports two weeks after the event for all staff who take the Health Checks
- Number of lifestyle checks completed
- Number of one to one advice sessions on stress and mental health

Collecting feedback from employees around what causes stress and how they combat it

Fruit Drops

In order to encourage our staff to eat healthier we are arranging for fruit drops at each of ours sites every two weeks on a Wednesday. Each site will receive 1 or 2 seasonal boxes of fruit.

Global Corporate Challenge (GCC) – now rebranded Virgin Pulse Global Challenge

DHU have agreed to nominate teams to take part in the GCC again during 2016 and 2017 as part of our drive for Health & Wellbeing at DHU. We are doing this again in May 2017 although GCC has been taken over by Virgin Pulse Global Challenge

Virgin Pulse Global Challenge produced posters / e-flyers for us for before the programme started so that our Communications team could co-ordinate this for us throughout our workforce.

Every journey starts with a single step and whatever your current level of activity, the GCC has a place waiting for you. We will fund ten teams containing seven colleagues. They will all receive a GCC Pulse which tracks movement throughout the day - every type of activity counts!

In May teams will start a 100-day virtual journey around the world with 50,000 other teams from across the globe. The more active you are, the further you and your team progress and the more virtual locations you'll unlock. Whether it's the virtual trophies, leader boards or stories from the GCC Community, you'll find your own source of inspiration to achieve milestones along the way.

Internally DHU will be awarding a prize for the team that walks the most steps.

The aim of this is that it will be a great team building exercise within our own organisation as well as taking part on an international scale.

Other DHU initiatives

In order to help with Health & Wellbeing, motivation, engagement and staff retention these are some of the other initiatives being used by DHU:

- **Employee Benefits:** Westfield Health Insurance, Eye Care Vouchers, Flu Vaccines, Childcare Scheme, Free Tea & Coffee, GCC, Discount shopping, Counselling, Reflective Supervision, Mini medicals
- **Games:** Rounder's, Bowling, 5 A-Side
- **Nutrition:** Snack Machine, Microwave Ovens
- **Engagement Events:** Family Fun Day, Pantomime, Westfield Roadshow, Dress Down days, Fancy Dress, Smoking Cessations, Gay Pride
- **Process:** Return to work support
- **Recognition:** Limelight Award, CARE Team Award, Loyalty Award
- **Representation:** Staff Survey, Health Champions, Communications & Engagement Forum
- **Training:** H&S, Workplace Assessments
- **Recruitment:** Refer a Friend

DHU
Derbyshire Health United

		KEY ELEMENTS	RISK APPETITE
CONTRACT/FUNCTION	HR	FINANCIAL	X
OBJECTIVE	Health & Wellbeing initiatives	QUALITY	
RISK	Failure of health & Wellbeing initiatives to improve morale, retention and absence.	REGULATION	
EXECUTIVE RESPONSIBLE	David Walsh	REPUTATION	X

Risk Ref.	Initial Risk Rating			Current Risk Rating			Target Risk Rating			Date Established	Date Updated	Date for Completion
	Likelihood	Consequence	Score	Likelihood	Consequence	Score	Likelihood	Consequence	Score			
HR01	1	5	5	1	5	5	1	1	1	4/1/17	28.2.17	1.4.17

Controls (what are we currently doing about the risk):
In order to improve health & wellbeing we are looking to manage stress by arranging mini health checks for people who enrol for a health check.

The aim of the event are to:
- Involve DHU staff in Health Checks over a day
- Provide lifestyle analysis and advice after each Health Check
- To present the damages caused by stress and how to combat stress/mental health in an informative manner
- Provide relevant health information for staff to take back to work/home and incorporate into their lifestyle

Benefits for our business:
- Provides a valuable employee benefit package
- Improves staff productivity, motivation and morale
- Helps to recruit, retain and reward our staff
- Helps as part of pay reviews
- Help employees with stress related problems

Assurances (how do we know we are making an impact):

1. Staff morale - will measure this in next employee engagement survey
2. Recruitment and retention - labour turnover is reported monthly in NHS111 Board Meetings (currently improving). We will measure this effect every month with the anticipation that recruitment and retention will improve.
3. Absenteeism although still variable will also be reviewed each week and departmental action plan is being put in place.
4. We report on these measures at The Board meetings every month with the anticipation that recruitment and retention and absence will improve.

Gaps in controls (further actions that would help achieve the target):

1. Unable to turn on HR to Payroll integration tool until April 2017
2. Managing absence through spreadsheets.

COMMENTS:	**UPDATE DECEMBER 2015** Payroll and Finance have identified a HR & Payroll system which is called Miracle Dynamics. This system is based on the NAV system which is used by and will align to Finance. The risk of supplier failure will be greatly diminished as a result. We will order this system and install it early in 2016.
CHANGE:	

Health & Wellbeing Action Plan

No	Action	Who	Date (s)	RAG
1.1	Managing stress - DW to arrange mini health checks for people who enrol for a health check. This will be done by NHS Arden & GEM CSU team to provide checks on Stress & Mental Health for all of our staff. The aim of the event are to: • Involve DHU staff in Health Checks over a day • Provide lifestyle analysis and advice after each Health Check • To present the damages caused by stress and how to combat stress/mental health in an informative manner • Provide relevant health information for staff to take back to work/home and incorporate into their lifestyle	Dave Walsh / Luke Mosley / Arden & Gem	9 & 13/11/2016	Complete
1.2	Health & wellbeing - arrange mini health checks, work with Westfield Health to set up employee helpline to deal with health issues. Staff will have access to: Company Doctor Big White Wall 24/7 Access to Emotional Support Physiotherapy Assessment Occupational Health Managers' Helpline	Dave Walsh / Luke Mosley / Arden & Gem	02/02/2017	Complete
1.3	Benefits for our business: • Provides a valuable employee benefit package • Improves staff productivity, motivation and morale • Helps to recruit, retain and reward our staff • Helps as part of pay reviews • Help employees with stress related problems • Can support our duty of care obligations	ALL	Ongoing	Ongoing

1.4	The tangible benefits of this for our business: • Provides a valuable employee benefit • Improves staff health, motivation and morale • Helps to recruit and retain our staff • May help staff with stress related problems • May help staff with musculoskeletal problems • May help reduce absence	ALL	Ongoing	Ongoing
2	**Measurements**			
2.1	Staff morale - will measure this in next employee engagement survey	Pauline Hand	30/06/2017	Planned and running past Communications & Engagement Forum - Ongoing
2.2	Recruitment and retention - labour turnover reported monthly in NHS111 Board Meetings (currently improving). We will measure this effect every month with the aticipation that recruitment and retention will improve.	Vicki Brown	31/03/2017	Ongoing
2.3	Absenteeism - still variable - will review each week and pull together department action plan. We will measure this effect every month with the aticipation that recruitment and retention will improve.	Vicki Brown / Emma Gilliver	31/03/2017	Ongoing

Project 4 – DHU – Mental health nurses, support & upskilling the workforce

Contact details	
Name of Organisation	Derbyshire Health United 111 (East Midlands) CIC
Postal Address	Mallard House, Stanier Way, Wyvern Business Park, Derby, DE216BF
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Contact Number (Mobile / Landline)	0300 1000 404 x5632
Date of Report Submission	5th June 2017

Project Summary

The project focused on mental health patients who contacted the DHU 111 service. Particularly looking at improved support for the DHU clinical and non-clinical 111 advisors, and improved outcomes for these patients. Also as a result of improved outcomes the project hoped to reduce inappropriate referrals to urgent care services.

The project provided a dedicated mental health/NHS Pathways trained resource to give support to 111 Clinical Advisors and 111 Health Advisors when assessing patients with mental health issues who contact the DHU 111 service.

The mental health nurses were able to give advice on any caller to the DHU 111 service, and if necessary take over the call to complete the assessment. They were based at the DHU Chesterfield and Derby call centres, but were available to all DHU staff via a dedicated mental health advice line number.

This resource was provided by agency nurses who were already trained on NHS Pathways, following an induction into DHU. The nurses were available during the out of hour's periods (18:00 – 02:00 Monday to Friday and 06:00 – 02:00 at weekends and bank holidays).

The 111 service provided by DHU covers the whole of the East Midlands (Leicestershire, Nottinghamshire, Lincolnshire, Derbyshire and Northamptonshire) and Milton Keynes. Data from previous month's calls indicated that approximately 1300 patients per month with mental health issues could benefit from this enhanced service.

Background

There is a current gap in the appropriate management of patients presenting with mental health conditions to the NHS 111 service. NHS Pathways is not comprehensive enough in its assessment of these patients and has a tendency to reach an urgent face to face outcome which is not always the most appropriate method or place of care for these types of patient.

Some regions within the East Midlands area have provision for referring certain patients with specific mental health symptoms onto providers of specialist mental health care but this is not consistent or comprehensive. As a consequence a number of mental health patients who don't meet the specialist referral criteria wait for a call back from a DHU111 general trained clinician and are potentially then referred on as an urgent referral when they are not truly in need of an urgent level of care.

With this project we hoped to ascertain if by using trained mental health nurses as a resource to support 111 advisors with their mental health patients pathways assessments we could improve the outcomes for these patients, and by doing so have a positive impact on the urgent care services within the East Midlands. We also hoped to improve the confidence of our current 111 advisors when managing mental health calls as we were aware many advisors struggle with these calls, and this can impact negatively on them.

Challenges

- Prior to the project there were no mental health nurses working for the DHU 111 service.
- Due to the DHU 111 service being provided from 3 separate sites (Chesterfield, Derby and Leicester) communications to staff regarding the pilot would be challenging.
- The DHU 111 service is extremely busy and there is ongoing Pathways training for new staff which limits the amount of additional training resource available to support mental health nurses requiring inductions.
- Current NHS Pathways/DoS configuration does not allow the passing of mental health calls to an internal mental health resource without manual manipulation.
- The 5 different commissioners DHU provide the 111 service for all have different services allocated to managing patients with mental health issues, making it challenging to ascertain which calls are appropriate to pass to internal mental health clinicians and which should go to a dedicated service.

- Evidencing the effectiveness of the pilot mental health clinicians on the DHU 111 service, and monitoring the individual performance of the mental health clinicians.

- Establishing the impact of the pilot on the experience of patients with mental health issues contacting the DHU 111 service, and their outcomes.

Approach

- Project lead maintained ongoing communications with agencies to ensure sufficient mental health clinician resource sourced.
- Project lead liaised with DHU communications lead to ensure pilot was advertised to all 111 staff groups, and ensured real time reminders sent out to all staff groups via live updates and Adastra messaging.
- Pre-pilot mental health call survey via survey monkey developed and advertised to all staff groups prior to pilot, and regular reminders sent out via email/newsletter and Adastra messaging to ensure staff awareness.
- DHU CQI and DoS leads supported induction of 111 trained mental health leads supplied by agencies.
- IT set up dedicated 111 mental health clinician advice line number to enable DHU 111 advisors to seek advice from pilot mental health nurses and to warm transfer patients with mental health issues to mental health clinicians where appropriate.
- Project lead composed and distributed guidelines for DHU 111 advisors and pilot mental health clinicians to ensure they were aware of the processes for accessing pilot mental health advisors, and which calls were appropriate to pass to mental health clinicians.
- Post pilot mental health call survey via survey monkey developed and advertised to all staff groups following pilot, and regular reminders sent out via email/newsletter and Adastra messaging to ensure staff awareness.
- DHU Data Analysts asked to provide weekly reports regarding pilot mental health clinicians' performance, and outcomes for mental health calls to the DHU 111 service.
- DHU 111 audit team asked to audit 5 calls for each pilot mental health clinician.
- DHU clinical governance team asked to provide data regarding any change to the feedback from patients with mental health issues over the duration of the pilot.

Intended outcomes

Aims

Provide an enhanced service for patients contacting the 111 service with mental health concerns.

Ensure these patients are not referred inappropriately to urgent outcomes.

Objectives

- Provide an expert mental health resource for DHU 111 patients.
- Provide support to DHU 111 advisors with calls from patients with mental health symptoms.
- Evaluate the impact of an additional mental health resource on the 111 service provided by DHU.
- Assess the need for ongoing additional mental health resource for the DHU 111 service and potentially other national 111 services.
- Identify if there is a need for improved training on mental health for 111 advisors.
- Assess the impact of an enhanced triage on callers to the service with mental health issues.

Measures

- Pre and post pilot survey
- Weekly report from data analysts on mental health call outcomes
- Feedback from mental health clinicians
- Clinical governance feedback

There were no changes required to terms and conditions of employment.

The project supports the urgent care workforce programme agenda through the support to development of a workforce fit for the future appropriate to patient need.

Intended outputs

We intended to ensure mental health patients contacting the 111 service receive the best possible assessment and outcome to deal with their concerns effectively.
We also wanted to ensure that all 111 advisors are supported with their assessments of patients with mental health issues, and are provided with ongoing support through improved training in the area of mental health.
The improved triage and referral of mental health patients will have the wider benefit of diverting these patients from inappropriate services such as emergency departments and 999 services.

The main strengths of this project are:

1. Relatively easy to implement as there is already a resource we can access to provide enhanced triage.
2. Not particularly expensive as the systems are already in place and just require some modification to support the project.

Using mental health clinicians solely for mental health calls is innovative, as NHS Pathways users who are not mental health trained tend to have a more

generic approach, and do not necessarily have the skills required to deal with some mental health patient presentations.

Details of resources and any potential partnership

Additional funding to employ mental health clinicians via an agency and to provide IT, clerical, training, clinical governance and management resource.
Agency input to source trained mental health clinicians.
Partnership working with NHS Pathways and DoS leads to enable seamless transfer of calls to internal mental health clinicians.
Partnerships with mental health support groups to help monitor the impact of the service, and assist with future development.

Obstacles and issues

- Although 2 agencies initially advised it would be easy for them to access 111 and NHS Pathways trained mental health clinicians, and initially supplied names of several potential candidates it soon became obvious that very few of them actually could/would commit to the project. This led to a delay in the commencement of the project. 3 dedicated clinicians were eventually sourced to cover the out of hour's periods when call volume was at its greatest, but only when increased rates of pay were offered.
- Originally we hoped to be able to map particular pathway's outcomes to go through the DoS to the in-house pilot mental health clinicians to enable a streamlined transfer of calls. However due to the diverse number of mental health services that different commissioners are currently providing it was not feasible to do this mapping in the limited time available to commence the pilot. We then had to revert to written processes and manual transfers, which were particularly convoluted when requiring transfer from a DHU 111 clinician to a mental health pilot clinician as the call had to be closed on NHS Pathways, and then reopened to allow access to the mental health clinician.

Actual outcomes

We identified through the pre-pilot survey that our current 111 advisors felt there was a definite need for support with mental health calls received by the DHU 111 service. Only 50% of the advisors surveyed felt confident managing mental health calls, and 60% felt that the NHS Pathways assessment tool did not support them particularly with their assessments. 82% of respondents felt that having a mental health trained clinician for support would be beneficial, and

although a high percentage of staff had completed the NHS Pathway's mental health consolidation pack, and DHU's 'Managing Challenging Calls' in house training, over 97% felt that additional training would be beneficial.

The post-pilot survey showed that over 75% of respondents found the service helpful or very helpful, with 77% advising they would find this resource beneficial on an ongoing basis.

The survey also showed 60% of respondents found their confidence improved with managing mental health calls due to the advice line being available.

Of the calls audited for the mental health clinicians only 1 called failed the audit. The calls were generally well managed, but tended to be longer than those of generic clinicians (as previously noted).

Data on mental health call outcomes was collected prior to the commencement of the pilot, and during the pilot.
Prior to the pilot around 60% of all calls received by DHU with a mental health symptom group, assessed by a non-mental health advisor, went to 'urgent outcomes' i.e.

Red 2 ambulance
Green 2 ambulance
Green 4 ambulance
Attend Emergency Treatment Centre within 1 hour
Attend Emergency Treatment Centre within 1 hour for Mental Health Crisis Intervention
Attend Emergency Treatment Centre within 4 hours
Speak to Primary Care Service within 1 hour
To contact Primary Care Service within 2 hours
Speak to Primary Care Service within 2 hours

The data for the 5 weeks the pilot ran shows that of the calls assessed by mental health clinicians on average only 27% went to the same urgent outcomes.

The pre-pilot data showed only 0.5% of mental health calls assessed by generic 111 advisors had an outcome of home care, and 4.1% had an outcome of 'Must contact own GP within 3 working days'. The data from the calls managed by the mental health clinicians showed 4% of calls going to home care, and 9.5% of calls with an outcome of 'Must contact own GP within 3 working days'

Actual outputs

The use of mental health clinicians would appear to be cost effective as for a potentially low financial investment fewer 111 callers with mental health problems were referred to emergency departments and the ambulance service.

However the data collated during the pilot showed the mental health calls tended to be substantially longer than generic pathways calls (nearly double the length), which in itself would have a cost implication for any commissioner wishing to utilise this enhanced service.

The evidence from our pre and post surveys showed there was an obvious benefit of improving the confidence of our generic 111 advisors when they are managing these calls, and there is a very obvious appetite for ongoing support with these calls.

As part of our clinician development meetings we were able to offer question and answer sessions with the pilot 111 mental health clinicians, these were extremely popular as they gave the clinicians to raise concerns they had around particular types of mental health calls, and scenarios, and we had extremely good feedback from attendees.

Lessons learned

- If intending to use mental health trained clinicians to manage callers with mental health conditions it would be preferable to employ them substantively rather than offering shifts via a nursing agency. This would be more cost effective, and it should also mean a more reliable workforce.
- It would appear from the differing outcomes for generic 111 advisors using NHS Pathways, and mental health clinicians applying their knowledge to the assessment that there is room for improvement in the NHS Pathways 'mental health pathways', and this could be explored with NHS Pathways authors.
- To enable as smooth a patient journey as possible the correct IT and DoS system adjustments should be put in place to allow easy transfer of calls between generic advisors and mental health advisors, and mental health services available within commissioning areas. It would also be preferable to have an easy way to identify mental health calls within a queue, or a separate queue for mental health calls.
- Feedback from the mental health pilot clinicians indicated they were frustrated that they were unable to see patients medical records (which would have assisted their assessment), and that crisis teams were not willing to take direct referrals from them. If these issues were addressed it would help to avoid unnecessary referrals to GP services.
- From the pre-pilot survey, and feedback from the pilot mental health clinicians, it is obvious that generic advisors (clinical and non-clinical) require some more robust effective training around mental health calls. A national training programme specifically for telephone triage advisors would help to address this, and help with consistency throughout the 111 service.

- The call lengths for calls assessed by mental health clinicians could impact adversely on a 111 provider's statistics. It would be preferable to potentially have a separate target for these calls to prevent this.
- Setting up local links to mental health groups in a position to provide feedback to assist with service development proved impossible within the time span of the pilot. This would need to be addressed to effectively monitor the impact of enhanced mental health assessment on the mental health community.

Next Steps

With the introduction of the suggested changes in 'lessons learned' it would appear that this project would be sustainable as an ongoing service.

We have shown that having a dedicated mental health clinician resource within the 111 service would enable us to manage mental health calls more effectively, and would reduce the number of patients accessing inappropriate services with mental health conditions.

From the post-pilot survey it is clear that the majority of our generic 111 advisors found the support of the mental health clinicians very helpful, and they would very much appreciate this as an ongoing arrangement if it could be resourced.

Project 5 – IC24 – Developing remote consultation educational course for all clinicians

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Project Summary

Development of a multi-disciplinary remote consultation course for all clinicians working across the integrated urgent care system.
The training was aimed at a multi-disciplinary advanced practice level that included General Practitioners, Advanced Nurse Practitioners and Advanced Paramedics.
As we are developing a Clinical Assessment Service in our Norfolk locality this is where we decided to focus the training schedule

Background

From observation and intelligence both within the organisation and in the wider NHS system in relation to audit of advanced practitioners consultations, serious incident investigations and trends and themes in complaints; the level of emotional intelligence and self-awareness of the practitioner is paramount in achieving an optimum and effective consultation with patient particularly in a remote environment. These consultations should therefore include the patient's understanding of an outcome and the practitioner's ability to coach and mentor patients when the outcome may have not met the patients expectation. This type of training is very common in Leadership roles but not common in training programmes designed for front line clinicians. Leadership skills are essential for front line clinicians in regard to effective communication with patients.

Challenges

Considering this training was aimed at advanced practitioners, the main concern was lack of engagement due to either lack of interest and understanding in this area of learning or lack of ability to commit to all modules.

Ideally for the best learning outcomes practitioners would need to attend all four teaching sessions. This type of learning is unchartered territory for many advanced practitioners and therefore they can have a tendency to disengage.

Time constraints and the level of financial investment dictated that the sample size is small and the evaluation is brief, potentially limiting any impact of evaluation.

Approach

Workshops were delivered prior to the training development to explain the training and identify the most appropriate logistical timing and spacing to gain the highest possible engagement.
Based on the feedback given, the modules were therefore delivered in the evenings as
3 hour sessions over two months with two modules delivered each month.

Intended outcomes

The aim of the project is to demonstrate that practitioners' enhanced understanding and reflection of their own personality type and style of communication would lead to more effective communication with patients and potentially lead to better outcomes for patients.

The objective was to deliver four sessions over two months in order to give practitioners time to digest and reflect on their learning and consider how that relates to their practice.

The modules focused on specific learning objectives:

- To understand better how people prefer to operate, including yourself, so that you can work to your strengths;

- To better understand your own Myers Briggs Type Indicator preference and to understand our strengths and development areas;
- To better understand how different preferences interact and how we may use this knowledge to develop our remote consultation skills;
- To understand our own reactions under stress and how patients may communicate in stressful situations.
- To consider how we can put these techniques into practice.
- Understanding how we can work to create a good 'Thinking Environment for our patients during remote consultation;
- How can we support patients under stress during remote consultation using these techniques?
- To consider how we can put these techniques into practice.

Identifying challenging consultations

- What is challenging?
- Why does the challenge affect you?
- How do you handle these challenges?
- What if you could do something differently?

Identifying the mismatch between patient and clinician agendas. Group workshops.

- Calibration of senses and learning to mind read
- Identification of own state
- Non-verbal communication skills
- Belief in self
- Giving receipts in consultations and how to use softening and reflective language patterns.

Based on the evaluation of this project some of the core competencies essential for effective remote consultation in an advanced practitioner may be realised.

Intended outputs

Intended outputs

(The products to be delivered by this project, what are wider benefits if any that could not be seen at the outset. What is a main strength of this project?

What is innovative about this project? What techniques can be adopted by projects from wider national programmes?)
The main intended outputs from the project are:

- Extend and enhance skills of advanced health care professionals
- Increased confidence in remote consultation for both professionals and patients
- Improved disposition outcomes and advice for patients
- Increased positive patient experience
- Develop core competencies for this speciality

Due to time restraints of the project the full evaluation in regard to the impact of the training on practitioner consultations will not be complete until December 2017. Below is the scope of the evaluation that is being undertaken.

Evaluation

Methodology

1. **Literature review**

- Remote patient consultation
- Contribution of training as it stands
- Potential of new schemes of learning to contribute to this emerging speciality
- Evidence of how 'soft' skills contribute to advanced communication

2. **Evaluation of Impact**

Two perspectives and two methodologies

Quantitative

- Patient experience including outcomes from individual consultations
- Individual practitioner data.

Qualitative – changes in individual practice:

- weekly entry – 10-15 minute structured for 3 months
- telephone survey – structured with each individual at 6 months

Data collection points

- Pre-programme –individuals baseline data
- 3 months – diaries for qualitative and individual outcome data
- 6 months – telephone survey to staff and individual outcome data

This type of training is unchartered territory for many front line clinicians. We intend to demonstrate that this type of training should be included.

Details of resources and any potential partnership

The project required senior clinical leadership time within the organisation to develop and organise.
Workshops to scope the training sessions.
Partnership with external providers to develop the content and deliver the four modules.

Obstacles and issues

Despite the preliminary work to ensure the times and dates were logistically relevant for the attendees, we did not get attendance from all practitioners to all sessions.

However the engagement and enthusiasm from practitioners to undertake the learning and the appreciation of the benefit the learning would have on practice and feedback for all sessions was extremely positive which was not anticipated.

Some examples

I personally felt it was excellent, pitched at the right level by a skilled, engaging presenter. The session was active, and the time passed quickly. I think it gave each of us interesting info not just on a personal level but also about patients and how their preferences may act as hurdles to a smooth consultation.

The speakers were extremely engaging and tailored the session to the audience really well.

We were taught NLP techniques which we could apply to the consultation (and daily life).

The session was interactive and informal but also well-planned and the speakers provided an agenda and evaluation form.

I wanted to say thank you very much for the excellent training session you kindly delivered for us.
I found it insightful, thought-provoking and it really made me want to learn more about NLP. It has been really useful to reflect on my own triage style.

Actual outcomes
We have delivered all four sessions to a multi-disciplinary team with much higher engagement than expected. The initial feedback is that the training has been excellent and practitioners feel that this will change their practice. Whether an actual change in practice occurs will be monitored through evaluation
Actual outputs
This will be available as part of the evaluation. The potential is for not only an improved experience for patients and practitioners, but a system wide effect if the disposition for a patient is improved. For example if an increased amount of consultations are resolved as a phone call or there is a reduction in referral to A&E or 999.

Lessons learned
With an increased amount of time better planning could be undertaken to ensure that all practitioners completed the full programme.

Next Steps
A full and detailed evaluation report will be produced by December 2017 based on the information provided in this report.

Project 6 – LAS – Exploring the potential for integration between the 999 and IUC/NHS 111 clinicians

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Project Summary

This project sought to explore the potential for integration between the 999 clinical hub and 111 clinicians, focusing on three Programme themes:

- Clinical Assessment Services (clinical hub);
- New Workforce Models; and;
- Integration across Urgent & Emergency Care.

The project embedded 999 clinical hub staff in the 111 service, seeking to identify the gap between our 111 & 999 clinicians in terms of skills, knowledge, experience, and clinical confidence. Data was collected and interrogated from the start of December
2016 for a period of 12 weeks with further work required once the 999 clinicians had started working at 111 from March. We also sought to understand the reasons why a minority of callers experience multiple handoffs between the services with a view to eliminating this phenomenon.

Background

The LAS is a 111 provider covering South East London, managing circa 27,000 calls per month directly through 111 and approximately 157,000 calls referred from 999 where the ambulance triage has identified that they do not require an emergency ambulance immediately.

The South East London area covers 6 boroughs – Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

The 111 and 999 clinical hubs are geographically located in different parts of London, and have not previously worked co-located in one site.

The LAS has experienced a phenomena of patients “cycling” between the 2 services – this results the possibility for a patient to get ‘lost’ in the system. For example, a caller who calls 999 and is triaged through the Advanced Medical Priority Dispatch System (AMPDS) and is identified as low acuity, and not immediately requiring an emergency ambulance, will be asked to call 111 for further assessment. An ambulance will not be sent at this point in the patient episode. Upon calling 111 the patient is re-triaged through Pathways and, if clinically indicated through the NHS pathways assessment, may end up re-presenting to the 999 system on the conclusion of that triage. Clearly, for these patients the experience is poor and their time from first call to resolution is significantly extended.

Furthermore, the LAS receives referrals for ambulance dispatch from 111 and IUC providers across London, which are subsequently closed through Hear and Treat by LAS 999 clinical hub clinicians – the patients also frequently report they did not want an ambulance attendance or conveyance to hospital. This duplication of work extends resolution time for patients and provides poor value for money to the tax payer and poses some questions about how to achieve the most effective CAS. The difference in outcome for the patient may be explained by the fact that the LAS clinical hub uses a different clinical support tool (Manchester Triage System) which is not algorithm based but a supportive tool which relies on senior clinicians using clinical experience and knowledge.

This project therefore sought to understand the reasons why these issues occur; any gaps between 999 and 111 systems and clinicians, and understand the pathway towards integration in order to inform the next steps towards meeting the Integrated Urgent Care Commissioning Standards.

Challenges

The funding for this project provided backfill for the staff involved in the project To be able to provide a fully serviceable clinical hub separate funding would be required to purchase further network capacity at Southern House (principle integrated hub location), client devices (PCs, screens, phones, NHS Smartcard card readers etc.) and project and service management support (people) to implement, test and bring the new service live and oversee the clinical governance and outcomes.

In addition, any clinical hub provision beyond HQ and Bow would need to take into account the clinical hub developments currently underway (2017-2018 CQUINs) as this will potentially impact on the technical provision required. There were however sufficient tools in place to run a project as there is access at Southern House to the
CAD system in use by the LAS 999 service.

Whilst planning the project we recognised there would be concurrent operational pressures given that we had to undertake detailed planning during the winter pressures period, and that the project was due to run at the same time as we were due a 999
CQC inspection. It was also acknowledged that SEL would be progressing a re- procurement of the service during this time.

There is currently no automatic transfer of calls from 999 to 111, nor any warm transfer involving our 999 call takers. Whilst it is reasonable to assume that most callers comply when we ask them to hang up and dial 111, a small audit by LAS 111 tracing end-to- end calls indicates some do not and seek advice elsewhere or present at an emergency department.

Calls from 111 being referred to 999 for an ambulance response are transferred across an electronic link, however this only includes particular patient details and not the whole record – both services hold different patient information that the other service cannot easily access in a timely manner. This creates a barrier to joined-up working and potentially impacts the patient experience (for example by being asked the same questions by two different clinicians and getting different outcomes).

We knew that the limited timeframe for the project, and the fact we were assessing human issues across a diverse staff group, might limit the outcomes. It should be noted that our outcomes may not be readily transferable, generalisable or be necessarily representative across the entire staff group.

Approach

The project was split into 2 phases.

Phase 1 involved data collection and analysis to determine the cohort of patients (or pare down some subsets of patients) who would most benefit from the activities in phase 2. Phase 1 was commenced whilst detailed planning for phase 2 was still ongoing, and during this time we also sought funding for the additional equipment required to provision a full 999 clinical hub at our 111 site.

Due to the concurrent activities within the Trust (detailed above) we appointed a project manager to assist with keeping the project activities running to schedule.

In phase 2, our 999 clinical hub clinicians were embedded within 111 to work in partnership with the clinicians and call handlers to improve the patient experience for patients experiencing a handoff between the 2 services. Two motivated and experienced paramedic trained staff who had no previous knowledge of the 111 call handling and triage processes were selected and worked fast to familiarise themselves and understand the integration gap, spending the first week of phase 2 observing with call handlers and clinicians as well as speaking to managers and Business Intelligence staff. This generated ideas for further development and improvement which were scoped and incorporated.

Further details about the activities in phases 1 and 2 are detailed in the following sections of this report. A third phase was also provisionally scoped to re-collect and analyse the data over a comparable period of time during phase 2, although ultimately this was not progressed due to reasons described elsewhere in this report.

Intended outcomes

We intended, through the phase 1 data analysis, to identify and quantify the number of patients who experience multiple handoffs between our 999 and 111 services. We expected the analysis would provide information on trends in this subset of patients (in order to target activities during phase 2) and would provide information on some of the factors involved in multiple hand offs. This data would then be re-collected and analysed for a comparable time period during phase 2 to assess the effectiveness of the pilot project's intervention. This analysis would include looking at the total patient cycle time from first LAS contact to discharge of care, patient outcome/disposition (where obtainable), re-contact rates, complaints/adverse outcomes and their root cause, and feedback from patients. Additionally, we considered analysing the unknown quantity of patients who are advised by 999 to contact 111 who fail to do so. This was not able to be progressed within the time frame and capacity available but represents an area of work that we consider important to pursue further.

We planned to consider the potential benefits for having dual trained 111 and 999 clinicians, able to use both of the triage systems in use in our clinical hubs (NHS Pathways and the Manchester Triage System (MTS)). This would inform future projects to test rotational working between the two services for improved integration, job satisfaction and to allow scope to flex staffing in response to fluctuating demand in either the 999 or 111 services.

Our 999 clinical hub clinicians, who were unfamiliar with 111 call handling and triage processes, would gain insight in the 111 system and its practices, and use that insight to identify areas for closer working, integration, and service improvement. In doing so, they would identify the gaps to full integration of the 111 service and 999 clinical hub, and also understand the human and other issues that might explain the differences in behaviour between 999 and 111 clinicians. They would also be able to share this knowledge with colleagues as the knowledge of NHS 111 and pathways assessments in the wider health service is limited and, on occasion, unfairly criticised.

LAS continues to receive, via 999, a significant number of referrals from 111/IUC services which are subsequently closed through hear and treat, or conveyed to an Emergency Department in a taxi, or our Non-Emergency Transport Service (NETS), as it is identified that the patient does not require the clinical skills of a frontline ambulance en-route. The challenge, therefore, is how to deal with these patients safely with fewer repeated over the phone clinical assessments and how to utilise appropriate non ED pathways and non-ambulance conveyances. .

This project also presented the opportunity to explore the possibility for operating a remote clinical hub environment outside of the 999 Emergency Operations Centres, and understand the governance, technical and human factors that might influence this.

Intended outputs

We intended to improve the patient experience and clinical risk by reducing 'hand offs' between services, especially pass backs to the service that the patient originally contacted, focusing on those patients that were likely to ultimately not receive an ambulance dispatch but be closed by 999 clinical hub clinicians through hear and treat. This would therefore lead to a reduction in the volume of South East London calls referred from LAS 111 to LAS 999.

By understanding the factors involved in these hand offs, and by reducing the number of hand offs or improving the process for those patients who are referred between the services, we aimed to reduce the overall patient cycle time from first contact to discharge of care.

As a measure of quality and safety we aimed to reduce or at least have no difference in re-contact rates, and positive patient satisfaction surveys.

Details of resources and any potential partnership

The project was funded for 2 senior managers at 0.1 WTE each, a 1.0 WTE clinical hub manager to develop and plan the project, a 0.1 WTE business engagement manager from our IM&T department to lead technical aspects of the project, and a 0.2 clinical operations manager at 111 to oversee the embedded staff during phase 2.

In addition we required (and therefore funded internally) a 0.2 WTE project manager, and the two 999 clinical hub staff that we embedded at 111 (1.0 WTE for 8 weeks).

There were no external partnerships required to deliver the project.

Obstacles and issues

Our original plan for phase 2 was to focus on those subset of calls where there were multiple handoffs; that is, patients who call 999 and are referred to 111, and who are subsequently referred back to 999. Because these patient journeys are so poor, they are the ones that concern our clinical and call handling staff. There was a widely held belief amongst our 999 clinical hub staff that there were a significant number of these calls which needed exploring. When we analysed the data, there was indeed a significantly extended patient journey from first call to final resolution, but the volume of these calls was very low. Whilst we should continue to seek to improve these patient journeys, the benefit of focusing solely on them for this project would not be sufficient to justify the cost. Therefore, we recognised that the focus of the project had to change.

Whilst we had to change the focus of the project, the same underlying principle applied to the principle of the project which was to close the gap between 111 and 999 – providing a safe and high quality service with more seamless patient experiences, less handoffs, smoother referrals, and providing the most appropriate outcome in the least possible time, regardless of the patient's point of entry into the system (i.e. be it via 111 or 999). This underlying principle applies not only to the patients with multiple handoffs but to all patients who get referred between the services, especially because we are aware that the lack of electronic transfer of calls from 999 to 111 impedes true integration. The focus remained on dealing with those patients who get referred between the services, and we broadened the scope of the patient groups we would look at, to all patients that our 999 clinicians are currently able to assess.

Once the clinicians started to try and assess the differences between themselves and the 111 clinicians, it became clear that drawing conclusions might prove harder than anticipated. Reasons for this were:

- As the project clinicians had not been trained in and were not familiar with NHS Pathways, they had some uncertainty when trying to draw conclusions about the influence it has on the triage decision made by the clinician; The 999 clinicians use a less structured triage tool when assessing patients, and the very structured nature of Pathways contributed to the difficulties encountered;
- There were inevitable human factor issues with pilot project clinicians not wanting to appear to undermine either their colleagues or NHS Pathways by disagreeing with the clinicians working in 111;

- It was sometimes difficult to be able to make an objective decision when listening in to a 111 clinician making an assessment, as each

clinician's own line of questioning for history taking would be different;
- Differing experience and expertise in hear and treat resulting in perspectives of staff in terms of clinical opinion; and;
- Lack of understanding of each other's system of work in general.

The clinicians witnessed variability in skill, knowledge, and decision making, as might be expected, due to clinical background, past experience and training. All of these factors contributed to making it difficult to make objective decisions on patient disposition. Ultimately, our 999 clinical hub staff felt conflicted about challenging a clinical colleague, especially with a pilot project focusing on integration. This was a difficult issue to attempt to resolve with the project timeframe.

Some staff expressed concerns regarding governance issues if our 999 clinician were to influence the outcome for a patient, which again was difficult for our staff embedded in 111 to easily resolve. This was precipitated by working in an unfamiliar environment, as in actuality the clinicians would be free to make the same decisions that they do in the 999 clinical hub as long as these were appropriately documented.

A key aspect of phase 2 was identification of the potential for some patients who were identified as needing transport to hospital with no clinical interventions (green ambulance dispositions) to be fast-tracked to our Non-Emergency Transport Service (NETS) or contracted taxi service. Whilst this was initially scoped as being a key output that could be implemented quickly, the restrictive response timelines given by NHS Pathways for these patients caused a conflict with NETS who usually accept patients with an agreed timeline for ambulance attendance of up to 4 hours. The creation of a Standard Operating Procedure (SOP) for NETS to overcome this is discussed later in the report, but the team also underestimated the amount of basic introductory work that needed to be undertaken because our 111 service had minimal knowledge of NETS and its function/remit.

Actual outcomes

A positive outcome that was certainly realised was better shared awareness, especially increased awareness of 111 by our 999 clinicians. The project highlighted the work required to integrate the two services as they operate independently in terms of surges in call volumes, and have no visibility of the services immediate pressure. We know that, in the 999 service, during times of excessive call demand we advise an increased number of lower acuity patients to call 111 for a further telephone assessment and extend response timelines for 999 hear and treat assessments, in accordance with the clinically agreed surge plan, to ensure we preserve our response to the most acutely unwell patients and manage held calls safety. During this time 111 providers may continue to send low acuity patients into the system even when notified of a change in surge level. If our 999 clinicians critically review the risk assessment for a patient based on knowledge of pressures on the system, then 111 could do the same. This would, of course, require a framework to be built around it that ensures the focus is providing the safest outcome for the patient, but it is easy to see how this shared awareness could provide benefit to patients.

The shared awareness of intermittent pressure on the 111 system (including the other 111/IUC providers across London) may assist our clinical hub in responding more flexibly to demand; at times of incoming call pressure on 111, green ambulance referrals may be referred to 999 without clinician assessment for clinical safety however our 999 Emergency Operations Centre (and therefore our 999 clinical hub staff) have no awareness that this is happening – a method of highlighting the green ambulance calls which have not been clinically assessed has been discussed previously but now needs to be developed. The future implications for further integration of the 2 clinician delivered services are clear, both in terms of shared awareness and of being able to respond to incoming call pressures in either system. There would also be benefit from our 111 call handlers and clinicians undertaking observations at our 999 Emergency Operations Centre to have a better understanding on the mechanisms in place to manage calls and vice versa.

Our 999 clinical hub clinicians were impressed by the NHS Pathways system and recognised its comprehensive nature. It is beyond the scope of this project and this evaluation to fully consider the influence of NHS Pathways, and it is certainly not our intention to provide here a critique of NHS Pathways, but our clinicians did highlight several recurrent observations about questions that the NHS Pathways system led to during their experience.

111 clinicians, whilst openly stating they were confident to make clinical judgements, did not always demonstrate the autonomy they hold through their

actions. NHS Pathways is an algorithm which is more didactic than the Manchester Triage System used in the 999 clinical hub, and this appears from the experiences in this pilot project to result in more clinical autonomy being demonstrated by 999 clinical hub clinicians. NHS Pathways supplies all appropriate and relevant post triage information and worsening care advice whereas the MTS (Manchester Triage System) used by the 999 clinicians relies more overtly on the knowledge base of the assessing clinician. It is suggested that MTS allows greater clinical interpretation, but in doing so requires a high standard of current clinical competence to follow; further research would be required to understand these dynamics further.

Our clinicians felt that the frequency and/or recent amount of face-to-face patient contact may well influence behaviour and confidence, and would make clinicians less reliant on the NHS Pathways triage tool as they would have recent experiences to correlate their thoughts and decisions with. There is therefore a case for investigation whether skill decay occurs, and whether decision making is degraded, the longer a clinician has been away from face-to-face patient contact.

We are keen to stress that the 999 clinicians are not necessarily better trained or better clinicians but to undertake hear and treat they are all required to undertake continued frontline shifts and have considerable pre-existing frontline experience. It is suggested that a variety of factors in the 111 environment, which from the observations in this pilot project include Pathways questioning and governance protocols and lack of recent patient contact, potentially leads to some decision making, clinical confidence and autonomy not being fully exercised. These are the conclusions made by our staff, and also witnessed during end to end call reviews, result in an increased number of patients being referred to 999 that do not require or want an ambulance response.

Another important outcome experienced by our staff in this pilot project was a perceived improvement in work/life balance and wellbeing from being able to perform their core duties from an alternative location that avoids a lengthy commute into one of the LAS Emergency Operations Centres. This project has enabled us to understand in practical terms the technical requirements of such an undertaking, and it is suggested that this could potentially improve recruitment & retention to 999 clinical hub posts. Additionally staff in the 111 service enjoyed having the wider understanding and information provided by the 999 clinicians.

Actual outputs

During phase 1 of the project we analysed the volume of 111 referrals received by the 999 service during December 2016. For each provider, we analysed the volume of calls that were closed by the 999 clinical hub as a result of telephone assessment, including those patients who were sent to an Emergency Department or alternative care pathway by taxi. The analysis revealed that with the LAS 111 site, 26.34% of calls received were closed by our 999 clinical hub clinicians. Other London 111 providers varied from 26.92% to 33.71%. The 999 Clinical Hub is also undertaking hear and treat assessments on 999 calls so it is possible that this number of 111 calls who are able to be managed closer to home, without an ambulance or attendance at ED, could be significantly higher if capacity permitted.

We conducted further analysis to identify those patients who were subject to multiple hand offs (i.e. referral back to the originating service), although as previously discussed the volume of these calls was very small and no further analysis was done on this dataset.

