

Integrated Urgent Care / NHS 111 Workforce Blueprint



Workforce Governance Guide



Contents

Background and introduction	3	Moulage and simulation	24
Equality and diversity	5	Mentorship and preceptorship	24
Good governance: Summary	6	Secondments and job rotation	25
Table 1: Recommendations summary checklist	6	Difficult calls	25
Table 2: Common features of professional registration	12	Overcoming geographical barriers	26
How good governance can help	13	The workforce	28
Leadership for governance	13	Innovation	28
Closing the loop	14	Career advancement and governance	29
Professional registration, supervision, feedback and appraisal	15	Governance: successful recruitment	29
Professional registration, renewal and validation	15	Keeping good team members	32
Appraisal	16	Physical environment	33
Supervision and 1:1 meetings	17	Staff wellbeing	34
Clinical supervision	17	Flexible working	35
One to one meetings	18	Remote working	36
Team meetings	18	Implementing change	37
Audit	19	Risk issues	39
Formal training and qualifications	20	Conclusion	40
Multi source feedback	21	Appendix 1: Skills and values common to all roles	41
Networks, staff groups and communities of practice	23	Appendix 2: Recruitment and retention	42
Schwartz Rounds	23	Appendix 3: Staff wellbeing	44
		Appendix 4: Career pathways	47
		Appendix 5: Co-production	52
		Acknowledgments	54

Background and introduction

This guide outlines the governance, both formal and informal, that will support the Integrated Urgent Care (IUC) / NHS 111 workforce to continue to deliver excellent frontline care to the public. It includes recommendations on appraisal, revalidation, supervision, and using audit to support these. In response to engagement exercises, it also touches on governance around recruitment, reducing attrition and on the physical environment that team members work in.

The guide looks at the elements that are particularly important to the IUC / NHS 111 environment, and is not intended to replace or contradict any of the requirements laid down by an individual team member's professional bodies, where they have one.

However, all team members will benefit from this guidance and there are common themes for team members from all backgrounds, including those who are not registered health and care professionals. Lessons from the health and care environments around the importance of supervision, reflective practice, active support and positive use of information from audit can be used to support better practice across the whole team. This guide was developed based on existing evidence.

As the evidence base is lacking for some forms of governance and support, there is also evidence drawn from engagement with NHS England, Health Education England, and existing IUC / NHS 111

providers. This has provided information on existing good practice, and areas where governance can support further improvement.

This guide should be read in conjunction with existing legislation and national policy in key areas such as the Data Protection Act (1998), the Public Interest Disclosure Act (1998), the Equality Act (2010), existing legislation governing mental capacity, and the results of major enquiries such as the [Francis Inquiry report](#). Further detail of these acts and inquiries lies beyond the scope of this guide, but the guide is not intended to in any way replace, or contradict, existing legislation or good practice.

It is also intended to work in conjunction with the standard duties and good practice in public disclosure, assessing mental capacity, and equality and diversity for each role within the health and social care environment. More detail on these duties will be included in the Workforce Blueprint Career Framework, as part of competency based job descriptions.

IUC / NHS 111 have an essential role as a front door for the wider NHS, offering patients rapid access to advice, information and treatment. IUC / NHS 111 arrange out of hours and emergency primary care for patients, advice on self-care and treatment for minor ailments, and advice on when to seek hospital care. This guide forms part of the IUC / NHS 111 Workforce Blueprint¹ and should be read in conjunction with the

1 The Blueprint comprises the following components:

1. Career Framework; competency based job descriptions - Skills for Health Levels 2-7
2. Career Framework; core and specialist competencies - Skills for Health Levels 7-9
3. Apprenticeship Scheme
4. Workforce Governance Guide
5. Workforce Mental Health and Wellbeing
6. Accreditation and Qualifications Guide
7. Leadership Development
8. Workforce Modelling
9. Career of choice
10. Workforce Survey: Recommendations for Managers

[Five Year Forward View Next Steps](#), the Workforce Blueprint Career Framework and competency-based job descriptions, and the [Integrated Urgent Care Service Specification](#).

Patients experience periods of ill health, rather than episodes of care, and the IUC / NHS 111 services are an important element in ensuring good care and a positive patient experience. The remote call centre environment has distinct features from hospitals or clinics.

Firstly, the NHS 111 component involves working remotely from the patient, meaning that clinicians have to rely on what the patient is telling them, and cannot examine patients, run tests or see body language. This means that they are reliant on Clinical Decision Support Systems (CDSSs) such as the NHS Pathways Programme, which is strongly evidence based and algorithm driven.

Secondly, it shares some features with a call centre, including team members who do not have a clinical background (call handlers/ health advisors), a similar physical environment to call centres and similar pressures in terms of answering phones quickly. It is very unusual for such an environment to also rely on nursing, pharmacy or other healthcare professional staff, which IUC / NHS 111 centres do.

Thirdly, the environment is in competition with many other information sources. This includes:

- Well validated NHS sources such as NHS websites and the pilots for NHS 111 online,
- Commercial websites such as those belonging to pharmacies (both in the UK and abroad),
- Advice from charities and patient groups,
- Advice from the news media, both new and traditional, often with no verification or scientific background,
- Advice from other individuals via social media and website forums.

Research and theory warns that people's decisions are weighted towards information that supports pre-existing beliefs, social norms and familiar information². IUC / NHS 111 services need to be trusted and this will be affected by word of mouth recommendations along social, personal and online networks. This places pressure on every person speaking to the public in this setting to be an ambassador for both the NHS 111 service and the NHS.

2 Sanders Thompson VL. Making decisions in a complex information environment: evidential preference and information we trust. *BMC Med Inform Decis Mak.* 2013;13 Suppl 3:S7. doi: 10.1186/1472-6947-13-S3-S7. Epub 2013 Dec 6.

Equality and diversity

All team members have a role to play in supporting and championing equality and ensuring that our workplace and the services we deliver are free from discrimination. This includes delivering the organisation's obligations as they are set out within the Equality Act and Public Sector Equality Duty, which means not only ensuring equal opportunities for staff and service users, but also ensuring that patients have equal access to NHS services and that health inequalities are reduced across all protected characteristics, and between people who do not have protected characteristics but do have specific needs. Treating people equitably may mean treating people differently or more favourably, in order to ensure equal access – for example, by giving staff with dyslexia more time to sit tests, or by giving people with learning disabilities longer appointments.

All staff must ensure that they have the skills, knowledge and competences outlined within the competency framework to ensure that their practice and the care they provide meets the needs of all individuals with protected characteristics or other specific needs, where appropriate taking account of cultural or language needs, respecting difference and taking action to reduce health inequalities.

All employees must be aware of their obligations and to abide by the spirit and nature of these requirements to avoid direct and indirect discrimination, instead championing equal access to health and care outcomes.

Good governance: Summary

Good governance makes sure that everyone working in the IUC / NHS 111 environment knows what good performance looks like, and has the support they need to deliver excellent care. Information from governance arrangements, like audits, 1:1 meetings and the processes around registered health professionals maintaining their registration, can be used to support service improvements, individual team members constantly improving how they work, and to identify where people or teams need more training and support.

The key recommendations are summarised on pages 6-11, with more detail provided on pages 15-40 and in the appendices.

