NHS
Leicester City
Clinical Commissioning Group

HEALTH AND WELLBEING SCRUTINY COMMISSION

21 APRIL 2016

Report following whistleblower allegation into NHS111 service provided by Derbyshire Health United

Background

1. This report details the findings of the investigation into Derbyshire Health United (DHU), the provider of the NHS 111 service in Leicestershire, Derbyshire, Nottinghamshire and Northamptonshire. It follows allegations by a whistleblower, which was reported by the Daily Mail on 29th and 30th September 2015. These allegations were previously reported to the Health Overview and Scrutiny Commission.

2. These allegations raised concerns about the safe staffing of the Derbyshire Health United NHS 111 service and its impact upon patient care. The individual raising the concerns was employed by DHU as a NHS 111 Call Advisor initially based at the DHU training centre and later, whilst on probationary period at Mallard House, Derby. The individual was employed by DHU from 5th January 2015 to 20th April 2015.

3. The investigation was undertaken by North Derbyshire CCG and overseen by NHS England. Derbyshire Health United has also carried out a full internal review of all allegations. This review also examined the commissioner assurance processes and considered whether these assurances provided an accurate view of DHU as a healthcare provider of NHS 111 Services.

4. The outcome of the investigation identified that the allegations were comprehensively investigated and the CCG was assured that the core of the allegations had no substance.

5. The findings and recommendations have been shared with all associate commissioners and the North Derbyshire System Resilience lead has been nominated to coordinate and monitor an associated action plan. As part of our assurance processes Leicestershire CCGs participate in quarterly board to board meetings with DHU to monitor performance, quality and finance.

6. In addition to the actions of the North Derbyshire CCG, in November 2015 West Leicestershire CCG (on behalf of all CCGs in Leicester, Leicestershire and Rutland) undertook an unannounced quality visit to the Leicestershire call centre where no concerns were identified relating to staffing rotas.

Main Findings of the Review

7. DHU has been subject to considerable scrutiny since 2014 and external reviews such as CQC inspections have not identified any serious staffing concerns. There were no outstanding actions from previous reviews at the time of completion of this report.

8. The review identified regular variance between forecast staffing levels and actual staffing but did not identify a negative impact on the safety of the service as a result. The review

identified robust methodology for forecasting demand and staffing but recognised the common difficulty of recruiting nursing staff in particular.

9. The review identified a number of key changes to human resources, recruitment and retention policies to support DHU to recruit, train and retain high-calibre staff.

10. The review identified that there are sufficient trigger points within the DHU escalation plan and guidance for escalation in relation to these triggers. However, the review identified that there was no clear mechanism in place for CCGs to check provider compliance with the triggers in the escalation process and that a process should be implemented.

11. The review found no evidence of noncompliance with the provider policies and procedures for warm transfer of calls to nurse advisors**.** It noted that prior to August 2015 DHU had a higher than average warm transfer rate which may have impacted efficiency. It also found that the change of procedure for warm transfer in August 2015 limits the number of dispositions in line with mandatory dispositions to maximise the appropriate use of nurse advisor resource, and noted the extra support to call advisors via the dedicated nurse advice line.

12. The review examined extensive information and determined that DHU has in place robust policies for safe recruitment. The review found that DHU are compliant with NHS Pathways training and licence and that there was clear evidence that the high standards for NHS Pathways training are in place.

13. Evidence was found to show that staff are moving appropriately from training to permanent employment and that DHU has implemented new policies to support effective recruitment, retention and support to staff. No other allegations were raised with commissioners by DHU staff during the review process.

14. The review identified that the messages describing “no nurse available” were incorrect and that these messages referred to Dental Nurse advisors. This inclusion of dental nurse advisors within the service provided by DHU is not a requirement of the NHS111 contract.

15. DHU uses an instant messaging (IM) message system and it was found that this was an effective method of sharing information with staff but is currently open to misuse. The review identified that the IM message system was being used inappropriately by some staff and requires a DHU change of policy to address this.

16. Performance reports were reviewed for the previous three months to establish if the reports being tabled at the various contract meetings were accurate and match the auto-generated performance reports. It was found that these performance reports were accurate, that no anomalies were apparent and that commissioners can be assured that DHU are sharing critical data with commissioners in an open and transparent way.

17. The review noted that key performance indicators, staffing and clinical audit are regular themes of discussion throughout contract meetings. It also found that the commissioner quality assurance and accountability structures across the four counties are complex and have potential to cause a disjointed view of the single provider and recommends that these structures are reviewed.

Recommendations

18. The report set out a number of recommendations both for DHU and commissioners.
19. To support the performance standards for urgent access to care, commissioners must continue to monitor DHU staffing forecast and triangulate with actual staffing during the winter pressure period and report concerns directly to System Resilience Group(s) and Quality Assurance Group(s). Commissioners should also receive regular reports from DHU on workforce, recruitment and retention metrics as a standing item at Quality Assurance Group(s).

20. It was recommended that commissioners develop a system for regular audit of DHU compliance with escalation plan triggers. Commissioners should also ensure systems are in place to capture the information and outcome of all DHU escalation to CCG Directors on Call and share information with the lead commissioner.

21. Commissioners must continue to monitor key performance indicators reporting any underperformance or safety concerns to System Resilience Group(s) and Quality Assurance Group(s) paying particular regard to warm transfer and call back targets in view of changes made to procedures.

22. Commissioners and DHU are reviewing the recommendations of the ECIST report and developing an implementation plan. Particular reference is to be made to the review of the local performance indicator for warm transfer and call back**.**

23. Commissioners are reviewing the effectiveness of the accountability structures and collaborative arrangements for monitoring quality and performance and sharing information.

Next steps

24. The findings and recommendations have been shared with all associate commissioners and the North Derbyshire System Resilience lead has been nominated to coordinate and monitor an associated action plan. As part of our assurance processes Leicestershire CCGs participate in quarterly board to board meetings with DHU to monitor performance, quality and finance.