An SOP which allows for 111 clinicians to identify cases suitable for NETS or taxis has been drafted which protects the clinicians in terms of governance but also allows them to express the information required by the NETS team to accept the case when it is transferred to 999. A barrier to faster implementation is that 111 clinicians are not permitted to change the timeframes suggested by NHS Pathways, which would be necessary to match up with NETS. This SOP will give them the authority to pass that information, and it is currently going through Trust approval processes. It is interesting to note that NHS Pathways will only allow a maximum of 60 minute response to be suggested, when in the 999 emergency environment we can allocate a 2-4 hour response to a case once it has been clinically assessed. Further work in the future to align this would assist integration of the services.

Due to the challenges encountered by our staff (as previously detailed), other intended outputs weren't realised and there was no further data analysis as the comparable data would have been insignificant.

Lessons Learned

Our enthusiasm to work towards integration of the 2 services led us to detail too many objectives, intended outputs and areas to explore; with hindsight it was not possible to plan to look at all of these with the timescale of the pilot project and level of resource that we had. As many of us have likely experienced previously, it would be better to have only a few key objectives and measures to focus on to improve the outcomes of such a small scale pilot project. We do however, firmly believe, those objectives not realised during the pilot project still warrant exploring.

The project approach turned out to be less effective than we planned and we will take these experiences forward to future projects of a similar nature. A key point would be to have trained our 999 clinicians in NHS Pathways beforehand and have them work independently rather than work with a 111 clinician. This would have prevented potential conflict and some of the human issues and would have provided some comparable data to determine whether differences in background might affect patient disposition.

We should have created a more detailed plan for phase 2 and effectively understood and agreed the exact way the clinicians would work. Our plan from the outset was to identify the integration gap(s) however the overall quality would potentially have been improved had we undertaken scoping during phase 1 of the way to agree the way we expected our clinicians to work.

Our technical requirements should have been planned earlier so that funding negotiations could have been commenced earlier. A project manager being engaged in the project from the outset might also have resulted in better outcomes.

We have identified the potential to build a framework to provide safer services during times of excessive call demand even in the absence of additional virtual capacity or electronic transfer of calls - shared awareness of the wider system, for example using wallboards and electronic signs, can help clinicians to steer decisions to ensure safe approaches to care. We would need to understand how we could build this for all of the 111/IUC providers across London to ensure equity of provision for all patients, and to provide a more effective and safer service overall.

We have been able to realise the possibility of provision of remote clinical hub services away from our Emergency Operations Centres, and the advantages that this provides through better shared awareness, learning, job satisfaction and wellbeing improvements for our staff. This provides the evidence to consider the establishment of a remote clinical assessment service at our 111 site, which may also assist in extending this project.

It is not clear at this stage whether the experiences during this project can draw any conclusions about the use of NHS Pathways and whether the system itself contributes to the variability in the quality of assessments observed. It is also not clear to what extent, if any, the lack of patient facing duties amongst 111 clinicians may affect their approach to clinical assessment and this would require further research to be able to draw any significant conclusions. It was identified during the project that the 999 clinicians, who continue to have face-to-face patient contact on a regular basis, in addition to using a triage tool that necessitates additional freestyle questioning, are in some instances more confident to make a decision.

The project incorporated the side by side working of two services, 111 and 999, by one provider the London Ambulance Service NHS Trust. The innovation of incorporating the working of both from one site meant each provision had insight into the live demand of the other at any one time. The ultimate goal should be that regardless of whether a patient calls 111 or 999 it should be a single point of contact and dealt with by the most appropriate trained clinician from that provider.

Next Steps

We continue to progress the approval of the NETS / Taxi SOP so that 111 staff can consider the timeframe suitable for a NETS vehicle to be sent to the patient which will prevent the need for re-assessment once the call presents at 999. This will reduce the need for 999 clinical hub staff to repeat clinical assessment and should help to both increase NETS utilisation and reduce the patient cycle time.

There is interest from 111 staff in gaining better shared awareness of the 999 environment and this shows potential for a future project to take the next step toward integration. We recognise improvements that could be achieved through dual training of clinicians, providing flexibility to respond to pressures within an individual system, and are committed to future work to progress this.

A visit to a Trust using Pathways in a 999 clinical hub setting might assist us in assessing its use and to consider further research and confirm the potential for dual training.

The next logical step to extending this pilot project without NHS Pathways training would be to have 999 clinicians working independently to assess patient using MTS & their clinical knowledge, to understand whether this contributes to different patient dispositions. They would likely focus on calls that do NOT originate from 999 as we know there is already a low incidence of 999 calls referred to 111 that end up being referred back to 999, so the impact on this cohort would be low, however due to the lack of electronic transfer of these calls it might be difficult to differentiate them.

Better shared awareness using automated wallboards and electronic signs may assist in changing clinician behaviour away from 999 referral. This would not only potentially reduce pressure on 999, but also improve safety for the patient.

Project 7 – LCW – Reducing referrals to secondary care including ambulance, ED and UCCs

Contact details	
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Date of Report Submission	31st May 2017

Project Summary

The project sought to reduce referrals to secondary care (including referrals to the London Ambulance Service (LAS), Urgent Care Centres (UCCs) and Emergency Departments (ED) by providing clinical staff in 111/out-of-hours/Integrated Urgent Care with additional tools received via further training. The project required the following innovations:

- Enhancing competencies of existing clinical and operational workforce by identifying potential skills gaps through non-conveyance and ED referral data with a source of 111/OOH/IUC
- Introduction of video conferencing facilities to aid telephone/home visit assessments
- Introduction of ANPs for home visiting in order to retain experienced GPs in clinical hub for assessment and clinical oversight, and to increase capacity and responsiveness downstream at patient's home

The project sought to reduce referral rates to LAS Ambulance rates by up to 3% and ED rates by 2%, conferring an approximate £170,000 annual saving for each service (based on a median cost of £200 per ambulance attendance).

Project Geography & Population Coverage

The project covered the following geographies:

Inner Northwest London
Circa 0.7 Million patients
CCGs: Central, West and Hammersmith & Fulham

North Central London
Circa 1.3 Million patients
CCGs: Camden, Islington, Enfield, Haringey and Barnet

This accounts for approximately 32,000 combined total monthly contacts.

Targeted Staff Groups

The following staff groups were covered by this project.

- Clinical Advisor
- TAS Nurse
- GP Triage
- Pharmacists

Background

More and more people are visiting Emergency departments and Urgent Care Centres – which is stretching the ability of the departments to cope. Whilst many of the visits are unavoidable, it was anticipated that an analysis of the types of cases that were being referred from London Central and West to secondary care would reveal a pattern in the types of cases that could be managed better at the initial point of contact, thereby avoiding onward referral.

This intention, coupled with a commissioning standards expectation that all 111/IUC services increase clinical participation in calls from between 10–30% above current levels, means that the project sought to optimise the clinical capacity available and develop clinical skills to achieve improvements in decision making.

Challenges

The following are some of the operational/strategic problems London Central & West are currently facing:

- Increased Service demand
- Sufficient clinical resource to meet demand
- Aging population with more complex needs
- Increasing consultation rates - the level of healthcare received by the elderly has risen

The project aims to set in motion practices that would optimise clinical consultations, in terms of the time they take to complete and their outcomes.

Approach

The approach that was submitted as part of the original proposal was subject to change after project initiation. The deviations and the reasons for them will be stated in later sections of this report. The overarching project concept remained the same, with the design method continuing to rely on qualitative and quantitative markers in order to establish benefits of the improvement initiative.

<u>The Method</u>

The project can be divided into three distinct phases. They are as follows:

Phase 1: Metric Analysis

In order to determine whether the project was successful, it was important to establish a baseline. This was done by looking at the number and types of cases being referred to LAS, UCC and ED. To do this, we were required to carry out an end-to-end pathway review, developing an understanding of which presentations led to common/specific outcomes, and how these outcomes were arrived at. We created the following datasets spanning 1 December 2015 - 31 December 2016:

- Number of cases referred to LAS

  - Number of conveyed vs. non-conveyed
- Number of cases referred to UCC & ED
  - Charing Cross Hospital used as the focus
  - Identification of which presenting complaints/problems are referred in disproportionately high numbers
  - Carry out qualitative analyses of the cases referred to determine a pattern

Phase 2a: Training

The analysed data from Phase 1 was used to develop the content of the training for all clinical staff, including Clinical Advisors, TAS Nurses, GPs and Pharmacists. Originally, the pilot sought to undertake training with the entire call advisor team, however, after conducting a cost-benefit analysis it was determined that doing so would have a negligible impact on reducing the number of cases referred to secondary care, so the project scope was amended.

In conjunction with an external training provider, we worked to develop the course content for a half-day seminar. This was not limited to covering content that related to the outcome of the analyses and audits that were carried out, but considered anecdotal feedback from clinicians regarding additional topics that presented particular difficulties when managing patients on the telephone or during a visit.

Originally, we had expected to develop our own in-house training. However, the outcome of the audit failed to provide a conclusive outcome and therefore meant that training had to relate to broader, less specific themes. The objectives of each of the seminars was as follows:

- Updates regarding the features of the most common presenting clinical conditions
- Enhancement of the clinical skill-set to manage patients more effectively.
- Provide the tools and framework to rapidly develop an evidence based answer to presenting clinical problems

The content of the three-hour training session covered the following topics:

1) Telephone consultation
2) Urinary tract infections in adults
3) Chest/cardiac pain of recent onset/ACS
4) Suspected PE
5) Antibiotic prescribing
6) Sepsis
7) Fever in children under 5
8) Bacterial meningitis
9) Suicide mitigation
10) End of life care
11) Symptom control in palliative care

Phase 2b: Advanced Nurse Practitioner (ANP) Introduction

The introduction of ANPs into the clinical workforce model served three purposes:

- Alignment with commissioning standards expectation that all 111/IUC services increase clinical participation in calls from between 10-30% above current levels
- Greater retention of GPs at the bases to undertake telephone triage, utilising ANPs to carry out home-visits
- The development of a more cost effective workforce model, providing increased value for commissioners

Phase 2c: Video-technology

Implementing video-technology was undertaken to support ANPs who required further clinical input whilst carrying out home visits. Using the technology in

this way, we were able to mitigate further clinical risk by providing the ANPs with GP support should they need it.

The use of video rather than telephone, enables the GP to support the consultation by responding to the patient's visual cues rather than solely relying on the reporting of the ANPs. In this way, the GP is able to provide more relevant support, and can begin to identify the ANPs weaker areas of practice.

Working in this way, exposes some of the clinical staff to new ways of working involving technology and means that adoption in the future of such ways won't be met with apprehension or negativity.

Phases 2a, 2b, and 2c will run concurrently.

Phase 3: Evaluation

The evaluation of the project was scheduled to take place at least 2 months after the training had been carried out, and the ANPs and video-technology had been in place for the same length of time. The evaluation will look at:

- Whether there has been any reduction in ED/Ambulance referrals initiated by the trained staff group
- The overall impact on assessment outcomes and onward referral points for the trained staff group, compared to the staff group that hasn't had the competency training.
- The instances of utilisation of the video conferencing technology
- The impact on consultation outcomes where video conferencing was and wasn't used
- Producing a statement of any consent/technical issues between the clinician and the patient in using video conferencing facilities
- Reviewing the functionality enabling ANPs carrying out home visiting to contact a senior clinician within clinical hub
- The clinical effectiveness of ANPs to carry out home visits producing largely the same clinical outcomes as GP colleagues
- Measuring staff satisfaction in response to the improved changes and the training

Intended outcomes

As a result of the project we would expect to see:

- A reduction in the number of secondary care referrals in the trained staff cohort – particularly in those presentations that result in higher secondary care referrals.
- Clinical staff reporting that they feel the training provided them with additional skills relevant to their practice
- A reduction in the numbers of secondary care referrals resulting from a retention of GPs at the base to carry out telephone triage. This is based on the assumption that GPs make less referrals to secondary care than other clinical staff groups

Barriers to Success

These include/d:

- **Internal & External Stakeholder 'buy-in'** – the project required the support of partner organisations to conduct an end-to-end pathway evaluation for particular presentation types. Steps taken to mitigate included:
  - Seeking early buy-in from internal and external stakeholders
  - Seeking CCG/NHSE support
  - Communicating and 'selling' broad benefits around resource optimisation and risk reduction
- **Adjustment to new ways of working** – the use of video-conferencing technology will present unique challenges for the staff using it. It will take time for staff to adjust and gain confidence in the technology and pathways. Steps taken to mitigate included:
  - Robust SOPs and T&D practices
  - Support from MDOs
  - Regular process reviews
- **Pilot evaluation** – the project requires the complex review of data across multiple providers. In order to ensure this happens effectively, the following steps were taken to mitigate:
  - Set clear measurable objectives and agree reporting criteria during the early project phases

- **Unable to source ANPs** – having never engaged this staff group before, it is unclear the availability of staff with skills suitable to our requirements
    - Seek to engage ANPs via multiple sources: agencies, existing clinical network, and NHS Jobs

Integrated Urgent Care Workforce Programme Agenda

The pilot directly addresses the Workforce Investment Fund Theme as stated in the Workforce Investment Fund Evaluation Report – Phase 1: Theme 2 - Enhancing clinical capability of the services including the development of multi-disciplinary clinical hubs.

Intended outputs

Wider Benefits

When commencing this project, it was unclear what benefits beyond those anticipated would be conferred. Whilst the pilot is still underway and we are unable to provide a comprehensive evaluation of the project, the following additional benefits have already been identified:

- Improved clinical engagement – throughout the project, all clinicians were regularly kept up-to-date with project progress. This has led to an improvement in clinical staff morale and a greater dialogue around what further service improvements can be made
- Development of training for coach – Whilst the ANPs have not yet sought further clinical input via video-conference from GP colleagues, there has been feedback from GPs that further training on 'coaching and collaboration' should be provided and made mandatory for all GP staff. Accordingly, we are in the process of developing as the need for this skill beyond this project is great. For example, there is a requirement for similar competencies within the *5/6/7 pilots that provide direct access numbers for care/clinical professionals in a number of settings. Moreover, as the clinical expertise available in the Clinical Assessment Hubs becomes ever more diverse, there will be a greater need for more collaborative practice, and techniques should be taught to address the complexities.

Project Strength and Innovation

To be provided in the more comprehensive final evaluation.

Techniques for wider adoption

- The developed governance processes for ANPs
- The ANP onboarding process
- The use of video technology to support clinicians undertaking home visits

Details of resources and any potential partnership

The following resources are being/have been utilised in this project:

Project Initiation	Director of Ops - Overall Project Advisory & Support
	Medical Educator/Trainer - Clinical & Educational Advisory
	111 Service Manager - Operational Advisory
	External Stakeholders - LAS, UCC, & ED
	Medical Director - Clinical & Educational Advisory
Metric Development	External Auditor/BI
	LCW Business Intelligence Support
Advanced Practitioner	Practice Consultant - ANP Governance Development
	GP Trainer (Advanced Practitioner Support)
Skill Enhancement	NB Medical (Course Providers) - 3 seminars
	Clinical Staff Backfill
	Venue Hire - 3 seminars
	Refreshments - 3 seminars
Video Conferencing	Logitech C920 - Webcamera
	Video-Replay - 3 months (12 month contract with 3 month break clause)
	Mobile Devices for use in Community
	LCW IT Support
Project Management	Project Manager

Required Partnerships

- **NB Medical** – LCW partnered with this market leading provider of clinical update courses to develop a bespoke course for our clinicians. The training was delivered as a series of seminars to which over 170 clinicians attended.
- **Vidyo** – LCW partnered with Vidyo to provide the software for video-conferencing.
- **Charing Cross Hospital** – LCW partnered with this Trust's ED and UCC to carry out a qualitative analysis of the referred cases.

The input of additional partners was required, but couldn't be fulfilled due to the competing demands faced by each of the partners.

Obstacles and issues

These will be expanded in the final, more comprehensive evaluation paper: However, at this point in the project we faced the following issues and challenges:

- Receiving input from provider partners. As stated previously in this paper, there was a requirement to carry out an end-to-end pathway review. This was difficult to undertake due to provider partners' competing demands. The result was a change to the scope of the baseline measurements and subsequent evaluation.
- Condensed timeframe. The expedited and contracted timeframe for the project meant that it was/has been incredibly difficult to undertake all that we had intended to do.
- Competing operational/organisational demands. During the project, (please refer to the Additional Comments section for further information) several organisational/operational emergencies resulted in distraction from the project. These were overcome by constant communication about the project to the stakeholders to keep them informed of the next steps, and ensure that the project was still an organisational priority. It was the responsibility of the Project Manager to immediately resume the project at junctures it was possible to do so.

Actual outcomes
To be confirmed. Please refer to the ‘Additional Comments’ section.
Actual outputs
To be confirmed. Please refer to the ‘Additional Comments’ section.

Lessons learned

These will be expanded in the final, more comprehensive evaluation paper: At this point in the project, the following lessons have been learned:

Things that didn’t go so well

- Engage partner organisations earlier. The project was developed with collaborative working in mind. However, the proposal was submitted to NHS England without prior engagement with our proposed collaborators. On approaching these provider partners it became apparent that they had no capacity to collaborate and therefore the scope of the project had to change.
  - Working with partners to develop the initial proposal will ensure that projects remain within scope and can be delivered in such a way that considers the existing and future pressures on provider partners.
- Earlier notification of training. While staff were provided up-to-date information on the project and the next steps, the communication providing the exact date of the training sessions was provided three weeks prior to the first training session.
  - Notifying clinicians 6 weeks or more in advance of training would lead to more clinicians attending the sessions. That said, consideration needs to be given to the fact that LCW operates a 24/7 service with clinicians who have multiple roles, and therefore it would be quite difficult to get 100% clinical attendance.

Things that went well

- Communication of project updates
- The training sessions were described as “fantastic”, “highly relevant”, “useful” and “well organised by some of the attendees
- The overall attendance at the training sessions was high, and each of the training sessions were oversubscribed despite the notice given
- The decision to run three training session
- The addition of Advanced Practitioners into the workforce model was well received by the other LCW clinical staff groups
- The established governance for ANPs is robust, and provides a mechanism for solid evaluation of their effectiveness

Next Steps

As the project is still in progress, the following will be the next steps

- Continue with phases 2b and 2c
- Develop existing service models to extend the use of video-technology to support the use of telemedicine/teleconsultations. This will be done by working closely with the INWL commissioner and INWL provider partners to develop telemedicine competencies and develop a Single Point of Access for specific users
- Undertake a comprehensive evaluation of the outcome data

Additional Comments

Unfortunately, project delivery has been delayed due to several unforeseen circumstances. The first of these related to the analysis of the referral information by our partners. We initially also sought input from several provider partners, however, they were unable to provide any input due to the current demands on their service. We therefore had to narrow the scope of the evaluation, which led to an inability to perform a comprehensive end-to-end pathway review.

Once we had narrowed the scope of the required data, there were further delays and complications with our partner that meant we were unable to progress to

developing an appropriate curriculum for training our clinicians. This delayed the project further.

An organisational SI prevented any organisation-wide actions related to the project being taken in the immediate aftermath of the SI coming to light. Consequently, it has been very difficult for LCW to meet the final report submission deadline as the pilot has not yet collected sufficient data from which to draw valid and meaningful conclusions. We are expecting a final report to be drafted and submitted by Monday, 31st July.

Project 8 – Solihull CCG – Working with high volume callers and service users to reduce demand via Health Coaching

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Date of Report Submission	31/5/17

Project Summary

Project drivers

One of the many areas of increasing NHS spend in relation to unscheduled care is the growing emergency ambulance call out rates as well as those who go on to attend A&E Departments and are subsequently admitted. Heart of England NHS Trust's Accident and Emergency attendances increased by 4% in 2016 and Solihull CCGs 999 incident rate (YTD, March 2017) is currently 4% above planned activity. Across Birmingham and Solihull (BSol) the population experiences a high level of psychosis and Mental Health Act detentions. The (BSol) Sustainability and Transformation Plan (STP) also identified that Birmingham's population as a homelessness level more than three times the national average (21/10/2016).

Health coaching

There is an increasing acceptance across the NHS that facilitating individuals to identify their own health and wellbeing goals, and crucially how they might choose to 'journey' towards fulfilling those, has potential to release valuable NHS resource and improve individual outcomes. "There is a move away from a paternalistic healthcare model where clinicians 'do things to' and make decisions for people towards helping people take more control of their health and wellbeing, sharing in decision-making and self-management" (The Evidence Centre, 2014).

'Health coaching' is an umbrella term that draws on the science of health behavior change. The approach is characterised by a conversation, based on an equal partnership between the individual and the practitioner, to guide them towards alternative health behaviors and greater responsibility (A Better Conversation, www.betterconversation.co.uk, 2016). NHS England's Five Year Forward View

(2014) identifies this as a priority across the workforce 'as the patients' organisation National Voices puts it: personalised care will only happen when statutory services recognise that patients' own life goals are what count' p12.

Prior learning

The BSol Clinical Commissioning Group's (CCGs) frequent 999 callers pilots in 2015/16 originated from Blackpool and Fylde CCGs project working with their top 100 frequent callers. Right Care (February, 2015) published a casebook outlining the Blackpool and Fylde project (2013 to 2015) managed the top 100 most frequent, chaotic and vulnerable callers of 999, reducing the number of calls by 88% which was sustained over an 18 month period (assuming their pre-intervention levels was to remain constant). Principles of case finding, health coaching, individualised care planning, de-escalation in a crisis and demedicalisation were adopted to support health behavior change.

"Prior to this work it was felt that the group being focussed on would be unresponsive to any intervention and that there would be poor compliance with any actions agreed. This perception was proved to be incorrect with people responding well to having someone to talk to about their wider social needs and helping them to address them" (Right Care, 2015).

Target group and geographical coverage

The combined population of the Birmingham and Solihull CCGs is 1.3 million people served by West Midlands NHS Ambulance Trust (WMAS), two local authorities, seven acute hospitals, one mental health trust and one community health trust (the other is vertically aligned within an acute trust. These BSol 2015/16 pilots identified the top 300 frequent 999 callers accounted for a substantial NHS budget spend when viewed across 999 calls, conveyances, A&E attendances and subsequent emergency admissions. Our respective evaluation reports demonstrated it was possible to reduce these costs, whilst improving individual outcomes, by applying these principles alongside 999.

Project themes

- Integrated Urgent Care (IUC) Clinical Assessment Services (CAS) Clinical Hubs contribution to this cohort
- Health coaching competencies for health professionals E.g. Mental Health (MHNs), General Nurses (RGNs), GPs
- Patient perspectives - bringing services, front-line and patients together to improve services

- Empowering compassionate and caring practice via telephone/remote practice
- Integration across 999 and 111/ CAS
- Willingness to adopt health coaching competency across NHS111/ IUC services to support frontline 999 staff and this cohort
- How could we de-escalate in a crisis, to release 999 crews, whilst drawing on IUC developments?

Background

Ambulance Response Programme

West Midlands Ambulance NHS Trust (WMAS) piloted the Ambulance Response Programme (ARP), alongside two other Ambulance providers, and demonstrated substantial reduction in the proportion of calls requiring an 8 minute (Red) response. Dispatch on disposition provides call handlers with more time to assess 999 caller needs, except when emergency dispatch is required, in order to improve patient safety and experience. Their trial has contributed substantially to the development of the ARP recommendations that are due to be signed off by the Secretary of State this summer.

IUC procurement across the West Midlands

BSol CCGs were part of the Integrated Urgent Care (IUC) Procurement that brought in a new 111 Provider and GP Out of Hours Providers and linked those with existing GP Out of Hours Providers in an Alliance Agreement. The new service started in November 2016. A component of this IUC alliance is the clinical hub that has GP, nursing staff (including mental health nurses and dental nurses) and Pharmacists.

The development of the IUC clinical assessment service provided an opportunity for us to map a system-wide pathway for this cohort offering cohesion rather than fragmentation. Therefore, BSol's integrated urgent care stakeholders were keen to build upon the success of the frequent caller pilots by relaunching a consistent model across the combined footprint. The regional NHS 111 CAS provides a pathway for flagged patients using special patient notes (SPNs) with individualised care plans and is therefore well-placed to offer joined up urgent care by collaborating with 999 staff and frequent caller initiatives.

Outline model

Our aim was to use a non-judgmental health coaching approach to support our high volume 999 callers to reduce their dependency upon unscheduled care and improve their health outcomes by working together. The project enabled us to test shared principles, develop a common understanding of how we might apply these in practice,

to begin defining roles and responsibilities, the added value of using telephone/ remote working coaching competencies across the system and what our workforce development gaps were across organisations.

Baseline data

For Solihull CCG, an analysis of A&E and WMAS 2014/15 data revealed that the top 100 high intensity service users visited A&E a combined total of 1,396 times. In 1,111 instances service users either received no treatment, or were discharged with guidance only. It was identified that 700 of the 1,396 A&E visits were as a result of an ambulance conveyance, at an average cost of £164.76 per conveyance, resulting in a total cost for all 700 conveyances of £115,000.

Further, A&E data identified the top 100 service users accounted for 1,052 non-elective hospital spells, with 4 patients alone accounting for 10% of the top 100 patients total activity. This data also revealed that 21 service users fell within both the top 100 patients admitted as an emergency and the top 100 A&E users, with a total cost to Solihull CCG of £356,000 for the last financial year.

System pressures

There is a pressing requirement that urgent care systems evaluate outcomes across their organisational boundaries, in order to meet the health needs of their population more effectively whilst demonstrating best use of public funds. The early outcomes of Solihull CCGs 12 month system evaluation across WMAS 999 call outs, conveyances, A&E attendances and linked non-elective admissions (52 cases using pseudonymised data) identified a net cost benefit of £104k.

Patient experience

Examples of patient outcomes, following an approach of health coaching and coordinated multi-disciplinary team (MDT) working, were:

- Individuals with multiple social isolation issues following a bereavement identifying the need to move closer to their family for support
- An individual was supported to purchase an iPad and since utilising online support forums their calls to the 999 service ceased
- Patients engaging with new activities i.e. ramblers – calls to the 999 service ceased
- Key to several of these individuals making positive changes was accessing the Solihull Integrated Addiction Support (SIAS) with a coaching approach from the WMAS coordinator.

Staff feedback

Examples of paramedic feedback that emerged from the pilots were an increase in morale due to:

- An ability to convey a higher proportion of patients in need
- That they were able to refer those frequent 999 callers to an actual "service" with confidence this would lead to an effective care plan (as opposed to individuals being passed around the system or falling through the gaps).

Working across multiple organisations

The project team consisted of Care UK's (NHS 111 provider) regional clinical hub leads, West Midlands NHS Ambulance Trust along with local and regional IUC Commissioners. The aim was to develop an agreed local model with WMAS and NHS 111 that improved health outcomes for this group of people, supports frontline emergency crews and delivers cohesion across the urgent care system.

The project sought to consider how this cohort could be served by the regional 111 IUC pathways and interoperability gains i.e. complex flagged patients with individualised care plans. In addition, the regional hub was well-placed to offer joined up urgent care by collaborating with 999 staff and frequent caller initiatives. WMAS frontline line staff and the High Intensity Service User (HiSU) Leads would be able to work with the regional hub clinical staff across broader mental health, pharmacy and primary care pathways to support this cohort.

Challenges

Strategic context and operational issues

BSol's STP outlines three underpinning factors challenging the system; suboptimal system-wide focus on use of resources, too much care that can be delivered elsewhere is provided in a hospital setting and variation in clinical services. Therefore system leaders have committed to creating efficient organisations and infrastructure that embraces community care first by maximising prevention and self-care.

Each organisation however only sees a part of each of these frequent 999 callers NHS experience; it has therefore been difficult at times to focus effort, implement and operationalise this project when combined with huge system pressures and competing organisational priorities.

Our primary operational challenge was the necessity for the pilot's seconded paramedics (2.00 WTE) to return to their WMAS 999 frontline rotas in November 2016 as part of winter preparedness. Due to the length of time these roles have been

vacant our cohort will require re-engagement for relaunch and we acknowledge this leaves a significant gap in patient experience for co-production and learning.

Governance and data sharing across organisations

Our objective was to develop robust IUC governance and operating processes which enabled the combined workforce to support high volume 999 users effectively whilst providing tax-payer value for money. By working together to design a system-wide pathway (utilising telephone support across NHS 111 and 999) we could better understand how individuals are presenting in order to provide cohesive and individualised support.

Approach

Meeting system pressures

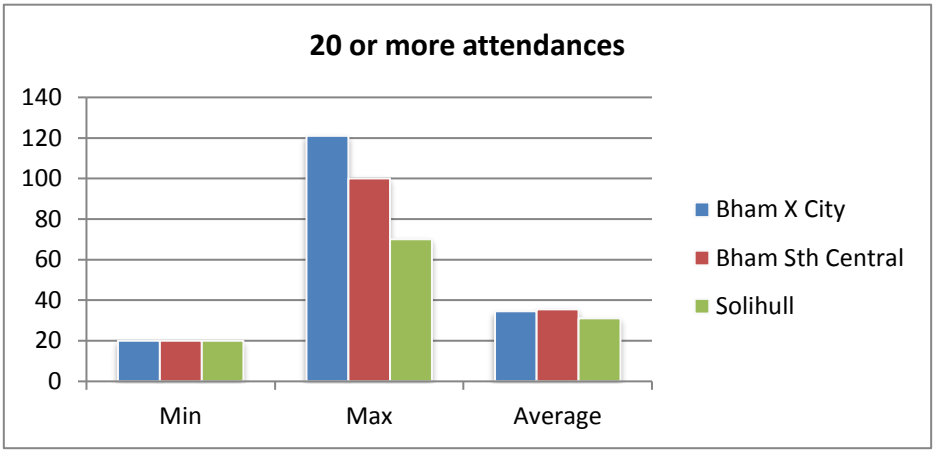
Taking into account the growing demand for emergency care, BSol commissioners and WMAS NHS Trust (WMAS) agreed to develop a system-wide model to relaunch our High Intensity Service Users (HiSU) initiative across the combined footprint.

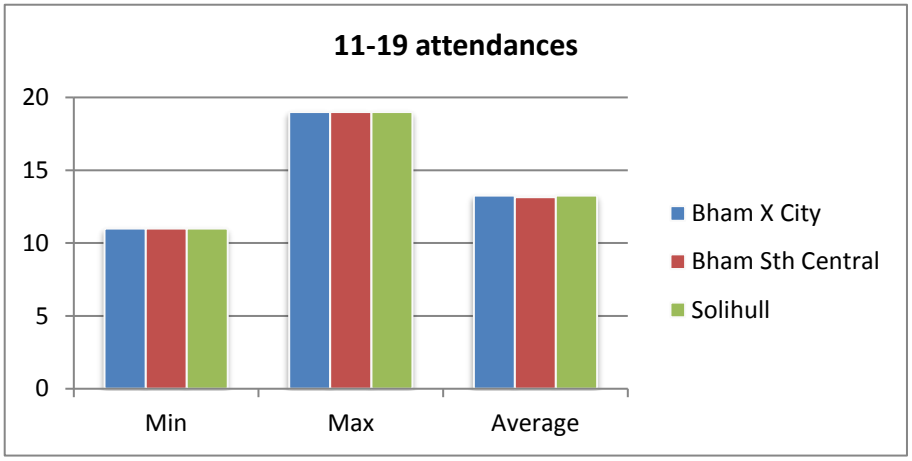
Local population assessment and baselines

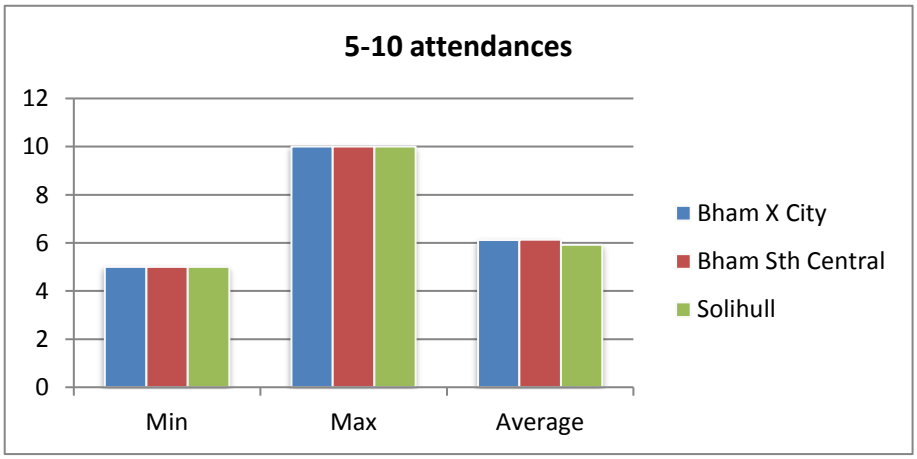
In order to understand our current population for relaunch we analysed our 2016 A&E attendances and linked non-elective admissions, in brackets of >=20, 11-19 and 5-10, in accordance with the Right Care HiSU resource pack. We also examined the data according to age and gender profile for each CCG as well as mode of arrival (self, emergency conveyed and other).

- 140 people attended our A&E departments 20 or more times in 2016 at an overall cost of £963k (excluding 999 incident costs) at an average cost of £7k per individual
- 436 people attended A&E departments 11-19 times at an overall cost of just over £2 million, averaging £5k per person
- These attendances are spread across age brackets and gender.

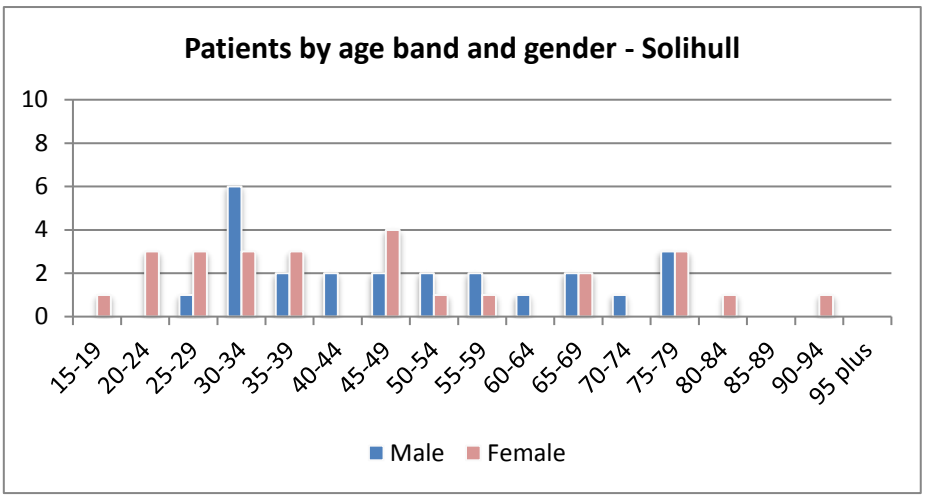
BSOL CCGs A&E High Intensity Service Users baseline - January to December 2016

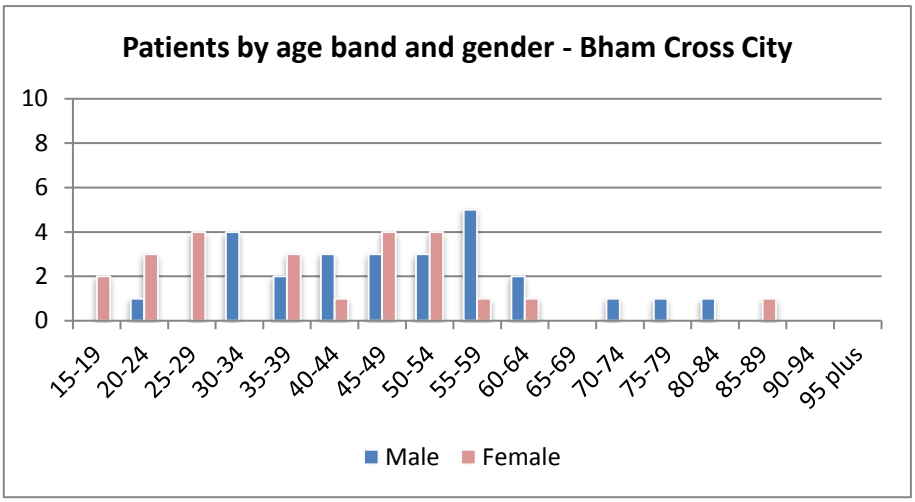


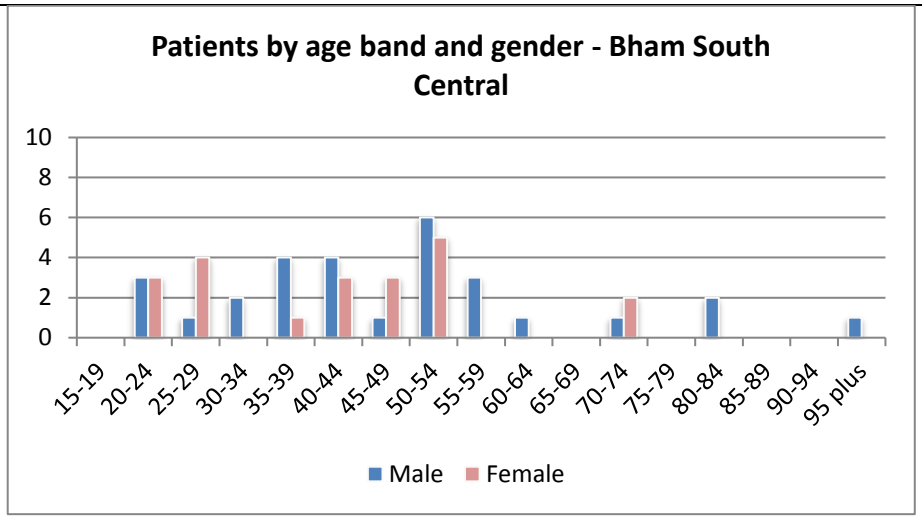




BSOL CCGs A&E High Intensity Service Users baseline (age and gender) – January to December 2016







Project management approach

As a project group our work breakdown structure delivered an agreed BSol HiSU model, shared governance/ IT interoperability and scoped the workforce development needs.

Develop BSol HiSU model for relaunch across stakeholders:

- Agree service specification (including system-wide evaluation)
- Agreed Band 7 job description (RGN or AHP)
- Confirm partner organisations and information governance requirements
- Joint recruitment and development strategy
- Joint training needs gap analysis.

Develop shared governance:

- Frequent caller definitions agreed across NHS 111 and 999
- Respective organisations can routinely report according to these defined groups for
- case finding and system evaluation purposes
- Ability to flag/ recognise if incoming calls are from individuals that have personalised care plans as part of the project across NHS 111 and 999
- NHS111 agreed mechanism in place to notify HiSU Lead when contact has been made with the Clinical Assessment Service (CAS) HCP
- Confirmed mechanism for CAS HCP's to support 999 crew on-scene

- Clarify the added value CAS HCP's can add to releasing emergency crew on-scene and de-escalation in a personal crisis.

Assessed IT Interoperability (through the IUC):

- Special patient notes (SPNs) across General Practice, NHS 111 and 999
- SPNs review processes
- Post-event messaging considerations.

Workforce development needs (inter-organisational):

- Health coaching evidence base and competency gap analysis
- Training needs for HiSU IUC relaunch including key IUC CAS roles
- Planning for managing relapse
- Understanding the BSol population needs (gender/ age distribution) for this cohort.

Intended outcomes

Project aims

To articulate the West Midlands IUC Clinical Assessment Services (Clinical Hub) contribution towards supporting WMAS 999 frontline call takers, paramedic crews and Clinical Service Desk (CSD) staff to meet growing emergency demand.

Project objectives

To understand what health coaching competency is required for health professionals working with this cohort across NHS 111 and WMAS e.g. Mental Health RGN's, GPs and HiSU Leads. Thereby facilitating compassionate and caring practice via telephone/ remote working that supports improved patient outcomes. To bring services together, across their organisational boundaries, in order to focus on patient experience and learning from other frequent 999 caller initiatives.

Barriers

The barriers we encountered were typical of the challenges system leadership presents across organisational boundaries, i.e. governance, data sharing, use of the voluntary and non-NHS commissioned agencies. Further, each organisation only sees one aspect of the patient experience and these individuals do not neatly fall into organisational boundaries. In addition a health system that traditionally 'tells people what to do' is not able to harness the resources each individual possesses.
In addition to the significant operational pressures it is a changing landscape on a broader basis; for example CCGs are looking to functional merger, large acute trusts are seeking permission to merge, the IUC is still developing its offer and the associated timeframes across this landscape do not necessarily align.

Conflicting timescales across IUC and ARP projects

The regional work plan for IUC for example piloting of NHS 111's dedicated health care professional phone lines extends beyond phase two of the Workforce Investment Fund (WIF) Phase 2, i.e. May 31st 2017. Further, the ARP recommendations require Secretary of State sign off for summer now which has been taken into account with the outline pathway for 999.

Measured impact for staff, patients and service users

Service baselines are covered in the sections entitled "approach"

Intended outputs

Key product - system working and evaluation

Our ability to evaluate individual outcomes across the IUC system, rather than triangulating individual provider data, is a key innovation. Typically other projects can describe Ambulance Trust inputs (999 calls, time on scene and incident outcomes) but not the system-wide impact. Our report describes how this will be achieved building upon Solihull CCGs 2015/16 pilot.

Initially the highest 50 A&E attendees for each CCG (using the local A&E patient identifiers, provided by our CSU business intelligence) will be overlaid by the HiSU Lead working closely with 999, A&E and primary care colleagues. Thereafter, working with a rolling annual cohort of approximately 100 HiSU cases (using A&E and 999 data for case finding).

Health coaching patient benefits

The key to this approach is effective engagement rather than traditional health interactions that 'tell' the individual what to do. Our HiSU Leads will seek to engage these individuals with telephone contact, followed up by a letter of intent, explaining the service would like to work with them to better understand their concerns and needs. We have developed a bespoke training package to support the HiSU Leads to apply health coaching principles over the phone for this initial conversation and throughout the intervention. Our intention is to build upon the health coaching momentum nationally and regionally across the NHS and Social Care.

Determined a new data flow

With support from information governance and business intelligence leads across all our partner organisations we have created a new data flow (see Appendix 1).

Creating a new data set

Our plan is to review this data set as we operationalise this project. We will produce monthly and quarterly reports to identify the overall number of active HiSU cases that:

- Have been successfully engaged with a phone call
- Went on to identify individual health and wellbeing goals as part of their personalised care plan
- And where SPNs have been added by their GP to assist IUC colleagues across WMAS 999 and NHS 111 CAS HCP's.