Table 1: Recommendations summary checklist

Area	Recommendation checklist
Professional registration, renewal and revalidation	Employers must keep up to date on changes to professional registration, renewal and revalidation requirements; appoint a responsible officer if needed
	Employers must encourage supervisors to use routine audit, call feedback and supervision to help all team members build Continuous Professional Development and Learning CPD portfolios in real time
	Line managers must encourage team members at all levels to maintain evidence for their appraisals and registrations (where needed) year round. This can include information from formal CPD, supervision, audit results, patient feedback and records of additional tasks and projects
	Line managers must encourage team members at all levels to use audit results, patient feedback and records of additional tasks and projects to support career progression and continuing professional development
Appraisal	Supervisors and line managers must undertake regular appraisals with all their team members. These should include detailed reference to the Workforce Blueprint Career Framework and competency based job descriptions , and should be conducted by people who have been fully trained and are competent in this skill
	Supervisors and line managers must use appraisals to identify training needs and create professional development plans for team members at all levels, and audit whether opportunities have been identified and followed through
	If a team member is employed by more than one organisation, appraisals at both organisations may not be needed. If this is the case, and the IUC / NHS 111 service is not the appraising organisation, then the team member's line manager must make sure that the appraisal has taken place and is held on file

Table 1: Recommendations summary checklist *continued*

Area	Recommendation checklist
Supervision and 1:1 meetings	<p>Line managers must provide relevant staffing groups with regular clinical supervision in line with professional standards</p> <p>Line managers must provide all team members with 1:1 meetings. The frequency of these can be adjusted in line with locally agreed needs, and if a team member works for more than one organisation, but must be regular and frequent enough to identify issues with performance and stress</p> <p>Staff working part time, flexibly, and predominantly over evenings and weekends must also receive 1:1s and appropriate supervision</p> <p>1:1s must be offered proactively, not solely in response to performance issues or difficult calls</p> <p>Do not allow 1:1s to be frequently cancelled due to operational pressures and ensure that cancelled 1:1s are rescheduled. Do not omit 1:1s</p> <p>Organisations must offer supervisors training in supporting reflective practices</p> <p>Organisations must encourage team meetings and team training to encourage team spirit and provide positive team norms. These meetings must not exclude part time and flexible workers</p> <p>Organisations should consider establishing an employee forum</p>
Audit	<p>Managers must make sure audit is used to create change, as quickly as possible after the initial audit is complete</p> <p>Senior team members must help teams to understand that audit is a positive lever for change, and clearly link change programmes to audit results, so that it is not viewed as punitive or “box ticking”</p>
Formal training and qualifications	<p>Organisations must provide appropriate local induction as well as formal training, e.g. in the Clinical Secision Support System (CDSS).</p> <p>Organisations must work towards acknowledging the training that is provided by other relevant, CQC accredited organisations, to prevent team members having to take the same training twice (see the Workforce Blueprint Accreditation and Qualifications Guide)</p> <p>Senior team members must link training to needs identified at audit and in 1:1s and supervisions</p> <p>Organisations must make training available to all team members, including those who work part time or flexibly</p> <p>Organisations must make reasonable adjustments to allow team members with protected characteristics to access training and qualifications, such as support for those with dyslexia to access exams</p> <p>Training must support leadership at all levels (see the Workforce Blueprint Leadership Development guide)</p>

Table 1: Recommendations summary checklist *continued*

Area	Recommendation checklist
Networks, staff groups and communities of practice	<p>Organisations should encourage networks, communities of practice and employee forums to provide mutual support and advice</p> <p>Line managers should support individual members of the team in accessing networks, communities of practice and employee functions, and view them as a safe space to raise concerns</p> <p>Organisations must provide guidance and training on the use of social media channels</p> <p>Organisations should encourage communities of practice around shared interests or protected characteristics</p>
Schwartz Rounds	Organisations must offer Schwartz Rounds or comparable opportunities to reflect on practice as a team, to all team members
Moulage and simulation	Organisations must use call simulations in training and recruitment
Mentorship and preceptorship	<p>Organisations should identify mentors for team members who will benefit, for example those who are dealing with change, or who are seeking career development and advancement</p> <p>Organisations must support preceptorship programmes for relevant health and care professionals</p> <p>Line managers identifying mentors and cooperating with preceptorship programmes must ensure that mentors and preceptors understand the IUC / NHS 111 environment sufficiently to support team members in their roles</p>
CPD, secondments and job rotation	Line managers should support secondments and job or task rotations for team members at all levels, either within the organisation or across organisations
Difficult calls	<p>Supervisors, floor walkers or shift leaders must proactively take team members away from their work stations for a brief break following a difficult call</p> <p>Line managers must offer specific reviews of difficult calls</p> <p>Senior team members publicise these measures, as there have been cases where team members have been unaware of the policy</p> <p>Organisations must refer to the Workforce Blueprint Mental Health and Wellbeing document in conjunction with this guide</p>
Overcoming geographical barriers	<p>Organisations should investigate the use of modern technology to support distance learning and supervision</p> <p>Supervisors and Line managers should schedule supervision and training to consolidate events in distant locations</p> <p>Senior leaders should identify local supervisors for team members, to maximise day to day contact with supervisors as far as shift patterns allow (see also section on team work)</p>

Table 1: Recommendations summary checklist *continued*

Area	Recommendation checklist
Governance: successful recruitment	<p>Recruiting managers must use real world tasks, call simulations and values based questions in the recruitment process</p> <hr/> <p>Evaluate candidates on the aspects of their roles that are most relevant to the unique IUC / NHS 111 environment; good face to face skills are not the same as good telephone assessment skills</p> <hr/> <p>Organisations must keep clear records on recruitment numbers, tracking successful candidates and recording how long team members stay in their roles following recruitment</p> <hr/> <p>Recruiting managers must ensure that working hours and conditions, e.g. number of weekends likely to be worked, are clear to candidates, both verbally on the day and in written form in the recruitment paperwork</p> <hr/> <p>Recruiting managers should give reasonable consideration to whether a role could be supported part time, on flexible hours or as a job share, and to what reasonable adjustments could be made to support the recruitment of people with different protected characteristics under the Equality Act (2010)</p>
Keeping good team members	<p>Managers must conduct exit interviews routinely, and record reasons for leaving, including promotion, taking on different roles in the NHS or other providers, or leaving due to stress, ill health, poor provision for their needs under the Equality Act (2010) or bullying. Organisations should track trends and take action from this data recorded</p> <hr/> <p>Organisations must support team members in raising concerns, under the Public Disclosure Act (1998), and in raising other grievances</p> <hr/> <p>Enabled by organisation policies and procedures, managers must ensure they provide team members with adequate breaks, access to meals and refreshments, and appropriate levels of noise, light, and comfortable workspace, and ensure that issues are recorded and dealt with when they arise. This includes remote workers. Evidence that this is happening should be retained</p> <hr/> <p>Organisations must make physical space for breaks, to facilitate breastfeeding and to meet the spiritual needs of team members available, and protected. Do not use such space for meetings</p> <hr/> <p>The organisation, through its managers and supervisors, should ensure that it does not become normal to work through breaks</p> <hr/> <p>Supervisors, floor walkers or shift leaders must proactively facilitate team members to get away from their work stations for a brief break following a difficult call, or one that otherwise impacts them. Audit can support the identification of particularly problematic types of calls, times of day, etc</p> <hr/> <p>Managers should use 1:1s with staff to identify if issues are arising from repeat calls, or as a result of repeated exposure to low level stressors. This will identify any occasions where breaks from duties are appropriate</p>

Table 1: Recommendations summary checklist *continued*

Area	Recommendation checklist
Keeping good team members <i>continued</i>	<p>Line managers should assess flexible working requests in line with legislation, and in the spirit of understanding that they can benefit the organisation. They should record the decisions made and the reasons behind them</p> <hr/> <p>Organisations should consider what activities occupational health or HR functions could provide to improve the working conditions for individuals and teams</p> <hr/> <p>Organisations should implement workplace wellbeing schemes using staff engagement to address concerns or cynicism. Ensure that goals are clear from the start and that evaluation criteria are built in from the beginning, and well communicated to your teams. Make sure the IT and other support is in place from the start</p> <hr/> <p>Organisations should give good notice of shift patterns, based on local agreements with team members</p>
Implementing change	<p>Build evaluation in from the beginning of all change projects</p> <hr/> <p>Team members must be involved in change projects from the design stage through all stages to completion and evaluation. Organisations should include a diverse range of team members in this, and give consideration to any equalities issues or differential impact of change that could arise</p> <hr/> <p>Organisations should include external partners such as Local Authorities, patient groups and Third Sector/Voluntary organisations in the coproduction of improvements</p> <hr/> <p>Share the results of evaluations where possible through publications and where appropriate incentives, to benefit the wider system</p> <hr/> <p>Build relationships with commissioners, Academic Health Science Networks (AHSNs) and other organisations whose mailing lists contain links to funding for research</p> <hr/> <p>Create an identified channel to raise ideas for improvements and innovations, and make sure that all team members are aware of how to do this</p> <hr/> <p>Organisations must look for opportunities to partner organisations around research and innovation, including the potential for academic posts working with universities or Deaneries</p> <hr/> <p>Form partnership boards and joint agreements across providers to support change across the workforce. Clinical Commissioning Groups (CCGs), Sustainability and Transformation Partnerships (STPs) and Accountable Care Organisations (ACOs) will support this, and many have existing forums that perform this role. Senior team members should form partnership boards and joint agreements across providers to support change across the workforce. CCGs and STPs will support this, and many have existing forums that perform this role</p>

Table 1: Recommendations summary checklist *continued*

Area	Recommendation checklist
Risk issues	Senior leaders should seek advice from legal teams or commissioners where workforce governance issues are identified
Career pathways	Line managers must work with team members to identify where there are apprenticeship routes open to team members (see also the Apprenticeship section of the Blueprint)
	Supervisors should support team members to gain the entrance requirements for further or higher education, and wherever possible allow study leave for exams and assignment deadlines
	Line managers should offer interested team members mentorship and shadowing opportunities
	Line managers should support team members in identifying projects, job rotations and tasks that will allow them to gain promotion, or widen their existing skills within their current roles
	Organisations should work with organisations such as the Local Workforce Action Boards to identify opportunities for rotational roles, broader roles, and for advice on how to harmonise conditions for team members and identify which organisation is responsible for their official line management and any registration requirements

Table 2: Common features of professional registration

	Link to Statutory Guidance	Feedback on Practice	Significant Event Review	Clinical Audit	Reflection	CPD Activity Requirement	Appraisal	Statutory Revalidation	Periodic Renewal	Regulatory Body	Regulation
General Practitioner		Required	Required	Contributes to Quality Improvement requirement	Required	Not prescribed	Required Annually	Yes	5 Yearly	General Medical Council	Statutory
Registered Nurse		Required	Contributes to Reflection Requirements	Contributes to CPD & feedback requirements	Required	35 hours over 3 years	Contributes to CPD requirement	Yes	3 Yearly	Nursing & Midwifery Council	Statutory
Paramedic		Contributes to CPD requirement	Contributes to CPD requirement	Contributes to CPD requirement	Contributes to CPD requirement	Not prescribed	Contributes to CPD requirement	No	2 Yearly	Health & Care Professions Council	Statutory
Pharmacist		Peer review required	Contributes to CPD requirement	Contributes to CPD requirement	Contributes to CPD requirement	9 CPD activities per year	Contributes to CPD requirement	From April 2018	Annual	General Pharmaceutical Council	Statutory
Dentist		Contributes to CPD requirement	Contributes to CPD requirement	Contributes to CPD requirement	Required	100 Hours per year	Contributes to CPD requirement	Enhanced CPD	Annual	General Dental Council	Statutory
Dental Nurse		Contributes to CPD requirement	Contributes to CPD requirement	Contributes to CPD requirement	Required	50 Hours per year	Contributes to CPD requirement	Enhanced CPD	Annual	General Dental Council	Statutory
Physician Associate	none	Required	Contributes to CPD requirement	Contributes to CPD requirement	Required	50 Hours per year	Annual with Supervisor	N/A	Annual	none	Faculty for PAs operate a Managed Voluntary Register
Non-Registered Staff	N/A	Contributes to CPD	Contributes to CPD	As part of service audit schedule	Strongly Advised	Contributes to Appraisal: No set hours	Annual with Supervisor	None	None	None	None

How good governance can help

The core purpose of governance is to ensure visible, transparent standards for quality care; in this case, through the supervision, training and support offered to team members in IUC / NHS 111. The emphasis is on delivering care that meets the needs of our patients; the right care, in the right place, from an appropriately skilled and qualified individual, in a timely manner. Good governance also helps support team members and patients, including by ensuring consideration is given to their diverse needs with reference to protected characteristics under the Equality Act (2010). These are:

- Age
- Disability
- Gender Reassignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

It should be a routine part of everyone's management practice and daily activities, not an extra set of tasks. Good governance makes it clear to people what they should be achieving, the standards and values they should be meeting, and what they can do if they identify problems or opportunities to do better.

Hastings et al (2014)³ explored the relationship between governance mechanisms in healthcare and healthcare workforce outcomes in a systematic review. They found the most important factors were that governance should build trust (see section on Audit below), consider the workforce throughout the process of planning, implementation and evaluation and providing strong leadership.

Leadership for governance

Leadership is vital for good governance and a culture of support. Leaders must be seen to value contributions from all team members, act on the results of audit and incident analysis, and encourage supportive, positive practices and embracing diversity. Providing clear direction and role models will be essential in embedding any change.

Leadership can be demonstrated in any role, at any level of the organisation; a good team member can take on informal leadership for improving change or sharing information on performance or patients' diverse needs. However, organisations should make sure that they maximise the role of the Non-Executive Directors and similar critical friends as a source of independent oversight. Opportunities to involve patients as change leaders and in service improvement should also be actively sought out.

³ Hastings et al. 2014. Exploring the relationship between governance mechanisms in healthcare and health workforce outcomes: a systematic review. BMC Health Services Research, 14:479.

Closing the loop

Throughout this document, audit is used in its broadest sense. This includes the call audits that are mandated in the licences for delivering IUC / NHS 111 services, clinical audit, audits undertaken to identify training needs, unmet patient need, issues around diversity and equality, as well as those that involve potential process improvements.

Several organisations reported that they are more tightly governed and audited than other services, such as 999, and that individual incidents are carefully recorded and analysed. This is fed back to individual team members, but not always in time to prevent other similar incidents. The results of audit and other forms of governance are also not analysed at an organisational level and fed into wider training or communications.