The following data set will be submitted monthly by HiSU Leads for CSU business intelligence:

- Active cohort engaged using the Hospital Patient Identifier (HID)
- Each individual's total 999 call volume and outcomes (Hear and Treat, See and Treat, See and Convey)
- NHS numbers
- Local A&E (HID)
- A&E primary reason for attending (drop down menu)
- Date intervention commenced
- Personalised care plan/ SPN's in place
- Dates discharged/ onward lead agency or the date the individual moved out of the area/ deceased.

Purpose and Objectives of the Data Sharing

The HiSU Leads appointed for our relaunch are employed by another NHS trust, therefore in order to provide and support direct care to frequent 999 callers, a letter of authorisation is required rather than an honorary contract (IGA, version 1.0 22/07/15). The purpose of the BSol HiSU data sharing agreement is to allow partner organisations to share minimum up-to-date data relating to participants in the HiSU Project with relevant GP Practices and other care providers in identifiable form to support direct patient care, and with the CCGs in pseudonymised form to enable monitoring and measurement against our project objectives. Pseudonymisation of data is facilitated by the DSCRO (hosted by Midlands and Lancashire CSU).

Unintended benefit of data sharing approach

An unintended benefit of the project is that GPs have agreed to this data sharing, and having taken some time to achieve this prior across the whole of the Solihull Borough, we are able to show that this has worked effectively and efficiently whilst positively impacting on patient care for a group of patients that are often seen as hard to support.

Details of resources and any potential partnership

Project leadership

The key to success here is a dedicated project lead that is capable of working across organisations, understands different operational and strategic drivers and can maintain sight of the impact on the system and on patient care and outcomes.

Our use of the system's existing structures rather than setting up new ones has also been a key strength to ensure buy-in. This project sits in the BSol STP delivery plan as well as the IUC regional programme.

Whole system working

This underpins the success of this project and this will require an ongoing partnership forum. In order to plan relaunching this initiative the key organisations have been WMAS, Birmingham Community Healthcare NHS Trust, Heart of England NHS Trust (Emergency and Community divisions), Care UK (NHS 111 provider) regional IUC and local CCG urgent care commissioners.

Project investment

BSol commissioners have invested £150k (FYE) to recruit 2.00 WTE Band 7 community nursing HiSU Leads, this also includes a bespoke training and mentoring package across key IUC staff (IUC CAS and HiSU Leads).

Staff competencies

Our HiSU relaunch will involve experienced community nurses:

- Engaging individuals over the phone who may lack trust in statutory services
- Securing credibility with their paramedic colleagues as a priority and developing effective working relationships across WMAS
- Networking extensively across the region with other frequent 999 caller projects and demonstrate compassionate clinical leadership
- Extending professional credibility across frontline A&E departments, mental health, primary care, social care, police and fire service and third sector colleagues.

Obstacles and issues

Solihull CCG had sought to continue with this pilot via WMAS but this ceased due to the pressure on WMAS to use senior paramedics in front line roles. Attempts have been made to use paramedics who are on "light duties", however the lack of continuity this would provide to patients along with the ability to enter an unpredictable/ potential high risk environment limits the overall outcomes.

Therefore, we agreed a way forward by exploring internal expressions of interest with various community providers to backfill these roles, on the basis they would have an honorary contract with WMAS as well as the required data sharing agreements. This has required substantial project management to articulate the benefits for each organisation in order to secure the necessary commitment from system leaders.

Actual outcomes

Data sharing and information governance issues across a complex system
As described above and to be further refined.

Agreed job role
Across the system we agreed that core outcomes for the HiSU Band 7 (RGN or AHP) roles, using a health coaching approach, could be delivered predominantly via telephone or remote working.

Delivering personalised care:

- To engage users using an empathic and coaching approach (as opposed to enforcement wherever possible) to understand their needs and 'de-medicalise' as appropriate
- The ability to build rapport over the telephone/ remotely to understand their issues and needs
- Information gathering, according to job role, in accordance with information governance and primary care data sharing agreements
- Information gathering across social care, community mental health and nursing/therapy services, alcohol and drug dependency services and other agencies as relevant e.g. the police or fire service
- Identifying and de-medicalising their needs, as appropriate, using advanced telephone communication and clinical reasoning skills
- Facilitating health behaviour change using evidence based models and techniques suitable for telephone / remote practice
- Promote/ monitor the use of SPNs for active cases with the registered General Practitioner (advising local commissioners if there are any issues arising)
- Receiving nhs.net updates from the NHS 111 CAS HCP's who have provided telephone/ remote support to active cases
- Using NHS 111 CAS updates (post-contact) to continually assess/review the effectiveness of personalised care plans and integrated protocols.

De-escalation in a personal crisis:

- Facilitating immediate access to an appropriate support service (social, emotional and/ or financial) to prevent repeated 999 calls, avoidable conveyances/ linked non-elective admissions associated with that crisis episode
- Developing advanced telephone/ remote support first aid mental health competencies
- Working closely with NHS 111 and 999 to provide timely intervention and cohesive support
- Effective networking and relationship building across local support services to increase timely access
- Providing telephone follow-up the next working day to ensure integrated outcomes are achieved (thereby promoting health behaviour change and a relationship of trust)
- Joint working with primacy care, mental health colleagues, social care and other third sector agencies according to Integrated Urgent Care protocols.

Personalised discharge planning:

- Using health coaching skills to plan for discharge in consultation with other agencies and primary care
- Requesting, coordinating and/ or facilitating MDT case conferences with the patient, carer/ significant other, primary care and agreed lead agencies
- Monitoring call volume activity 999/ 111 post intervention against the user profile (frequency and chief complaint e.g. falls)
- Acknowledging the likelihood of relapse in a planned and open manner with the individual as part of joint discharge planning with other agencies.

Compassionate leadership across IUC:

- Ensure that a smooth running service is provided at all times, ensuring a high standard of service delivery and adherence to information governance
- Develop Integrated Urgent Care by promoting multi-disciplinary co-operation and learning across organisational boundaries (i.e. HCP telephone/ remote working for this cohort)
- Creating an environment where those HiSU cases that have engaged feel listened to able to identify new ideas and involved with co-production going forward.

Frontline paramedic experience

- WMAS 999 engagement told us that that frequent 999 callers often have complex needs that are not being met with conventional service models
- Many have mental health issues (diagnosed and undiagnosed), or other long term care needs that result in them using 999 frequently, “not because they want to, but because we are often seen to be the only service that answers the phone quickly, and never says no”
- Certainly the frequent 999 caller pilots have shown the benefit of facilitation to develop an alternative ‘go to support’ that is responsive and centres on the individuals concerns. This may also involve a voluntary service that supports ‘chaotic’ individuals to attend appointments at addiction services or provides social support to access a new activity or interest
- Paramedics welcome a system-wide model to support their frequent 999 callers which works across organisational criteria and boundaries.

Service user experience and outcomes

We have been unable to secure this whilst the HiSU roles have been vacant. However, this is a priority objective for relaunch to firstly understand the specific outcomes that matter from the perspective of our service users i.e. did they feel truly listened to? Thereafter identifying how we routinely feed this back to a wider group of stakeholders to develop our strategy for co-production that align with social care, mental health and joint commissioning.

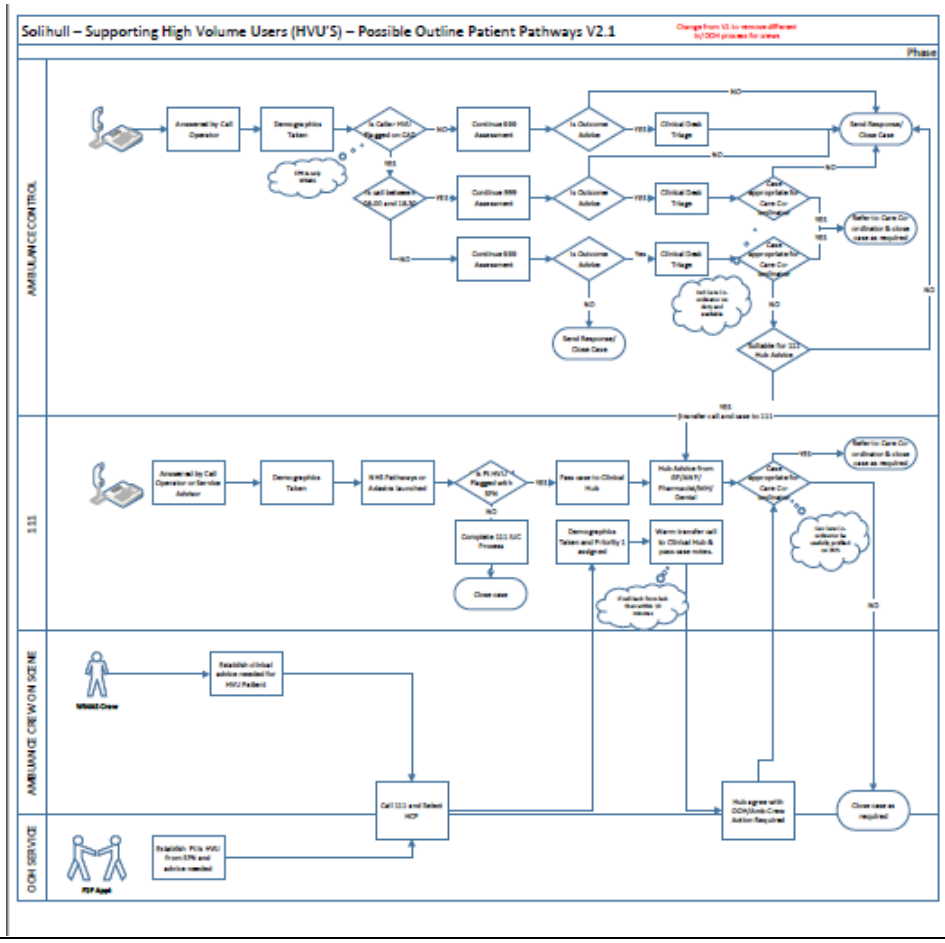
Whole system pathway for this cohort

The IUC Clinical Assessment Service (CAS) NHS111*5 is designed to support emergency ambulance crews and is expected to be implemented in September this year. This will allow crews to call in, once medical red flags have been ruled out, in order to stand down frequent 999 callers confidently as they can hand over patients to this approach.

Actual outputs

Cost benefit modelling

The net cost benefit associated with a 20% reduction in avoidable 999 incidents, A&E attendances and linked non-elective admissions have been modelled across BSol. The project team has created the foundations for a system-wide patient outline pathway for this cohort focusing on the opportunities IUC provides. This work will continue as part of the regional STP and IUC programme.



Lessons learned

Recruitment and retention

The necessity of appointing individuals capable of working across organisational boundaries whilst adopting a health coaching culture cannot be underestimated. It has taken our project seven months to appoint suitable individuals with community health experience for these roles whilst consolidating the necessary partnership arrangements. Plan for an effective induction and training package for individuals who have not had exposure to health coaching principles and practice prior. These roles require substantial emotional resilience and therefore effective line management and mentoring arrangements are advised.

System engagement

The capacity to deliver at pace, within the timescales associated with the Workforce Investment Fund (WIF) phase two, has been challenging. Inter-agency working is time consuming and ultimately constrained by the ability of organisations to respond due to conflicting priorities. Projects of this nature therefore create an ideal opportunity to understand the challenges of working across IUC by breaking down the barriers, developing relationships, improving patient pathways and hence their experiences and outcomes as part of wider IUC. The learning from our project will be transferable to other projects across IUC.

Evaluation

Commitment is required for a minimum of one to two years across the system to recruit suitable individuals and implement the necessary data sharing agreements. Our experience has been the longer individuals had engaged with the scheme the greater the benefit in terms of reduced dependency upon unscheduled care (999 and A&E). In order to understand what success looks like stakeholders (including service users) need to plan the data set (quantitative and qualitative) as well as an independent evaluation method.

Next Steps

Sustainability

Our intention is to demonstrate a reduction in see and convey 999 outcomes as well as subsequent acute attendances and admissions for this cohort should an emergency response be indicated, according to the recommendations of the ARP. The outcomes of this project, as we relaunch, will be routinely shared across our STP urgent care forums, IUC regional meetings and Solihull Together (our partnership across Solihull CCG, Solihull Metropolitan Borough Council, Heart of England NHS Trust and WMAS).

Relaunch will enable us to test the IUC system as an enhancement with mental health colleagues, public health leads within social care and primary care. The outcomes will inform stakeholders as to how health coaching and personalised care plans can be implemented successfully along with the pitfalls to avoid.

IUC meeting structure

Going forward IUC commissioning meetings are changing to facilitate the integration of 999 and NHS 111. Our HiSU Leads will participate in IUC

development meetings to monitor and develop complex patient pathways, governance and effective joint working. These forums will develop recommendations on how services, access and the sharing and use of patient records can be improved. Recommendations on support to high intensity service users beyond the end of the project will be shaped here to inform future commissioning decisions.

Service user experience and co-production

We will be focusing on defining the outcomes that matter to our service users as our first step towards co-production. This will require close working with public health and joint commissioning colleagues to align relevant projects and initiatives i.e. the Solihull Anti-Poverty Strategy with a focus on the multi-agency referral system for advice, information and counselling on debt, education, training, employment, welfare, housing, and health (Solihull JSNA 2016/17). Our HiSU Leads will assist us to capture recurring themes that indicate barriers or gaps in the health and social care system that are contributing to dependency upon emergency services.

Additional Comments
Appendix 1 – High Intensity Service User (HiSU) Data flow (excel document)

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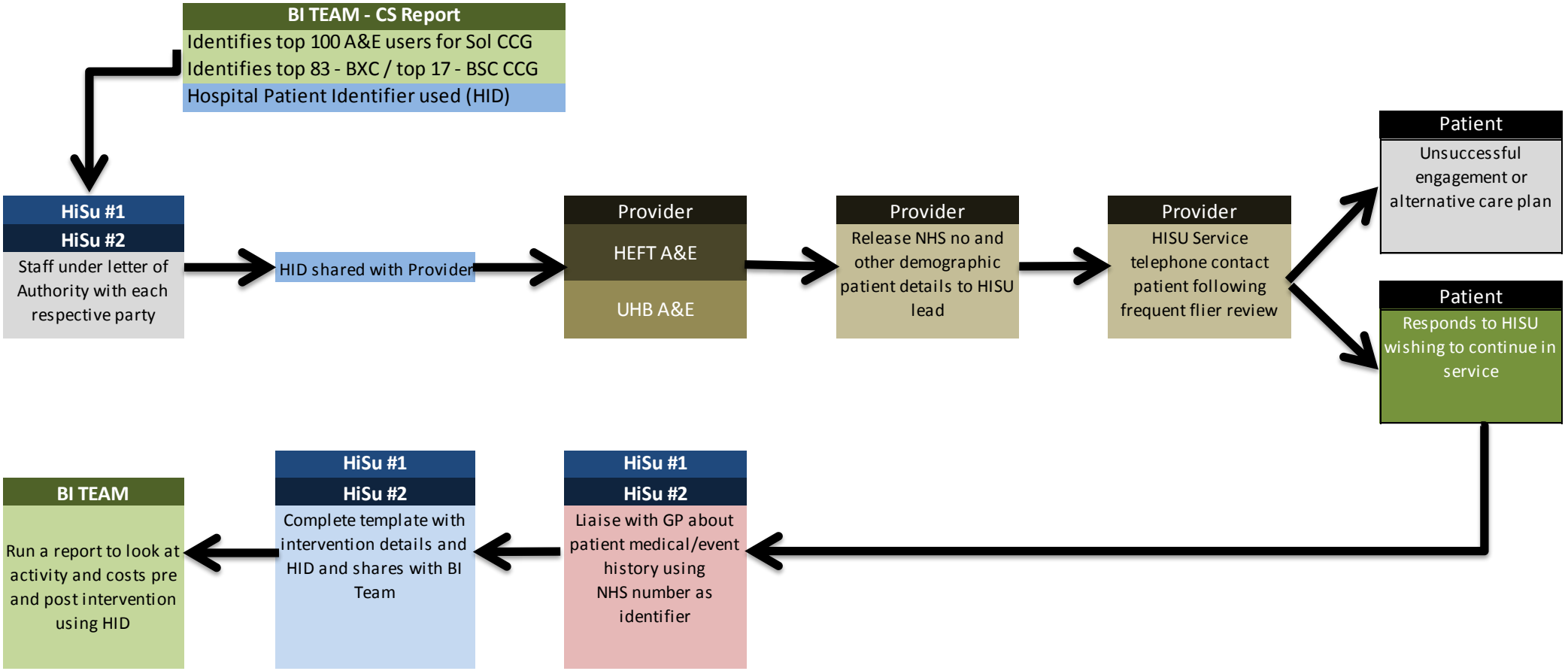
The Birmingham and Solihull (BSol) Sustainability and Transformation Plan (STP)

Solihull Metropolitan Borough Council and Solihull Clinical Commissioning Group. Solihull Joint Strategic Needs Assessment 2016/17.

The Evidence Centre, April 2014. Does health coaching work? Summary of key themes from a rapid review of empirical evidence.


BI TEAM - CS Report
Identifies top 100 A&E users for Sol CCG
Identifies top 83 - BXC / top 17 - BSC CCG
Hospital Patient Identifier used (HID)
HiSu #1
HiSu #2
Staff under letter of Authority with each respective party
HID shared with Provider
Provider
HEFT A&E
UHB A&E
Provider
Release NHS no and other demographic patient details to HISU lead
Provider
HISU Service telephone contact patient following frequent flier review
Patient
Unsuccessful engagement or alternative care plan
Patient
Responds to HISU wishing to continue in service
HiSu #1
HiSu #2
Liaise with GP about patient medical/event history using NHS number as identifier
HiSu #1
HiSu #2
Complete template with intervention details and HID and shares with BI Team
BI TEAM
Run a report to look at activity and costs pre and post intervention using HID

Project 9 – Vocare – Enhancing clinical competences of NHS 111 clinical advisors in Urgent Care

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Date of Report Submission	31/05/17

Project Summary

This project was intended to serve as an example through which a workforce could be developed in order to convey a benefit to both staff and the organisation. We identified a skills deficit in one specific area of the business and acted to address the issue by providing a development solution that focussed upon delivering training to enable a workforce to operate across multiple services.

To this end, Vocare seconded a cohort of existing NHS 111 clinical advisors into a temporary development role, whereby candidates were given the opportunity to complete clinical skills training and consolidate their practice in urgent care.

The initiative was also intended as an opportunity to establish an improved clinical career pathway in integrated urgent care via the development of a job description, person specification and competency framework for the role of Junior Integrated Urgent Care Practitioner. This was to be a substantive role designed to reflect the demands of the service and function as a template that could be exported to the various regions in which Vocare operates UCC /NHS 111 services:

- North East (NHS 111/UCC/ GPOOH Clinical model)
- Somerset (NHS 111/GP Out Of Hours model)

- Staffordshire (NHS 111/GP Out Of Hours model)
- South West London (UCC/NHS 111/GP Out Of Hours model)
- Devon (NHS 111 model)

Background

Recruitment and retention of staff within any organisation represents an ongoing and potentially challenging commitment. Whilst identification of those areas in which the problem posed is significantly more acute are routinely established by review of regional workforce statistics, examination of the underlying reasons behind these figures has been established with reference to data compiled from staff surveys/exit interviews/CPD meetings/various other modes through which staff are able to provide feedback.
One such area whereby the evidence relating to retention of staff highlighted concern, were those services that dictated the use of staff working as streaming clinicians in urgent care centres (UCCs) often co-located alongside local ED departments. The common themes distilled from review revealed three distinct categories of reason precipitating staff turnover:

- Lack of defined career pathway
- Lack of opportunity for clinical progression
- Dissatisfaction with a lack of activity variation within job role

In addition to the staff-centric data demonstrating the need for a corresponding initiative, it is also clear that the material benefit delivered through staff development would serve as a means through which specific service weakness could be addressed.

The NHS Pathways system is widely regarded as a safe and effective way in which triage can be employed for those patients presenting with relatively simple conditions. However, NHS 111 clinicians are expected to deal with a spectrum of health complaints ranging from unary complaints to cases involving significant degrees of complexity. Prior to commencement of the project, it was already determined that the relative lack of skill and experience prevalent in this group was justification enough to develop a series of Clinical Assessment Services (clinical hubs) with the sole purpose of managing more effectively those cases necessitating the input of clinical competence beyond that already offered within services. Although the development of several key roles remains subject to ongoing development, the pilots have largely been deemed a success in terms of reducing ED/ambulance disposition rates. However the notion that such an overt skills gap could mandate the outsourcing of such a critical

function has prompted an appetite to adopt a more direct approach pursuant to locating a longer term remedy. A workforce imbued with an enhanced clinical skillset would allow for a greater proportion of patients to be conclusively assessed, across a shorter frequency of contact intervals, without referral to emergency services.

Therefore, the focus of the project became orientated around the development of a Junior Integrated Urgent Care Practitioner role, equivalent to Skills for Health level 5/6. Candidates were selected from a range of existing NHS 111 services operating nationwide and enrolled in a clinical skills course at Sunderland University, in addition to being provided with structured support sessions based at local UCCs in order to consolidate the theoretical learning set out in the syllabus in the context of a practical environment. The organisation facilitated additional training to maximise each candidate's exposure to a variety of different clinical settings including: Out-Of-Hours General Practice, Pharmacy and several community based services. Candidates were also encouraged to explore opportunities outside of that which was direct provided – ie placements secured within ED/ambulance services ensured candidates had a holistic understanding of the urgent care system.

The terms of the secondment dictated that each candidate commit to 7.5 hours a week of academic study, coupled with an additional 15 hours of consolidated learning time, the majority of which was based at local UCCs. The remaining contractual hours were to be worked as per their NHS 111 role. This condition was included in order to provide assurance that NHS 111 services were not disadvantaged by the loss of experienced clinicians, but would instead derive the benefit of a workforce with an increased capacity to perform higher levels of assessment, whilst at the same time providing staff with an opportunity to broaden their skills and experience for the benefit of patients across the integrated urgent care system.

In summary, it was hoped that the introduction of these new roles into integrated urgent care systems would:

- Improve recruitment and retention of clinical staff
- Actively work towards NHS 111 Career Pathway for clinicians
- Improve staff satisfaction
- Foster integration between services
- Make 111 an attractive career choice

Challenges

There were several operational/strategic issues identified prior to implementation of the project.

Perhaps the most obvious challenge presented by the project brief was mitigating a tendency within NHS 111 Pathways to produce disposition outcomes that through virtue of acuity exceed a clinical skill level that could otherwise be largely accommodated through workforce investment. It was agreed that there would likely be a net positive benefit from both the provision of increased knowledge and practice in addition to the cumulative confidence that such experience would convey.

The degree to which organisational services are compartmentalised can also act to impede the provision of quality patient care. An opportunity to install a workforce with a an ability to operate across multiple disciplines, in both NHS 111 and Urgent Care Centres systems, allows an organisation increased resource flexibility as well as importing a greater degree of interoperability between staff working across distinct services.

The convoluting effect presented by an identifiable skills gap on the patient journey was another salient feature of the case for workforce development. It is widely accepted that the exercise of a more capable workforce would likely result in a reduction of patient contacts and an improvement in overall patient satisfaction. It was hoped that this expertise would also equate to a specific reduction in 999 and ED referrals, thereby fulfilling an obligation as an urgent care provider to ensure the right patient care at the right place within the right time.

This notion that there was scope to up-skill a significant proportion of a clinical workforce is something for which there was an evident appetite, as reflected upon review of staff feedback through survey. Analysis of the main reasons behind staff departure from exit interviews indicated a firm correlation between perceived lack of training and confidence in role. There was also a nexus between the same perceived lack of training opportunity and the scope for progression within the organisation, which had a negative effect on staff morale and was identified as a key motivator in terms of staff turnover as well as handicapping effective recruitment. Any means through which staff retention and recruitment could be improved would not only constitute effective business practice but would also furnish a potentially substantial cost saving – which could be reinvested back into service delivery.

Approach

The organisation adopted a practical approach to deliver on the project goals.

The plan dictated the selection of six clinical advisors that were already working within NHS 111 services based across the country for enrolment in a university accredited level 6 clinical skills course. The academic study was then supported by an opportunity to consolidate practice in local urgent care centres.

Candidates were selected after an internal referencing process followed by individual structured interviews conducted by the Workforce Development Programme Manager. The process was designed to determine enthusiasm for the project, gauge commitment, decipher capacity and delineate the individual benefit that engagement in the programme could potentially convey.

Successful candidates were comprised from a range of experience levels, so as not to bias the measurement of the impact of the project, and constituted a sample from an equally diverse clinical background.

The recruitment model used necessitated submission of application to the Workforce Development Programme Manager. A job description and person specification were developed in order to provide a framework through which the organisation could advertise and locate the most suitable candidates.

The initiative did not mandate a change in substantive role for candidates, and therefore did not require a corresponding change in terms of rates of pay – candidates were paid according to a current salary rate over an average period of twelve weeks. However, project data is constantly used to inform workforce forecasting with respect to these sorts of changes, and as such might well be used to justify future pay scale amendments in line with wider organisational considerations.

The course was based on an existing Sunderland University programme which provided clinicians with physical assessment skills rooted in the following physiological areas: skin, cardiovascular, neurological, musculoskeletal, ear/nose/throat, gastrointestinal, respiratory and endocrine.

Vocare agreed to work in partnership with Sunderland University to develop the course in order to ensure that management of a range of minor illnesses and injuries was also covered as part of the course content. The degree to which the content could be moderated allowed the organisation to identify the specific areas in which further training would deliver the greatest benefit in order to achieve maximum efficacy in terms of the project aims. In addition to affording

the organisation an opportunity to engage in local healthcare orientated partnerships, it also allowed for the utilisation of a learning template that could potentially be applied for workforce development moving forwards. And although the course syllabus was based upon a set of competencies focussing on physical assessment skills, there is an ongoing discourse with the University around development in order to incorporate the management of patients in a face to face situation and telephone environment.

Course lectures were delivered centrally at Sunderland University campus. To this end students from alternate sites were provided travel/accommodation over the duration of the course. Each session included a formal lecture structured around physical assessment skills, the corresponding application to minor illness and injury in that system and the management of common presentations, and a forum to explore the assessment skills and through classroom based case presentation discussion.

The organisation enshrined the learning commitment within contractual terms in the form of a partial secondment agreement calculated based upon the funds available for backfill of clinical resource. The terms afforded 25 hours per week over a period of three months, including the fifteen weeks duration of the clinical skills course, the subsequent examination and weekly sessions providing the opportunity for clinical practice in an integrated urgent care service. The candidate's remaining contractual hours were to be worked within their existing NHS 111 role, so as not to erode the commensurate skills set and unnecessarily impact service delivery.

The contract itself outlined the context of the initiative, the mutual expectations of each party and included a commitment from the candidates selected to honour the investment by agreeing to a minimum attendance level (subject to extenuating circumstance) and continued employment term following completion of the training. This was intended to maximise the extent to which each candidate benefitted from the programme in addition to securing an albeit finite retention of the workforce subject to development, if only for the organisation to more accurately measure the long term impact of the training.

Students were allocated a workplace mentor who assumed responsibility for ensuring that the practical requirements of the course were satisfied, that learned competencies were signed off to the mandatory standard, that the students were provided ongoing support, as well as being integral to the facilitation of additional learning opportunities. A consistent approach to mentorship and assessment of competence was ensured via the selection of mentors based on their relative strengths and previous experience in similar

roles, and cultivated through feedback to/communication with local Clinical Support Managers and ultimately the Clinical/Project Leads.

The Clinical Lead for the project conducted a formal induction which served as a means through which the organisation could troubleshoot any initial concerns, communicate the relevant expectations and provide further information relating to the structure of the programme. The Clinical Lead also ensured each candidate was familiar with the necessary e-systems as part of the induction and acted as a general clinical point of contact for the candidates. Further 1:1 sessions were scheduled in order to monitor candidate progress and shore up the project support framework.

Practical experience was facilitated via regular rostered sessions based in whichever urgent care service was most proximate to the candidate's primary place of work. All UCCs utilised for the purposes of the project function to provide care for minor illness/minor injury management. Candidates were required to submit a log of the session that was signed by a mentor. The scheduled sessions also incorporated working in local GP out of hours to extend exposure to more acute presentations.

In addition to attendance at the course and working in UCCs, students were encouraged to seek placements with as many other services as would inform their ongoing learning such as; emergency departments, ambulance services, mental health services, pharmacies, community and palliative care services (Vocare were able to provide some exposure to services directly). Vocare also provided an opportunity to engage in several educational seminars based at Sunderland Hospital in addition to an external BLS/PLS/anaphylaxis training package.

The governance of the candidates remained the primary responsibility of local Clinical Support Mangers, worked closely with the project leads to ensure that on-going clinical supervision and continuing professional development was made readily available. Local Clinical Support Mangers provided the project with ongoing ED/999 conveyancing data in addition to information relating to audit review in order for the project to be adequately evaluated.

The Project Administrator was made responsible for ensuring that the logistics of the project remained on target through ongoing task meetings, whereby issues/risks arising from any aspect of the project could be identified and actions assigned accordingly. All candidates were provided with a dedicated inbox through which grass roots issues could be addressed and any necessary changes incorporated into the project plan.

Project feedback was routinely provided at regular intervals to the Workforce Development Programme Board responsible for the ultimate delivery of the project. The Board comprised from:

- Chief Executive
- Finance Director
- Local Clinical Director
- Regional Operations Development Manager
- Head of Assurance
- Head of Nursing
- Workforce Development Programme Manager

All data relating to evaluation of the project was shared with the wider organisation and serves to inform the direction of the associated policy discussion as per the group obligation to do so under Early Adopter Site terms for the NHS Integrated Urgent Care Workforce Development Programme.

Intended outcomes

It was anticipated that full implementation of the project would have a positive impact on the following service elements:

- Recruitment and retention
- Patient experience
- Staff morale and motivation
- Cost and effectiveness of the service
- Integration between services
- The number of multiple patient contacts
- The number of referrals to ED
- The number of referrals to 999

The aims were congruent with the Integrated Urgent Care Workforce Programme agenda in that they were all implemented to support and develop an optimal NHS 111/Integrated Urgent Care workforce.

From the commencement of the project, the organization recognized the benefit of working in partnership with local education and training groups, evidencing this through the relationship cultivated with Sunderland University and the various seminars/learning opportunities arranged to meet the project goals

It was hoped that direct investment into training a workforce would exercise a positive impact upon increasing the clinical capability and support within the NHS 111 service. The extent to which the increased clinical capability/confidence would translate into improved staff satisfaction was a primary concern, as this would invariably mitigate the issues associated with staff attrition and high turnover. The creation of a competency framework around which the integrated urgent care role would function was fundamental to the promotion of improved quality/practice in addition to the implementation of a defined career pathway to ensure staff satisfaction.
It was also intended that the mode of training selected for the initiative would also serve to decrease ambulance conveyance to emergency departments within a shorter frequency of patient contact, the net effect of which would be to increase the proportion of calls resolved through *'hear and treat'*.

In order to measure the aims of the project/impact upon staff the organization developed a two-tier methodology. It was accepted that the relatively small sample size utilised for the purposes of the project would likely not be sufficiently large to demonstrate any changes that could be considered statistically significant in their own right. Therefore, although quantifiable data relating to the current 999/ED dispositions generated by the group of students was extracted for the purposes of the evaluation in order to discern any improvement in correlation with the training provided, it was recognized that the data should be understood in these terms, and where possible with reference to other sources.

For this reason the project employed a qualitative analysis which sought to gauge current clinical satisfaction as it related to job opportunities within an integrated urgent care system. This was measured again once the project was completed and students were asked to evaluate the programme to identify any improvements for future intake.
Vocare also solicited feedback from the mentors involved in the administration of the project ends, to record their experience and establish ways in which the project could perhaps be improved.

Once the project has been fully evaluated and the benefits established, the organisation will decide upon how best to progress the programme of developing 111 clinicians, with a view to establishing the post of a Junior Integrated Urgent Care Practitioner substantively and incorporating the post as part of a clinical career pathway.

Intended outputs

The main products to be delivered by the project was an improved workforce, improved outcomes for patients and facilitation of career pathways within NHS111 with the development of a dual role promoting integration between services. This was to be evidenced in terms of both the clinical skills to be legitimised upon successful completion of the university module and overall staff confidence/role satisfaction.

The cost savings posed by the potential mitigating effect on recruitment/retention, in addition to the direct service benefit derived from having candidates able to effectively support in face-to-face patient care are hugely advantageous.

The continued development of local partnerships would certainly constitute an indirect benefit in terms of project satisfaction. The active cultivation of local relationships with external training providers/agencies was not only useful in terms of the benefit to be gained by the project but also the likely benefit to be gained by future projects. Engagement with such academic stakeholders is key to further support educational programmes and will assist in further career opportunities within integrated urgent care.

Direct working between services in order to facilitate the project aims probably served as another opportunity for adjacent services to gain an insight into areas of functionality to which they might not have otherwise been exposed. Furthermore, the experience accumulated through administration of the project by all parties concerned, whether it be realised in the aggregation of a pool of mentoring ability or a template through which similar projects could be modelled, the project delivered a huge benefit in terms of the potential for future operational application.

The main strengths of the project were rooted in its flexibility. The project structure tended to allow issues to be reported relatively quickly, and regular meetings encouraged the grass roots inculcation of ideas/feedback from various parties into the mechanism of the project plan.

More generally the project served to make the case that even in the context of service provision contingent on the award of medium term contracts, there is scope to deliver workforce innovation via new modes of investment in order to ensure quality effective patient care.

Details of resources and any potential partnership

Workforce Development Programme Manager	Project Sponsor	Registered nurse with extensive experience of urgent care. Organisationally responsible for workforce development and in particular workforce development in relation to integrated urgent care	0.2 FTE
Project Administrator	Admin Support	This will be a key role in supporting the Workforce Development Programme Manager to develop plans, implement the project, arrange meetings and liaise with other parties	1 FTE
Clinical Support Manager	Clinical Lead	Registered nurse with extensive experience of delivery of 111 service and clinical responsibility for GP OOHs and 111 – North East	0.1 FTE
Head of Recruitment	Project Support	HR professional with experience in recruitment, staff engagement and staff development across a range of sectors	0.1 FTE
Clinical Support Manager	Project Support	Registered nurse with extensive experience of delivery of 111 service and clinical responsibility for 111 service – North East	0.1 FTE

Clinical Support Manager	Project Support	Registered nurse with extensive experience of delivery of 111 service and clinical responsibility for 111 service – Staffordshire	0.1 FTE
Clinical Support Manager	Project Support	Registered nurse with extensive experience of delivery of 111 service and clinical responsibility for 111 service – North East/South West London	0.1 FTE
HR Business Partner	Project Support	HR professional with experience in employment organisation, staff engagement and staff development across a range of sectors	0.1 FTE
Information Analyst	Information Management	This will be a key role in terms of developing the questionnaires and datasets required to support the evaluation	0.1 FTE
Sunderland University	External Partnership	Clinical Skills course provider	n/a
External Training	External Partnership	Quality local provider of BLS/PLS/anaphylaxis training	n/a
Miscellaneous Costs	Miscellaneous Costs	Including candidate travel/accommodation expenses/uniforms/direct and indirect costs associated with mentorship/additional training	n/a

JIUCP Clinicians	Clinical Backfill	6* NHS 111 clinicians (including 1* candidate >WTE) seconded for 25 hours per week for length of project	3.99 FTE

Obstacles and issues

Delivery of the project presented several key challenges.

The first issue encountered concerned the method through which candidates were recruitment onto project. To ensure the process was fair, the organisation utilised specific adverts/job specifications/interview questions as part of the recruitment process. This was in part responsible for ensuring that the sample of candidates were as varied as possible in terms of both individual clinical background and service distribution. But it also ensured that the opportunity was properly communicated, and that the visibility attached to the advert served to galvanise an appetite for staff engagement in the project.

The nature of the training to be employed necessitated a discussion around the corresponding contractual structure to be used. In order to maximise the extent to which the NHS 111 services would benefit from the experience the contract enshrined the training opportunity for each candidate in conjunction with their current role as secondment. The terms of the secondment were such to have minimal impact on holidays/existing pay arrangements and were fully explained to each candidate before formal acceptance onto the course. All candidates were required to have the full support of their operational and clinical managers before the application was made. The degree to which this was proactive was a conscious decision to avoid any contractual gripes arising from a perceived lack of transparency and ensure the success of the project. All candidates have completed the course.

Balancing project interests with service demand was a frequent issue over the length of the project. This was manifested in both extent NHS 111 services who requested a greater deal of flexibility regarding the placement of student hours to combat critical demand and the UCC training sites who advised regarding the delays experienced through virtue of facilitating shadowing sessions. Both issues were resolved by high frequency communication around the problem areas, in addition to the introduction of a formalised rota for the candidates. The

rota considered existing staffing concerns/peak service periods/opinions of locals operational and clinical leads and allocated sessions for each candidate accordingly. These issues were resolved quickly after being raised and with the support of the management team, did not impact upon clinical skills practice.

Establishing a uniform level of training also presented a challenge, in that each nurse had a variety of unique experience that needed to be reconciled with a group standard. By using the group training matrix, in conjunction with external training providers where necessary, the project coordinators could ensure mandatory training modules were delivered using online resources.

Actual outcomes

The evaluation data seems to indicate that the project was largely successful in meeting the project aims.

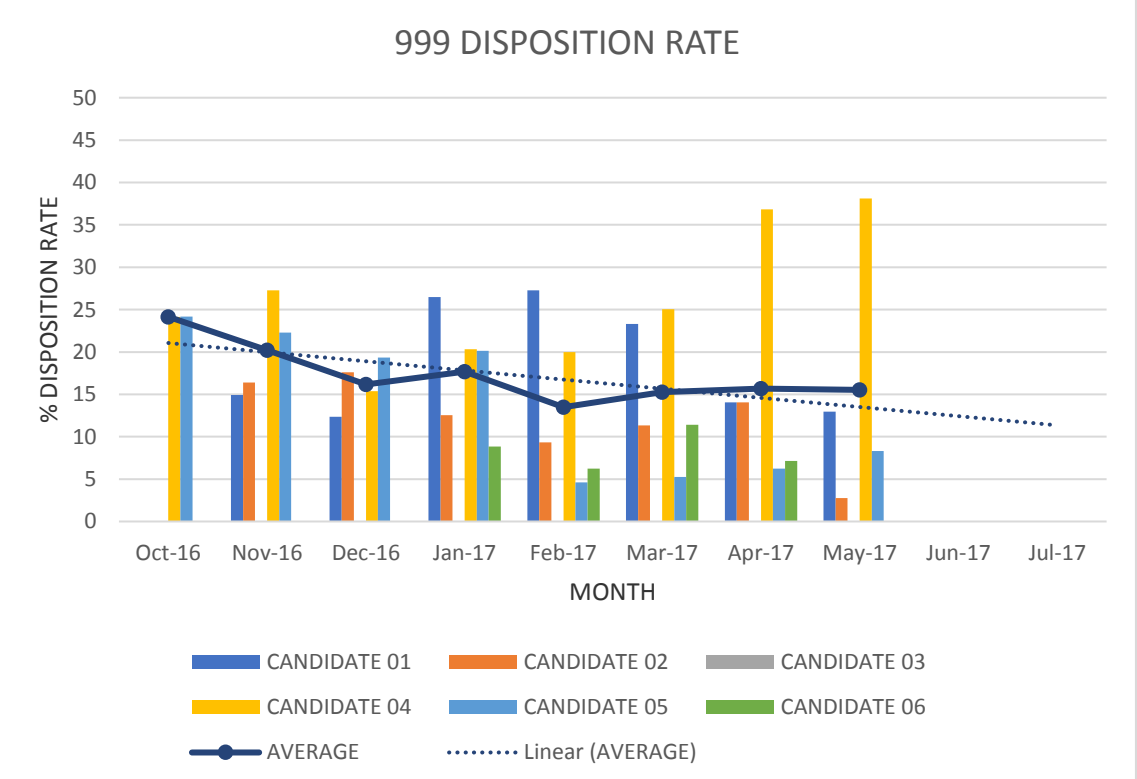

Fig 1

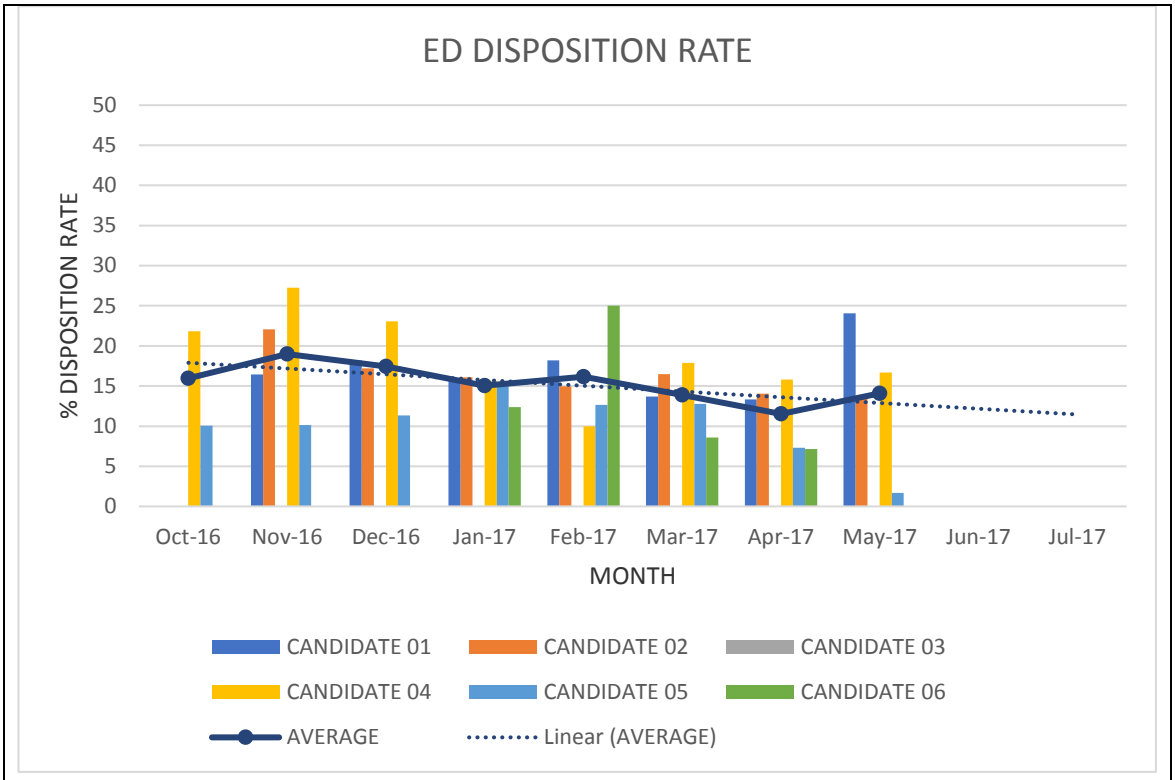

Fig 2

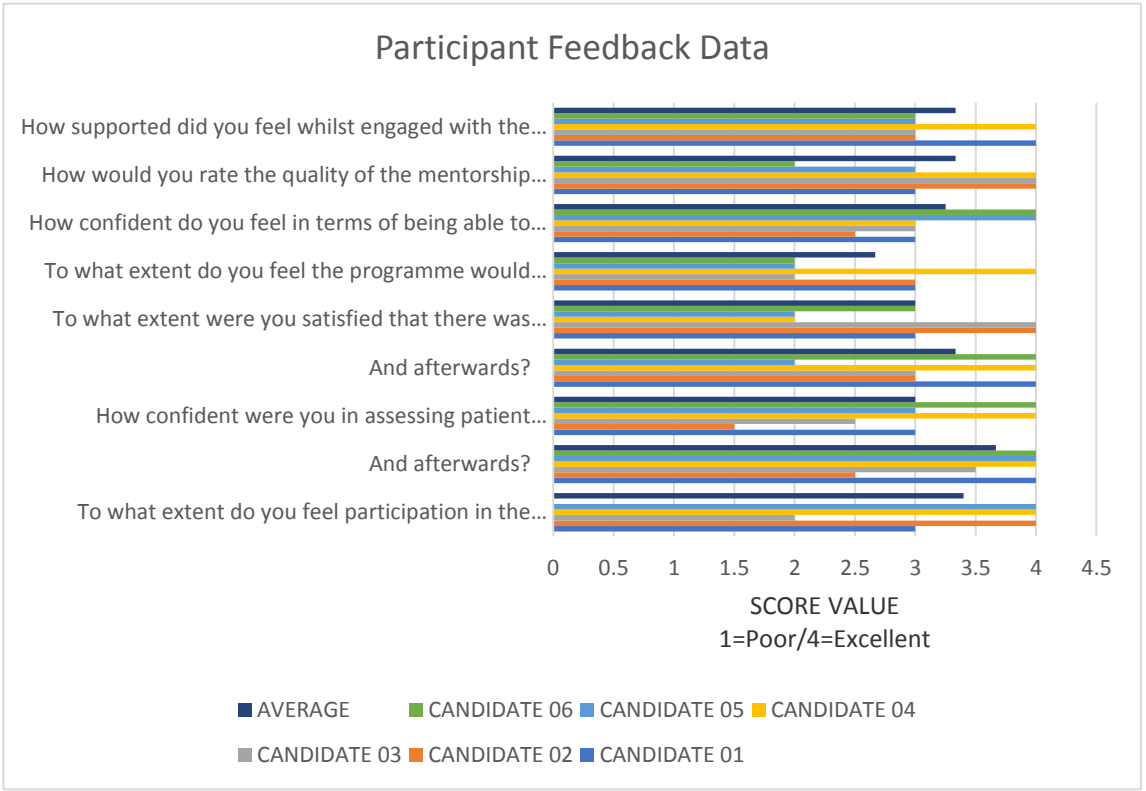

Fig 3

Both Figures 1 & 2 show a clear reduction in both ED and 999 disposition rates amongst the candidates.