Information from training, support and incidents can be useful to the organisation in a number of ways.

- If there is an increase in calls relating to a specific pathway, this may trigger reminder training on this pathway.
- If several team members have highlighted similar training needs through 1:1, or if audit has highlighted gaps in several team members' confidence or knowledge, this can identify a need to run an in house training event rather than pick it up with individual team members.⁴
- Themes around the diverse needs of patients, with reference to the protected characteristics under the Equality Act 2010, communication needs, new ways of using the service and emerging clinical needs can be used to improve the service for others.
- Increases in certain types of call can be good intelligence for the wider health community; for example calls around respiratory viruses may warn hospitals of increases in respiratory admissions.

This sort of information needs to be acted on quickly, and team members informed that the reason for action is information from audit or other supervision. This in turn will build the trust that Hastings et al (2014)⁵ viewed as essential to creating good governance.

⁴ Information from engagement, with thanks to North West Ambulance Service.

⁵ Hastings et al. 2014. Ibid.

Professional registration, supervision, feedback and appraisal

Both Statutory and Voluntary Registration arrangements are in place for healthcare professional roles working within IUC settings.

A summary of the registration and CPD arrangements for principal roles within IUC / NHS 111 environments is shown on page 12. This is correct at the time of publication, but providers must check with each professional body as several professions are currently consulting on requirements; links are included. Nor is this an exhaustive list of potential professional backgrounds.

Professional registration, renewal and revalidation

- Employers must keep up to date on changes to professional registration, renewal and revalidation, to support individual registrants' responsibilities. Appoint a responsible officer if needed.
- Employers should require supervisors to use routine audit, call feedback and supervision to help all team members build CPD portfolios in real time.
- Line managers must encourage team members at all levels to maintain evidence for their appraisals and registrations (where needed) year round. This can include information from formal CPD, supervision, audit results, patient feedback and records of additional tasks and projects.
- Line managers must encourage team members at all levels to use audit results, patient feedback and records of additional tasks and projects to support career progression and continuing professional development.

Revalidation is a rapidly emerging concept, grown out of CPD requirements and periodic registration requirements. The process and language is evolving, and third party verification and feedback is becoming more prominent. It is a requirement for several

professional groupings, including GPs, nurses and pharmacists, and consultation is taking place at the time of publication for other professional groups, such as physician associates; for these groups it has specific legal meaning. It is not a requirement for non-health and care professional roles, such as Service and Health Advisors, but a light touch version of CPD portfolios will benefit team members at all levels.

Revalidation can be seen as onerous, coming on top of other measures such as 1:1s, clinical supervision and audit, and feedback on calls. However, all these other measures can be part of the evidence gathering for revalidation. IUC / NHS 111 also offer opportunities to learn from other professionals, and to get feedback from non-clinical colleagues and the public. This can support development and revalidation. Team members can also keep records of compliments and complaints in real time, which prevents having to build evidence later.

Some organisations are worried that it is not possible to maintain face to face skills in the NHS 111 environment, although organisations that offer face to face services through IUC service have an advantage in that team members can rotate amongst roles.

Some professions may have to make decisions on maintaining specific competencies. For example, Dental Nurses have enhanced CPD requirements from 2018, requiring them to demonstrate ongoing competence and CPD in areas in which they continue to practice. This means, that Dental Nurses in the 111 environment may lose competence in, and therefore the ability to do, x-rays unless they maintain second roles where this skill is used and CPD offered. So far, this has been possible within most providers employing Dental Nurses. It is the responsibility of each individual team member to maintain awareness of their professional requirements, and each employer to support this. The common features of professional registration are laid out in the matrix on page 12.

Team members who do not require revalidation or registration will benefit from maintaining clear records of CPD and the outcomes of audit, colleague and public feedback and reflection. This will support annual appraisal and further professional development.

Appraisal

- Supervisors and line managers must undertake regular appraisals with all their team members. These should include detailed reference to the Workforce Blueprint Career Framework and competency based job descriptions, and should be conducted by people who have been fully trained and are competent in this skill.
- Supervisors and line managers should use appraisals to inform and identify training needs and create professional development plans for staff at all levels, and audit whether opportunities have been identified and followed through.

- If a team member is employed by more than one organisation, appraisals at both organisations may not be needed. If this is the case, and the IUC / NHS 111 service is not the appraising organisation, then the team member's line manager must make sure that the appraisal has taken place and is held on file.

Everyone should be appraised annually. This includes team members in non-patient -facing roles, such as IT team members, HR and Finance specialists. Any issues raised in appraisal around performance should be discussed during 1:1s as well, and all team members must have the opportunity to discuss their concerns and develop a professional development plan to address any training needs, aspirations and professional interests.

Where team members are employed by more than one organisation, employers may wish to agree that one organisation is the lead employer and that separate appraisals in each organisation are not needed. It is important that no team member is excluded from this process, and line managers in the IUC / NHS 111 provider organisations should ensure that an appraisal has taken place and is held on file.

Appraisals are an opportunity to identify training needs, including those for team members who are aspiring for promotion, further training or wider tasks within their current roles. These should form the basis of an achievable personal development plan, and audits can be considered in terms of whether team members are meeting their goals, and, importantly, if opportunities that have been promised have been offered.

Supervision and 1:1 meetings

- Line managers must provide relevant staffing groups with regular clinical supervision in line with professional standards.
- Line managers must provide all team members with 1:1 meetings. The frequency of these can be adjusted in line with locally agreed needs – and if a team member works for more than one organisation – but must be regular and frequent enough to identify issues with performance and stress.
- Staff working part time, flexibly, and predominantly over evenings and weekends must also receive 1:1s and appropriate supervision.
- 1:1s must be arranged proactively, not solely in response to performance issues or difficult calls.
- Do not allow 1:1s to be frequently cancelled due to operational pressures and ensure that cancelled 1:1s are rescheduled. 1:1s are valuable and should be protected at all times.
- Organisations should offer supervisors training in supporting reflective practices.
- Organisations must encourage and facilitate team meetings with both clinical and team development focus and team training to encourage team spirit and provide positive team norms and opportunity for clinical levelling; this will help individual team

members highlight issues and support each other. These meetings must not exclude part time and flexible workers.

- Organisations should consider establishing an employee forum.

Clinical supervision

The evidence linking clinical supervision to the quality and safety of patient care reveals that supervision is most effective when its educational and supportive functions are separated from its managerial and evaluative functions. To be successful, supervision should also be professionally-led and learner centred rather than externally imposed and centred on institutions (Tomlinson 2015⁶). Although there is a lack of consensus around what forms are most effective and a large variation in practice (Pollock et al 2017⁷), Snowdon et al (2016⁸) found that in general clinical supervision was associated with safer surgery and medical procedures, and the same improvements are likely in the IUC / NHS 111 settings.

Clinical supervision should not be confused with 1:1s, but they can be conducted in tandem for relevant staffing groups.

Many people working in the IUC / NHS 111 environment work part time, and work during evenings and weekends. They must also receive appropriate clinical supervision, 1:1s, and protected training time.