The evaluation survey completed by each candidate (Figure 3) also seems to support the idea that there was discernible correlation between participation in training and a positive effect on existing role. Candidates were asked to rate to what extent they were confident in assessing patient symptoms within the remit of their current role before and after participation in the programme. On average the results showed a 16.17% increase in confidence as measured by each candidate.

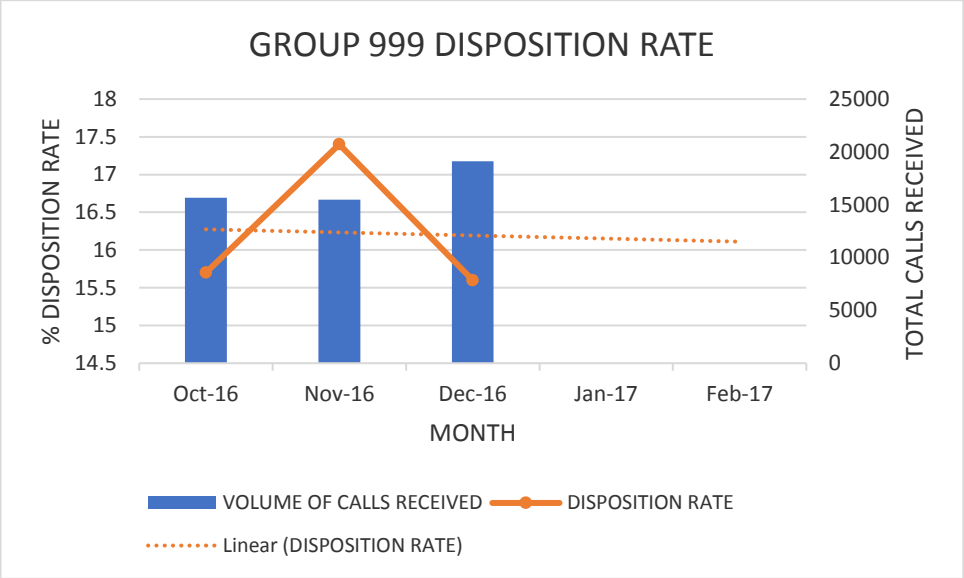

Fig 4

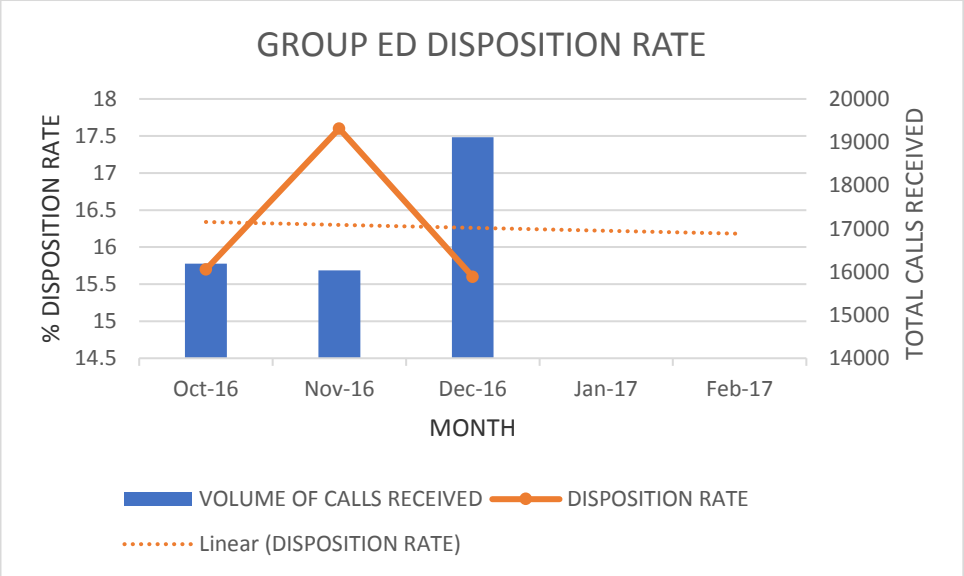

Fig 5

And although Figures 4 & 5 clearly show a similar downward trend in terms of ED/999 disposition rates across the group, it is clear from the figures that the percentage decrease exhibited by the candidates is more marked by comparison.

The figures show on average a 26.61% decrease between 999 disposition rates recorded between October 2016 – December 2016 and January 2017 – March 2017 amongst the candidates. This reduction rate exceeds forecast for the group and the candidate figures relevant to January – March represent a 1.05% reduction when compared with group rates for the previous three months.

ED disposition rates indicate similar patterns. There was on average a 13.92% decrease in conveyancing rates across a similar period amongst the candidates, which equated to a 7.79% decrease based on group figures for the previous three months.

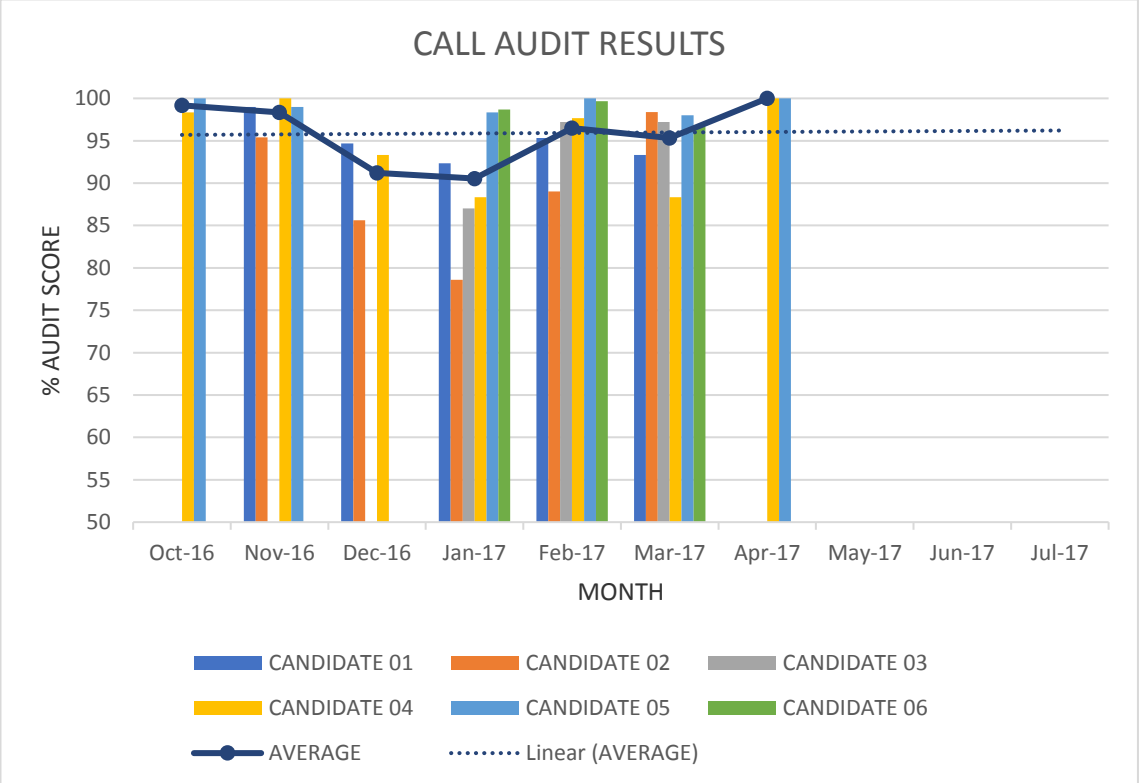

Fig 6

Fig 6 also shows a general pattern of quality improvement amongst the call audits reviewed for candidates. The competency areas subject to review are as

follows: effective call control/skilled questioning/active listening/skilled provision of information & advice/effective communication/practices according to designated role requirements/skilled use of pathways functionality/delivers a safe and effective outcome for the patient. Thus, the criteria are an apt means by which the project could establish the indirect impact on quality of patient experience and likelihood of multiple patient contacts

However, there were discrepancies in this data, as not all candidates were subject to the same number of reviews and there were significant decreases during the initial project period which could be due to increased workload (the feedback data does suggest some candidates found the course more challenging than anticipated).

Fig 3 generally indicates that the candidates found the programme to have a positive impact.

When asked whether they felt participation in the programme informed the way in which they dealt with patients in their current role, the candidates generally answered in the affirmative responding with a score of 85%.

The questions relating to recruitment/retention were generally positive, albeit less conclusive. On average, there was an 8.5% increase in terms of the way in which the levels of career progression were perceived by the candidates. Although the extent to which the candidates perceived the programme as representing a tangible incentive to remain with/join the organisation was perhaps lower than anticipated – on average candidates returned a score of 66.5% relative agreement. Although it was clear from the additional comments attached to the survey that there was some ambiguity in terms of the way in which some candidates interpreted the question (from there own employed perspective/from that of a prospective clinician) and an issue applying the scale included on the questionnaire (not fit for purpose), which could account for the scores.

Most candidates agreed there was a distinct impact on the broadening/deepening of individual skills, competence and confidence. And there was a unanimous verdict amongst the candidates that they would recommend the programme to friends/colleagues and > 75% satisfaction rating overall.

Feedback from mentors was congruent with themes already identified in previous meetings/discussions and stressed the correlation of training and improved clinical autonomy.

Actual outputs
The outputs delivered by the project were: • An upskilled/multidisciplinary workforce, as evidenced through call audit/ED/999 disposition data and feedback through formal survey and regular meetings and impending OSCE examination/portfolio submission. This has the potential to allow a greater degree of flexibility/reactivity in terms of the way the organisation is able to utilise staff resource to meet service demand • The potential to institute similar initiatives that will improve recruitment/retention/general morale and motivation amongst staff – thus representing a firm cost benefit • The potential to incorporate this workforce practice into commercial bids to evidence both staff investment and quality of workforce – ultimately making the organisation more competitive • Demonstrating active investment in the workforce to create dual roles within Vocare has positive ouptut • Unfortunately too early to quantify retention rates as the practitioners are still to complete the OSCE and portfolio submission

Lessons learned
Although a specific recruitment model was utilised, due to the relatively tight time restraints involved in delivery of the project, the initial recruitment logistics were managed centrally by the project administration team. This divorced the project from crucial expertise at a sensitive stage of project delivery that would have benefitted from such input. Failure to adopt the routine recruitment channels not only required the use of additional HR resource to determine the contractual terms of secondment, but also centralised the allocation of labour causing critical delays prior to candidate enrolment. The qualitative feedback received from candidates suggests there was a general consensus that communication practice could have been improved. In retrospect, given that the candidates originated from a variety of different services from around the country, it might have been more prudent to nominate regional points of contact to ensure that communication practice remained as robust as possible. The erosive effect of day-to-day service pressures such as annual leave/disparate working patterns might have been better mitigated through a discussion around specific response KPIs, or more generally

increasing the number of facets through which candidates could choose to engage.

Another constructive criticism drawn from the evaluation data was the sometimes confused approach to the provision of mentorship within the project. The mentor structure was initially devised on the basis that each candidate would have access to both a UCC mentor and overall course mentor. The former would assume responsibility for the practice element of student support within the remit of each shadowing session, and work in conjunction with the Clinical Lead that would be ultimately be responsible for ongoing CPD/1:1/academic and clinical issues. Initially the project had a dedicated clinical lead who was acting within a learning support coordinator role. but due to business need, this resource was reallocated. Gross underestimation of the need of such a valuable resource had a negative impact on the project, which meant time was spent by senior members of the team to ensure appropriate organisation and mentor allocation for the candidates. The project would have been better served by emphasis upon individual mentorship from the outset. This would have involved incorporating individual mentors into project conversations thereby utilising valuable insight, affirming their expectations in terms of the delivery of mentorship and instilling confidence in candidates. Furthermore, more timely discussion with mentors might have acted to minimise disruption by more readily reconciling rota friction and the degree to which service pressures were balanced with the demand of facilitating shadowing sessions.

Finally, on revision of all aspects of project delivery, it is fair to say that the programme would have undoubtedly benefitted from incepting the idea of ongoing evaluation into the project mentality from commencement. The typical weighting of evaluation towards the chronological end of a project is unhelpful, in that it precludes the possibility that such data could be used to inform and direct the project during the lifetime of delivery.

Next Steps

The development of specific dual job roles is the next step to ensure that the value derived from the project is conveyed to the wider organisation. This will further cross boundaries from the traditional roles of all disciplines to deliver a cost effective and quality service. Innovations within service/staff development and service delivery are being discussed with Commissioners to further promote the advantages of dual roles and patient experience.

The data drawn from the project is part of a portfolio of evidence supporting the appetite for further investment into workforce related projects across the spectrum and serves to inform the wider policy debate.

This project has highlighted many workforce development opportunities and has further influenced Vocare's Workforce Development Strategy.
From this particular project, it has enabled Vocare to develop a new and attractive role within the NHS111 service. The Workforce Development Programme Team will continue to monitor the success in this project and would welcome opportunities to further support in NHS 111 Career Framework.
Whilst, too early to predict/ measure staff retention rates, it would be favourable if this dual role would impact on retention rates and sickness rates.
As stated previously, a job description has been written with a person specification and will be rolled out across the regions. One area has already approved this role and will be implemented following the candidates passing their summative and formative assessments. This is an exciting step forward.
It may also be a worthwhile exercise to offer NHS111 Pathways training to experienced Urgent Care Practitioners again to facilitate the NHS111 Career Framework to gain a full understating of Integrated Urgent Care.
It would be a positive step if Vocare could offer this opportunity again but much planning, rota fills and budgetary management may hinder this process.
This project has enabled many employees, both clinical and operational, the opportunity to develop professionally and personally

Moreover, the delivery practice fostered by implementation of the project has also been used as a template, through which the group hopes future projects will find success.

Additional Comments
As an organisation, Vocare has relished the support and practical tools offered by NHS England and the Workforce Investment Fund. The organisation looks forward to the opportunity to continue to develop workforce best practice in line with the national Integrated Urgent Care Workforce Programme agenda within the Workforce Investment Fund.

Project 10 – Vocare – Developing & implementing training programme for Clinical Advisors

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Date of Report Submission	31st May 2017

Project Summary

This Phase 2 project involved the development of a training programme for Clinical Advisors which focused upon validation of ambulance and emergency department dispositions.

Vocare operates four NHS 111 services in the following areas:

- Staffordshire NHS 111 – site is in Staffordshire
- Somerset NHS 111 – site is in Somerset
- Devon NHS 111 – sites in Devon and Newcastle
- South West London NHS 111 – sites in London and Newcastle

We also provide Clinical Advisor support to the North East NHS 111 Service, which is operated by North East Ambulance Service.

- North East NHS 111 Clinicians – site in Newcastle

Therefore, the project ran across these sites and services to ensure a wide participation of staff.

Background

This project is a continuance of the Phase 1 project which was run by Vocare in 2015/16. Phase 1 aimed to identify the training needs of call and clinical advisors with a view to developing additional training to address these needs.

The findings of that project were that Clinical Advisors should be the focus for additional training, as a result of the validation of ambulance and ED dispositions, we the focus for additional training actually needed to be on clinicians rather than call advisors. Therefore, the project was to develop a training programme for these staff members.

Some of the learning outcomes from the WIF 1 project were that:

- As a result of the validation of ambulance and ED dispositions the focus for additional training actually needed to be on clinicians rather than call advisors
- Clinicians felt frustrated by the lack of feedback they received which tended to focus only on calls that were subject to investigation or the monthly call review results

We attempted to address a number of recommendations from the Phase 1 project by:

- Running a similar project with a larger group of staff
- Developing methods for gathering more feedback for staff, with a particular focus on 999 and ED
- Setting internal targets for the use of the Dx11 – speak to GP 1 hour dispositions and aiming to achieve this through staff training and developing

Challenges

Across Vocare's NHS 111 services the current rate of referral to an ambulance is 15.8% with a target of 9%, similarly the current rate of referral to ED is 8.7% against a target of 4%.

Validation continues to be part of the way in which the services attempt to reduce the number of inappropriate referrals to 999 and ED. Validation involves call advisors reaching a green ambulance or ED disposition (where there isn't a suitable alternative to ED available) transferring such calls to a clinician to further assess the patient's needs. Ultimately, the validation process did not appear to be working effectively in terms of maintaining the rates below the targets.

The 111 services have high levels of attrition for Clinical Advisors which means that there is a continual process of training staff and losing skilled team members. This greatly affects the skill and experience mix of the staff, and subsequently the ability to meet targets.

Patient outcome data is not routinely shared between organisations. This is largely due to Information Governance restrictions and a lack of interoperability between systems. As such, there are few options for clinicians when they want to understand the outcomes for a patient they spoke with, for example whether a patient was conveyed to hospital following a 999 disposition. This leaves clinicians frustrated by the lack of feedback, as they tend to only hear of outcomes when they have been adverse and are subject to investigation.

Approach

The project aimed to address these challenges by taking the following steps:

Data Analysis

Firstly, we wanted to collate data on the ambulance, ED and Dx11 dispositions generated by different clinicians. In order to determine our foundations for the project, we needed to be able to compare and contrast the rates of the 111 Clinical Advisors with those of other clinicians. The data that we collected was:

- Reviewed ambulance, ED and Dx11 dispositions generated by NHS 111 clinicians. Data from October, November and December of 2016 was analysed.
- Reviewed ambulance, ED and Dx11 dispositions generated by Advanced Nurse Practitioners. Data from October, November and December of 2016 was analysed.
- Reviewed ambulance, ED and Dx11 dispositions generated by Emergency Medicine Doctors in a clinical hub project. Data from October, November and December of 2016 was analysed.

We cross-analysed the ambulance and ED dispositions of the NHS 111 Clinical Advisors and identified clinicians that fell into the 15th percentile and those that fell into the 85th percentile.

One to One Feedback

We invited the clinicians to attend a one to one interview. This was to try and ascertain why the clinician felt that they were in the lowest or highest percentile.

A questionnaire was developed to form the basis of the interview. From those in the lowest percentile we aimed to discover what training and experience is a pre-requisite to being effective at validation and how this can be used to develop other clinicians. For those in the highest percentile the purpose was very similar. However, we also reviewed 5 recent random calls to identify if there were any obvious development needs.

Following the one to one, we analysed outcomes to compare between different skillsets and between staff who have worked in the service for under 6 months, over 6 months, and over 1 year.

Training

We developed an individual training package with staff in the highest percentile. These included training sessions provided by an Emergency Department Consultant, shadowing of more experienced peers (including Clinical Advisors, and Emergency Medical Doctors) and shadowing within other services such as an Urgent Care Centre. We then monitored their referral rates before, during and after the various training sessions.

Common development needs of the clinicians were used to produce a training session for all 111 clinicians. Working with an ED Consultant, we developed a 2 hour training session which included active elements such as listening to anonymised calls and discussion based learning. This was delivered in person at Vocare House, and simultaneously streamed via video conference to the four other sites on 3 separate dates and times to encourage attendance.

Following the one to ones interviews, a number of clinicians were also offered the opportunity to shadow more experienced peers. We utilised EMDs who currently work for Vocare as part of a separate validation pilot, and arranged for shadowing sessions. The EMDs were observed for 8 hours on shift, with the clinicians listening into the calls and recording any queries or learning on a shadowing form.

We also had a number of clinicians take part in shadowing sessions with ANPs within our Sunderland Urgent Care Centres. This afforded the NHS111 Clinical Advisors the opportunity to experience cases from the perspective of a frontline primary care service, and helped with their understanding of appropriate referrals.

Patient Outcome Feedback

We have attempted to develop feedback mechanisms on ED and 999 referrals. This involved working with 999 providers to develop methods for finding out what happened to specific patients following a referral. Ambulance conveyance rates were requested from all local ambulance services, to allow us to match referral rates. The data has been received from four of the five services, and has been added into our reporting structure. The information is received monthly, and will be shared with the Clinical Support Manager of each NHS 111 service. We are also aiming to add this data into the services' Daily Situation Reports (SitReps) but the appropriate format of reporting has not yet been agreed to allow for this to be imported.

The conveyance rate data will now form part of the appraisal and one to one format for the NHS 111 Clinical Advisors. It can be used to support analysis of their rates of ambulance referral, by showing the percentage of ambulances performed 'See and Treat' or conveyed the patient to the Emergency Department.

Where we have integrated urgent care services we have arranged internal end to end meetings. These are to support the relationships between the services and allow for joint learning. The first meetings are arranged for June, and attendees will be from a range of roles within the service (Clinical Services Managers, Local Clinical Directors, GPs, Clinical Advisors etc) to allow for concurrent representation. Meetings will include listening to calls and a case discussion as a means of both gathering feedback and enhancing learning. During the meeting the group will review cases that have generated a Dx11 disposition. Where themes are identified the teams will work together to develop condition specific training for all 111 clinicians.

Project Evaluation:

This project has been evaluated though a number of measures including:

- Rates of referral to 999, ED and Dx 11 before and after the project were analysed. The data was broken down by clinician skillset, time in the role, and we also tracked individual progress across the training period.
- For those individual clinicians who had further training and development, we developed a questionnaire to measure their self-assessment of competence before and after this was implemented.
- Comparing the average costs of a care episode pre and post development.

- Estimating the cost savings to the organization associated with the use of competent staff for validation.

Intended outcomes

Aims and Objectives:

Vocare is currently trialling the use of EMD consultants based in the North East working for Staffordshire who validate 999 and ED cases. To date there has been no comparison work to identify whether their impact is better than the use of experienced Clinical Advisors in this role.

NHS 111 clinicians are currently selected for the validation role on the basis of their experience of working in 111. Their call outcomes should also indicate that they have a low percentage of referrals to 999 and ED. In practice there is little scrutiny of how well this approach is working. There is also a lack of training for this role.

Based upon this information, the project was focused on using data to identify:

- Which type of clinician provides the best outcome
- What development is required to help NHS111 clinicians improve their rates of referral to 999 and ED as well as ensuring that they are competent to meet the needs of ambulance and ED validation

As part of the development of clinicians the project also aimed to:

- Develop methods for gathering more feedback from staff, with a particular focus on 999, ED and “speak to 1 hour” dispositions
- Set internal targets for the use of the Dx11 – speak to GP 1 hour dispositions and aiming to achieve this through staff training and developing
- Develop group and individual training for clinicians who require assistance with the appropriate use of 999, ED and speak to 1 hour dispositions

Benefits:

The projected was expected to benefit the Clinical Advisors by providing further training, improving their confidence in utilising pathways effectively and using their clinical knowledge when changing dispositions.

We hoped to develop a more robust validation process for 111 cases, and ultimately positively impact upon referrals to 999 and ED. In achieving this, we aimed to reduce the cost of care episodes by ensuring patients reached the most appropriate service for their needs.

Another benefit to the organisation would be the creation of training materials which can be used as routine development of new staff. Training needs analysis will be used to develop a training package for all NHS 111 clinicians which will be incorporated into the Module 2 training of clinicians. This work is presently still under development. There is also work being undertaken separately to address the high staff turnover rate.

Intended outputs

From this project the team strived to deliver the following products:

- One to One feedback structure and survey creation which can be used to support future meetings of this kind.
- Referral rate reports to be created to enable continuation of monitoring.
- Data reporting to be created to enable continuation of analysis
- Shadowing form development with training on how to use appropriately to achieve improved outcomes
- Pre and Post Training Questionnaire, including evaluation
- Training handbook to aid learning

The main strength of this project is that, once implemented, the monitoring can be continued to help reduce rates across Vocare's NHS 111 services. The data will help us to recognise trends in the referral rates, and have early warning signs for clinician's who may be struggling. This will allow us to better support our staff and improve the efficiency of our service and could be suggested to increase the number of "speak to" referrals as part of NHSE vision and development if the Clinical Assessment Service

The project is innovative as it will compare the work of ED clinicians Vocare is currently trialling. The ED consultants validate 999 and ED cases. To date there has been no comparison work to identify whether their impact is better than the use of experienced clinical advisors in this role. This is one aspect that Vocare will conduct.

Details of resources and any potential partnership

Internal Resources:

Current Role	Role in Project	FTE
Project Manager	Project Manager	1
Admin Support	Project Administrator	0.5
Head of Human Resources	Project Support	0.1
Workforce Development programme Manager	Project Sponsor	0.2
Clinical Support Manager	Project Support	0.1
Clinical Support Manager	Project Support	0.1
Clinical Support Manager	Project Support	0.1
Team Leader	Project Team Manager	0.2
Team Leader	Project Team Manager	0.2
Team Leader	Project Team Manager	0.2
Information Analyst	Information Management	0.1

External Resources:

Current Role	Role in Project
ED Clinicians	Shadowing / Mentoring Support
UCC Clinicians	Shadowing / Mentoring Support
ED Consultant	Training Provider

Obstacles and issues
It has been challenging to gain the engagement of staff and managers in some of the service locations, and unfortunately this has affected the success of the project at these sites. This has been due to several different factors; Firstly, there was a lack of engagement with regional managers at the initiation stages of the project impeded outcomes. On reflection, the expectations and requirements of the project could have been outlined more effectively to ensure consistent buy-in from the regions. Within the later stages of the project, work to improve communication with these managers increased our direct contact with them via telephone calls, emails and utilising the engagement of the executive team. A Workforce Development project newsletter was developed and distributed throughout the organisation. As the project was focusing on the Clinical Advisors, extensive input from their line managers was required– the Clinical Support Managers (CSMs). Lack of capacity of the CSMs has caused some delays to the project, specifically in the completion of audits and to one to ones. This has been due to extensive workload and conflicting priorities within the regions. We attempted to alleviate this by involving Assistant CSMs and highlighting the importance of the project to the Regional Directors. It has been difficult to manage a project over five sites (and five services) that are very geographically dispersed. Three Team Leaders were seconded to aid the project from across two sites (covering four services) and this had favourable outcomes Plans were also made to visit all sites and involve local staff by using conference and video calling facilities. However, the performance of the project could have been further improved by including staff from the remaining two sites in the project team. It was found that the sites that did not have a designated project Team Leader are those which experienced delays in the project development, or had reduced numbers of participants. There were also unforeseen circumstances which affected the projects progression. From the end of December until 27th February, NHS 111 services were all subject to rota realignment. This was the creation of a new rota for both operational and clinical staff to better correspond with our service level forecasting and demand Unfortunately, this meant that there was block on staff

being removed from the rota within this period and there was a ban on overtime. It was therefore difficult to book training or shadowing shifts for staff due to the rota being changed. To assist in addressing this issue, we communicated openly with the regional teams and created a schedule with a number of options for each member of staff. Therefore, if the service level was too high on that date and they could not be released, further dates on which that staff member could complete their one to one or training, were provided.

Actual outcomes

Training Outcomes

We aimed to provide feedback and training to 111 Clinical Advisors in order to improve individual clinician's rates of referral to 999 and ED and to ensure that they are competent to meet the needs of ambulance and ED validation. From our project, we found that referral rates for ambulance, emergency departments and Dx11 (Speak to 1 hour) reduced once this competence had been established.

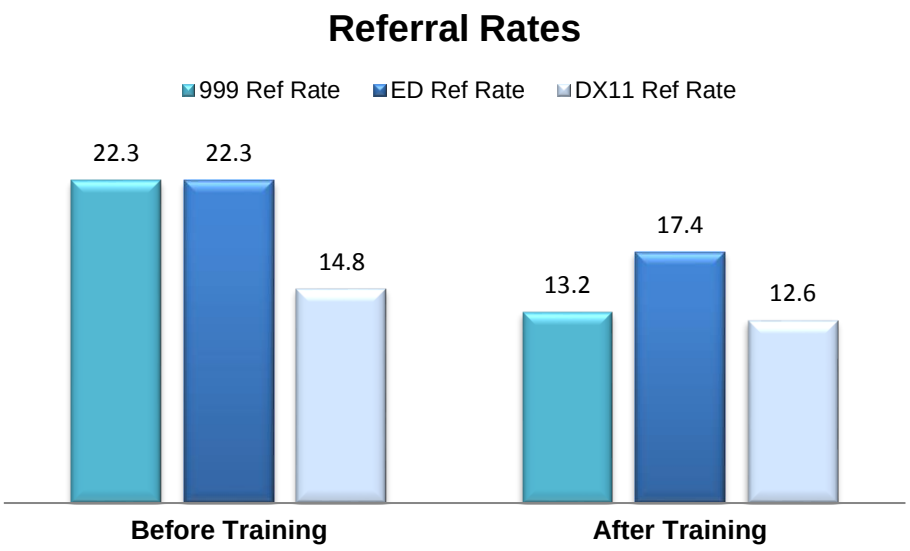

Fig. 1 Graph showing referral rates pre and post training.

Figure 1 shows the referral rates of staff who attended a training session and/or shadowing. Rates were determined using median values from three months pre-training (October, November, December) compared with median values post-training (February, March, April).

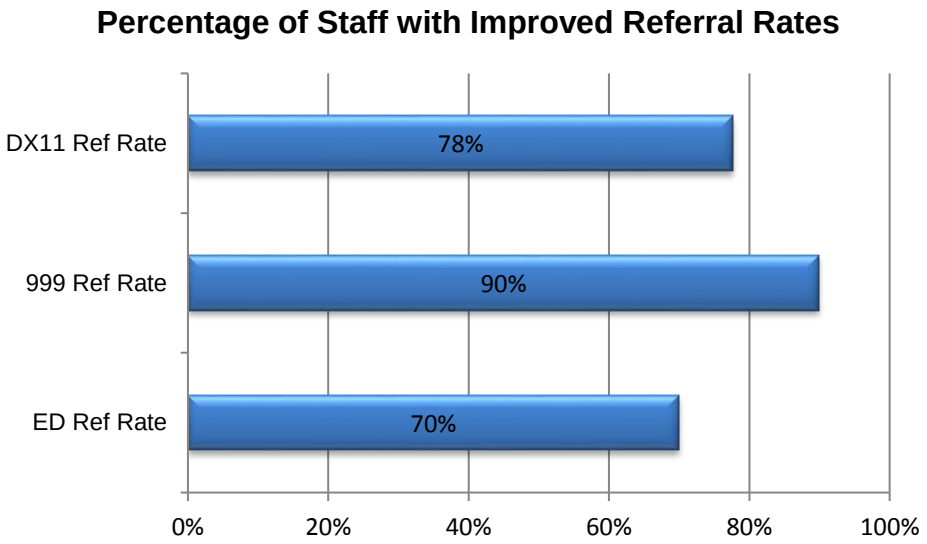

Fig 2. Graph showing percentage of staff with improved referral rates

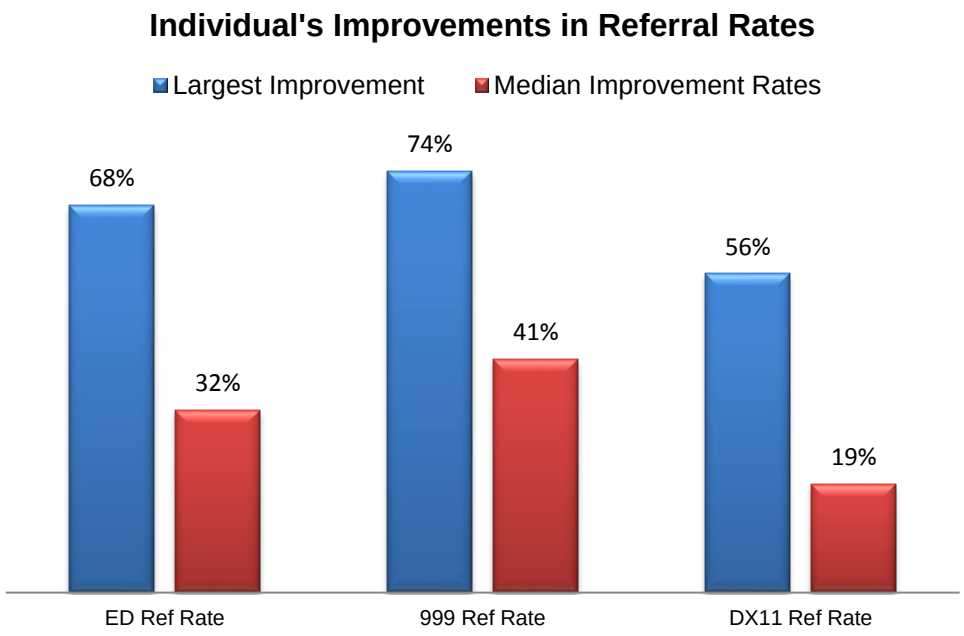

Fig 3. Showing the highest percentage of improvement in referral rates and the average improvement rates across all participating staff. Percentages are shown in relation to starting rate.

Our data evidences that the Clinical Advisors overall referral rates have improved across all three of the dispositions. The rates of referral for these staff are still above our overall target, but trending shows that the levels are continuing to reduce.

The Dx11 referral rate has overall decreased by 2.2%, which is a reduction of 19% from its initial starting point. It was expected that although clinicians would feel more comfortable in downgrading the ambulance and ED positions, this may increase the still refer to GP surgeries for the 1 hour call back.

We found that 38% of clinicians in the top 15th percentile work predominantly overnight shifts. We considered that their higher rates will be due to lack of access to other services during this time, and less support within the working environment due to reduced numbers of staff. It was not within the scope of this project to consider implications of this, or how to better support these staff, but would be useful to consider for the future continuation of this project.

When analysing the clinical experience and background of the staff, we found that the most common clinician type in the top 15th percentile was paramedics. This can be taken into consideration when running future training and updates, as we may need to consider tailoring to clinicians based upon background, to ensure they have the right knowledge and skills to fulfil the role.

Cost Benefit:
Consideration was given to the average number of calls that these clinicians would take over the course of a month. Six months of data to find the average number of calls taken by the group of clinicians was 1238.

	Before Training (%)	**After Training (%)**
ED Ref Rate	22.7	17.3
999 Ref Rate	22.8	13.5
DX11 Ref Rate	14.6	12.8

Table 1. Showing Referral rates before and after training.

	Number of Cases	**Cost £**
ED Ref Pre Training	281.21	28121.17
ED Ref Post Training	214.30	21429.78
Savings	66.91	£6,691.39
Amb. Ref Pre Training	281.71	61975.52
Amb. Ref Post Training	166.78	36692.48
Savings	114.92	£25,283.04

TOTAL Savings	£31974.43

Table 1. Showing average estimated cost benefits to the NHS from reduced referrals to ED and ambulance services.

From looking at our conveyance rate data, we estimated that 70% of ambulances convey patients to ED. The other 30% see and treat. This has been included into our workings.

On an average month this group of staff managed 1238 calls. Using the averaged data, where previous 281 of these calls would be a referral to ED this has now reduced to 214 calls. If this reduction was calculated using NHS England care cost data (costs for ED referrals at £100 per patient) this reduced costs by £6691.

Ambulance costs can be estimated as £150, 30% of which be "See and Treat" patients. If the other 70% are conveyed to hospital, this would equal £250 per case. Using this data, the reduction in ambulance referrals post-training would save approximately £25,283.

A more in-depth return on investment is still in development to allow for cross reference with the on-going EMD clinician pilot.

Training Questionnaire:

For clinicians who had further training or development in the form of shadowing shifts, a questionnaire was developed to measure their self-assessment of competence before and after this was implemented. This was to obtain an understanding whether it has been possible to close the learning loop by providing clinicians with more information relating to referrals to other services, focusing on emergency and urgent cases. The results of the survey showed:

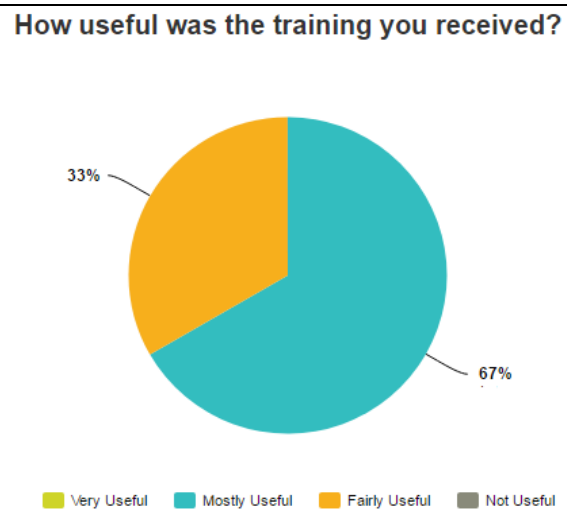

Fig 4. Showing 67% of staff felt the training was 'Mostly Useful'.

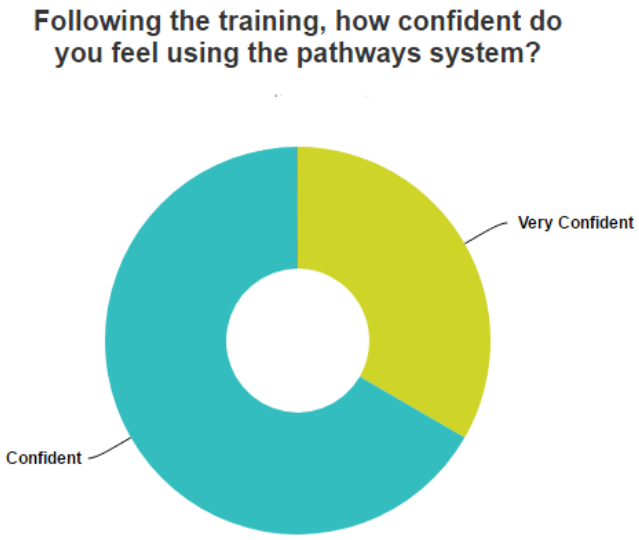

Fig 5. Showing 100% of staff were confident or very confident using pathways following the training.

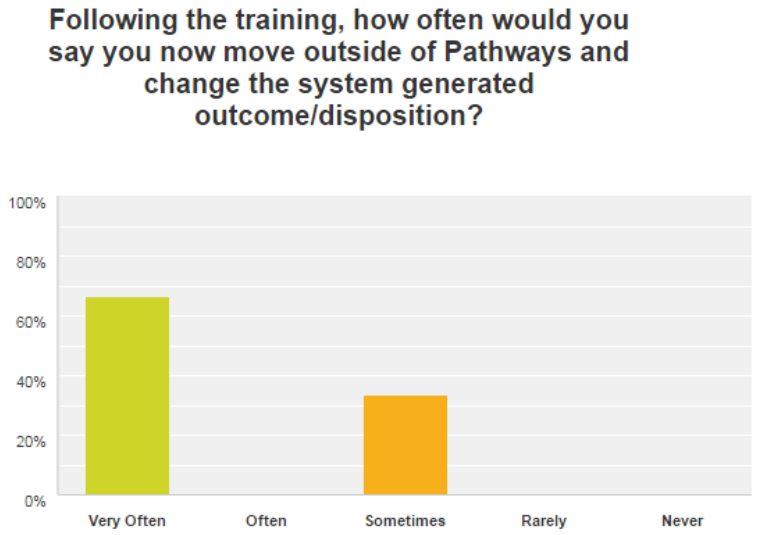

Fig 6. Showing that 67% of staff now move outside of Pathways to change dispositions.

Three surveys were completed, therefore the analysis of the data is not significant. Key comments about the training were:

- Made me more aware of the issue
- Outlined the percentages involved in the referral rates
- Increased awareness and confidence in the system
- Discussion with the consultant allowed for specific concerns to be addressed e.g. minor mouth lacerations and when it is acceptable to give home care advice.

Actual outputs

One to One feedback structure and a pre-training survey was created which can be used to support future meetings of this kind. Reports on referral rates of our NHS 111 Clinical Advisors were created.

Clinical Support Managers have been given access to these reporting tools, to facilitate enable continued monitoring and analysis of outliers or trends.

Conveyance rate data reporting has been agreed with ambulance services working with four of our NHS 111 services. Discussions are still on-going with the one ambulance service. This information is included in our reporting structure. The information is received monthly, and will be shared with the

Clinical Support Manager of each NHS 111 service. This data will be built into the services' Daily Situation Reports (SitReps) but the appropriate format of reporting has not yet been agreed to allow for this to be imported.

A shadowing form was created for recording learning from shadowing shifts. This can be used throughout the organisation, and will ensure that structured and comparable results are recorded.

A post training questionnaire was created using an online survey site. This gave the NHS 111 Clinical Advisors who had attended training to provide feedback, complete a self-assessment and identify any further training needs.

The benefits of this project are that Clinical Advisors are ideally placed to influence further training and development to improve and share their clinical skills to ensure optimum results for patients. It could be suggested that this is positive step in career frameworks and development within the NHS111 service to address high turnover of staff within this group. Training and development will only enhance service delivery and have a positive impact on the whole healthcare community.

Lessons learned

The one to one interview questions that we used were paper based. Using an electronic survey – either web-based or excel – would have been more efficient and easier to analyse. The one to ones also took a significant amount of time and resource, it may have been better to ask the staff to complete the questionnaire prior to the meeting and then have shorter one to one meetings to discuss the most salient answers.

As discussed previously, the project may have been improved by either reducing the pilot area – for example running the service over two sites rather than five – or increasing the project resource across all of the sites. We wanted to offer all our Clinical Advisors the opportunity to be involved in the project and receive training, but recognise this was ambitious.

From the conception through to the delivery of this project, many lessons have been learnt and improvement has been attempted throughout, thus improving services for patients as well as training for staff.

Next Steps

The success of this project has been evaluated, and the data evidences that the 82% of clinicians who attended the training subsequently had reduced rates of ED referrals, and 86% had reduced rates of 999 referrals.

Now that the monitoring systems and reports are in place, the data (for example ambulance conveyance rates) can be used to extend the positive outcomes of the project. The data can form the basis of future one to one meetings, and will support sustained learning.

We will continue to utilise reports on the top 15th percentile for ED, Ambulance and Dx11 referrals to help us monitor the performance of the staff who were involved in the project, and also to identify any further clinicians who may require support.

The aim to produce a training manual for 111 Clinical Advisors was not met although there are education materials at hand within the “pods” including guidelines for Sepsis/ and NICE Guidelines etc . This manual will be developed post-project and distributed throughout our services. Common development needs identified through the post training questionnaire, will be used to develop a training package which will be incorporated into the Module 2 training for clinicians.

A summary of the project, including the findings and benefits will be shared with all Clinical and Operational Management staff in our NHS 111 services as well as be presented to the Vocare Executive Team. The findings will also be published within the Vocare newsletter to raise the importance of such innovative work. This will ensure continued organisational learning from the project, and re-emphasise the importance of the work that has been done.

Additional Comments

The Workforce Development Team have fully embraced the challenges that this project has presented. It has given the Team the opportunity to develop both personally and professionally ranging from finance exposure to business analysis skills. Project management skills have been demonstrated and a thirst to further develop is evident within the team. From the data that has been analysed, it has demonstrated that additional training to that provided by Pathways, is key to ensure the best outcome for the patient.

Recommendations will be made to extend/ add to the training offered currently. It could be suggested to be part of an extended induction programme and be delivered in stages therefore refreshing NHS111 Training further equipping clinical staff with the skills to enable to make decisions and encourage prompting questions.

Work is currently being undertaken by Vocare to review attrition rates for this group of clinicians. It will be interesting to monitor, following on from this training, whether increased investment in staff and clinical support with the development of progression tools have an impact upon retention rates of staff.

The development of the training handbook / portfolio will be developed in the coming months to ensure continuous development of staff that enable them increase confidence and exercise some clinical autonomy in the interest of patients.
Cost implications for this training have been favourable given the estimates reported above. These findings will also be presented to the Executive Team.

Project 11 – Vocare – Developing competences in mental health for Health Advisors

Contact details	
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Date of Report Submission	31st May 2017

Project Summary

As part of a Phase1 project it was identified that 111 staff found mental health calls the most challenging to effectively resolve, due to issues with both confidence and competency.

This Phase 2 project involved the development of a training programme for Call Advisors which focused on mental health. This included developing mental health training and a supervision model with the aim to improve the management of calls involving mental health issues.

Vocare operates four NHS 111 services in the following areas:

- Staffordshire NHS 111 – site is in Staffordshire
- Somerset NHS 111 – site is in Somerset
- Devon NHS 111 – sites in Devon and Newcastle
- South West London NHS 111 – sites in London and Newcastle

The project ran across these sites and services to ensure a wide participation of staff, with a total of 258 Call Advisors across these services.

Background

Vocare's experience of delivering NHS111 services together with the Learning and Development Programme initiated by NHS England indicates that many Call Advisors struggle with taking mental health calls.

Vocare ran a Phase 1 project in 2015/16 which focused on the theme of staff attrition and retention. From the project, we came to understand that calls from patients with living with mental illness health problems can be distressing and challenging to complete due to the caller's distress and/or challenging behaviour. As a result, Call Advisors often find that calls of this nature can leave them feeling inadequate, worried and in some instances so distressed by the experience that they consider leaving their role.

To date Vocare has piloted the use of mental health nurses in the call centre (supplied by a local mental health trust) and the use of trainers from MIND to provide mental health awareness training to call advisors. We wanted to build upon this and provide a training programme to improve our Call Advisor's management of calls involving mental health issues.

Challenges

Up to 5% of calls managed by a call advisors involve a potential mental health issue; a greater number involve calls from callers who display challenging behaviour.

The NHS Pathways training does provide some guidance on challenging calls as part of the development of communication skills. In practice, it is known that this is not sufficient and as a result Call Advisors will often use the early exit function in the Pathways system to pass a call to a clinician to complete.

Within a busy service, it is difficult to find time and resources to provide additional training. Although we provide Pathways updates alongside hot topics and probing workshops, it was found from the Phase 1 data that Call Handlers required more sessions dedicated to discussing mental health calls and how to manage them appropriately.

Approach

Project Initiation:
A full Project Initiation Document (PID) and Project Plan was created by a contracted Project Manager who has extensive experience working within this role in the NHS. This defined the scope of the project and ensured that all elements would be delivered within a timely manner. We arranged fortnightly Task and Finish Groups in which the project actions would be discussed and delegated effectively.

Scrutiny Group:
We had aimed to create a national group consisting of local mental health experts. This group should have included patient representation we had sourced through the mental health services working on the project. The aim was for the group to meet throughout the project acting as a steering group.

We did create a group to help manage the project aims and ensure that the objectives of the project were being met. The group consisted of three Team Leaders from across two of our sites (covering four NHS 111 services). This meant the team were experts regarding NHS 111 and their local services. Furthermore, one member of the team is a mental health advocate who also works for St Johns Ambulance service as an Advanced Technician. This staff member has previously worked with MIND charity, and is currently a “Blue Light Champion” for St Johns Ambulance service. Their involvement in the project ensured that we had representation from a staff and advocate perspective. The group also included a Clinical Development Manager for Vocare, who has extensive experience of NHS 111 and dealing with mental health patients.

We also began collaborating with ReCoCo (Recovery College Collective), which is an independent organisation supported by Tyne and Wear NHS Foundation Trust. ReCoCo incorporates Tyneside Recovery College, Launchpad charity and other voluntary sector organisations to form a mental health collaborative which is run by and for service users. We had hoped to work with ReCoCo and Launchpad service users to help us form the scrutiny group but did not have time to implement this. As part of the future development of this project, we hope to work with ReCoCo to improve our service user engagement and patient forums.

Local Resources:
As a first step, the project group were asked to identify local mental health resources that were available to support the development and delivery of the project. Electronic and paper based resources were sourced from MIND and/or local mental health trusts. The Staffordshire 111 service and the South West

London 111 service had both already established regular contact with local mental health service providers and were therefore in a position to support the other two services. We also used the NHS 111 Mental Health training which was available on the portal, as this was both service and topic specific. This information was then shared across the services, and visual aids were displayed at the various sites.

As part of our pre-project research, we created a survey which was sent to mental health providers to seek their opinion of NHS 111. The survey was sent to 60 providers – ranging from national charities such as MIND, BipolarUK, to local mental health trusts within the local regions that we provide NHS 111. An impressive return rate of 33% was received.

Pre-Training Questionnaire:
The project group then developed a staff questionnaire which explored the current competences and confidence of Call Advisors in regards to completing calls from patients with mental health issues. It consisted of 15 questions and was emailed to all 258 Call Advisors across the company in early January. Examples of the questions asked are as follows:

1. How confident do you currently feel dealing with calls from patients with mental health issues?
2. Would you say you are competent at taking calls from callers with mental health issues?
3. Do you feel that there is support readily available if you have a challenging call?

The results from this questionnaire were then collated and analysed by the project group. The results helped to shape our requirements for the external training.

Training:
The Clinical Development Manager in the project group then approached several different training providers to estimate costs of providing training across the sites. We first approached MIND to provide training at three of the sites (Newcastle, Staffordshire, Somerset), however the dates available were for the end of March or early April. As the project was due to finish on the 1st April, these dates were not viable as they would not allow for an appropriate evaluation period. Further research was completed to find an alternative training provider, and Tutor Care were found to be the most appropriate service.

Training sessions on mental health awareness were developed and delivered in February by TutorCare. These were 3 hour sessions, which included CPD accredited certificates, and were run across four of our sites. The aim of the session was to build the capacity of the Call Advisors in the field of mental health so that they are able to effectively respond to the mental health needs of service users. The training covered:

- the symptoms of mental health disorders
- how to respond appropriately to people experiencing these symptoms
- understanding the appropriate services available for these service users
- how to effectively support people with mental disorders

The training session was interactive, allowing time for discussion and group activities to support different ways of learning.

We also arranged information sessions with Dementia Friends. This is an Alzheimer's Society led initiative which aims to increase dementia awareness. The session focused on improving inclusion and quality of life for people with dementia, including how to make NHS 111 'dementia-friendly'.

Post-Training Questionnaire:
A second staff questionnaire was then developed after the training. This questionnaire was created using SurveyMonkey and emailed to the 185 members of staff who had attended the training session with TutorCare. Results are discussed in the Outcomes section.

1. Did you find the training relevant to your role?
2. Evaluating your training, how confident do you feel dealing with calls from patients with mental health issues?
3. How do you hope to change your practice because of this training?

The results of the questionnaire were then collated and analysed by the project group to help establish lessons learned from the project and any future actions required. Results are discussed in the outcomes section.

Clinical Advisor Questionnaire:
As part of the project, Vocare has also explored the potential for the development of a similar programme for Clinical Advisors.

Following the training and analysis, a questionnaire was developed to explore the current competence and confidence of Clinical Advisors in completing calls from patients living with mental illness. The purpose of this was to identify if

there is a similar need for the Clinical Advisors which can be addressed at a later stage. Results are discussed in the outcomes section.

Intended outcomes

The project aimed to improve the outcome of patients contacting the NHS111 service as well as addressing learning needs of staff in order to support them when mental health patients contact the service. This involved the development of a staff questionnaire to assess competency, confidence, and training needs. From this feedback, we wanted to provide a mental health awareness training package for Call Advisors in partnership with a training provider or mental health charity.

This project aimed to:

- Build greater competence and confidence and provide support in Call Advisors in relation to managing calls from callers with mental health problems
- Empower compassionate and caring practice
- Provide enhanced supervision and feedback on calls relating to patients with mental health problems
- Explore opportunities for greater integration between services by developing greater local knowledge of mental health services

It was envisaged that the provision of mental health awareness training and supervision in relation to calls from patients with mental health problems would help deliver the requirements of the Commissioning Standards for Integrated Urgent Care (NHS England, 2015), Compassion in Practice (NHS Commissioning Board, 2012) as well as addressing some of the evidential requirements for an inspection by the Care Quality Commission.

Project Evaluation:

The approaches undertaken to understand the impact and effectiveness of the project were:

- Recording the monthly total number of calls to the NHS 111 service by participating area.

- Comparing the number of 111 calls involving a mental health problem that are managed by Call Advisors before and after the project, within each participating area.
- Comparing the number of 111 calls involving a mental health problem that are early exited and passed to a clinician before and after the project, within each participating area.
- Average handling time of 111 calls managed by Call Advisors involving a mental health problem before and after the project by participating area.
- Number of 111 calls involving a Clinical Advisor and the disposition that is reached before and after the project.
- Number of Call Advisors who attend the mental health awareness training.
- Comparison of the confidence and competence Call Advisors feel they have in managing calls from patients with mental health problems before and after the project.

Evaluation Exceptions:

We had aimed to compare how mental health providers feel about the NHS 111 service in its ability to manage patients with mental health problems pre- and post-training sessions. However, upon reflection, we felt that our project aims would likely not have been illustrated to the providers within the short timeframe of the project. As this was an external survey, we could not determine a control group for the data collection - as we would not have been able to ensure the same individuals/organisations would respond. Better integration with chosen mental health providers, including outlining the control group and expectations for change, would have help achieve this aim.

Intended outputs

The following products were to be delivered by this project:

1. Develop a scrutiny group for Mental Health
2. Source local resources for training and awareness of Mental Health
3. Liaise with mental health trusts and providers to understand areas for improvement in NHS 111
4. Engage staff in a survey to determine training needs

5. Develop and deliver mental health training to Call Advisors across the services
6. Evaluate the outcomes of the training

This project followed a Phase 1 outcome which showed key trends in Call Advisors requesting training in dealing with mental health calls. Therefore, the main strength of this project is that we are engaging staff and delivering outcomes based upon their feedback. We are investing in our workforce, in order to make them more comfortable when managing difficult calls, and ultimately also improving the experience for the patient and confidence of the workforce.

Mental Health is a priority for the NHS, as outlined in the agenda for the Five Year Forward View. It was important for Vocare to incorporate this vision into our NHS 111 services and deliver a project which aimed to support our staff, our patients and the national strategy.

Details of resources and any potential partnership

Current Role	Role in Project	FTE
Project Manager	Project Manager	1
Admin Support	Project Administrator	0.5
Workforce Development programme Manager	Project Sponsor	0.2
Clinical Development Manager	Project Support	0.1
Clinical Support Manager	Project Support	0.1
Clinical Support Manager	Project Support	0.1
Team Leader	Project Team Manager	0.2
Team Leader	Project Team Manager	0.2
Team Leader	Project Team Manager	0.2

Information Analyst	Information Management	0.1

External Resources:

Current Role	Role in Project
ReCoCo	Training Provider
TutorCare	Training Provider
Various Mental Health Trusts and Charities	Resources and Feedback

This project would work well by forming joint partnerships with a mental health trust or charity to inform or deliver bespoke training on mental illness.

Obstacles and issues

It has been challenging to gain the commitment and engagement of staff and managers in some of the service locations, and this has affected the success of the project at these sites. This has been due to several factors.

During the initiation stages of the project, there was a lack of engagement with regional managers. . This caused some delays in achieving the project aims. The expectations and requirements of the project could have been outlined more effectively to ensure consistent buy-in from the regions. The project team worked to improve communication with these managers by increasing direct contact with them and providing updates on the project progression. We also reviewed other forms of communication, and created a Workforce Development project newsletter which we distributed throughout the organisation.

As the project was focusing on the Clinical Advisors, we required extensive input from their line managers – the Clinical Support Managers (CSMs). Lack of capacity of the CSMs has caused some delays to the project, specifically in the completion of audits and to one to ones. This has been due to extensive workload and conflicting priorities within the regions. We attempted to alleviate this by involving Assistant CSMs and highlighting the importance of the project.

There were external factors which altered the outcomes of the project. We had initially aimed to work with MIND to provide the mental health training but they could only offer dates in late March or April. These dates were not viable for the project as it would not leave appropriate time for evaluation. Therefore, we had to research and procure contracts with other potential training providers in order to move forward with the project.

It has been difficult to manage a project over five sites that are very geographically dispersed. We seconded three Team Leaders to aid the project from across two sites (covering three of the services; Staffordshire, South West London and Devon) and this worked well. We also made arrangements to visit the other sites and involve local staff by using conference and video calling facilities. However, the performance of the project could have been further improved by including staff from the remaining two sites in the project team. We found that the sites that did not have a designated project Team Leader are those which experienced delays in the project development, or had reduced numbers of participants.

Finally, there were also unforeseen circumstances which effected the project's progression. From the end of December until 27th February our NHS 111 services were all subject to rota realignment. This was the creation of a new rota for both operational and clinical staff in order to better correspond with our service level forecasting. Unfortunately, this meant that there was block on staff being removed from the rota within this period and there was a ban on overtime. It was therefore difficult to book training sessions for the Call Advisors due to the rota being changed. In order to address this issue, we communicated openly with the regional teams, remained flexible where possible on training dates, and created in-depth schedules to ensure the majority of the staff were able to attend one of the 3 hour workshops.

Actual outcomes

Mental Health Provider Feedback:

We created a survey which was sent to mental health providers to seek their opinion of NHS 111. The survey was sent to 60 providers – ranging from national charities such as MIND, BipolarUK, to local mental health trusts within the regions that we provide NHS 111. We received 20 completed surveys which was 33% return. Please find below analysis of the data.

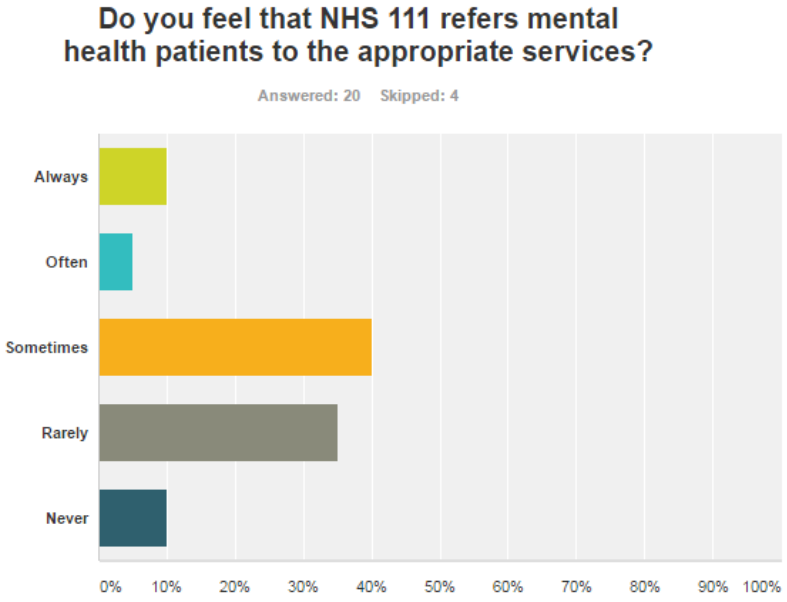

Figure 1. Graph showing responses to whether providers felt NHS 111 referred mental health patients to the appropriate services.

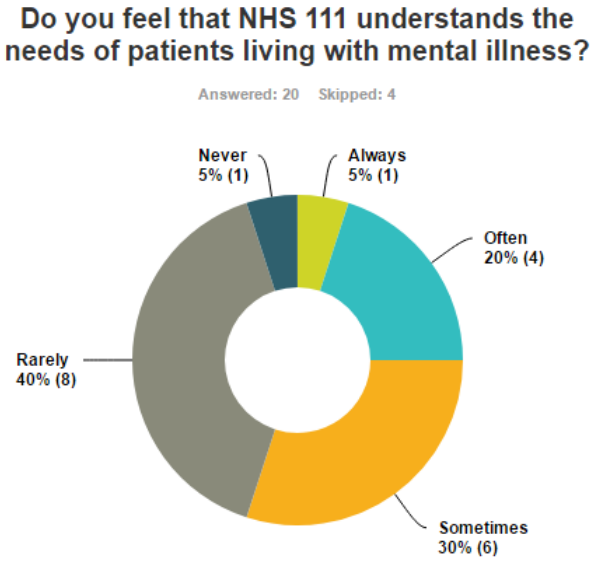

Figure 2. Graph showing responses to whether providers felt NHS 111 understands the needs of mental health patients.

We asked “How would you rate NHS 111’s ability to help patients who are experiencing mental health problems?” Responses were as follows:

Answer Choices	Responses	
Excellent	0.00%	0
Good	19.05%	4
Not Sure	42.86%	9
Fair	14.29%	3
Poor	23.81%	5
Total		21

When asked to explain this rating, examples of responses we received were:

- Insufficient triage before signposting
- Quick to refer to ED, without consideration for other options.
- I don't think enough training is given to determine a mental illness, even though it is covered in a 'pathway' the symptoms are sometimes masked with physical illness and can sometimes be missed
- An ambulance is sent out to MH patient when they do not require medical intervention. Other services like the crisis team or street triage should be contacted instead. MH patients can wait hours in A&E due to level of urgency and if they spoke to alternative services it would be quicker. We get feedback from patients and frustrated families that they have waited in A&E and only sent home.
- They are brought to A&E when there is no medical reason, instead of contacting the Crisis Team

The overall themes of these responses are that providers do not feel NHS 111 refer patients to the appropriate services, often sending patients to A&E. It is not within the scope of this project to look at DOS options, but this is something which could be considered for future projects. However, we could use the comments to inform our training plan, to make Call Advisors aware of different mental illnesses and when A&E is appropriate.

We asked “How can NHS 111 improve, in order to better support and provide for patients living with mental illness?” Responses were as follows:

1. 46% of respondents mentioned further training to improve knowledge of mental health conditions
2. 40% respondents advised referring patients to alternative support services within the local community
3. Closer working and sharing information with secondary services

4. Have dedicated mental health professionals embedded into 111

Pre Training Questionnaire Analysis:

One of the initial project activities was sending a questionnaire to all Call Advisors across the four regions. Out of a total of 258 Call Advisors across Vocare we received 60 completed questionnaires (a 23% return). The completed questionnaires were then collated and the findings were used to help establish what areas of development were required. The questionnaire consisted of 15 questions, which we analysed the responses to. Please find below an example of the salient responses we received:

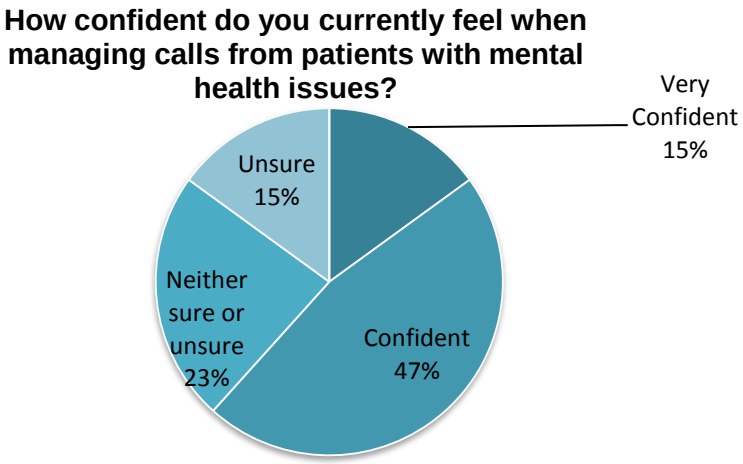

Figure 3. Showing 38% of staff did not feel confident with their management of mental health calls.

Key reasons for feeling unsure:

- All mental health calls are different, so it is difficult to be fully prepared for them.
- Needing a better understand/training on mental illnesses
- Feeling that the help 111 can offer is inadequate/not appropriate
- Scared to 'say the wrong thing' to these callers

Questions	Yes	No	Unsure
1. Have you had any bad experiences relating to calls from callers with mental health issues?	31	28	1
2. Would you say that you are competence at taking calls from callers with mental health issues?	51	7	2

3. Do you think you would benefit from having someone to talk to about this type of call?	46	11	3
4. Do you feel that there is support readily available if you have a challenging call?	32	19	9

52% of staff who responded had bad experiences relating to calls from patients with mental health issues. When asked to expand upon this, the most common answers were in regards to the management of calls from suicidal patients and effectively dealing with abusive or threatening behaviour. The leading theme was that Call Advisors did not understand mental illness and therefore were not able to adapt their manner or call to the patient's needs.

85% of staff felt they were competent at taking mental health calls. However, 49 of the 60 respondents also suggested training or support that they felt would help them to manage these calls.

Call Advisors requested further training in these key areas:

- General mental health awareness training
- How to effectively engage and speak with callers living with mental illness
- How to de-escalate when dealing with abusive callers
- Feedback, or a chance to reflect on complicated or emotional calls
- More support from Clinical Advisors and Team Leaders.
- More information on local mental health services

53% of staff felt that there was already support in place to help manage challenging calls. Areas identified to help with this were:

- Taking time out after challenging calls
- Having someone to talk to following emotional calls
- Stress workshops

Post Training Questionnaire Analysis:
Of the 185 staff members who attended the training, 44 completed the post-training questionnaires (24% return). The results can be summarised as follows:

- 73% of staff found the training relevant and useful
- 66% of staff now feel that support is readily available if they have a challenging call

Key feedback we received about the training:

- Engaging training
- Covered a wide spectrum of mental illness

- In-depth training and provided different insights into the different mental illnesses

Following the training, the key ways in which Call Advisors stated they would change their practice are:

- Being more understanding of mental illness
- Being more empathetic
- Understand the characteristics of mental illnesses
- Understand how I can help the patient
- Will feel less flustered, and will now know what to say when have these calls

The Call Advisors have suggested the following improvements for further training:

- What to say to suicidal and distressed patients
- Techniques for how to manage a patient in crisis or who is aggressive
- More linked to pathways
- Role play on how to manage calls

These comments suggest that the future training sessions should be more prescriptive to the Call Advisor's role in NHS 111. For future training sessions, it may be beneficial to provide training which is more practical in helping deal with challenging calls. This may be in the form of role plays, case studies and group discussions. Going forward we would like to complete another training program and develop specific guidance/ templates for managing these calls. We have already been in discussion with other training providers to develop this.

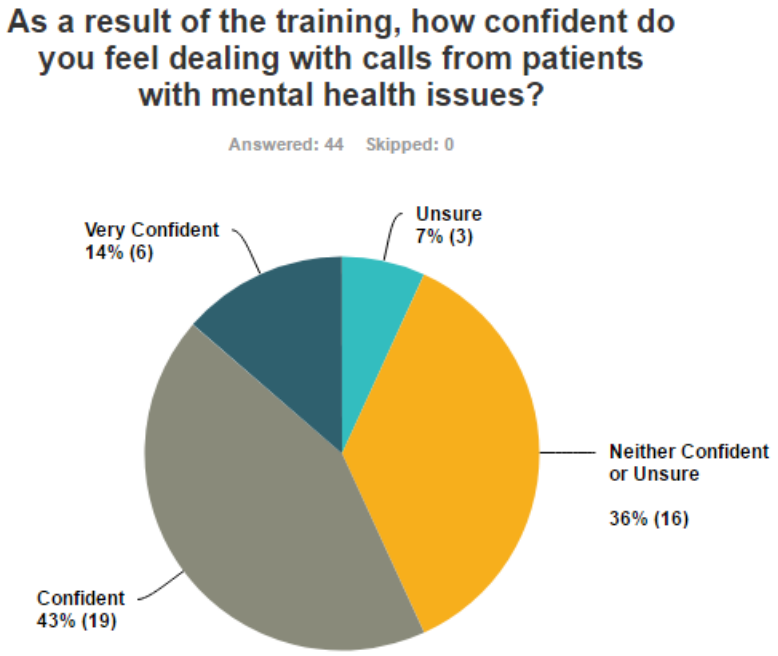

Figure 4. Showing that the majority of staff (56%) are confident dealing with calls from mental health patients.

Unfortunately, as Fig.4 shows the rates of 'Very Confident' and 'Confident' have reduced. Before training, 62% of staff felt confident managing mental health calls, and after training this is at 56%. The percentage of 'Unsure' answers has reduced by over 50%, but the 'Neither confident or unsure' answers have increased. We would have expected the overall confidence of staff to have increased following the training sessions. We feel that this difference in rates will likely be due to the smaller data sample and different modes of collecting the data. The question was asked in the same format, with the same answer choices to ensure that a comparison could be made. However, the initial questionnaires were completed on paper forms by Call Advisors on shift. The post training questionnaire was an online survey, which allowed for more anonymity. Furthermore, although we focused our post training questionnaire on the 185 staff who had completed the session, it may have been more beneficial to reduce the target audience to those who had completed the previous survey and completed the training. This could further support the need for a mental health professional to be positioned within the Clinical Assessment Service.

Clinical Advisor Questionnaire:

As part of the project, we have also explored the potential for the development of a similar programme for Clinical Advisors. We received 26 responses.

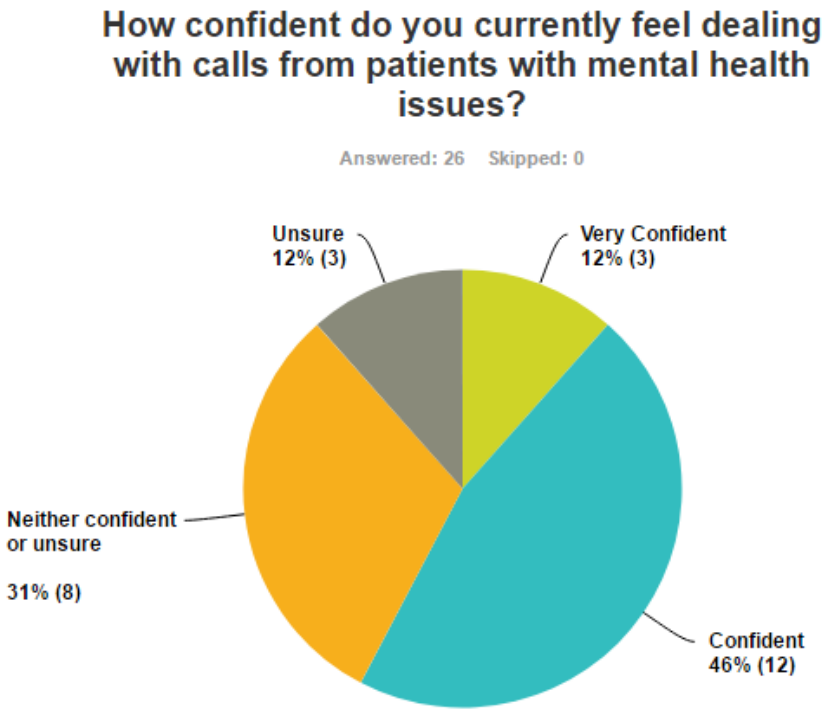

Figure 5. Clinical Advisor survey showing levels of confidence managing mental health calls.

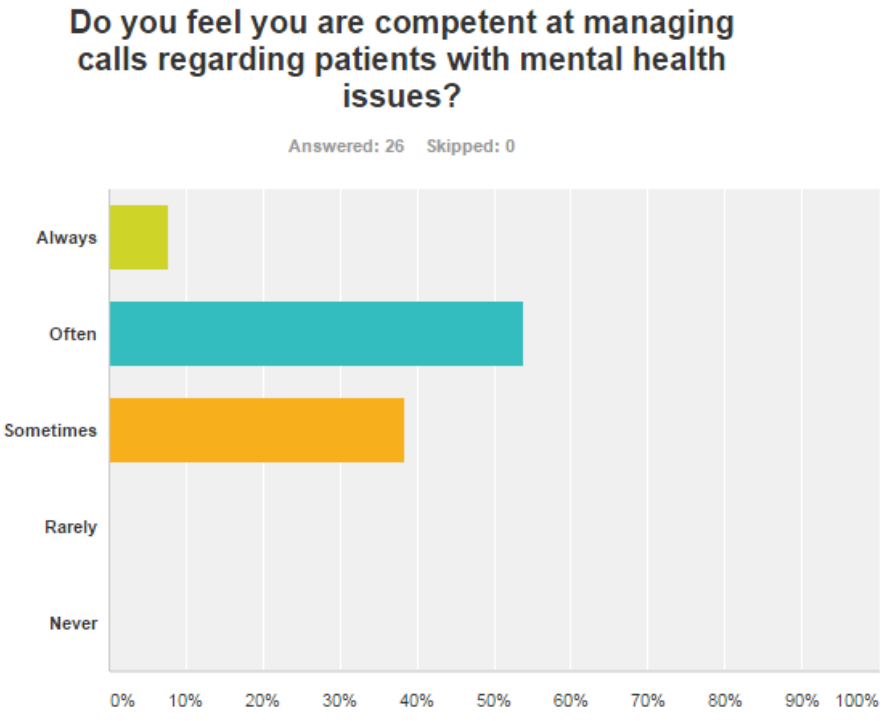

Figure 6. Clinical Advisor survey showing high levels of stated competency when managing mental health calls.

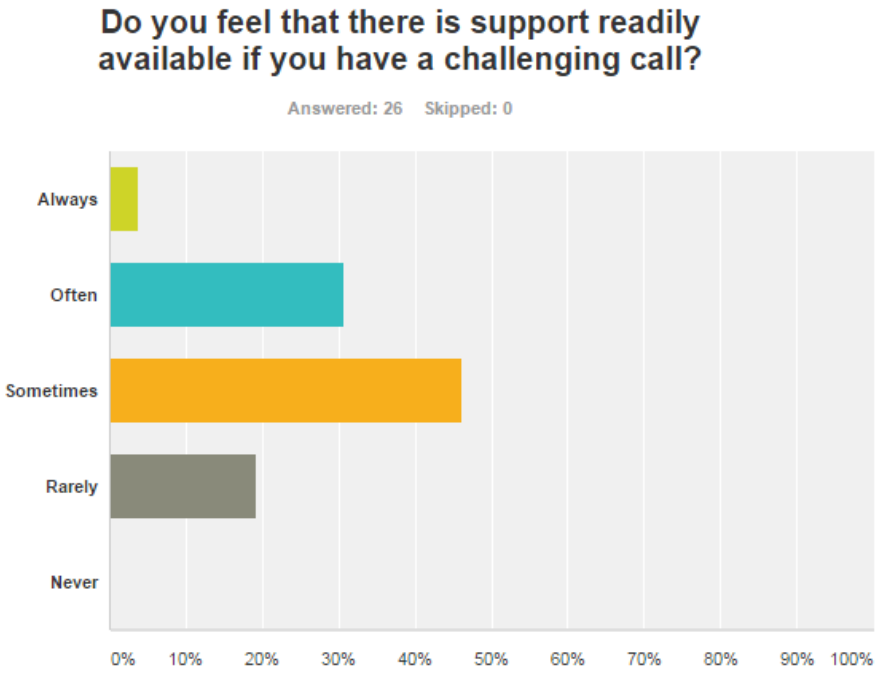

Figure 7. Clinical Advisor survey showing levels of support

Figure 7 shows that 81% of Clinical Advisors feel that support is available if they have a challenging call. However, 46% of this is within the “Sometimes” frequency bracket which we would like to improve upon.

We asked what training or support the Clinical Advisors felt they needed. We received 24 responses, and the key themes are summarised as:

- Mental health awareness training
- Specific training for better management of mental health calls
- Mental Health trained nurse on call or within the call centre
- Talking to mental health workers
- More information about mental health services in the local area

Actual outputs

We have sourced a number of useful resources about staff wellbeing and patient mental health which we have distributed across the organisation. We

also have training resources from two training providers which can be used as part of future development and support of staff.

Mental Health Awareness training was delivered to 185 Call Advisors across four NHS 111 services.

We compared the number of NHS111 calls involving a mental health problem that are managed by Call Advisors before and after the project, within each participating area.

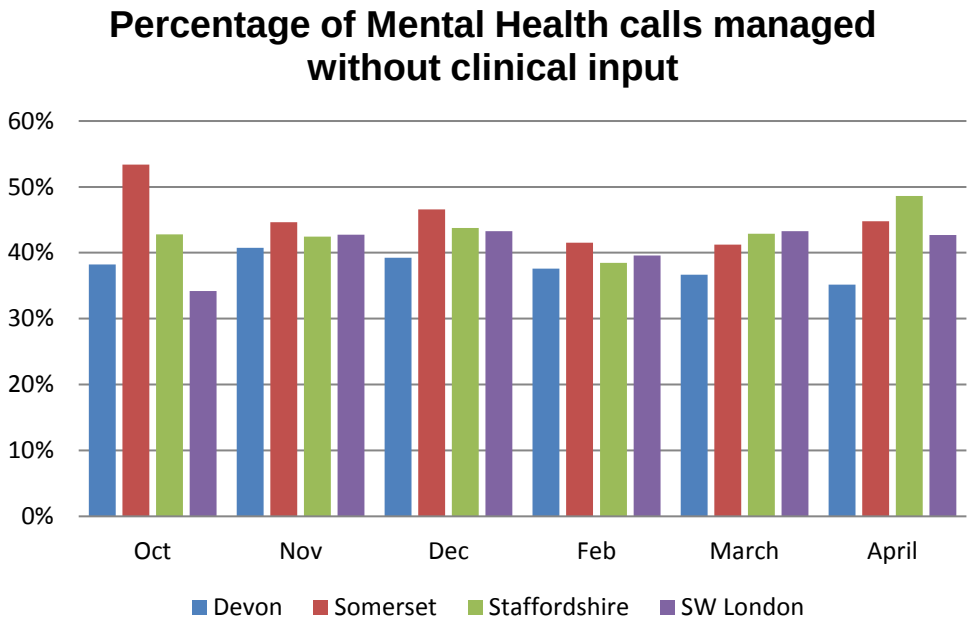

Figure 8. Showing the percentage of Mental Health calls managed by Call Advisors without clinical input

It was expected that there would be an increase in the percentage of calls managed by the Call Advisors, due to their increased confidence in taking these calls. However, as Figure 9 shows, the averages of the 3 months pre-training, and 3 months post training show that only South West London's call management numbers increased.

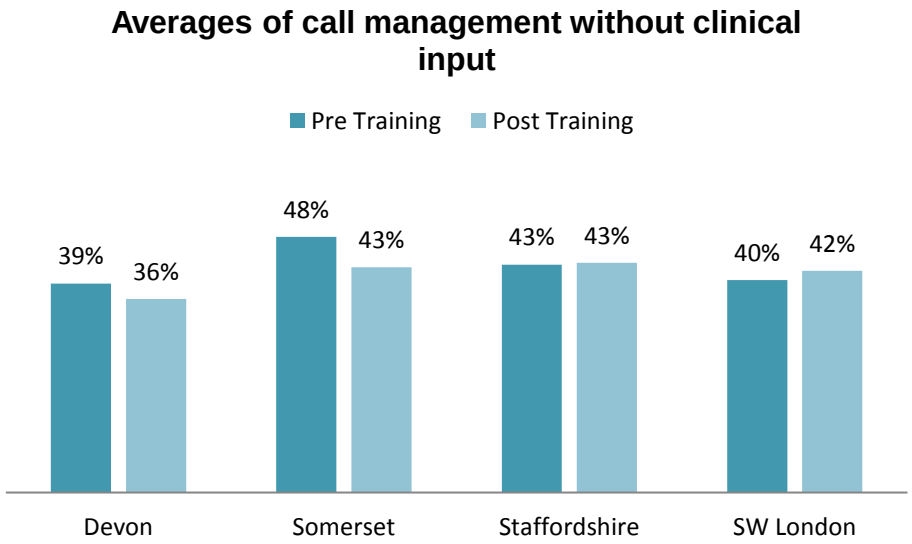

Figure 9. Showing the percentage of Mental Health calls managed by Call Advisors without clinical input. Data is an average of the 3 months pre training and 3 months post training.

We also compared the number of 111 calls involving a mental health problem that are early exited and passed to a clinician before and after the project, within each participating area. This is shown in Figure 7.

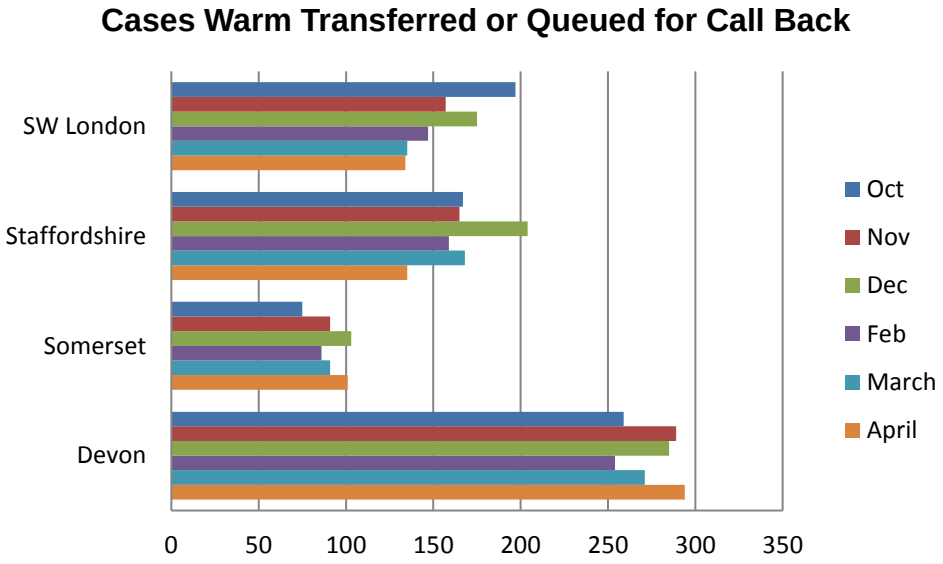

Figure 10. Showing the number of Mental Health calls transferred to a Clinical Advisor.

Our aim from the project would be for these numbers to reduce post-training. There does appear to be a reduction in Staffordshire, but it is not significant. There is a reduction in South West London, which would correlate with the

increased number of calls being manager by Call Handlers as shown in Figures 5 and 6. Further exploration of these findings is needed through continued monitoring of the data.