- 6 Tomlinson (2015). Using clinical supervision to improve the quality and safety of patient care: a response to Berwick and Francis BMC Medical Education, 15:103.
- 7 Pollock A., Campbell P., Deery R., Fleming M., Rankin J., Sloan G. & Cheyne H. (2017). A systematic review of evidence relating to clinical supervision for nurses, midwives and allied health professionals. Journal of Advanced Nursing 73(8), 1825–1837. doi: 10.1111/jan.13253.
- 8 Snowdon et al. (2016). Does clinical supervision of health professionals improve patient safety? A systematic review and meta-analysis. International Journal for Quality in Health Care, 28(4), 447–455 doi: 10.1093/intqhc/mzw059.

One to one meetings

All team members, including those working part time and flexibly, and those working predominantly during evenings and weekends, must be offered 1:1 meetings; this includes people from non-healthcare backgrounds, and those working in “back office” functions such as IT and finance. There does not appear to be a strong consensus on how often these should be done, with some organisations offering them monthly, some bi-monthly and one stating that team members mainly had 1:1s “when something happened.” As team members may not disclose “something” happening, 1:1s should be scheduled proactively. They should also not be used solely following performance issues, as this would lead to them being viewed as punitive. Simple records must be kept on the frequency of 1:1s for team members, and of issues raised.

Team members at all levels that are patient facing, deal with difficult and potentially emotional calls. This means that they will also benefit from reflecting on their practice on a regular basis. Supporting reflective practice may be a new skill for some supervisors, including those from a non-clinical and call centre background, and they may need extra training in this area. This is especially true as such supervision is also designed to help junior team members question received wisdom and the practice of more senior team members. Consider offering management coaching for all team members at the senior health advisor level and above. In addition, the implementation of Schwartz Rounds may prove useful in these aspects of support and professionalisation⁹.

Team meetings

Team meetings are a potential means of offering supervision and support that would allow team members to learn from each other. Types of team include those bound by supervision structures and line management, teams bound by professional groupings and teams influenced by working together frequently. Meetings can be hard to schedule due to shift patterns, so may be infrequent. However, team based training, working through call simulations together and discussing incidents and near misses as a group can create an opportunity to create positive team norms, a supportive culture and learning. Weaver et al (2014)¹⁰ found evidence that team training could positively impact team processes and patient outcomes. They also provide a forum to discuss and introduce new practice and improvements. Some organisations have improved uptake of a wellbeing programme by organising people into teams for the first time, and providing team supervisors, and team challenges around workplace wellbeing.

People who feel part of a team are a valuable source of informal support and supervision, able to identify problems and good practice, encourage talented colleagues to take up development opportunities and more likely to report incidents and near misses. Supervising very large teams can be difficult, and hard to govern. Some organisations have had success changing team structures to encourage closer team working and improve supervision (see example box). We recommend that providers look at staff survey results on how

9 George, M. (2016). Stress in NHS staff triggers defensive inward-focussing and an associated loss of connection with colleagues: this is reversed by Schwartz Rounds. *Journal of Compassionate Health Care* (2016) 3:9 Health Care (2016) 3:9 DOI 10.1186/s40639-016-0025-8.

10 Weaver SJ, et al. 2014. Team-training in healthcare: a narrative synthesis of the literature. *BMJ Qual Saf* 23:359–372. doi:10.1136/bmjqs-2013-001848 359.

supported team members feel by team and shift leaders, and ensure that there are sufficient, adequately trained team members in these roles, so that team members are able to access support when needed and get regular 1:1s. When the needs of teams are considered and meetings are scheduled, it is important to also consider the needs of part time and flexible workers and involve them as fully as possible.

The Partnership of East London Cooperatives has established an employee forum. It has been well supported and allows team members at all levels to engage with senior leadership on issues like drilling down into what staff survey results really mean. This has been instrumental in supporting staff engagement and wellbeing. Separate support groups have been established for offering support for mental health at work and stress. As employees have initiated this, it is seen as more positive than if it had been a top down invitation from senior leadership. This measure erodes the impact of team member's titles and implied status and encourages more co working.

Yorkshire Ambulance Service has undertaken work to improve supervision and team working. Teams were reduced in size, from up to 33 people to 15 people. This required appointing more team leaders, which was a cost pressure. However, the proportion of people in the pilot who felt supported rose from 74% to 95%, and the percentage of delivered 1:1s rose from 47% to 83%. Team members also saw an improvement in being able to access Team Leaders, who had previously sometimes not shared shifts with all team members and in some cases had had full email boxes, and in the number of professional development reviews created.

Audit

- Managers must make sure audit is used to facilitate and enable change, as quickly as possible after the initial audit is complete.
- Senior team members should help teams to understand that audit is a positive lever for change, and clearly link change programmes to audit results, so that it is not viewed as punitive or “box ticking.”

The IUC / NHS 111 environments are amongst the most heavily audited areas of the NHS. This is particularly the case for NHS 111, in response to the requirements of the Clinical Decision System licence and governance specification, although the licence only specifies call audits. Throughout this document, the term audit is intended to include call audits as part of the licensing for the service, clinical audit, and audits that identify workforce issues, process improvements and other issues. Audit should seek to reduce health inequalities, improve access and care for patients, and address any issues arising around protected characteristics for team members or patients.

While this is a positive, there is a need to make sure that topics audited in addition to call audits are useful, and the information fed back into the wider IUC / NHS 111 service as a driver for service and performance improvement. This must be done in a timely manner, which can be a challenge in a busy environment. This engagement has highlighted that there are lessons to be learned from the 999 service, where audit has become viewed more positively and less as an opportunity to catch people out. For example, North West Ambulance

Service NHS Trust, who run both ambulance and NHS 111 services, are appointing a specific Band 7 role to merge audit and training so that trends can be spotted and used to identify training and support needs.

Formal training and qualifications

- Organisations must provide appropriate local induction as well as formal training, e.g. in the Clinical Decision Support System.
- Organisations must work towards acknowledging the training that is provided by other relevant, CQC accredited organisations, to prevent team members having to take the same training twice (see the Workforce Blueprint Accreditation and Qualifications Guide).
- Senior team members should link training to needs identified at audit and in 1:1s and supervisions.
- Training should support leadership at all levels (see the Workforce Blueprint Leadership Development guide).
- Organisations must make training available to all team members, including those who work part time or flexibly.
- Organisations must make reasonable adjustments to allow team members with protected characteristics to access training and qualifications, such as support for those with dyslexia to access exams.
- Link training to needs identified at audit and in 1:1s and supervisions.

All team members should have access to formal training and qualifications. This includes training essential to the role, but may include access to training that is not mandatory but does enhance their ability to do their job. The Workforce Blueprint includes an Accreditation and Qualifications Guide, which has details of how this should be supported. This document will also support organisations in improving access to training and qualifications for team members who have specific issues accessing training, for example individuals who left school without the specific formal qualifications needed to access a course. Organisations will need to consider how to support all team members, including part time workers, flexible workers and workers who need reasonable adjustments to access, training. Temporary adjustments to shift patterns may also be needed.

Any worker using the Clinical Decision Support System has a thorough training period, which is well validated, nationally recognised and governed by strict licensing. It concludes with an exam. Some organisations also offer less senior staff a **SHORTENED AND RESTRICTED VERSION OF CDSS** training, which allows them to direct calls on a limited range of issues (for example repeat prescriptions or calls from health professionals) without using the full programme. The training for this is shorter.

All members of a team should also be offered a broader local induction, covering “soft skills”, practice calls, a supervised period of call handling, and training in issues such as fire safety and equality and diversity issues. Organisations have also trialled introducing courses on emotional intelligence and self-awareness, which staff members have evaluated positively. It is also worth considering training and induction that will

support leadership at all levels; see Appendix 1 and the Workforce Blueprint Leadership Development guide.

Other specific skills can be offered to Clinical Advisors. Organisations have successfully implemented training in palliative care support, avoiding distressing and unnecessary transfers to hospital for people who have expressed a preference for dying at home. Some have developed training in mental health.

The Partnership of East London Cooperatives (PELC) are looking for providers to provide a two year structured training course for a broad range of team members, including those who do not have a clinical background. This will be taken whilst working in the service, and lead to a qualification in management. This aims to support team members who aspire to management roles within the organisation.

Many staff will work in more than one organisation. This can lead to duplication of training courses, including life support, safeguarding, and equality training. Whilst local induction in certain areas such as fire safety, equipment and specific contacts and operating procedures will always be needed, organisations should work towards acknowledging training from other CQC registered organisations and nationally accredited courses like Advanced Life Support. Separating local and standard aspects of induction may allow shorter versions for appropriately qualified staff. Support should be sought from commissioners where needed. The Workforce Blueprint Accreditation and Qualifications Guide should also be referenced.

Multi source feedback

- Supervisors should facilitate and provide team members with feedback from multiple sources of feedback, including feedback from 360 degree processes, and information collected from patients, during incident investigations and through 1:1s.
- The organisation should seek feedback from their partner organisations, including on how co-working could be improved and other aspects of how the services interact. Organisations can include NHS providers and commissioners, third sector and voluntary bodies, local authorities and patient forums.
- The organisation must provide support and training for team members who are not used to reflecting on feedback to learn how to use the information they are given to improve practice.
- Supervisors must include positive feedback as well as constructive critical review through the ongoing supervision and management processes.
- Organisations must look for opportunities to track patients through the patient journey, using NHS numbers or patient stories, and to engage with staff and patients through this process with appropriate data sharing agreement(s), to comply with information governance requirements.

Multisource feedback, or 360 degree feedback, gathers feedback on an individual's performance from more than one person, often including feedback from someone's direct reports, colleagues and where possible patients. There is some evidence (Ferguson et al 2014¹¹) that it influences professional practice, although further research is needed.

Patients are an essential source of feedback. This includes collecting patient comments, and proactively approaching patient organisations for comment. Healthwatch is another potential source of feedback, as are local authorities and voluntary and third sector organisations.

Organisations should also ensure that they make an effort to reach out across the community for feedback, including to organisations serving specific groups in society. This might include specifically asking if the service is meeting the needs of people from specific ethnic or religious backgrounds, the needs of the LGBTIQ+ community, or people who have other protected characteristics. These groups may not always be well represented in existing patient forums, but Healthwatch and other organisations can support proactive efforts to seek feedback.

Feedback from other organisations, on how well co working and partnership is working, perceptions of transfers and so on, can support organisational improvements.

Organisations should make sure that patient comments are passed on to the relevant team members, including congratulations from senior leadership when complements are received.

A lack of feedback on calls can be frustrating, and some team members feel that they only ever hear about calls that are subject to audit or incident investigations. This can contribute to attrition, as it can make it hard for healthcare professionals in particular to develop their skills. Providers should consider how this could be improved for team members. It is possible to track patients through their journey using NHS numbers. Work should be undertaken, with advice and guidance from organisations' Caldicott Guardians and Information Governance Leads, together with patient and public representatives, to ensure that this can be done across organisational boundaries and without breaching confidentiality and, where required, with patient consent. Support can be obtained from commissioners and partner organisations if needed. This feedback should be included in training, both at an organisational and individual level, and can be valuable in the appraisal process and as part of reflective practice.

In light of concerns, Yorkshire Ambulance Service instituted end-to-end call reviews, which allow team members to request a review of a specific patient contact and understand the final outcome. This allows teams to work to identify potential improvements on how the call could have been triaged through NHS Pathways, and reflect on how the call was handled. Sessions involve 6-9 people. The key findings were that workers felt more engaged and had more of a sense of how they add value to the service. It also improved confidence, understanding and recognition between clinicians and Health Advisors.

11 Ferguson et al. (2014). Factors influencing the effectiveness of multisource feedback in improving the professional practice of medical doctors: a systematic review. BMC Medical Education, 14:76.

Networks, staff groups and communities of practice

- Organisations should encourage networks, communities of practice and employee forums to provide mutual support and advice and opportunities for benchmarking and levelling of practice.
- Line managers should support individual members of the team in accessing networks, communities of practice and employee forums, and view them as a safe space to raise concerns.
- Organisations should encourage communities of practice around shared interests or protected characteristics.
- Organisations must provide guidance and training on the use of social media channels.

Healthcare professionals are often already members of formal or informal communities, providing access to conferences, forums and sources of advice and support. Whilst these are not directly related to governance, they can create positive social norms and advice streams that can support good practice. This will not be the case for call handlers/health advisors, but networks and communities of practice can form if they are encouraged to do so. This may include groups for people who have common interests, such as carers, or who share protected characteristics. Organisations should support these groups, but should take care not to impose them in a tokenistic way. People may be more likely to seek advice and support from people who do not supervise them.

One area where this can be problematic is where social media channels arise. As a less formal means of communication, these can result in people saying things that they would not say in a more formal space, risking reputational damage and harm to patients. We recommend that organisations encourage social media use, but provide training and guidance to ensure that patient and confidentiality is protected and conversation remains respectful.

Schwartz Rounds

- Organisations should offer Schwartz Rounds or comparable opportunities to reflect on practice as a team, to all team members.

More information on Schwartz Rounds can be found in Appendix 3. They have benefits in eroding barriers amongst professional groups, and reminding team members of their shared purpose in supporting patients. They are not widespread in the IUC / NHS 111 environments, although some organisations have successfully trialled them for health professionals. Any team member could have emotionally demanding encounters with patients. However, they may not feel able to raise their experiences with supervisors, or to tell them that they are experiencing stress. In addition, the insights of an “expert non clinician” into how team members, who don’t have clinical training or understand medical terms, may react can be extremely valuable to the whole team.

Moulage and simulation

- Organisations should use simulations and case re-enactment in training, supervision, governance and recruitment.

Many organisations use call simulations in their recruitment processes, and find that this is a more effective way of identifying which applicants are successful than traditional interview alone.

'Moulage' is used by some organisations, such as Air Ambulances to re-visit incidents. Through a governance and supervision process, those involved in the case can meet together with clinical supervisors, for the purpose of reflection and learning.

Some also reported using call playback in 1:1s and in dealing with the aftermath of a difficult experience or incident. Far fewer reported using moulage or simulation techniques in actual training situations. Yorkshire Ambulance Service identified this as a potential benefit following piloting end-to-end case reviews (see above). Used in this way, using actual calls as a starting point, makes it possible to support team members to look at how stressful calls could have been better handled.

Mentorship and preceptorship

- Organisations must identify mentors for team members who will benefit, for example those who deal with high levels of uncertainty, or who are seeking career development and advancement.
- Organisations must support preceptorship programmes for relevant health and care professionals.
- Line managers identifying mentors and cooperating with preceptorship programmes must ensure that mentors and preceptors understand the IUC / NHS 111 environment sufficiently to support team members in their roles.