Finally, we measured average handling time of 111 calls managed by Call Advisors before and after the project by participating area. We aimed for the call length to reduce, due to the increased confidence and ability of the Call Handlers to manage these calls effectively.

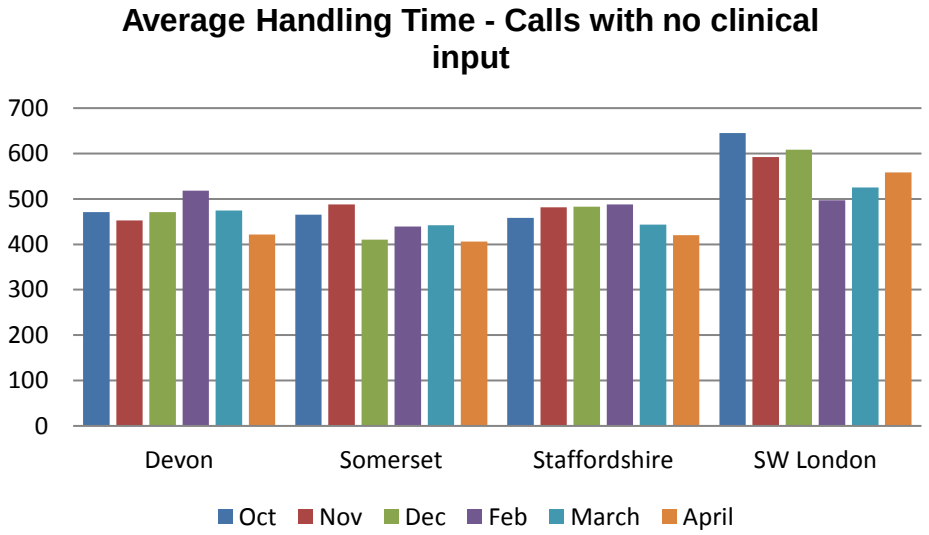

Figure 11. Showing the Average Handling Time in seconds.

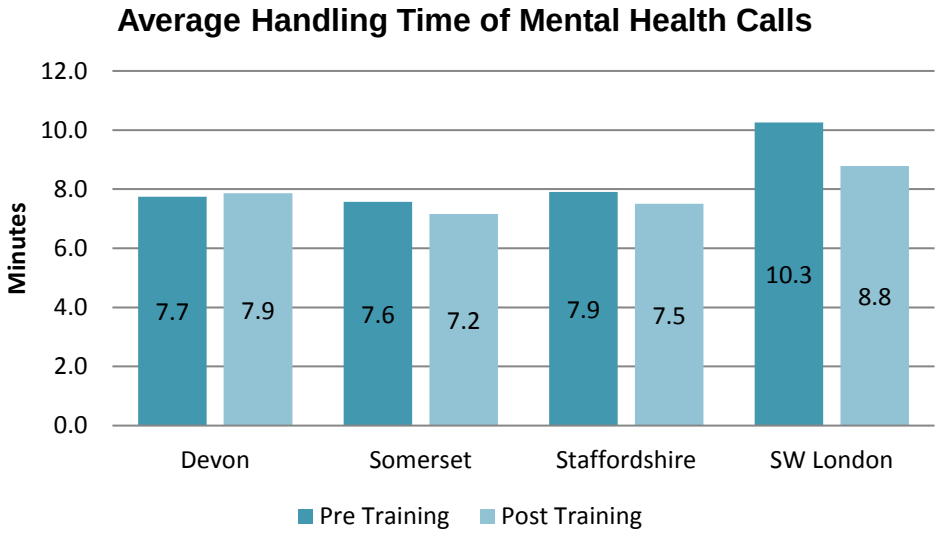

Figure 12. Showing the Average Handling Time of mental health calls managed without clinical input. Shown in minutes.

Our data illustrated that the average handling time for these calls did reduce in the 3 months post training (February, March and April) at for 3 of the services. For example, South West London's average call handling time reduced from 10 minutes and 20 seconds to 8 minutes and 46 seconds.

Lessons learned

Managing a project over five sites that are very geographically dispersed has been difficult. The sites and services that did not have a designated project Team Leader experienced delays in the project development, or had reduced numbers of participants. Therefore, the performance of the project could have been further improved by including staff from the remaining two sites in the project team. The project can be easily tailored for differently sized organisations, and the training programme could be segmented into smaller and more manageable areas.

We made an informed decision on training providers, using both the pre-training questionnaires and the experiences of our project group to help form our requirements. We had originally wanted to use MIND to provide the training, but this was not feasible within the project timeframe therefore TutorCare was selected. From the feedback received, it appears the mental health awareness training could have been more directive or prescriptive in advising how to manage mental health calls. For future development of this project, further research into how training is to be delivered, including having site visits from providers is recommended It would be worthwhile to run a pilot training session with small number of staff to ensure the training needs are met before being rolled out across the organisation.

When completing questionnaires or data samples, parameters to exclude data bias should be set. Our pre-training questionnaire was completed in paper form, and was not anonymous. We had 60 respondents. Our post-training questionnaire was on survey monkey, was anonymous and received only 44 responses. Therefore, we feel that it would have been more effective to use an online survey on both occasions, allowing for anonymity. Although we focused our post training questionnaire on the 185 staff who had completed the session, it may have been more beneficial to reduce the target audience to those who had completed the previous survey and completed the training.

Next Steps

We recognise that feedback from staff demonstrated that there is an appetite for further training which is more prescriptive in terms of the role in NHS 111.

For the future of this project, Vocare would like to establish further training for the Call Advisors which will include elements of role play, case studies and tips on “what to say”. We would also like to extend the training to Clinical Advisors, and include elements of staff wellbeing/mental health.

ReCoCo representatives visited our Newcastle site to observe staff working with the NHS 111 services. They lead discussions with a number of Call Advisors, Clinical Advisors and Team Leaders to consider what further support or training was required. ReCoCo established that the 111 staff would benefit from two separate aspects of training.

1. Training in understanding distress and increasing confidence in how to respond to distress.

This included elements of:

- understand origins of distress
- how to validate and engage with these patients
- de-escalation processes
- containment
- ending calls, including appropriate signposting

Our Clinical staff already deal effectively with calls from people in distress, but as shown through the Clinical Advisor Survey data, they would like additional training on mental health. We feel that this will:

- Acknowledge and build upon the skills they already have.
- Develop a deeper understanding of the difficulties people live with and why they might use harmful means of controlling emotions.
- Improve awareness of mental health providers
- Develop further skills and confidence in relation to ‘what to say’ in order to validate and contain a patient. Avoiding anxieties that they ‘might make it worse’.

2. For Call Advisors and Clinical Advisors - Staff Wellbeing

ReCoCo felt that given the pressure our staff work under, there should be an aspect of training that looks at wellbeing and personal responsibility in

maintaining individual and team wellbeing through the WAP (Wellness Action Plan). This would include looking at Wellness tools, early warning signs for when things may go wrong, post crisis actions and mindfulness exercises.

We have also liaised with The Point of Care Foundation to consider training a number of individuals within the organisation to deliver Schwartz Rounds. These are a forum for clinical and non-clinical staff to discuss the emotional and social aspects of working in healthcare. The purpose of the Rounds is to help staff feel more supported in their roles by allowing time for reflection and discussion. This would complement Wellbeing training by providing the environment of continued and structured support.

ReCoCo completed a training proposal for Vocare, which we were unfortunately unable to implement within the scope of this project. However, we would like to consider these two training courses for future development and support of the staff and to improve the service that we provide.

Additional Comments

The Workforce Development Team have fully embraced the challenges that this project has presented.

It has given the Team the opportunity to develop both personally and professionally. Project management skills have been developed with a thirst to further develop is evident within the team. From the data that has been analysed, it has demonstrated that additional mental health training is key to ensure the best outcome for the patient.

Recommendations will be made to extend/ add to the training offered currently. It could be suggested to be part of an extended induction programme and be delivered in stages therefore refreshing NHS111 Training further equipping clinical staff with the skills to enable to make decisions and encourage prompting questions.

Work is currently being undertaken by Vocare to review attrition rates for this group of staff. It will be interesting to monitor, following on from this training, whether increased investment in staff and clinical support with the development of progression tools have an impact upon retention rates of staff.

The development and implementation of the Schwartz rounds will be conducted as well as gaining an evaluation of the effectiveness of these. These findings will also be presented to the Executive Team.

Project 12 – Vocare – Developing a recruitment & competency framework for Pharmacists in IUC/NHS 111

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Date of Report Submission	31/05/17

Project Summary

The project aimed to develop the role of the pharmacist within an integrated urgent care setting. This would be achieved through the construction of a recruitment and competency framework intended to more accurately define and apply the work stream in the context of the wider organisational workforce.

To this end the project introduced a greater number of pharmacists into Vocare NHS 111 and GP OOHs services, supported by more robust and consistent governance practices. The aim was to measure the impact of using such a workforce and compare this against the extent data based largely on conventional clinical workforces.

The introduction of the pharmacy workforce was designed to reflect the demands of services nationally and function as a template that could be further developed and applied to the various regions in which Vocare operates IUC/NHS 111 services:

- North East (NHS 111/UCC/ GPOOH Clinical model)
- Somerset (NHS 111/GP Out Of Hours model)
- Staffordshire (NHS 111/GP Out Of Hours model)
- South West London (UCC/NHS 111/GP Out Of Hours model)
- Devon (NHS 111 model)

The project sought to develop modes of development across the following areas:

Job descriptions for pharmacists working in IUC. This included the standardisation of current job descriptions, the development of job descriptions for pharmacists working in different elements of urgent care along with corresponding job person specifications.

Recruitment and selection processes for pharmacists working in IUC, which included the development of adverts and scenario based interviews for candidates.

A competency framework for pharmacists working in IUC. This was developed to reflect the competencies required to work in various settings within an integrated urgent care service, including telephone consultations and face to face consultations.

A training programme designed to prepare pharmacists for work in IUC. This included telephone consultation skills, clinical skills, the use of PGDs and obtaining support and advice.

Governance mechanisms for continued oversight of the pharmacist workforce. This included the development of a more defined work pathway in addition to tools designed to monitor performance and quality of the work undertaken by pharmacists.

It was hoped that the introduction of a greater number of pharmacists into the IUC workforce will assist in the delivery of the requirements of the Commissioning Standards for Integrated Urgent Care (NHS England, 2015), increasing capacity within Vocare's current urgent care services to enable the workforce to meet growing patient demand and offsetting extent pressure on other work-streams, thus improving the efficacy of urgent care models employed across the organisation.

Background

The purpose of the initiative was to ultimately improve upon the way in which patients necessitating medication outcomes are processed by integrated urgent care services.

It is well recognised that NHS 111 services are expected to facilitate the right care, at the right time and in the right place. The reduction of unnecessary referrals to 999 and emergency department services is inextricably linked to the notion that patients' needs should ideally be managed within a minimum number of clinical contacts. However, in practice the NHS Pathways clinical decision support system is risk averse and as such will invariably tend towards multiple patient contacts within one episode of care as a default.

Research suggests that medication related issues constitute a group of patients who currently receive multiple contacts with urgent care services before finding remedy in a service area that serves to address their initial problem. This is one of the factors that has led to the development of Clinical Assessment Services (clinical hubs), which have the sole purpose of managing more effectively those cases necessitating the input of clinical competence beyond that already offered within services (now underpinned by commissioning standards NHS England, 2015).

Therefore it was hoped that a workforce designed to accommodate for a specific outcome demography would allow for a greater proportion of patients to be conclusively assessed, across a shorter frequency of contact intervals, without unnecessary referral to emergency services.

Vocare already had experience in the provision of Clinical Hub in its 111 services, which has included the use of pharmacists receiving calls from patients engaging with the NHS 111 service. Furthermore, the organisation has also established the role of the pharmacist within GP out of hours services.

Challenges

There were several operational/strategic issues identified prior to implementation of the project.

Perhaps the most obvious challenge presented by the project brief was mitigating a tendency within NHS 111 Pathways to produce disposition outcomes that through virtue of clinical outcome fail to reconcile with a clinical skillset that could otherwise be largely accommodated through workforce investment. It was agreed that there would likely be a net positive benefit from both the provision of a specific work stream intended to accommodate for medication outcomes.

The degree to which organisational services are compartmentalised can also act to impede the provision of quality patient care. An opportunity to install a workforce with a an ability to operate across multiple disciplines, in both NHS 111 and Urgent Care Centres systems, allows an organisation increased resource flexibility as well as importing a greater degree of interoperability between staff working across distinct services.

The convoluting effect presented by an identifiable workforce deficit on the patient journey was another key feature of the case for workforce development. It is widely accepted that the exercise of a workforce more specifically suited to meeting patient need would likely result in a reduction of patient contacts and an improvement in overall patient satisfaction. It was hoped that this expertise would also equate to a specific reduction in 999 and ED referrals, thereby fulfilling an obligation as an urgent care provider to ensure the right patient care at the right place within the right time.

Approach

The project was intended to run across five sites: Devon (London and Newcastle sites), North East, Somerset, and Staffordshire, with the evaluation data to be shared with the rest of the organization as a means of determining the trajectory of the workforce debate after the IUC project has concluded.

Vocare appointed a Pharmacy Lead who was responsible for overseeing delivery of the project terms in conjunction with a Project Administrator via development of a comprehensive project plan.
The Pharmacy Lead was also responsible for developing relationships with local CCG pharmacy leads, which was achieved by the group's commitment to communication/sharing of evaluation data after conclusion of the initiative, along with regional discussions around the use of pharmacists and to what extent this was mandated by local contractual agreements in already place.

The project utilised a group of recently recruited pharmacists, in addition to the wider pool of pharmacists operating nationally, in order to serve as an anchor on which the project aims could be measured. The Pharmacy Lead assumed responsibility for the recruitment and selection of any new pharmacists in conjunction with local teams. This was supported by the standardisation of recruitment and selection processes across Vocare in line with the job descriptions, competency frameworks and training that were developed by the project. All job descriptions, person specifications and competency frameworks were congruent with the terms dictated by early adopter sites for the Integrated Urgent Care Workforce Development programme.

The governance of the pharmacy workforce was the ongoing responsibility of the Pharmacy Lead who sought to develop mechanisms for monitoring the quality of the work undertaken by the pharmacists, including the implementation of an induction framework and supervision sessions (operated face-to-face and remotely) the undertaking of 1:1 reviews and accompanying feedback, the auditing of call consultations and the development of a self-assessment tool on which pharmacists could gauge individual strengths and weaknesses. All pharmacists working within the organisation also benefitted from indemnity cover through the Vocare group indemnity scheme.

The development of competence for consultations was achieved via reference to the clinical guidelines of relevant regulatory bodies and feedback from clinicians already working within Vocare services, ensuring that pharmacists were in receipt of both academic preparation and were able to consolidate that learning after the requisite supervision sessions.

Data relating to current calls involving a medication issue made to both NHS 111 and GP Out-Of-Hours services was analysed to identify how many pharmacist hours would be required to meet the corresponding case volume, including cases relating to medication enquiries, accidental overdoses, missed medications, health information calls, home management for minor illness, repeat medication.

Data was also gathered on a range of conditions that could be suitable for face to face consultation with a pharmacist as opposed to face to face consultation with a GP or other urgent care practitioner. This included some cases relating to allergies, constipation, coughing, cuts and grazes, diarrhoea, earache, haemorrhoids, hearing problems, insect bites and stings, skin conditions, sore throat and urinary tract infections.

The project aimed to identify which conditions justified the use of pharmacist in put with reference to individual case review/exercise of clinical competency judgement, that was informed by the induction, training and provision of a competency framework for pharmacists working within the organisation.

Collation of the data also aimed to highlight areas in the future workforce construction that could be altered in order to replace superfluous skill elements (operated by 111 clinicians and GPs) with pharmacists.

Intended outcomes

It is anticipated that the implementation of this project will have a positive impact in terms of reducing the clinical response time for patients engaging with local integrated urgent care services, in addition to broadening and expanding the current urgent care workforce.

It is also hoped that the project would convey a positive effect on the current clinical workforce as a result of the introduction of the expertise that pharmacists will import into the integrated urgent care system.

The methodology employed by the project was inherently replicable and as such presents utility in terms of the extent to which it will be applicable to other modes of workforce development.

The extent to which the aims of the project were satisfied was measured through reference to the following data sets:

- Current total number of calls to the 111 service across areas
- Number of calls involving a medication issue that were managed by 111 clinical advisors and/or by GPs before and after the project across areas
- Average handling time associated with calls involving a medication issue in 111 and GP OOHs before and after the project across areas
- Average number of patient contacts per care episode associated with calls involving a medication issue before and after the project, across areas
- Number of calls that are managed by a pharmacist before and after the project across areas
- Number of pharmacist hours supplied before and after the project across areas
- A staff satisfaction review identified concerns amongst the current clinical workforce in relation to the introduction of the pharmacist workforce.

Intended outputs

The main product to be delivered by the project was an improved workforce. This was to be evidenced in relation to the corresponding data collated from the period in which the pilot took place.

The cost savings posed by the potential use of a more cost-effective workforce, in addition to the direct service benefit derived from having candidates able to effectively support in face-to-face patient care were deemed to be hugely advantageous.

The continued development of local partnerships certainly presented an indirect benefit in terms of project satisfaction. Active discussions with local CCGs around the terms/aims of the project not only served to evidence an innovative approach in terms of the provision of workforce solutions to service issues but was also useful in terms of the likely benefit to be gained by future projects involving similar concepts.

Furthermore the experience accumulated through administration of the project by all parties concerned, which served as a template through which similar projects could be modelled meant that the project delivered a huge benefit in terms of the potential for future operational application.

The main strengths of the project could be attributed to its flexibility, in that the project structure tended to allow issues to be reported relatively quickly, and regular meetings encouraged the grass roots inculcation of ideas/feedback from various parties into the mechanism of the project plan.

More generally the project served to make the case that even in the context of service provision contingent on the award of medium term contracts, there is scope to deliver workforce innovation via new modes of investment in order to ensure quality effective patient care.

Details of resources and any potential partnership

Pharmacist	Pharmacy Lead	This person will be selected on the basis of their already working at an advanced level of practice as a clinical pharmacist.	0.5 FTE
Workforce Development	Project Sponsor	Registered nurse with extensive experience of	0.2 FTE

	Programme Manager		urgent care. Organisationally responsible for workforce development and in particular workforce development in relation to integrated urgent care.	
	Project Administrator	Admin Support	This was a key role in supporting the Pharmacy Lead and Project Manager to develop plans, implement the project, arrange meetings and liaise with other parties.	1 FTE
	Head of Recruitment	Project Support	HR professional with experience in recruitment, staff engagement and staff development across a range of sectors.	0.1 FTE
	Clinical Support Manager	Project Support	Registered nurse with extensive experience of delivery of 111 service and clinical responsibility for GO OOHs and 111 – North East.	0.1 FTE
	Clinical Support Manager	Project Support	Registered paramedic with extensive experience of delivery of 111 service and clinical responsibility for 111 service – Devon and Somerset.	0.1 FTE
	Clinical Support Manager	Project Support	Registered paramedic with extensive experience of delivery of 111 service and clinical responsibility	0.1 FTE

		for 111 service – Staffordshire.	
Information Analyst	Information Management	This was a key role in terms of developing the questionnaires and datasets required to support the evaluation.	0.1 FTE
Miscellaneous Costs	Miscellaneous Costs	Including project travel/accommodation expenses	n/a

Obstacles and issues

Delivery of the project presented several key challenges.

The first issue encountered concerned the recruitment of pharmacists on which data for the initiative could be based. In order to satisfy the training requirements set out in the project aims it was necessary to liaise closely with individual regions in which pharmacists were recruited. However, there were multiple issues orientated around the recruitment of certain candidates, which caused delays in terms of the project being able to facilitate training/supervision and sufficient data on which to demonstrate the impact of the project. The delays were largely due to local rota concerns and frustrations in terms of budgetary allocation for the pharmacist work group. The issue was highlighted as a risk in line with the methodology dictating the administration of the project and eventually resolved through ongoing communication, discussion around the consequences of further delays.

There were inevitable pressures experienced between local regional agendas and those involved in delivery of the project, including issues around the extent to which the use of pharmacists within local services reconciled with regional contractual commitments. This was circumvented insofar as was possible with regular meetings with regions, in which these sorts of issues could be highlighted and remedies discussed (including raising the potential for these contractual considerations to be reviewed). Despite administration of pharmacist recruitment necessitating close regional involvement, the project still identified

several issues concerning the expedient the allocation of shifts to pharmacists that could have been resolved sooner by a focus on increased regional engagement from the outset.

Establishing a uniform level of training also presented a challenge, in that each nurse had a variety of different experience that needed to be reconciled with a group standard. By using the group training matrix the project coordinator was able to ensure mandatory training modules were delivered using online resources.

Actual outcomes

The evaluation data seems to indicate that the project was successful in meeting some of the project aims.

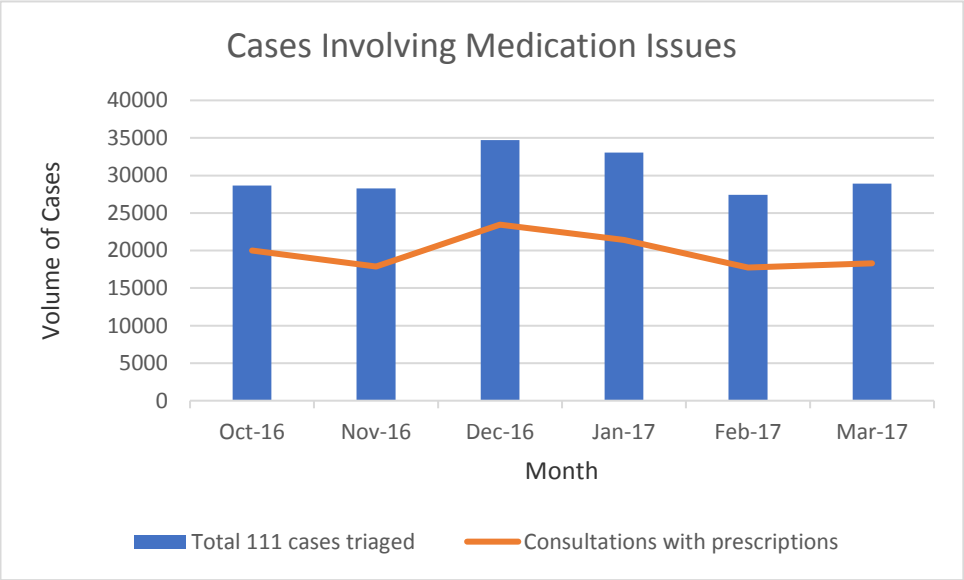

Figure 1

Data collated relating to the total number of calls received by each area is roughly congruent with the number of consultations equating to an outcome necessitating a prescription. Upon a review based upon a random sample of common presentations from a specific service area, it was expected that the proportion of cases able to be assessed by a pharmacist would equate to approximately two thirds of the overall volume of cases (see Figure 2).

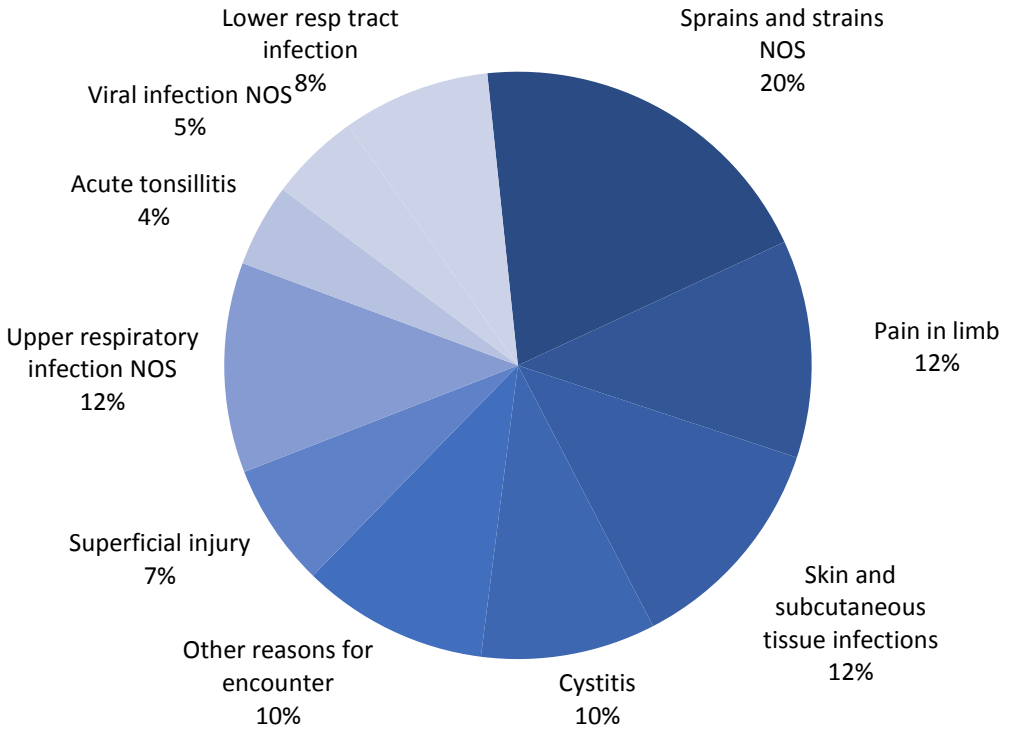

Figure 2

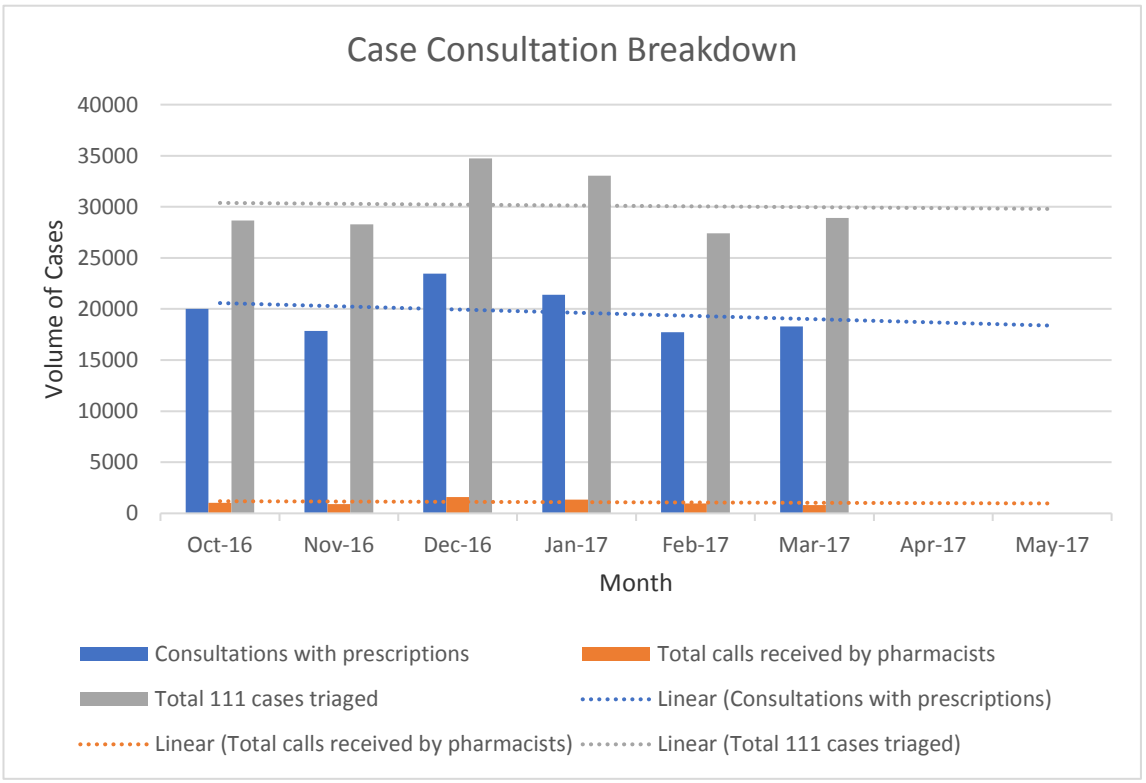

Figure 3

On further examination, although there seems to be some proportional correlation between the volume of cases that could be assessed by a

pharmacist and the volume of cases actually assessed by a pharmacist, there is a clear discrepancy between the two values. This is perhaps an indictment of the application of individual competencies exercised by each pharmacist when selecting cases to triage, but also accounts for the small proportion of pharmacists operating within each area when compared with the clinical workforce as a whole and the degree to which each pharmacist had access to different types of patient (those presenting in either the context of telephone advice or face-to-face).

The figures do suggest that although there is a seasonal downward trend in terms of the volume of cases and those capable of being assessed by a pharmacist, the number of calls actually assessed by a pharmacist remained fairly consistent. When interpreting the figures in relation to one another, it is perhaps indicative of a positive trend in terms of pharmacists being able to assess a greater number of cases, a factor made all the more overt when accounting for a general decrease in the number of pharmacy hours utilised across the organisation (highlighted in Figure 4).

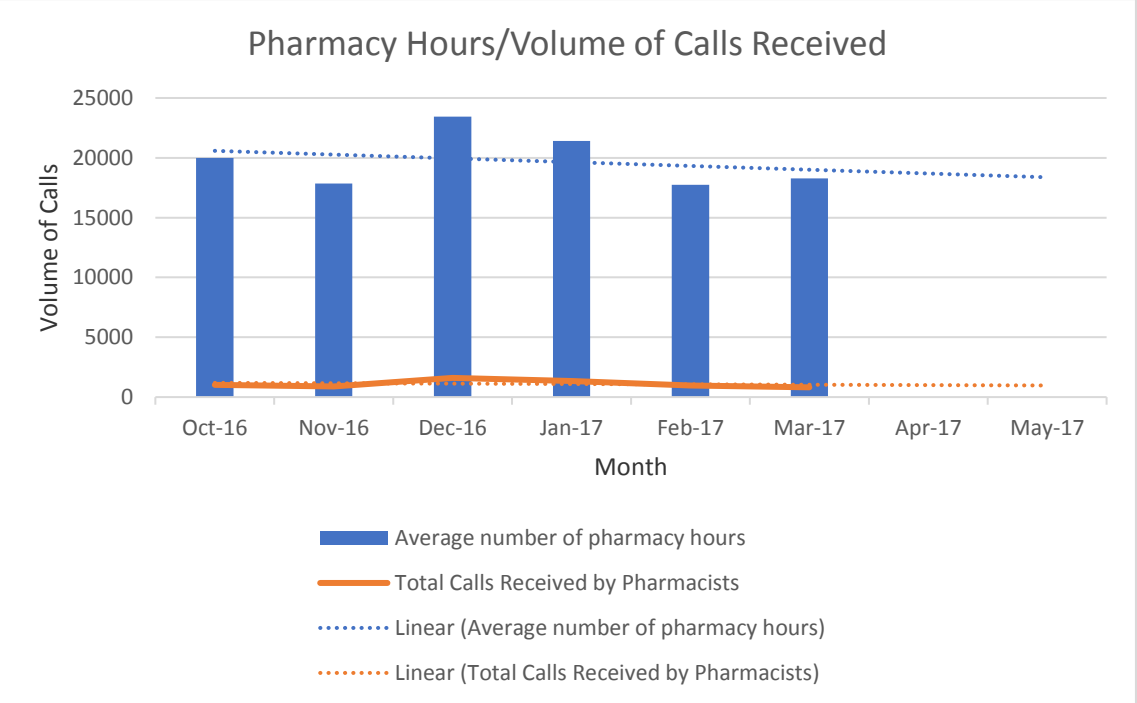

Figure 4

The reduction of overall pharmacy hours is not representative of a lack of appetite within the organisation for the use of pharmacists, but rather indicative of service demand/rota capacity over the same period.

Data relating to AHT and average number of patient contacts was less conclusive. Figures showed no positive trend in terms of a reduction of AHT and the number of patient contacts. The figures were roughly proportional to seasonal influx of patient volume – more cases over a month generally equated to an increased AHT and overall patient exposure to the NHS 111 service. However, the lengthy of the project was probably not sufficient to accurately measure the impact of pharmacist assessment, as the seasonal fluctuation was not absorbed by the length of time used for the purposes of evaluation.

Finally, the biggest clinical concern identified around the use of pharmacists within integrated urgent care settings related to the impact of service quality provided to patients. There was significant reluctance on behalf on certain CCGs and regional clinical leads to accept that the obvious cost saving presented by the initiative would not have a detrimental effect on overall patient safety. Although discussions around the subject are ongoing, in part informed by data relating to this project, the use of call auditing remains the strongest way in which the benefits of the pilot can be advocated.

The competency areas subject to review via call auditing are as follows:

- effective call control
- skilled questioning
- active listening
- skilled provision of information & advice
- effective communication
- practices according to designated role requirements
- skilled use of pathways functionality
- delivers a safe and effective outcome for the patient.

Thus the criteria are an apt means by which the project could establish the indirect impact on quality of patient experience and another factor influencing the likelihood of multiple patient contacts

Call audit data relating to a specific sample of pharmacists based in Staffordshire showcased a positive trend across all categories subject to audit.

Actual outputs

The outputs delivered by the project were:

- A workforce more reflective of patient need. This was evidenced through the firm correlation between the relative consistency of cases assessed

by a pharmacist compared to fluctuating call volumes and a general decrease in pharmacy hours across the period observed in the pilot. This makes the case for the continued use of pharmacists in the urgent care setting.

- The potential to institute similar initiatives that will improve patient care and overall satisfaction.
- The utilisation of resource made available through the application of the pharmacist workstream also served to impact the overall efficacy of the clinical workforce in a positive fashion – feedback from GPs and nurses in corresponding areas indicated that they felt more able to assess patients not in need of medication.
- The organisational cost benefit observed through the application of a more cost-effective workforce model.
- The potential to incorporate this workforce practice into commercial bids in order to evidence both staff investment and quality of workforce – ultimately making the organisation more competitive.

Lessons learned

Feedback received from pharmacists through meetings held throughout the pilot programme suggest that communication practice could have been improved. In retrospect, given that the candidates originated from a variety of different services from around the country, this might have been achieved through the nomination of regional points of contact to ensure that communication practice remained as robust as possible throughout the duration of the programme.

The erosive effect of day-to-day service pressures, including the provision of specific training shifts for new pharmacists, might have been better mitigated through a discussion around specific response KPIs, or more generally increasing the number of facets through which pharmacists could choose to engage. KPIs for internal staff communication, as they related to the delivery of the project terms, would also have presented a benefit. It was too often the case that delays were incurred a result of a comparatively low programme profile in the context of more pressing local service concerns. Furthermore, some of the regional issues might have been more readily averted by incorporation of local agendas into the project plans if only to encourage a positive discourse around troubleshooting the issues.

Another constructive criticism drawn from the evaluation data was the time spent around management of pharmacist expectation regarding the induction process. Although the pharmacists agreed the induction process satisfied the relevant learning criteria, it was clear that they were not kept sufficiently informed as to the timeframes for allocation of shifts, nor kept apprised of any delays effecting the project.

Finally, on revision of all aspects of project delivery, it is fair to say that the programme would have undoubtedly benefitted from incepting the idea of ongoing evaluation into the project mentality from commencement. The use of specific control groups might have served to help extract more definite themes from some data and the typical weighting of evaluation towards the chronological end of a project is unhelpful, in that it precludes the possibility that such data could be used to inform and direct the project during the lifetime of delivery.

Next Steps

The next steps for the project would be to ensure the pharmacy framework is further developed in order to satisfy the organisation's long terms ends, involving the use of pharmacists in all facets of clinical service delivery that convey a benefit in terms of cost and workforce efficiency.

Developing the framework in order to have pharmacists working in a multi-disciplinary capacity; triaging and seeing patients face-to-face, also serves to inform current group discussion about how best to move forward with the work stream.

The data drawn from the project is part of a portfolio of evidence supporting the appetite for further investment into workforce related projects across the spectrum and serves to inform the wider policy debate.

Moreover the delivery practice fostered by implementation of the project has also been used as a template, through which the group hopes future projects will find success.

Additional Comments
As an organisation, Vocare has relished the support and practical tools offered by NHS England and the Workforce Investment Fund. The organisation looks forward to the opportunity to continue to develop workforce best practice in line with the national Integrated Urgent Care Workforce Programme agenda.

Project 13 – YAS – Creating a supporting and developmental audit culture

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Project Summary

The Quality Audit feedback project falls under the Workforce Governance and Oversight theme.

The contract for the regional Yorkshire and Humber (Y&H) NHS 111 service region covers a population of approximately 5.2 million. Monthly call volumes average around 125,000 with peak winter volumes of between 140,000 - 150,000. We received 1,570, 254 calls during 2016/17. The service operates from 2 calls centres, Wakefield (24 hour call centre) and Rotherham. Current staffing levels are 360 (heads) call handlers and 107(heads) clinicians as substantive staff which is supplemented by agency staff for both skill groups.

Within the terms of the contract held with commissioners the Y&H NHS 111 service are required to audit each member of staff at least once a month, with the more stringent NHS Pathways licence audit requirements (which vary depending on the length of service / number of calls handled by the staff member)a further consideration. In addition to these requirements the importance of the audits as a tool to measure service quality and to aid individual and service development are recognised within the service.

Feedback from staff however, through aspects including comments made during the Care Quality Commission (CQC) inspection in October 2016, was that audits were not always considered positively and that feedback was more likely for negative reasons, therefore displaying the process as more punitive

than recognising quality and encouraging staff development. Comments made included:

- ‘Luckily I’ve not been on an action plan’;
- ‘You only get feedback when you have done something wrong’.

The project was aimed at creating a supportive and developmental audit culture. The project very much focused on working with staff and their ideas to change the culture of our audit process, recognising their role in supporting patients and the wider health system. Key considerations are:

- How the culture that currently exists within the call centres, around how people view call audits, can be positively affected?
- How to help improve staff understanding, improve confidence and more effectively foster a supportive environment?

Background

Following feedback received during the Y&H NHS 111 CQC inspection, the national NHS 111 Provider survey and local service intelligence gathered through a survey by Unite amongst others, it was recognised that the current approaches, and indeed recognising staff contribution, was inconsistent.

The Y&H NHS 111 service have previously undertaken workforce investment pilots linked to staff training and the value and benefits to staff of being able to complete full patient pathway results, and have successfully demonstrated the value of a change in approach. Similarly this project allows for a review of the current audit process and how this can be managed in a more inclusive way in order to foster on-going staff development.

Whilst call audits have always been undertaken there has always been a significant challenge in meeting the required numbers, ensuring that all staff member audits were completed together and that any trends could be easily identified. In recognition of this an interim role of Audit co-ordinator was introduced into the service and which whilst it helped to influence the overall number of audit, did not address the other issues referenced.

Due to the legacy issues of audits, and the technical challenges of identifying calls for review it has been recognised that a large proportion of calls audited were completed as a consequence of a patient complaint or Healthcare

Provider feedback. Therefore these calls are considered to be more likely to identify a disproportionate range of errors than other calls. This would also associate with staff comments that audits were more likely to be negative. The project therefore provided an opportunity to adjust the audit processes, increase people's awareness around audits and subsequently identify service wide development needs. A key aim of the project was also to increase the level of audits completed and to incorporate a wider method of identifying calls for review and to make this operationally more viable.

Through this greater recognition of the audit process and change of focus it is envisaged that audits will be seen more positively and thus deliver a step change in perception amongst staff with audits seen positively as a development tool.

Challenges

Operational challenges linked with audits have historically linked to:

- The resources required to audit calls recognising the total levels required have not always been met
- A lack of a holistic overview of call audits completed on staff members by other staff members, therefore creating a knowledge gap for Team Leaders about their staff members
- Lack of additional resource within the centres to support call audits and thus help to deliver the required volume of audits
- Release of staff, within their working schedule, to complete a self-audit

In addition to these a further factor is the perception of staff, as referenced above, around audits and therefore representing a challenge given the cultural shift being sought across the service

Approach

The project sought to address these challenges by recognising the need to allocate additional resources to the project. These included a project support officer, project manager together with releasing 4 FTE of Call Handlers each month on a rotational basis to supplement the audit pool. Therefore through this there was a significant increase in the available resources.

The idea of a rotational audit team was supported as an output from workshops held with staff to gather their ideas and views and a survey was also undertaken across staff to gather further intelligence. The audit team subsequently commenced from the 3rd April 2017.

The workshops held in Wakefield and Rotherham Call Centres, to gain feedback and ideas with small groups of staff. These were for 1 hour at a time. A staff survey was issued to all staff to capture feedback and ideas.

In recognition of service, and patient demands, it was agreed that time off of the phone would be scheduled for rotational staff although they may need to support front end duties if overall service performance was challenged or if a significant demand surge was seen. This replicates other steps within the service about maximising front end resource where needed as part of an agreed surge and escalation process.

To ensure that staff were able to effectively audit calls specific coaching was provided via an NHS Pathways coaching course, which was delivered through internal resource within YAS.

Actions around developing a more positive culture of audits were addressed through the workshops as described together with engaging with staff around changes to the self-audit process and the benefits that this would provide. This included aspects such as enabling Team Leaders to randomly select call to be audited both by the TL and forward to a staff member for them to review, and then discussed with the staff member in their one-to-one.

The project also occurred within the same time as the Support and Appraisal pilot and which dedicated specific time to Team Leaders to complete PDRs, one-to-ones and audits and therefore some benefits from this will have impacted on the audit project.

Technical challenges were addressed through internal development of the Call Audit reporting system (held on Sharepoint) to facilitate improved access and oversight.

Intended outcomes

The project is aimed at creating a supportive audit culture. With this in mind the objectives were to consider:

- How the culture that currently exists within the call centres, around how people view call audits, can be positively affected?
- How to help improve staff understanding, improve confidence and more effectively foster a supportive environment?

Through these activities the key benefits expected would be to improve the staff perception of audits, measured through staff feedback, and therefore aid and support personal development. This will be measured by workshops and a staff survey as was undertaken at the start of the project where the staff members will be able to give their opinion on how they have found the process and what they feel now the project has been running for 3 months.

The benefits of the technical developments to the Team Leaders would be improved awareness of audits that are being completed for their staff. This will be measured within the workshops and also by examining the Team Leader dashboards which detail the volume of audits each month.

Outcomes will be assessed through:

- The quality of calls and therefore quality of service to our callers will be measured by looking at audit scores once changes have been made to see if they have improved.
- The number of audits undertaken will increase which in turn will reassure our commissioners that we are able to deliver a quality service and will mean that we are able to meet the NHS Pathways licence requirements.

The project meets the national Integrated Urgent Care Workforce Programme as this is about supporting on-going staff development.

Intended outputs

The project is expected to deliver an alternate audit framework and process, and through this to evaluate the broader impact across the service and staff. This can then be reviewed for incorporation into the service.

The main strength of the project is that specific resources have been allocated, with dedicated training given to help support staff. Through this number of staff has increased and therefore provided the broader pool able to audit a call.

Innovative aspects of the programme are felt to be the rotational aspect of the team, thereby ensuring that they remain as a Call Handler and in touch with the reality and challenge of the role This differs to the approach of other NHS 111 providers, confirmed during benchmarking visits, where permanent audit teams are used.

Details of resources and any potential partnership

Resource requirements:

- Project Manager
- Project Support
- Audit Coordinator
- Practice Developer
- Head of Quality Assurance
- 4fte Call Handlers for rotational audit team
- BI Analyst
- IT Web Developer

Obstacles and issues

Allocation of coaches to support audits – this was mitigated by holding an in house NHS Pathways coaching course and therefore enable 5 people to be trained with additional courses undertaken to support further roll-out. This should ensure an adequate supply of coaches to support new staff as part of a buddying system that has been implemented.

Staff rotas - given that the project involved a new approach it was difficult to understand potential rota implications. This was mitigated for the project by agreeing flexibility in advance

Release of staff -To enable the release of staff within the timescales required we worked closely with workforce to look at when most staff could be released and put out requests for people to attend the workshops on overtime.

Technical system developments – the in-house Sharepoint system was developed to provide additional functionality and thereby more effectively support understanding of audits

Actual outcomes

Staff feedback gathered throughout the project has demonstrated that members feel more supported, valued and more positive about their own practice. Staff have increased knowledge on the audit process and are not surprised by the amount of audits undertaken on them. Additional staff feedback has included that the feedback given to them, particularly face-to-face, especially by the auditor direct has helped them to view their calls differently and will aid development moving forward. This was measured by workshops and a staff survey.

Whilst the period of the project is too short to fully provide a definitive answer it has already supported an increase in the overall number of audits with a 50% increase in April 17 as compared to the previous month – this will need to be monitored moving forward.

Testing an alternate model - The self-audit process changed so now the Team Leader will pick a call, will audit the call and provide the details of the same call to their team member to audit which is then to be discussed in their next 1-2-1; allowing a mini-audit- levelling session to take place.

Staff perception / view of audits - The call handlers have felt this process is really useful and feel it is of value. They are able to take something from the self-audit as they are not picking the call themselves. They also like discussing and comparing with the Team Leader

Technical Developments - Changes made to the Sharepoint system to enable us to report more effectively on the audits that have been completed. We can target a specific type of call to be audited and can provide detailed information regarding the audits completed. The Team Leaders now receive an email when a member of their team has received an audit. This allows the team leader to know who has had audits that month and be able to complete the required amount of audits per team member.

They also can give full detailed feedback to the call handler if the auditor isn't able to do this. It also helps the team leader to establish if their team members require any additional training or development needs.

Actual outputs

The awareness of the auditing process and reasons around audit are now more widely known. The training package used within the service has also been changed to encompass more about the audit process and reasons for it.

The recruitment and implementation of a rotational audit team, this has worked extremely well from every aspect.

The feedback from staff about the rotational audit team has been very positive. The call handlers feel very comfortable receiving feedback from their peers, it is less daunting and they respect the audits more as the auditor also take calls. They are getting used to being taken offline and given feedback face-to-face and as soon as possible after the audits have been completed. Therefore supporting the continuation of the model on an on-going basis.

As a consequence of the pilot training materials have been revised for use in our induction training to give more details on the audit process and why we audit. Training materials have been developed that will be used in weeks 5 and 6 of training when staff are first out in the call centre being supported by trainers. This session will introduce the audit tool and how an audit is carried out. This session will also include letting staff know that auditing of calls will now be starting and to expect to receive feedback and to re-iterate the reasons of why audit is done to make staff feel more positive about the process. In Return to Learn (in week 9 or 10), the plan is to introduce audit levelling into the training which will help to re-iterate the audit process, helps with consistency of audit whether this be self-audit or being part of the audit team.

An overall cost analysis was not completed during the course of the project although indicative costs are that to maintain the rotational audit team would cost approximately £100,000 across a 12 month period. Given the short time window of assessment a broader review would be necessary and therefore it will be recommended that the project window be extended to allow for a deeper analysis. This recommendation will be made via the service Operational Management Group, although additional investment would be required on an on-going basis. It is considered unlikely that a broader review will demonstrate evidence that such an investment would directly create

service efficiencies although it is felt that more of a commitment to staff through this process may positively impact on quality referrals for patients and general well- being of staff feeling more valued.

Lessons learned

Key lessons from this project have been the change in staff perception, seen to date over audits, and the value derived from the improved technical developments in identifying calls for review. This has supported more self and Team Leader audits and thus enabled more engagement over audits and the reduction in variance in assessment process. Staff feedback around this has been positive and whilst it has to be acknowledged that the project period was short, and coincided with an additional project to improve support, it did demonstrate positive steps.

The overall technical developments have supported operational managers but also members of the wider Operational Management Group has it has provided a more holistic overview of audits and themes to support continuous development of the service.

Next Steps

Interim findings of the project have been shared with key stakeholders (staff side and commissioners) and are due to be presented to the service Operational Management group.

Given the short time frame of the pilot the full staff survey has not been fully analysed and therefore a comprehensive review needs to be undertaken. Interim findings suggest that there have been improvements with access although additional suggestions have been made around how the audit team resource could extend access into the overnight period so that the benefit is felt across the full service. A snapshot of the May survey results are included in Appendix 4.

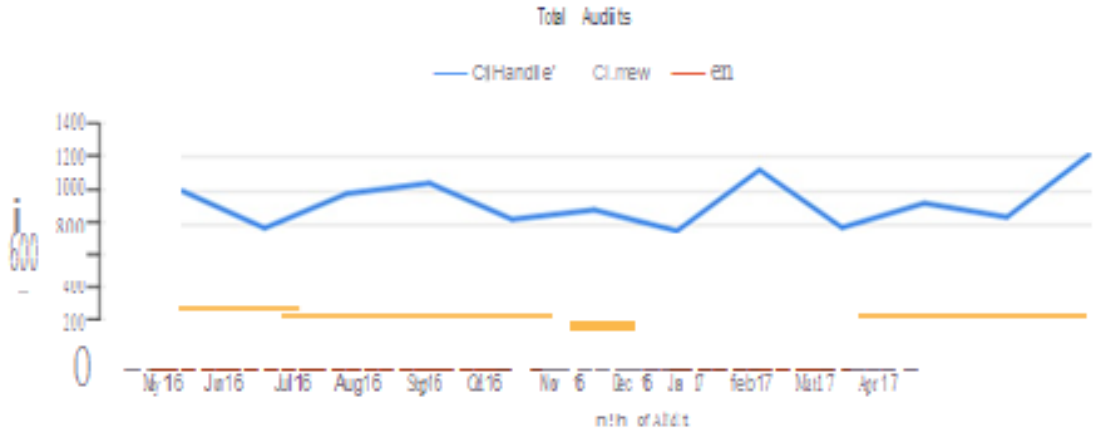
Due to the timescales of the projects and due date of the final report, the survey and workshops have had to be issued and completed earlier than would otherwise have been the case. Therefore a broader analysis would be required to demonstrate the wider benefits and the initial staff comments remain in line with those gathered and referred to in this report.

Appendix 1 – Call Audit Figures

Yorkshire Ambulance Service

April Audit Figures

	Apr 17					Mar 17				
	Self	TL	Trainer	Other	Total	Self	Trainer	TL	Other	Total
call Handler	215	258	123	625	1221	222	84	321	219	846
Clinician	45	65	30	88	228	65	2	101	71	239
		2			2			11		11
Total	260	325	153	713	1451	287	86	433	290	1096



Appendix 2 Quality Audit feedback Workshop (Pilot team) 2nd May

All the people in the group understood what audit was, and why we do it and felt that over the past few months that the understanding had grew in particular in relation to having the new audit team and the new self-audit team.

Feedback included:

- The group said they all feel really positive about the audit team.
- Felt that previously could get in a rut and didn't feel they got much in the way of feedback if any.
- I haven't had feedback on an audit for a long time, only brushed over in my previous 121's, now I am getting feedback on all my audits and feel better about the process.
- I have received feedback from 2 audits in the past month, really good experience, the people who gave the feedback had a good manner, it was good to get good feedback and has helped me to feel better about my calls. I have then had my 121 and received feedback using the new self audit process. This was also a really good experience as found out that I have been marking myself harshly and was able to do a mini audit levelling which has been useful
- All the group had had experience of the new team rotational audit team, all felt it was a positive experience.
- Receiving good feedback is good
- Getting feedback from the audit team feels more informal and has taken some of the fear out of it. Not worried about getting feedback now.
- All the group were happy receiving feedback from call handlers, felt this is more credible as team leaders don't taken calls very often if at all
- The group said they felt like they have learnt from the new audit team and self- audit process.

All the group have put their names forward for the coaching course, felt that this was good development and gave an opportunity to support new staff and to apply to be on the audit team. They saw this as a positive.

Appendix 3 - Evaluation of staff survey regarding audit (pre-project)

Facts and figures

- 89.25% of staff said they know how often they should be audited (83 people)
- 10.75% of staff (10 people) said they did not know how often they should be audit
- 97.87% of staff said they know why we audit (92 people)
- 2.13% of people said they do not know why we do audits (2 people)
- Most staff said that being audited leaves them feeling 'neither positive or negative'
- 53.36% of staff said they do regularly receive feedback regarding an audit (49 people)
- 46.74% of staff said they do not regularly receive feedback on audits (43 people)
- 52.17% of staff said they do not receive feedback for a passed audit (48 people)
- 47.83% of staff said they do receive feedback for a passed audit (44 people)
- 76.34% of staff said that they have completed a self-audit within the last month
    - (71 people)
- 23.66% said they have not completed a self-audit within the last month (22 people)
- 61.54% of people had an audit done by their TL within the last month (56 people)
- 38.46% of people had not had an audit done by their TL in the last month (35 people)
- 39.13% of people had an audit completed by someone else in the last month
    - (36 people)
- 60.87% of people had not had an audit completed by anyone else in the last month (56 people) – that they are aware of

Staff Comments on how to improve how we audit

- To have feedback on every call
- When asking to refer to SOPs, write it don't so we can find it
- There needs to be a designated team to do audits

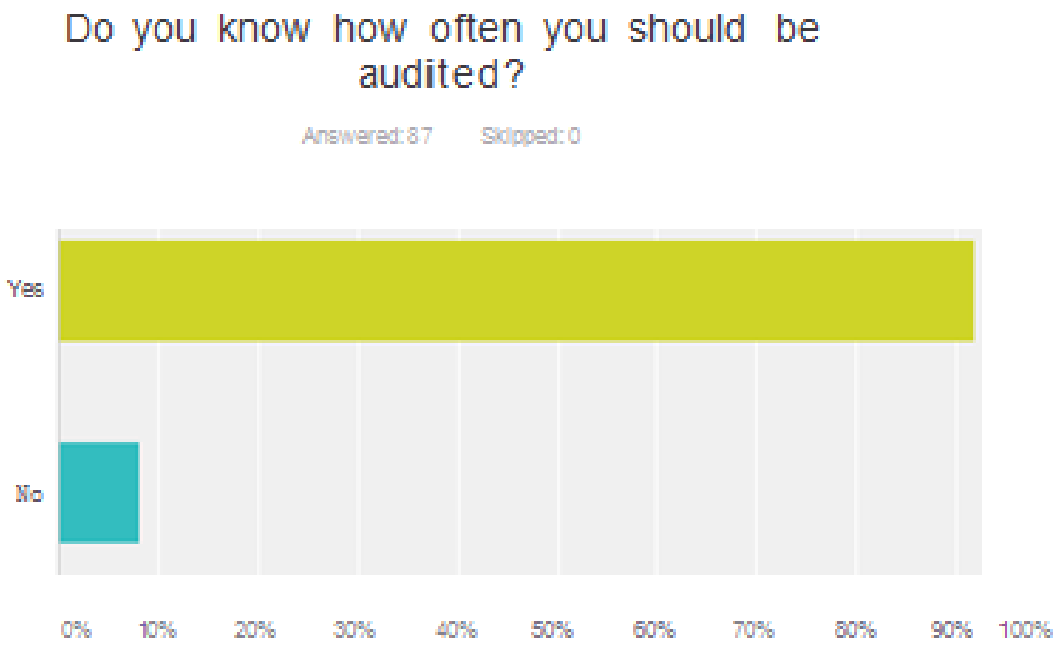
- More positive feedback to be given – not just negative
- To gain feedback for passed audits as well as fails
- Auditors need to understand what warrants a full/partial/not achieved
- There should be an audit team
- Would be good to be able to pause the call we are listening too
- Have set people to do audits
- Most people will only select a high scoring call to audit themselves
- Let other call handlers do remote audits on other call handlers
- Having an audit team so there are familiar faces that staff can send email to and get regular feedback.
- Team leaders don't take calls so how can this be fair for them to give any
- Feedback on how we do our jobs
- We need to receive more feedback
- Ensure 1:1's are carried out more regularly
- Reviewing audits would dispel the fear of audit and the negative feeling towards them
- Self-audits to be carried out in a quieter place
- It seems that call audits are a low priority when they are in fact an important factor for CH development
- I think upper management do not take audits seriously
- Time and dates should be given to do a self-audit rather than having to ask to do it
- People just self-audit a good call
- Consider getting peers to audit staff
- I don't know if an audit has been completed by anyone but myself
- Include peer audits
- Have an expert review team, both clinical and non-clinical
- I think we need a better understand of the reasons behind auditing
- Service level takes priority over audits and they are often cancelled and re arranged
- Feedback on positive calls. There is more focus on negative call audits
- Face to face feedback
- Call handlers should not receive an email regarding sections to improve
- My call was audited by two different people with two completely different
    - scores, it's not fair and ruined my entire shift
- On a self-audit you should be given a call to audit, not choose one yourself as most people self-audit following a good call.
- Staff need to understand the supporting evidence for auditing
- More emphasis on good practice
- Peer auditing would be interesting

- Only seem to get negative feedback which makes confidence drop
- It would be nice to receive more feedback from TLs
- More feedback, positive and negative
- We should be allocated time off the phones to do our self-audit
- It should be feedback in a 1:1 to maintain confidence in CHs
- Make audits more frequent
- Receive feedback for passed and failed audits
- Good feedback would be appreciated as well as room for improvements
- Self-audits are not an accurate way of monitoring as everyone just picks a call where they know they will score highly
- Peer audits would be a better way of learning
- Would be nice to receive positive feedback as well as negative. If Alex could do that personally face to face this would be nice
- Continuous feedback needed

Themes and trends from the staff survey

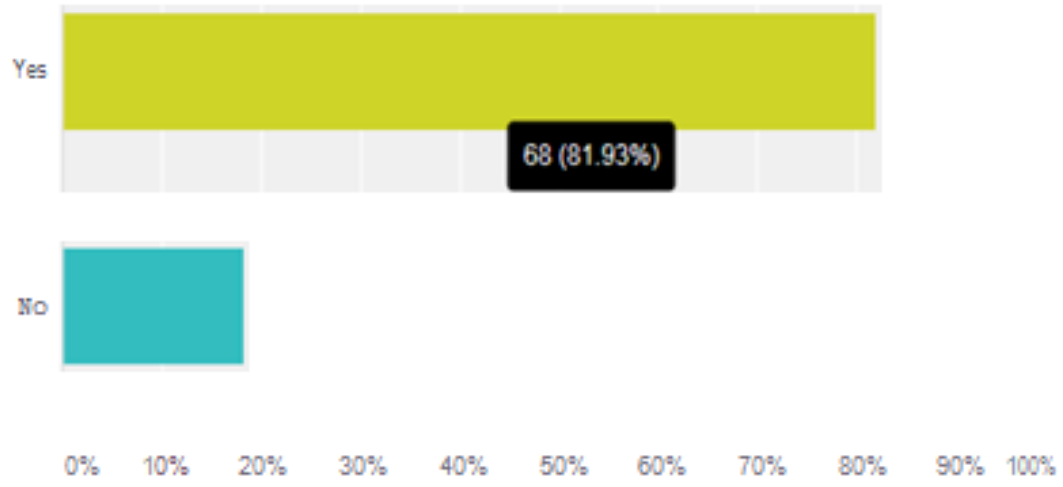
- Staff said that they wanted to be audited more frequently
- Staff want feedback for passed calls and not just negative
- A lot of staff said they wanted an audit team or peer audits.
- Staff admitted that a self-audit creates no learning as they all score a call they know they performed well in. they also said that they think it would be more beneficial to have a call allocated to them so it is random and learning can come from it.
- Staff said they do not get time allocated to do a self-audit and that they think it should be scheduled in (this should be happening already).
- The staff said that they wanted face to face feedback more regularly

Appendix 4 – Interim May Staff Survey results



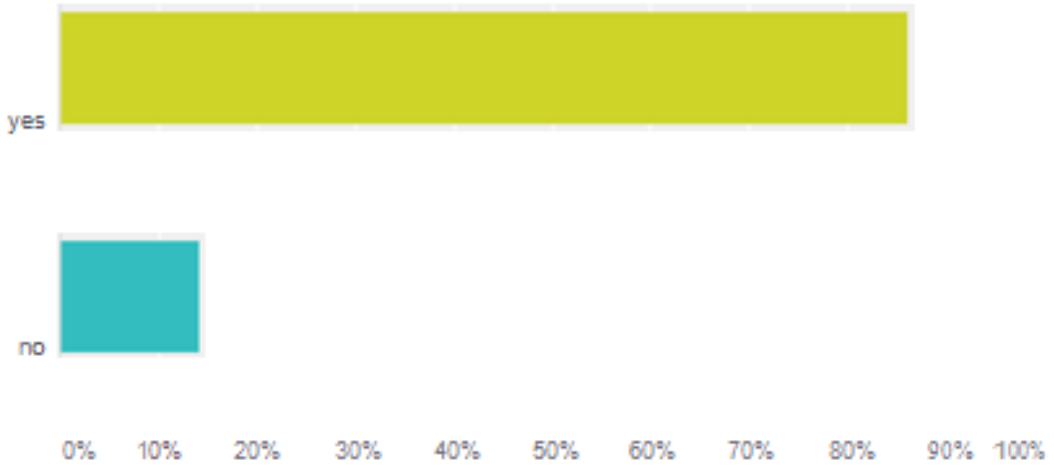
Do you receive feedback for a "passed" audit?

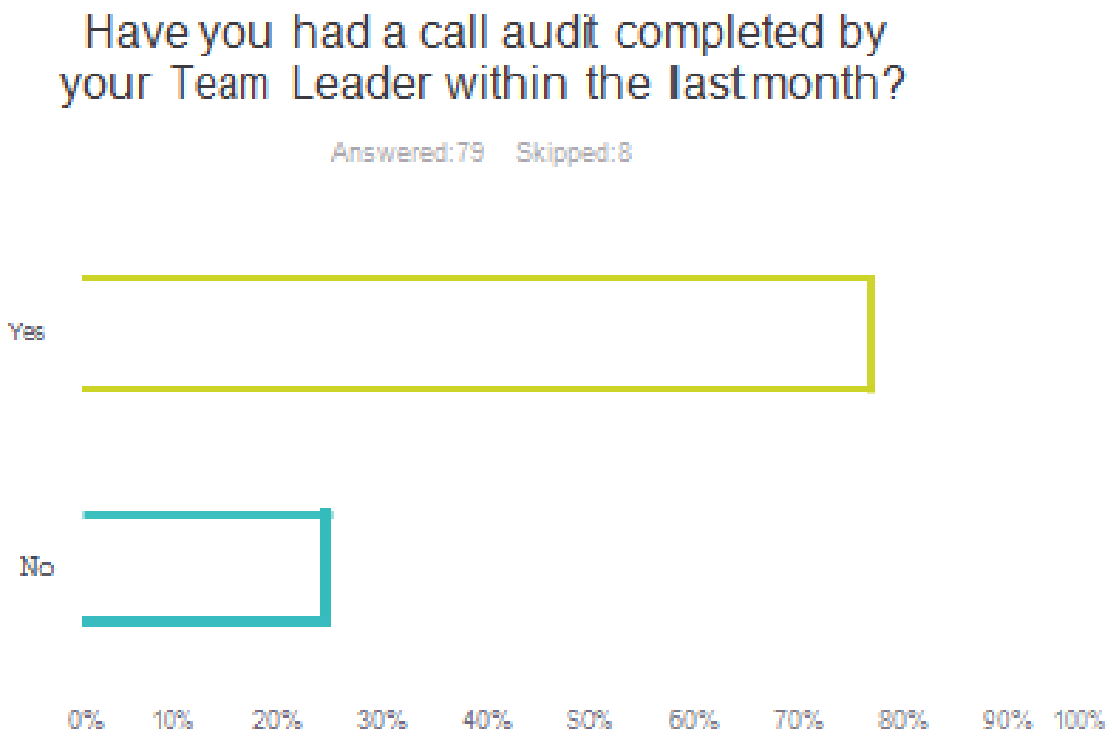
Answered:83 Skipped:4



Have you completed a self-audit within the last month?

Answered:86 Skipped:1




Have you had a call audit completed by your Team Leader within the last month?
Answered:79 Skipped:8
Yes
No
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Project 14 – YAS – Creating a supportive and developmental culture within the team through supervision

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Project Summary

The scope of the Supervision and Appraisal Project was to understand alternate models of supervision in order to identify an optimum model within the Yorkshire and Humber (Y&H) NHS 111 Call Centres, given the challenge of providing a 24x7x365 (6) service, and therefore with a large variety of staffing schedules.

Additionally the project explored the element of a 'team concept' within the Call Centres and whether this can truly work to provide benefits to staff, the service and overall care delivery. Team work is recognised as being an important factor in the delivery of quality care, improved patient safety and a predictor of employee satisfaction and intent to remain in their role (Source: West, M.A and Lyubovnikova, J., 2013, Illusions of Team Working in Healthcare). The nature of the NHS 111 service is that Call Handlers individually manage the majority of patient contacts in around 80% of calls, seeking advice and support where needed to ensure that an appropriate referral or care outcome is reached. Staff also work a variety of shift patterns to their Team Leader and team members, and therefore are more likely to associate with the overall service and colleagues who they sit with on a daily basis as opposed to colleagues aligned to the same Team Leader.

The project delivered an overall increase to Team Leader numbers within the service given that an additional 5 FTE was allocated through the project. In addition there were several changes of practice to support the evaluation of the impact of an alternate supervisory model:

- Protecting off-line time (time where Call Handlers are scheduled off of call taking) for one-to-one and Personal Development Review (PDR) meetings
- Assess alternate supervisor models in the call centres (span and schedule), in order to potentially identify an optimum model. This involved establishing a 'test group' where Team Leaders followed staff shift patterns. Other Team Leaders retained their existing rota patterns, therefore allowing comparison
- Creating a culture that is supportive and developmental, and builds upon the initial projects (around reducing attrition) which were completed under the first phase of the workforce investment fund. Both of those projects; end-to-end reviews for staff and new induction programme demonstrated benefits and are now embedded within our service as business as usual.

The project also aligns with feedback across the service around support and development and the quality and timeliness of a performance development review. This feedback includes that within the service (staff feedback, both Call Handlers and Team Leaders) and also external feedback received from the CQC report who outlined that:

"The provider should:

- *Regularly review the changes recently implemented in the management and leadership structure for call handlers, in order to ensure that all staff receive regular face to face feedback on their performance and call audits via the 1:1 process*

Background

The NHS 111 / IUC call centres are often stated to be a high-intensity workplace, especially in the out of hours period where call levels increase significantly (65% of calls are received between 18:00 and 08:00 during the week or across the full weekend period / bank holidays) therefore placing additional pressures on front line staff and on Team Leaders / Managers to effectively support them. The focus on delivering the service to patients and maximising staff availability to answer calls has resulted in the cancellation / rescheduling of one-to-ones and PDRs in order to maximise call handling capacity.

Additionally, and whilst the service is achieving a high percentage of PDRs

completed, staff feedback questions the quality and value delivered through one-to-ones and PDR's. A range of such comments include:

- "I don't see my team leader very often"
- "I had a PDR but not by my team leader"
- "I don't remember when my last one-to-one was."

The project was proposed to test an alternate model of support and to analyse the positive impacts that this may have on staff. Additionally the model was aligned to test the concept of 'team' within the service given the recognised impacts of effective team work on patient care but also the fact that peers are recognised as being an important support mechanism for staff (Source: Jackson, D., Firtko, A. and Edenborough, M, 2007, Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review).

Challenges

Operational issues identified prior to proposing this project are:

Line management ratios

- Current team alignments – the current process is focussed on maintaining the same spans across all team leaders, rather than on aligning teams based on schedules.

- Current team sizes – current spans in excess of 33, with some team leaders having up to 40 call handlers (this however was influenced by a decision to split the Team Leader role so that a proportion of resource was allocated to on day shift management in order to allow the remaining Team Leaders to focus on staff issues)

- High increase in the numbers of call handlers since starting the service in March 2013, without a proportionate increase in the number of team leaders

Work schedules

- Current rotas for call handlers – there are a number of rota patterns in the service, and each of these patterns has a 4 week rotation, with different staff on each week of the rotation.

- Current rotas for team leaders – current rotas are based on ensuring coverage for the service rather than aligning to the schedules of the call handlers

Team Leaders

- Ability of new Team Leaders, allocated through the project, to quickly pick up line management of the staff and to provide the appropriate training and support

- Dedicating and protecting off-line time for staff in the pilot group to have face-to- face one-to-ones and PDR's with their team leader meant a potential impact to service levels

- Training for newly appointed team leaders – new team leaders were appointed at the start of the project, and they needed to undergo training, which cut into time allotted for the project and for their new teams

- Team Leader sickness – levels of long-term sickness in the team leader group places additional work on the existing team leaders, and reduces support available for staff

- Shift Leader staffing levels / sickness – there are not enough Shift Leaders to cover a 24 x 7 schedule, and as a result, Team Leaders are pulled from their teams to run shift.

Wider issues acknowledged prior to commencing the project was that time was a limiting factor, even with the allocation of dedicated resources, in order to truly understand and evaluate the impact of an alternate model. This issue equally impacts on the ability to fully test the concept of team across the service and therefore it is acknowledged that in both areas the results may be interim and support additional or extended reviews.

Approach

One of the key objectives was to improve the level of support for staff. To achieve this, changes had to be made to address the challenges previously listed. First and foremost, the number of team leaders in the service was

increased by 4.1 FTE (2 x 1 FTE, 2 x 0.8 FTE, 1 x 0.5 FTE) to create the Pilot Teams. These teams were managed differently and had protected time for meetings (face-to-face 121s, PDRs, audits). The time for their meetings was scheduled in advance by the Workforce Management team, taking into account projected levels of staffing and call volumes. The teams also were smaller in size, with a span of 15:1 (compared to "business as usual" spans of 33+). To ensure team leaders had time to meet with their staff, teams were aligned based on schedules, and the team leaders adopted the schedule of their staff.

Another key objective was to improve the sense of team. This was achieved through the realignment of teams, with all team members and the Team Leader working the same shift pattern as their staff. The concept of "teams" was also introduced through the use of creating an identity through team colours. Each team leader in the pilot chose a colour and used that as their "branding" (example – Team Green). This branding is being carried through on documents and in communications. The Team Colour identity proved to be so popular that team leaders in the control group, and clinical team leaders, all requested team colours.

The project also aimed to analyse and gather feedback on what would make the job more effective and efficient for all team leaders (test and control groups). Workshops with the team leaders indicated enhancements could be made to their monthly dashboard (a tool used to track team activities and absence levels) to give them better oversight of tasks needing to be completed during the month. These enhancements were made and initial feedback is positive.

Additional feedback indicated that the team leaders did not have enough time to meet with all their staff, as their time is being diverted to other duties to assist with the management of staff on teams where the Team Leader is on long term sickness. Another factor impacting their effectiveness is that the team leaders get pulled from their team to manage the service. Management of the service is typically done by Shift Leaders, however, there are not enough Shift Leaders to fully man a 24 x 7 operation. As a result, a portion of the Team Leaders' time is being pulled to actively manage the service. For further detail regarding output from the workshops, please refer to
Appendix 5.

Ongoing work is being done to better understand how the team leader's time is spent and if improvements can be made. Tracking is done through the completion of activity logs, indicating how time is being spent, hour by hour.

Activity logs were completed daily for 4 weeks, followed by a 4 week break, and then an additional 4 weeks of logging activity. Initial findings from the first 4 weeks indicate that in excess of 40% of the team leaders' time is being spent on administrative work and absence management. This was consistent for team leaders in the both the test and control groups. To further illustrate this, each group is spending just over 30% of their time on administrative work. For a full-time person, this is roughly 11 hrs per week. This time is sufficient for the Pilot team leaders to complete all tasks for their team, as they are working to a span of 15:1. The control group team leaders are unable to complete all administrative tasks, as they are working at a span of 29+:1.

As the project is still ongoing, the second round of activity tracking is still in progress and full results are not yet available. Further work is scheduled to understand more about this. For more details regarding the findings of the first 4 weeks, please refer to Appendix 6.

Actions to support the project were:

Teams were realigned

- Teams in the test group were set a span of 15. Additionally, and most importantly, all call handlers on the same team worked the same rota pattern. This in itself was a challenge, as there are a number of rota patterns in the service, and each of these patterns has a 4 week rotation, with different staff on each week of the rotation. Due to the number of variations in rota patterns, there are some patterns with few people on them. A side benefit of this was that the creation of the new teams caused a slight decrease in the team sizes for those in the control group (dropping from c. 33 to c. 29).

Team Leader rotas were changed

- Team Leaders participating in the Pilot were flexible and changed their working pattern to mirror that of their team

Impact to service –

- To ensure minimal disruption to service, with regards to the protected time for 121s / PDRs, all meetings for the pilot teams were pre-scheduled by the Workforce team. This took into account projected volumes and staffing levels. Whilst it did not eliminate all impact, it allowed for better planning and ensured that not all team leaders were booking meetings at the same time.
- Team Leaders in the control group used the current process, which is to review their work schedule against those on their team, identify when

both were on shift together, and then review staffing forecasts for the day to determine when meetings could be held. In many cases, on-the-day decisions are made based on current volume and staffing trends. This means that the staff member doesn't have advance notice and time to plan for the meeting.

- Training for new Team Leaders
- Bespoke and tutor led courses were arranged with training conducted during the initial week of the programme. Whilst it delayed implementing the pilot by 1 week, this helped to prepare the seconded Team Leaders for the roles. Feedback was that it was beneficial in learning more about the role, the duties, and that it increased their level of confidence.
- A Team Leader Handbook was developed and implemented. The handbook serves as a quick reference guide for processes / systems / forms that the team leaders utilise regularly. It is also being used to identify and log all training for team leaders, through the inclusion of a Learning Passport. As such, it was rolled out to the team leaders in the control group as well, allowing their managers to identify if additional training was needed.

Team Leader sickness

The level of sickness absence amongst the current team leaders remained high, with several team leaders on long-term sickness, therefore requiring support within the Team Leader pool and whilst the pilot Team Leaders were ring fenced and protected from being pulled into a full range of tasks they did help support some on day activities, such as staff return to work interviews. (Additional detail on spans of the pilot and control group, as well as the impact of long-term sickness on current spans, please see Appendix 2)

Shift Leader staffing levels / sickness

This was managed by utilising the substantive Team Leaders (from the control group) to assist in managing the service from time to time. As part of the pilot, those team leaders with "pilot teams" were not eligible to be pulled to assist in running the shift. This ensured we were true to the pilot, which was to gauge improvements in staff support with lower spans and team leaders who were focussed only on their team.

Time for managing the project

- Additional resources were allocated to the project as described and to ensure that appropriate focus was placed on the key areas
- This involved both dedicated project management together with

additional support from an Operational Service Manager to help co-ordinate the operationalisation of the project

Evaluation – to support the evaluation control logs, measuring activities and Team Leader dashboards were enhanced to more effectively provide an oversight of Team Leader activity as it was recognised that there were knowledge gaps across both areas:

- Test and control groups are logging daily activities to understand how time is spent and to see if efficiencies can be gained. The aim of the activity logs is to identify any differences in how pilot team leaders and control group team leaders spend their time. On the back of this, it is anticipated that the results will also provide us with ideas and opportunities to improve efficiency. Full results are not yet available
- Team Leader dashboards were enhanced, incorporating feedback from team leader workshops
- Monthly results are being used to review and compare the effectiveness of the test and control groups

Intended outcomes

The scope of project aimed to pilot an alternate model of supervision, delivering increased support within the centre, and through this to identify an optimum model for potential roll-out. In addition the project assessed the sense of "team", across call centres that are 24 x 7 and whether realistically this can be achieved within the Yorkshire and Humber NHS 111 service. Detail regarding the objectives and aims have been referenced through this paper but principally align to:

- Assessing alternate support models within the service
- Benefits and value of more direct support and supervision for staff, assessing their perception and feedback as part of the process
- Understanding the concept of team, given that colleague support is academically recognised as being a key resource for staff to cope with work based stress / pressure.

Measurement of success was evaluated through a number of research methods, namely:-

- Qualitative analysis through staff feedback from workshops and staff surveys, both of which were completed before the pilot commenced and repeated again at approximately 6 weeks into the project. These surveys revolved around:
    - Staff / team leader survey on effectiveness of current model
    - Staff / team leader workshop on effectiveness of current model

The surveys by their very nature also allowed for statistical analysis in addition to the comments

- Quantitative analysis, through completion rates of staff one-to-ones, PDRs, and audit rates, as completed by team leaders and staff call audits.
    - Team sizes
    - PDR compliance
    - 1 to 1s delivered
    - Time spent on 1 to 1 / PDRs
    - Staff and team leader rota match – i.e how often do they see their 'team leader'

Intended outputs

In the short term, intended benefits include increased support for staff. This is to be achieved by reducing spans and aligning teams so that the team leader and their call handlers are all working the same schedule. This is a break from how the service has operated in the past. Since inception, team leader rotas have been developed to ensure the service has coverage, and were not linked to call handler rotas. Additionally, teams were aligned to ensure equity in span amongst all team leaders, and did not factor in the schedules of the staff or team leaders. The exception to this is night staff, as the service has 1.5 FTE of team leaders who have a preference for night shift, and as a result, had night staff assigned to them. Whilst this is the intended benefit, it is recognised there will be challenges with respect to scalability and the practical implementation of aligning schedules. This is further detailed in the Next Steps section of the report.

Longer term, the service anticipates that the improved support will lead to improved performance (patient care) and improved job satisfaction for both call handlers and team leaders. At present, it is too early to view metrics with

any certainty given the short duration of the pilot. It is envisaged that increased support would lead to improved attrition, although again this is difficult to measure over such a short interval and equally intelligence held within the service suggests that people leave the organisation for a variety of reasons.

The project has also delivered in an unexpected benefit in terms of Team Leader development packages and handbooks to support staff and to provide a consistent training offer. This was not in place prior to the pilot and therefore moving forward will provide more structure in training any new Team Leader recruits.

The strength of the project lies in the potential within the service to deploy the resources to deliver the project and to backfill Call Handler roles so that this does not impact on service delivery. Additionally it is recognised that a key factor in assessing the project is to evaluate the perceptions of staff given that their feedback has previously outlined the difficulty in accessing support. Therefore measuring and monitoring this through workshops and surveys is an important element of the project.
The product will also allow a judgement on the benefits of alternate supervision models, and through this to allow for consideration of what the impact would be for full service roll-out.

Details of resources and any potential partnership

Resources for the project were allocated from within the service. This included:

- 4.1 FTE of additional Team Leader resource in addition to the existing 17 FTE
- Dedicated Project Manager and Project Support Officer
- Operational Service Manager to help support, embed and deliver the project

In addition wider support was also provided through existing inter team relationships and using existing support services, for example the workforce management team to help schedule additional activities with staff.

No external partnerships were required for the project although local commissioners were engaged with around the recommendation to submit the project for consideration together with regular updates around the progression of the project.

Obstacles and issues

Key issues and challenges were centred on resources.

- Resources to manage and deliver the project were allocated in order to support project delivery
- Protection of staff to fulfil Team Leader duties without pulling onto alternate duties – as previously noted, Team Leaders in the pilot group were devoted to managing the pilot teams and were protected from covering team leader sickness. Team Leaders in the control group carried on as “business as usual”, and were called upon to assist in covering other teams (due to team leader sickness) and covering gaps in the shift leader rota. The impact of this is evident in feedback, as the Team Leaders in the control group acknowledged the benefits of the slight reduction in direct reports, but stated that they were still unable to achieve objectives due to being pulled to manage shift and to manage staff on other teams. It is acknowledged that whilst protecting staff from other duties was an important facet of the pilot that this is not something which could always be maintained moving forward

- Service levels – there were times where staffing levels had an impact on the service levels. As agreed, the pilot teams had their time protected so that one- to-ones and PDRs could be completed as scheduled. In a few instances, these meetings were postponed until later in the day, but for the large part, they took place as scheduled. It is difficult to fully attribute service impact to these meetings, but it is believed to have been minimal. Meetings were scheduled in advance during times where staffing was adequate. If gaps were created, the fact that the meetings were scheduled in advance provided the time to optimise breaks and slide schedules as required. This differs from the current process, where Team Leaders attempt to schedule meetings in advance, but often have to rely on day-to-day volume and staffing trends.
- Re-aligning teams caused some disruption, as there were some staff members who did not want to move to a new team (due to having built good working relationships). Additionally, some did not want to move to a team that was led by a team leader with high sickness levels, as they knew the level of support would reduce. Where possible, requests were honoured regarding reporting lines, but only if they also met the criteria regarding the alignment of teams and team leaders to set rota patterns. Whilst all staff understand this is a pilot project, if the pilot ends and teams are realigned back to previous reporting lines / previous spans of management, there will again be fallout. Those on the pilot teams are reaping the benefits of improved support, and having experienced what is possible, they will be reluctant to leave this behind. Reverting back to previous ways could cause an even higher level of dissatisfaction, as

staff will know what can be achieved with the right set-up (aligning schedules / decreasing spans).

Actual outcomes

The original aims of the project were to :

- Pilot an alternate supervision model, identifying an optimum model for future consideration, with appraisal activities protected
- Test and assess staff perception over the support received across the pilot group and wider service and incorporate this into the overall analysis
- Test the concept of 'Team' within the service

Outcomes of the project has been to demonstrate that the pilot approach demonstrated that :

An alternative model was piloted and demonstrated positive feedback around staff perception with the level of support and accessibility of the Team Leaders has improved (evidenced through staff surveys and workshops in appendix 3 and appendix 4).

- Prior to the pilot, 74% of staff felt they had enough support from their team leader and 6 weeks into the pilot results improved to nearly 95% for those on pilot teams.

- Positive feedback was also received within staff in the non-pilot test group with results improving from 74% to 86%. This could be a result of a reduction in span for the control groups.

- Face to face one-to-one meetings improved from 47% to 83% for the pilot group, whilst the control group improved to 64%.
- The level of Team Leader accessibility improved significantly. Prior to the pilot, only 14% stated that a Team Leader was "always there when I need one"; 6 weeks into the pilot, and the result for the pilot group is now at 46%, compared to 24% for the control group.

- Improvement in comments from members of staff around the support received. Comments from staff prior to the pilot included: "only had one 121 since starting", "not seen my TL since I started, never in on my shifts, unable to email as their mailbox is full", "I felt the organisation contributed to the lack of support". Comments from the pilot group 6

weeks into the pilot include: “I have been assigned to a pilot team leader for a month now. S/he has helped me gain valuable insight in to the areas of development needed to progress as a call handler. A real asset to 111”, “I find my TL much more accessible now and always available when I need him/her”, “miles better with pilot team leaders, much more accessible, problems get dealt with much quicker than previously”. Additional details are included in Appendix 3.

- Improvement in completion of supervisory tasks aligned to staff (as compared to non-pilot groups) indicate that the level of support and interaction between staff and the Pilot Team Leaders improved with most pilot team leaders fulfilling 100% of their one-to-ones and audits. Additional benefits also included a positive impact on overall service level completion of PDRs as pilot Team Leaders were able to address previous service gaps. Additional detail regarding these outcomes is outlined further in Appendix 1.

Qualitative and quantitative feedback from staff was positive (Appendices 1, 3, 4, 5). A decrease in span and a complete focus on team leadership (rather than assisting with service management) has increased the level of support and feedback with staff. Feedback also indicates that the span of 15:1 was low, and the team leaders feel they could achieve the same results with larger teams (in the area of 20:1). Results for the control group have also improved (span at 29:1), but are not at the level that is needed to significantly change the culture. A roll-out of the pilot will be challenging, as there are financial implications involved. Once the project is complete, a review of final results will be done to determine if cost / benefit can be quantified.

Whilst the pilot demonstrated the impact of this it is recognised that there are challenges with scalability. Equally learning from the project supported that staff ratios would need to be above the 15:1 as implemented during the pilot and could be changed to between 20 and 25:1. Unfortunately within the course of the pilot it was not possible to identify a definitive optimum number and the analysis, including a financial assessment, is continuing outside of the project timelines. Given the resource implications the overall findings of the pilot are due to be reported to the YAS NHS 111
Operational Management Group to assesses and determine any project extension

Benchmarking data held by the organisation (Dimension Data, 2017 Global Customer Experience Benchmarking Data) suggests an industry standard of 13 Call Handlers to each supervisor. Such a ratio would have significant

financial implications for the service and therefore the operational model. Data from another NHS 111 Provider has Identified a ratio of 24:1. The context of this is outlined below:

Model	Number of NCTL	Numbers of Call Handlers	Ratio to staff	Additional Cost
Current Team Leader Model (Pre-pilot)	12.5 FTE (4.5 FTE in addition allocated to	386	31:1	Existing staffing so no additional cost
Implications of adopting Pilot Ratios across the service	25.6 FTE (13.1 FTE above current	386	15:1	£416,307.52 (£31,799.20 per 1 FTE)
Industry standard*	29.5 FTE (17 FTE	386	13:1	£540,586.4 (£31,799.20
Addition of 5 FTE Team Leaders to current	17.5 FTE	386	22:1	£158,996 (£31,799.20)
Addition of 4 FTE Team Leaders with 1 x FTE additional Shift Lead	16.5 FTE	386	23:1	£158,996 (£31,799.20) NB cost remains same as shift lead

Table 1: Overview of cost implication of increasing Team Leader numbers

*2017 Global Customer Experience Benchmarking Report

Development of a sense of 'Team' across the service – whilst this is hard to fully assess in such a short time window feedback from staff throughout the process was that they were supportive of increasing team identity. The first aspect of this was to allocate individual team colours and to display this and team lists so that staff could more readily recognise and associate with their team. Individual contact with Team Leader was improved for the pilot and as staff were aligned more closely on shifts it did make it easier to run more team based huddle feedback sessions (ad-hoc staff feedback sessions on core topics where staff are taken where availability allows) than is the case where staff work a significantly different shift pattern.