Mentorship and preceptorship are separate to supervision, and offer longer-term support, advice and coaching. A mentor or preceptor must not be in a team member's line management chain (e.g. not their manager's manager), to allow for free discussion. Mentorship is a concept that is common throughout all professional groups. Preceptorship is more specific to health and care professionals, usually referring to a structured period of transition for newly qualified staff.

Mentorship is potentially useful to all team members, but in particular to those who:

- Are very senior and making decisions based on very low levels of certainty, and who do not have a more senior health professional in their own field to routinely seek advice from.

- Are new in a role and looking for opportunities to develop their skills or career.
- Have specific skills or interests they want to develop, especially if there is no specific in house training on these topics.

Neither of these roles are specific to the IUC / NHS 111 environment, but mentors and preceptors should be aware of the specific nature and challenges involved in these roles to best support team members with their development.

Secondments and job rotation

- Line managers should support secondments and job or task rotations for team members at all levels, either within the organisation or across organisations.

Many organisations responding to the engagement for this guide support team members who have portfolio careers, and larger providers may offer rotational roles where team members work for a number of weeks in the IUC / NHS 111 environment, then move through mainstream ambulance environments, urgent care environments or primary care. This has many benefits, including maintaining confidence in dealing with patients face to face, maintaining competencies in procedures, and developing relationships with the wider NHS. Supporting secondments and job rotations may also support equality of access into new roles for people who had not previously considered them, and therefore encourage a more diverse range of people to apply for new roles as they become available.

Smaller providers may not be able to offer formal rotational roles, but can support workers in taking on improvement projects for set hours a week; this can support them in gaining project management, general management, HR and other skills. More information on this can be found in Appendix 4.

Difficult calls

- Supervisors, floor walkers or shift leaders must proactively facilitate team members to get away from their work stations for a brief break following a difficult call or where staff are otherwise impacted by calls.
- Line managers must offer specific reviews of difficult calls.
- The organisation should publicise these measures to ensure and manage expectations.
- Organisations must refer to the Blueprint Mental Health Document in conjunction with this guide.

The nature of IUC / NHS 111 means that occasionally, team members at all levels may experience a call where a patient is very unwell, where the call has been distressing, or where a patient is abusive to the call handler. Provision must be made to support team members who have had difficult calls, both at the time and if emotions surface later. UNISON Calling (2012¹²) recommends making it normal and non-punitive to take a worker straight away from their workstations for a break if this happens. Employers have stressed the importance

12 UNISON Calling (2012) London: UNISON retrieved from <https://www.unison.org.uk/content/uploads/2013/06/On-line-Catalogue208653.pdf>.

of reflection on bad calls, which do not always sound as distressing when played back and people can hear how they handled the call. Facilitated workshops following difficult calls can also lead to shared learning and reduced stress.

Line managers should be aware that it is not always the most obviously difficult calls that have the highest impact on team members. They should be trained to help team members identify stress and to act on it as early as possible, in line with the Workforce Blueprint Mental Health and Wellbeing document. Where possible, line managers should consider factors relating to personal experience and diversity, such as whether a team member has had a recent bereavement. There may also be cultural issues around the expression of, or attitudes to, specific conditions such as mental health. However, organisations and line managers must also avoid making assumptions about what calls will be difficult for which team members. For example, a line manager may assume that a paediatric call would be extremely distressing to a recent parent, but underestimate the impact on a young team member without children but who has a young sibling in the family. The cumulative impact of calls that are not obviously difficult, but which touch on similar issues, should also be kept in mind.

Practices such as the availability of breaks after difficult calls should also be well publicised to teams. Team members working for one organisation asked for breaks to be made routine during a wider project to improve wellbeing. Leaders fed back that this had always been available, but supervisors were then encouraged to actively promote breaks after difficult calls.

Overcoming geographical barriers

- Organisations should investigate the use of modern technology to support distance learning and supervision.
- Supervisors and line managers should schedule supervision and training to consolidate events in distant locations.
- Senior leaders should identify local supervisors for team members, to maximise day-to-day contact with supervisors as far as shift patterns allow (see also section on team work).
- Organisations should seek to identify supervisors across professions, based on competences and appropriate seniority, to enable inter-professional supervision.

Many organisations run multiple centres, which can be considerable distances apart as measured by travel time. This can be a barrier to supporting team members in some locations. Basing services in multiple locations can be positive, however, allowing the recruitment and retention of team members from a range of local areas, who can offer local insights and knowledge into the population. There are also numerous reasons why team members may not be able to commute to central hubs. These may include being unable to travel because of financial constraint or disability, or long commutes being impossible due to caring responsibilities. Improving access to roles locally can therefore overcome some barriers for diverse groups of potential employees. As a final benefit, local hubs reduce the NHS's contribution to commuter based pollution.

Increasing access to technology, including video conferencing solutions, allows meetings to take place over distance. Organisations such as NHS Northumbria have pioneered sensitive patient consultations, IUC and HIV clinics, over distance. In other fields, telemedicine to ships, aeroplanes and climbing expeditions have all been successful¹³. If this can be governed for sensitive patient information, secure solutions could be found for staff supervision and multiple location team meetings. Organisations should horizon scan for affordable technological solutions to meeting over distance.

More simply, supervisors and managers should consolidate 1:1s, appraisals and training to minimise the need to travel between sites. They should also consider whether they could base themselves at sites that are not their usual place of employment for some shifts a month. Teams should also be organised in such a way to allow the identification of local supervisors wherever possible.

¹³ see e.g. www.stsmed.org.

The workforce

Innovation

IUC / NHS 111 have a diverse workforce. The IUC / NHS 111 Workforce Blueprint Career Framework and competency based job descriptions¹⁴ describe the most common roles. They vary from Service Advisors at NHS Skills for Health Level 2, through Health Advisors and Clinical Advisors, to very senior clinical colleagues. The backgrounds of team members working in the centres vary from school leavers and people with a call centre background, to nurses, GPs, paramedics and pharmacists. There will also be vital support teams, including IT teams, finance staff, HR specialists and communications officers, who should be included in governance arrangements wherever possible.

Despite the range of roles, all team members should have common values and skills. These can be found in Appendix 1. They also have comparable needs around CPD, outlined in more detail in the matrix on page 12.

Historically, the Clinical Decision Support systems used by provider organisations, such as the CDSS licence, are specific about roles and responsibilities, but several organisations have brought in specific new roles, professions and functions to meet patient need. These include:

- Dental nurses; high call volumes relating to dental care, and a lack of maxillo-facial, ENT or dental experience in the existing workforce, led to high redirection rates to emergency care. Many of these calls can now be concluded with self-care advice and routine appointments.

- “Floorwalkers”: senior team members who can offer Health Advisors immediate clinical advice without needing to redirect calls
- Healthcare professionals with mental health experience.
- Physician Associates: currently unable to prescribe and are not subject to statutory regulation. This limits their scope in the NHS 111 setting, e.g. due to CDSS licensing requirements, but they have potential for employment within IUC treatment centres, supporting their supervising GPs.
- Senior consultants; senior GPs, nurses, paramedics and mental health nurses capable of offering advice and support in extremely uncertain circumstances.

Governance for these roles was not as hard as anticipated. When legal advice has been sought, the new roles were viewed as a lower indemnity risk than not having the clinicians on board, and better than having to use agency staff to address general clinical shortages.