Additional actions planned to embed the team element further, within operational constraints, are to implement more team based activities (for

example quizzes) or performance and quality data (for example patient compliments, call audit scores).

Actual outputs

Alternate Team Leader rota patterns, aligned to staff member schedules to test - Whilst these helped to improve overall contact with a Team Leader it is recognised that this would have significant implications on overall staffing within the service and require additional Team Leaders to maintain the pilot ratios (please refer to Table 1 in the
Actual Outcomes section). The pilot did however help to assess the potential benefits of broader Team Leader schedule options (20, 24 and 30 hour options) rather than purely recruiting on a full time basis which had previously been the case. Therefore moving forward the overall recruitment model will be modified to promote more part time recruitment

Development of Team Leader dashboards - The team leader workshops gathered ideas to improve the dashboard which were implemented with positive feedback that they allow easier identification of completed audits and any scheduled feedback meetings. This enabled all Team Leaders more effectively plan and manage their workload. Whilst it is difficult to quantify these benefits the staff comments suggest that they are making a difference and thus enabling more effective support delivery

Modified staff development and mentoring model - an unexpected output is that at least one of the pilot team leaders was able to provide real-time side-by-side coaching, which was not done in the past (due to time and scheduling constraints). This however requires additional analysis in order to scope potential implications for future rollout although the benefits of such an approach are acknowledged

Improvement of focus on Teams within the service – as demonstrated an early action taken was to establish team identities within the service by the adoption of Team Colours. This was requested by staff themselves and therefore demonstrating the value that staff associated with it.

Lessons learned

A key lesson learned from the project was that limiting staff numbers; aligning shifts to that of staff and protecting certain activities would enable improvement in aspects such as PDRs and overall staff satisfaction. This outcome was expected and whilst the value was demonstrated the pilot also helped to

reinforce the challenge of implementing this across the wider service.

In hindsight there would have been benefits in assessing broader ratios of staff to Team Leaders beyond the 15:1, as this would have allowed a deeper assessment on scalability of the project across the service in order to inform the model. It would be recommended that the initial project be extended beyond 3 months to test this concept, and therefore analyse if wider benefits were delivered across existing teams. It is recognised that there are challenges to this given factors such as the financial consideration of increasing Team Leader numbers together with the practical challenge of then replicating rota patterns given that a significant proportion of staff have flexible work patterns.

The review though did demonstrate the positive impact on staff perception around increased support and an additional evaluation needs to take place to assess any quality impacts or improvements which would be difficult to measure in such a small time window.

Data from within the pilot has demonstrated how many other activities existing Team Leaders are asked to support, predominantly shift lead duties, and therefore this is an element that needs to be acknowledged and quantified given the associated impact on staff support. Therefore a further review needs to take place and be considered within the service over the current allocation of Shift Lead resource (currently 4.5 FTE and therefore not able to provide 24/7 coverage).

Next Steps

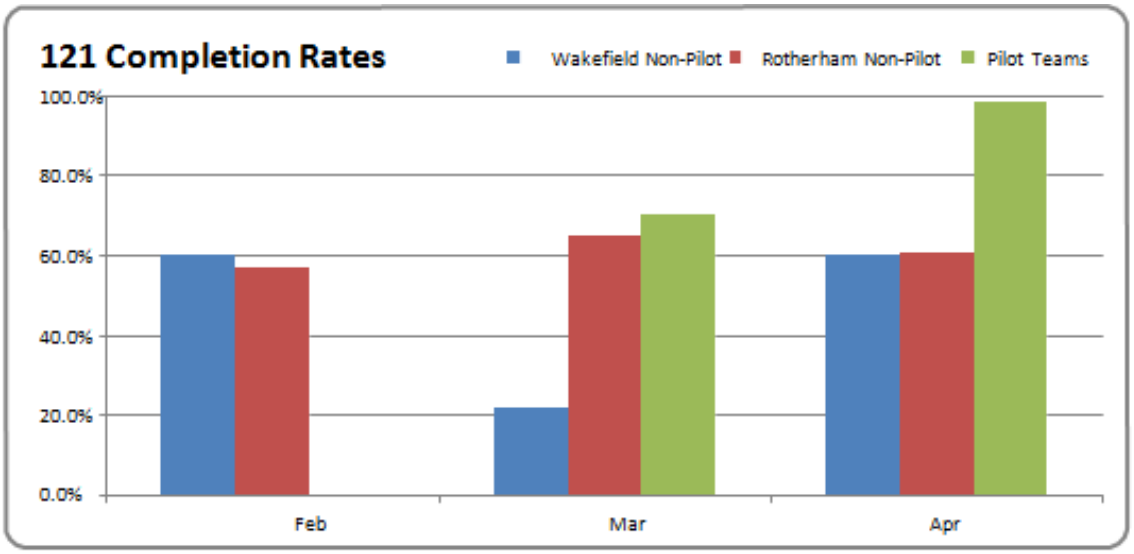
The pilot allowed for an evaluation of the model and to test staff perception around support given, although equally it outlined that the ratios were too low and subsequently impact on the overall assessment as practically this would need to be increased in order to implement any changes. It is also recognised that there are significant challenges to adopting this fully across the service and the extra investment required to implement any changes.

The next step of the project is to present findings to the internal service Operations Management group with a key outcome being that the review has demonstrated the benefits in adjusting the current approach.

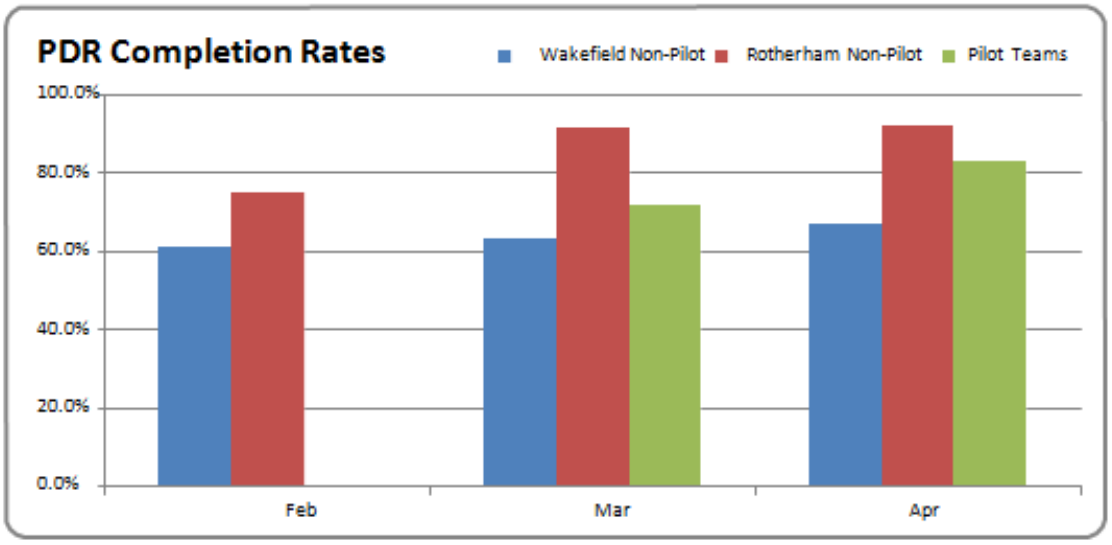
Appendix 1 – Dashboard Results

Pilot team leaders were assigned teams effective 13 March, and thus did not have them for the whole of March.

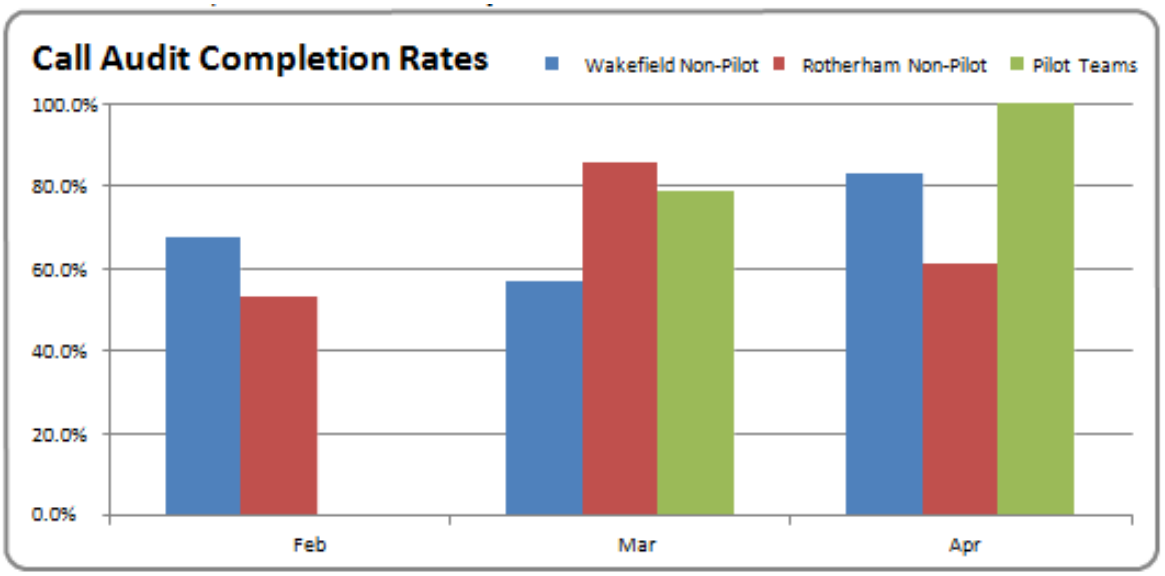
121 Completion Rates is the percentage of staff who have had a face-to-face one-to- one with their team leader at least once within the past 6 weeks.



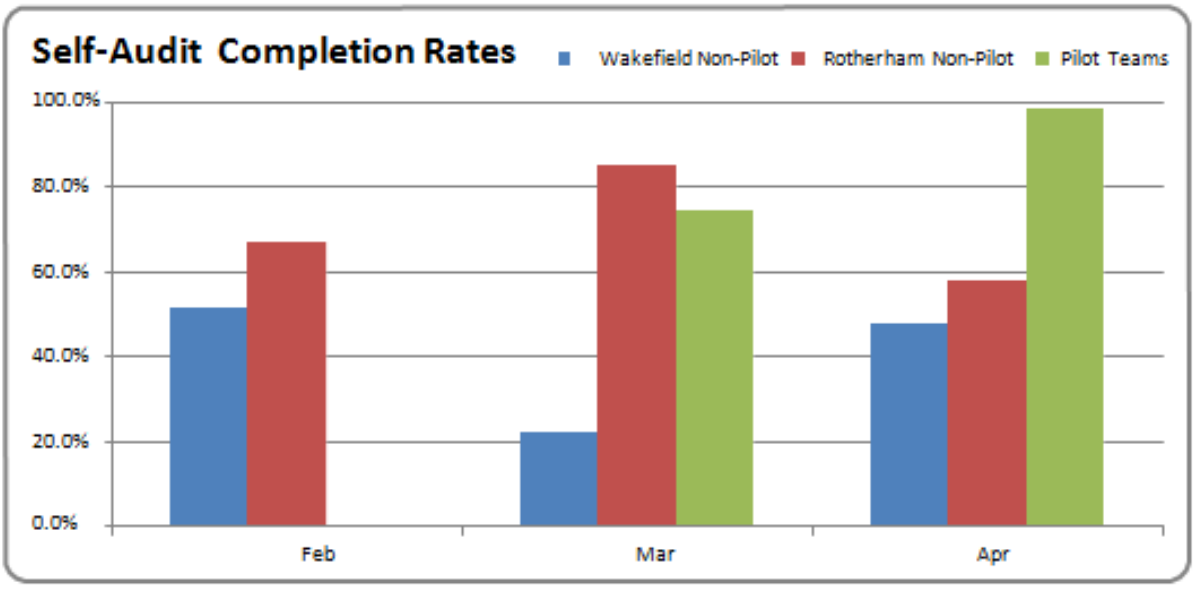
PDR Completion Rates is the percentage of staff who have had a PDR within the past 12 months.



Call Audit Completion Rates is the percentage of staff which have had a minimum of 1 call audit completed in the month, by their team leader



Self-Audit Completion Rates is the percentage of staff which have completed their self-audit during the month



Note: Wakefield Non-Pilot rates are impacted by 30% of the team leaders on long-term sickness. There is a further impact in March when 1 of the Team Leaders was away from role for 2 weeks conducting new hire training.

Appendix 2 - Spans

Spans by Site / Pilot Status	Before Pilot	Pilot
Wakefield Non-Pilot	34.3	25.8
Wakefield Non-Pilot*	49.4	37.2
Rotherham Non-Pilot	36.4	30.7
Pilot Teams	n/a	15.1

* 2 FTE Team Leaders are on long-term sickness: the remaining TLs are picking-up their work, thus creating an increase in span for those who are working

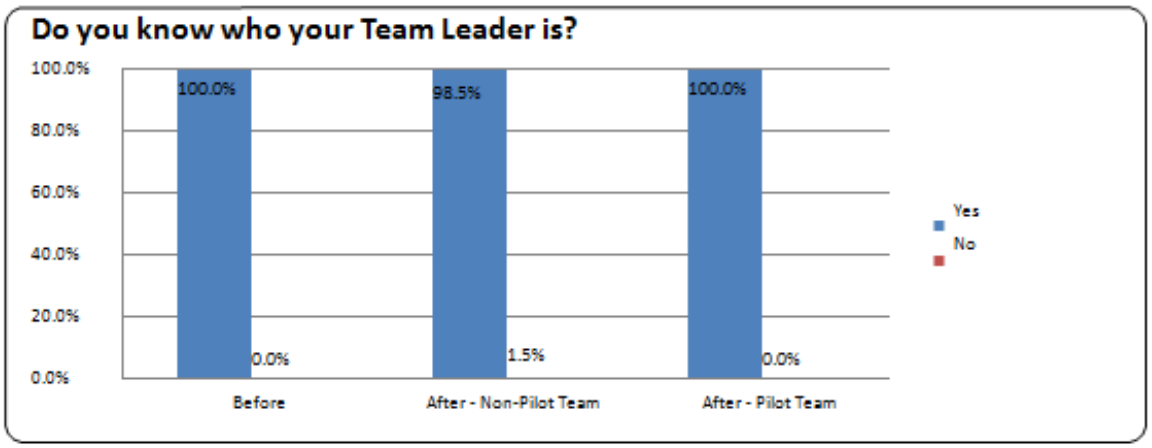
Appendix 3 – Staff Survey Results

To gauge the impact of staff feeling supported and to understand the level of interaction they have with their team leaders, a survey, which was completed anonymously, was sent to all staff prior to the pilot programme being implemented. The same survey was issued 6 weeks into the pilot to see if there was any change in results, and to see if the results between the pilot teams and the regular (control) teams differed.

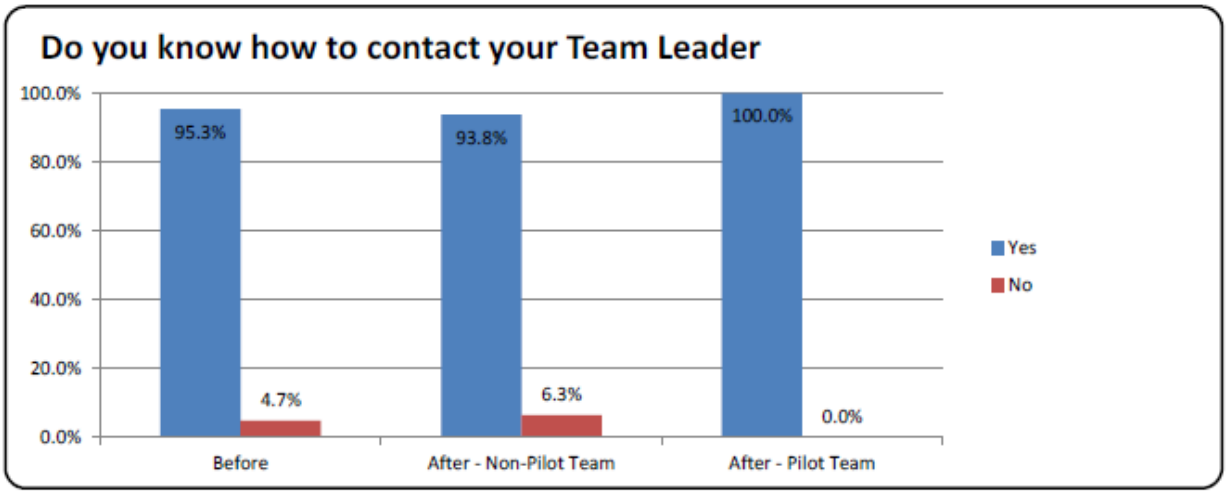
Based on the results, both groups showed improvements. However, results for the Pilot teams improved at a greater rate, and reflect that staff on those teams are receiving more feedback and feel more supported. By default, in building the new pilot teams, team sizes for the other team leaders decreased. An improvement in non-pilot team results is likely linked to this decrease in span.

In reviewing comments and results of the "After – Pilot Team" survey, it is believed that two or three staff members of Non-Pilot teams accessed the Pilot Team survey. One case was clearly identifiable as the staff member named their team leader (their results were moved to the non-pilot results). Results for the other 1-2 in question were left with the "After – Pilot Team" results. This could have some impact to results.

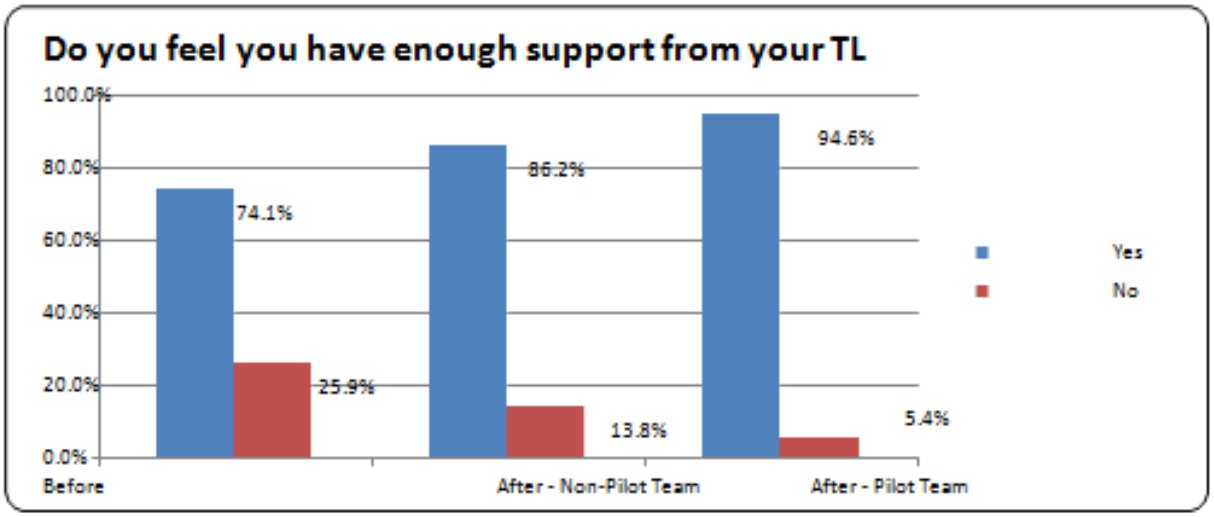
Included below are results of the survey, followed by comments from staff.



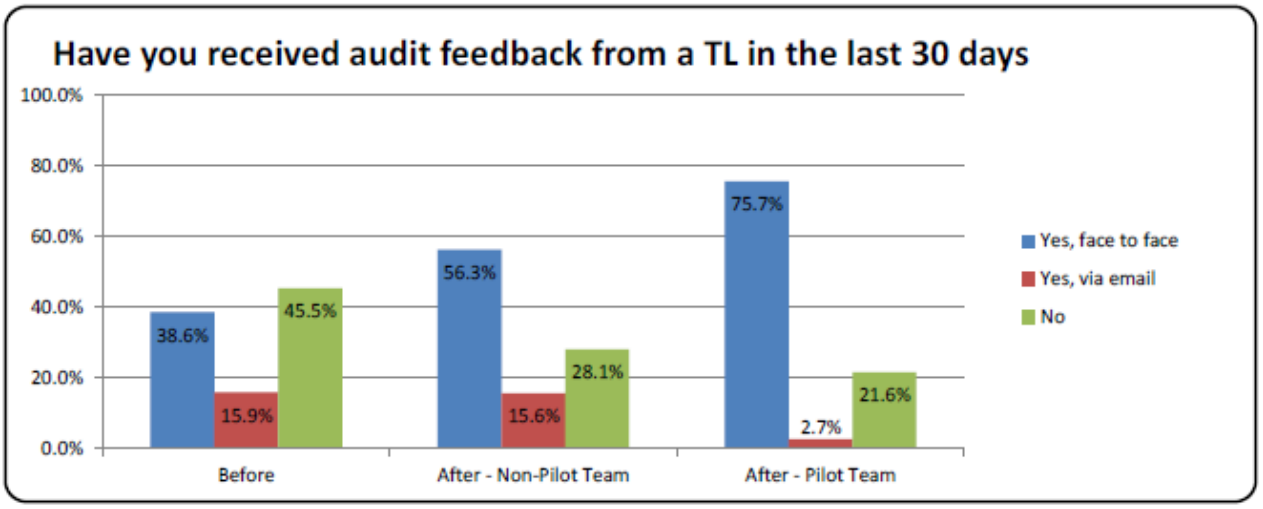
Some staff had to move to a new team, as their team leader moved to the Pilot programme. It is possible that during this transition, not all staff have had communication with their new team leader (possibly due to long term sickness)



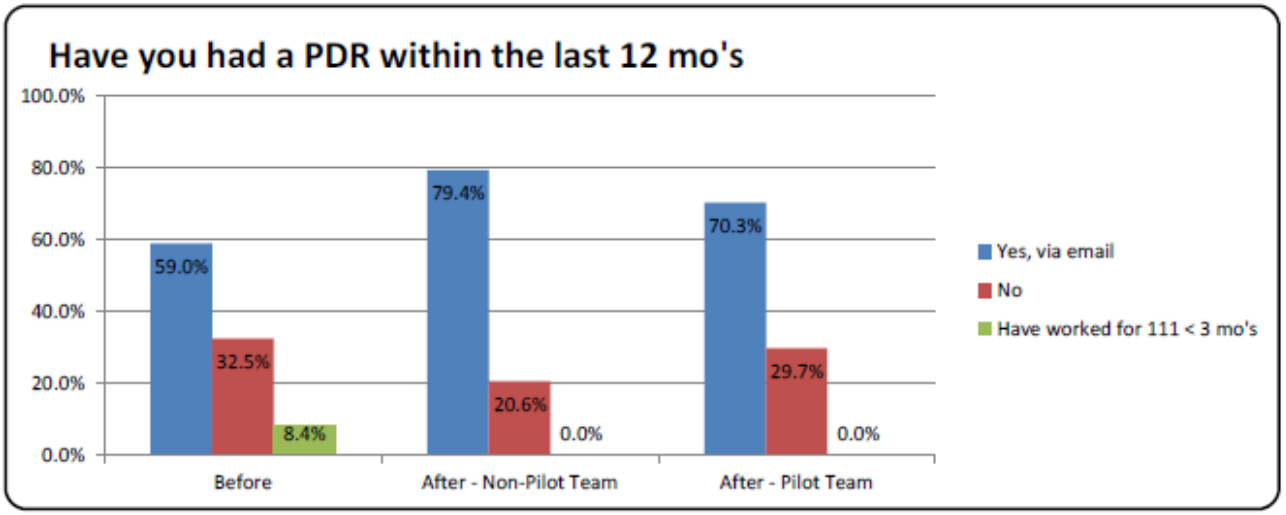
As noted above, and in the comments, not all staff on non-pilot teams have met their team leader.



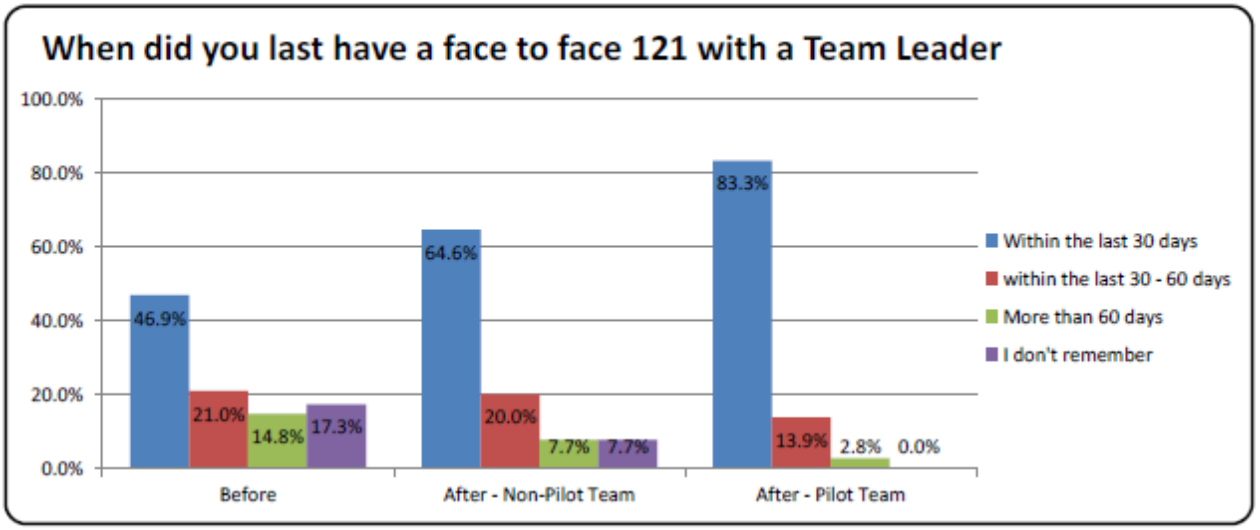
Some “After – Pilot Team” comments indicated their team leader worked opposite shifts. All Pilot TLs worked the same shifts as their team, so it is possible that the negative results in the “After – Pilot Team” are misplaced.



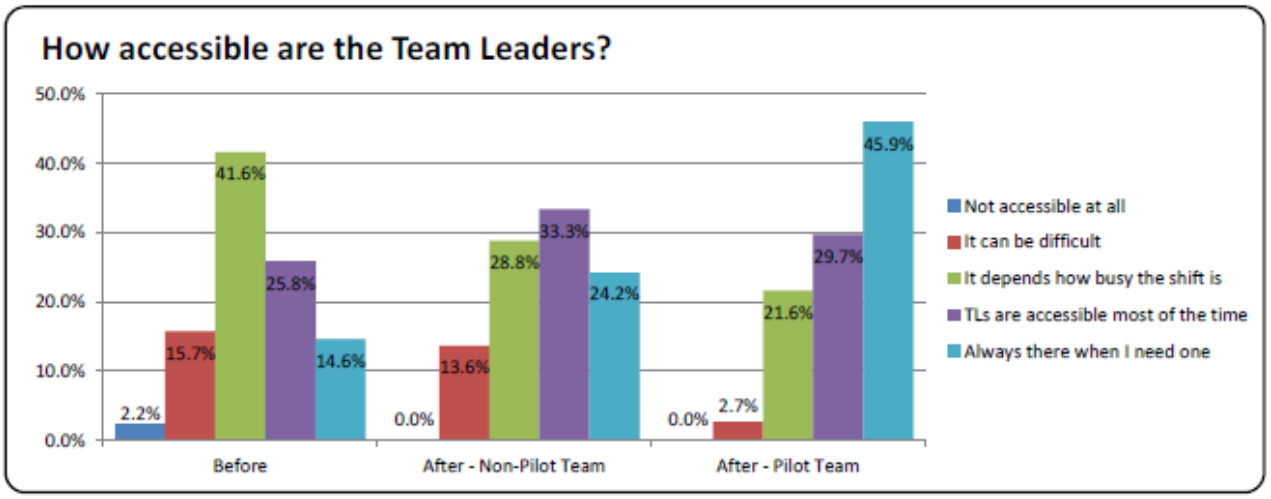
A significant improvement has been made regarding face-to-face feedback in the last 30 days. In addition to the team leader pilot project, some of this may also be due to the audit pilot project.



This section may be impacted due to some Pilot team leaders not yet attending PDR training. Additionally, staff they inherited had a low completion rate on PDRs. In total, PDR completion rates have shown improvement across the boar



As previously noted, there has been a significant improvement across the board. Two significant points here: 1) those having a face-to-face 121 meeting improved from 46.9% before the pilot to 83.3% for those in the pilot teams, and 2) prior to the pilot, more than 17% of staff couldn't remember when their last face-to-face 121 was. On the pilot teams, that number dropped to 0%.



As with other areas, there has been improvement across the board. It is significant to note that the "not accessible at all" category has now dropped to 0% in both groups. It is also significant that the pilot team now state that a team leader is "always there when I need one" 45.9% of the time, compared to 14.6% beforehand.

A sample of comments from the survey prior to the pilot programme:

- Never see my TL due to long term sickness
- Only had one 1:1 since starting
- Not seen my TL since I started, never in on my shifts, unable to email as their mail box is full
- I had to change TL as was not getting supported
- I felt the organisation contributed to the lack of support
- Received feedback from a different TL about an audit
- Did not receive feedback face to face but do not take offence as I know if there was an issue I would be made aware
- Was promised a PDR 9 months ago and this has never happened
- Nothing comes from PDR's anyway
- My PDR went very well, we discussed positives, negatives and moving forward
- I received my 1:1 by email which is fine with me as I am comfortable to approach my TL at any time should I need to
- My TL isn't accessible but others have been available

A sample of comments from the anonymous survey 6 weeks after the implementation of the pilot:

From staff on a Pilot team:

- Made a point to introduce herself to me
- Yes, I feel as though I can go to xxx with any problem I have and s/he will always be there to listen and provide help/advice
- Xxx (name omitted) is very supportive and very thorough in call audits and feedback and 121s
- I have been assigned to a pilot team leader for a month now. Xxx has helped me gain valuable insight in to the areas of development needed to progress as a call handler. A real asset to the team at 111
- Best team leader
- She is always there if I need any help
- Even on holiday, can contact xxx at any point as s/he has made the team aware he will answer us whilst on holiday
- I find my tl much more accessible now and always available when I need him/her
- My team is very accessible, others I question
- Since the pilot tls have started
- Miles better with the pilot team leaders, much more accessible, problems

get dealt with much quicker than previously

From staff on a regular team:

- I knew my TL was xxx whilst in training, and we had a 121 where soon into my start here at 111
- Only by name having never met her
- Very easy to contact xxx who always reponds quickly
- Unable to contact but I email or speak to my temp tl
- TL is very supportive
- Never had a 121 with my team leader or any other in her absence
- Since the restructure of the teams I have not had a 121 or a team leader audit. Whereas when I was with my last team leader I was getting full support /monthly 121 meetings and monthly call audits. I see my previous team leader and the new team leader more now since the restructure. yet i am not with any of them.
- My tl is available at anytime if I need her
- Have received feedback from an auditor
- Both face to face and email (re: receiving feedback within the last 30 days)
- Not sure what a pdr is
- Never had one (re face-to-face 121)
- Today! (re face-to-race 121_

Appendix 4 – Staff Feedback / Workshops

Non-Pilot Teams

- 121 for March not happened and not had one in April. I would like to have a
- 121. I do feel supported. Feel 121 process is good when I get them, never feel negative about 111.
- Not had a 121 since November, no 121 via email either, no audits done by TL, I think that the pilot team idea is good as people are seeing more of their team leaders
- Still not having 121's every month, but more often
- 121's are the same as before, I have my 121's, they happen monthly and stay consistent.
- My team leader comes to see me and check every time we are on a shift together

Pilot Teams

- I feel more valued and supported
- Team Leaders following same shifts is really positive
- My previous team leader was often sick, and when they're on sick leave, I get no 121s and have no one to go to
- Now that I'm on a pilot team and my team leader is here and available, I find I'm not bothering the shift leaders as much – I can go to my team leader when I have a question
- Now get time with their team leader; didn't previously
- Like being on the same shift – easier to sort things when needed, and they're
- getting more time with their team leader
- Previously I knew the name of my team leader but didn't know who they were
- Would like to sit together with the team if possible (rather than hot-desking)
- Would like to have a clinician "on the team"
- Existing team leaders always seem overrun with work
- The call centre feels more friendly, as my team leader always says hello
- Smaller teams are a good thing
- Can approach the pilot team leaders, they have time for you
- The group said that they had all got their 121's and audits scheduled in and
- they hadn't been moved; they liked this and said that it makes them feel valued
- Definitely have enough time with my TL

Appendix 5 – Team Leader Workshops / Feedback

To gauge the impact on job satisfaction and the ability to meet targets, workshops were held with the team leaders before the pilot programme was implemented, and again at approximately 8 weeks into the project.

Findings and feedback from workshops held prior to the pilot programme:

- Variances exist between sites (Wakefield and Rotherham), with Wakefield team leaders finding it more difficult to do their jobs. Reasons for this include long- term sickness within the team (30% of the team leaders) and the feeling that they are pulled more frequently to assist the Shift Leaders and the Governance team (complaint investigations)
- All team leaders are being pulled to help the Shift Leaders, answer questions, take calls. This takes them away from working with their team
- Could manage with the spans if they weren't pulled to help in running the shift or completing investigations for Governance. Some investigations can take a
- full shift to complete. Ideally, would manage 20 – 25 people. Realistically, could manage up to 30 if not pulled elsewhere. Managing 40 is not possible.
- Difficult to meet with staff and get work done during the out-of-hours period.
- Unaware of when, or if, other audits are being done on their team members (i.e.; by a PD or a trainer)
- 121s are scheduled, and then cancelled due to service – unable to get all meetings done
- Team Leader training is done "on the job" – no set training plan
- Requests made to enhance SharePoint so that TLs know when audits are done on their people.
- Requests made to enhance dashboards to provide more information on audits and more useful information regarding attendance management (i.e.; when next meeting is due).
- Failed audits and action plans take a lot of time to manage. As a result, unable to devote time to good performers.
- Unable to get work done due to picking up work for team leaders who are on long-term sickness.
- Feels the service level drives everything, even at the expense of supporting staff.

Findings and feedback from workshops held after the pilot programme:

From Non-Pilot team leaders

- Team size has reduced, but I haven't noticed a massive difference (possibly due to some team members with complex issues, that are taking

time to manage).

- I get the impression that call handlers managed by the Pilot team leaders seem to feel much better supported
- Team leader sickness still having a big impact
- Still being pulled to help with shift management
- Working shifts that don't align with my team, so 2 of 6 weeks, I don't see a lot of people on my team
- Changes were made so we now know what audits are being done on our team members, by others. This is helpful.
- There was a day when most of my team were in. I was able to pull them off for a huddle and said it was positive, as it felt like a team to all. There is benefit to doing this.

From Pilot team leaders

- I have found that following the same shifts as my team has helped hugely in being accessible to the team
- I find that I have a lot of staff from other teams looking to me for support as they either have never met their own team leader or they are never on the same shift.
- Being on the same rota enables me to offer far greater support to the team.
- 121's are easy to arrange when working the same shifts the only thing preventing them being completed is service demand. Again having 12 members on my team makes the audit process like the 121 process achievable even when several audits are required for individuals.
- Side by side coaching is one of the first changes I have made to the support I offer my team, I am trying to show greater support by being more hands on instead of sitting behind a desk auditing.
- One change I would like to put forward would be like with complaints having a rota, RTW's could do to have a rota also. If all TL's worked alongside their teams we could cover our own team's RTW's but until then a bit of structure would not only help time management but help to ensure that RTW's are done when they need doing.

- For me obviously there has been a big difference going from 40 staff to 15, although I am still dealing with a lot of my other staff as they have gone to team leaders who are off sick so the staff are still approaching me for help. I am finding it much easier with 1-2-1's and planning to see staff as I work the majority of shifts with them. I had no problems with completing my audits and 1-2-1's with the 15 staff I now have.
- The new dashboards are really useful and have taken on board some of the

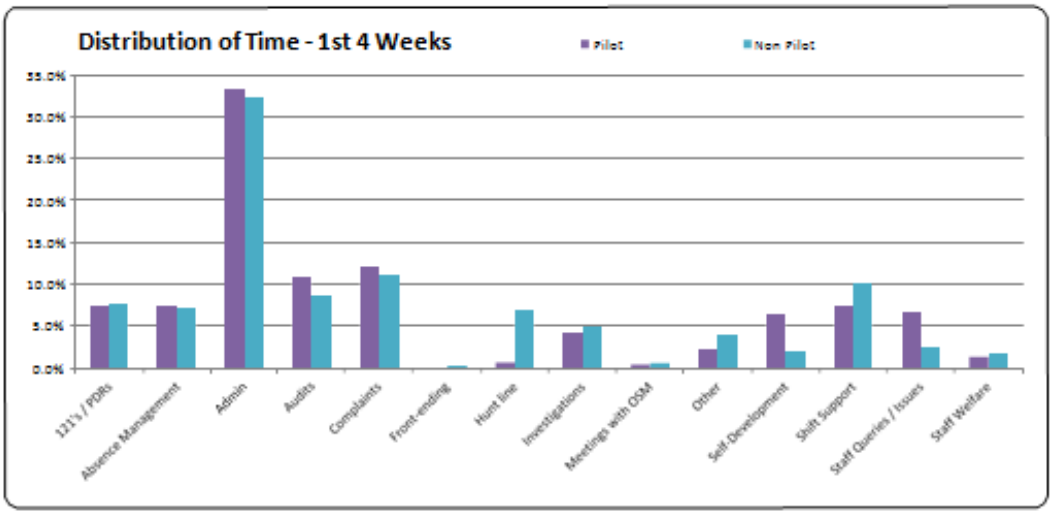
comments and suggestions we put forward, which is great, as this will help with management not only of our own team but other people's teams should we need to help.

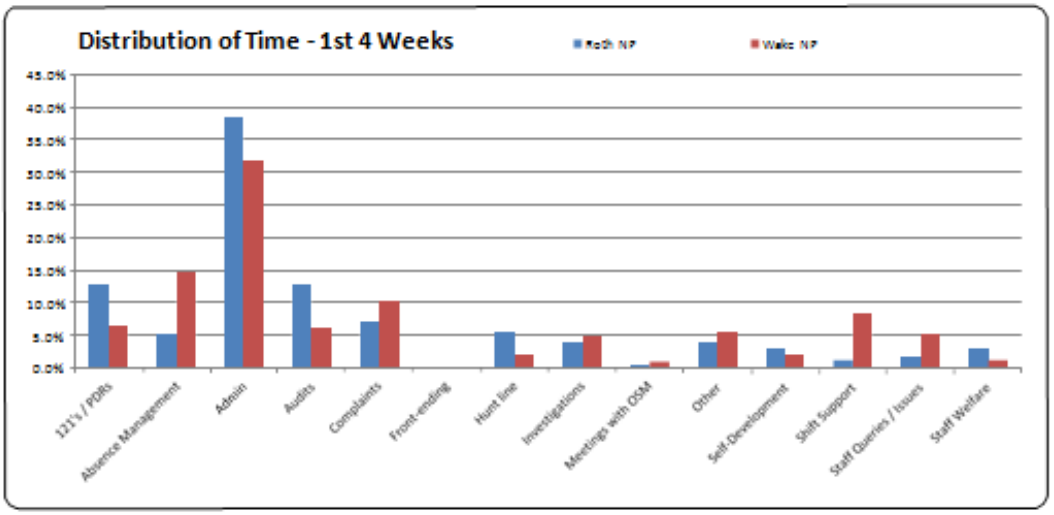
- I'm finding that a lot of my time is being pulled to help staff who report to one of the team leaders who are on long-term sickness
- I'm doing a lot of return to work meetings for staff on other teams. If all team leaders worked with the same schedules as their team, they would be able to do these for their team members.
- With regards of my team, first month I had plenty of time to do everything audits and 121's there was only one member that I didn't managed to get face to face contact with but that was due to her annual leave.

Appendix 6 – Creating Efficiencies

To identify and improve efficiencies, all team leaders were asked to track their activities for a 4 week period at the start of the Supervisor Pilot project (06 Mar – 02 Apr). This was followed by a 4 week break, before beginning another 4 week period of tracking activity (08 May – 04 Jun). This is currently a work in progress, so there are no results to deliver at this point. It is hoped that the introduction and bedding in of the Pilot project will show an alteration in how time is spent, which will lead to efficiencies in working.

Initial results indicate an inordinate amount of time being spent on admin and absence management. Further work needs to be done, following the final 4 week period oflogging activities, to determine what improvements can be made here.





END OF PROJECT REPORT

Appendix B – Distribution of themes within projects

Analysis against theme areas

Name	Project	1. CAS	2.Patient Perspective	3.Workforce Models	4. Mental Health	5.Recruitment & Retention	6. Workforce Governance	7. UEC Integration	8. WIF 1 Follow-up
Vocare	Clinical Roles/Skills	X		X		X			
Vocare	Emergency Dispositions								X
Vocare	Mental Health				X		X		X
Vocare	Pharmacists Development	X		X			X		
CareUK	Coaching Support					X			
DHU	Health & Wellbeing					X			
DHU	Remote Wk Pharmacists	X		X					X
DHU	Mental Health		X		X				
LAS	999/111 Integration	X		X				X	
Solihull CCG	High Vol 999 Users	X	X	X	X	X	X	X	
YAS	Workforce Governance						X		
YAS	Supervision Appraisal						X		
IC24	Telephone Triage Clins	X				X		X	X
LCW	Reducing ref to Amb/ED	X	X	X		X		X	