IUC / NHS 111 centres and treatment centres are part of a rich tradition of innovation, both in their current forms and in their predecessor organisations. Tapping into this organisational and team member memory will allow providers to identify potential solutions, and the barriers to implementation that were overcome in the past.

Innovations in the workforce are now enabled through and supported by the Workforce Blueprint Career Framework and competency based job descriptions, which are designed to be multi-professional.

¹⁴ <https://www.england.nhs.uk/publication/integrated-urgent-care-nhs-111-career-framework-and-competency-based-job-descriptions-skills-for-health-levels-2-7/>.

Career advancement and governance

Many organisations have stressed the importance of having clear lines of career advancement for team members, both healthcare professionals and team members from other backgrounds. This improves outcomes for patients and reduces attrition. Career advancement opportunities must be equitable, support a more diverse workforce, and be open to all team members. This should include reasonable adjustments to roles for people with protected characteristics, or unprotected needs such as parenthood that could impact on shift patterns, working hours or other aspects of the role. Reasonable consideration should also be given to offering roles part time, on flexible hours or as job shares.

More information on career advancement can be found in Appendix 4.

There are multiple possible routes to career advancement. These include team members moving up bands within their current training, healthcare professionals moving into management, and team members from call handling backgrounds moving into clinical training or becoming managers themselves. From a governance perspective, all audit, CPD, reflection on practice and rotational roles or extra projects and tasks should be documented. This will support team members in identifying their skills, interests, and development areas and make it more likely that they will be successful in interview.

Together, the Workforce Blueprint components address these issues of career progression and enable the Career Framework, supported by competency based job descriptions for Skills for Health levels 2 to 6 and Skills for Health Levels 7 to 9.

Governance: successful recruitment

- Recruiting managers must use real world tasks, call simulations and values based questions in the recruitment process.
- Organisations should evaluate candidates on the aspects of their roles that are most relevant to the unique IUC / NHS 111 environment; good face to face skills are not the same as good telephone assessment skills.
- Organisations must keep clear records on recruitment numbers, tracking successful candidates and recording how long team members stay in their roles following recruitment.
- Recruiting managers must ensure working hours and conditions, e.g. number of weekends likely to be worked, are clear to candidates, both verbally on the day and in written form in the recruitment paperwork.
- Recruiting managers should give reasonable consideration to whether a role could be supported part time, on flexible hours or as a job share, and to what reasonable adjustments could be made to support the recruitment of people with different protected characteristics under the Equality Act (2010).

Successful recruitment of the best possible team members supports the delivery of excellent services. Organisations must work towards recruiting excellent team members from across the community, including opening up roles (where possible) to people who can work part time or flexibly, to people seeking job shares, and actively seeking to recruit people from as diverse a range of backgrounds as possible. IUC / NHS 111 is also

a potential employer for people who have developed disabilities within the wider NHS and Care community, and who are unable to work in hospitals or on ambulances, but who do not want to leave health and social care; reasonable adjustments within roles could potentially support recruiting such people into the IUC / NHS 111 environment and so retaining expert team members.

Some organisations have told us that they have improved their recruitment system because they saw a lot of team members leave very shortly after they took the job. This implies that new recruits did not understand the role, or were not suitable for it. Focusing on real world tasks such as call simulations, values based questioning and listening exercises can alleviate this, as can being very clear on working hours and conditions both verbally at recruitment and in writing in job descriptions and person specifications. Clear records will be needed to ensure that this is happening consistently. These records should be kept in a way that allows the organisation to track how many recruits are successful at each stage and event, and how long they stay in the organisation, in order to spot any patterns or concerns.

Whilst this is time consuming, compared to just recruiting via an interview, it will save time later, due to reduced attrition. Call simulations can also be used to support training, if they are changed from time to time. Current team members could be offered the chance to be involved in the call simulations (as happens in some organisations), as a development activity as part of gaining a range of people management and supervisory skills and competences.

Derbyshire Health United (DHU) recruit pharmacists using telephone scenarios, in acknowledgment that this is a different skill from face to face communication.

Yorkshire Ambulance Service (YAS) know that finding the right people to work in NHS 111 centres is extremely challenging. The work is demanding, both in terms of shift patterns (with 3 out of 4 weekends being standard) and in terms of the emotional load of dealing with sick or frightened patients, and a wider variety of calls than is common even in 999 services.

They have multiple full days of recruitment a year, to make sure that they recruit people who have the right values, attitudes and experiences to best help patients. Over the last five years, they have worked hard to get a clear view of what they need from their team.

Each round of adverts, usually through NHS Jobs and the Ambulance Service jobs website, can attract 300 applicants. Applicants are shortlisted based on their skills and experience, and their qualifications; experience is viewed as central. At this point, around a third of applications are not successful.

The next stage includes a listening exercise, and some mock calls involving existing call handlers/health advisors acting as patients. Applicants are marked for accuracy, empathy and their ability to handle the call, and only progress to interview if they pass those elements. The interview is then more questions on likely scenarios. Out of 300+ applicants, approximately 35-40 people would be appointed. However, it should be noted that a percentage of people withdraw before the assessment date or simply don't turn up and don't let them know.

Although this system is labour intensive for the organisation, it has reduced the attrition rate after appointment. The emphasis on skills and empathy over experience or qualification, along with a realistic idea of what the job will involve, has meant that it is easier for YAS to assess whether someone will be good in the role and for potential applicants to withdraw if they decide the role is not for them. It emphasises the clinical, personal nature of NHS 111 over being "just another call centre".

People can also be brought in on a range of contracts, including fixed term contracts to cover the Christmas period. YAS also work closely with an approved Agency when looking to bring in temporary staff and ensure they meet the same values when recruiting.

Keeping good team members

- Managers must conduct exit interviews routinely, and record reasons for leaving, including promotion, taking on different roles in the NHS or other providers, or leaving due to stress, ill health, poor provision for their needs under the Equality Act (2010) or bullying. Organisations should track trends and take action from this data recorded.
- Organisations must support team members in raising concerns, under the Public Disclosure Act (1998), and in raising other grievances.
- Enabled by organisation policies and procedures, managers must ensure they provide team members with adequate breaks, access to meals and refreshments, and appropriate levels of noise, light, and comfortable workspace, and ensure that issues are recorded and dealt with when they arise. This includes remote workers. Evidence that this is happening should be retained.
- Organisations must make physical space for breaks, to facilitate breastfeeding and to meet the spiritual needs of team members. Such space should not be used for meetings.
- The organisation, through its managers and supervisors, should ensure that it does not become normal to work through breaks.
- Supervisors, floor walkers or shift leaders must proactively facilitate team members to get away from their work stations for a brief break following a difficult call, or one that otherwise impacts them. Audit can support the identification of particularly problematic types of calls, times of day, etc.

- Managers should use 1:1s with staff to identify if issues are arising from repeat calls, or as a result of repeated exposure to low-level stressors. This will identify any occasions where breaks from duties are appropriate.
- Line managers should assess flexible working requests in line with legislation, and in the spirit of understanding that they can benefit the organisation. They should record the decisions made and the reasons behind them.
- Organisations should consider what activities occupational health or HR functions, including Employee Assistance Programmes could provide to improve the working conditions for individuals and teams.
- Organisations should implement workplace wellbeing schemes using staff engagement to address concerns or cynicism. Goals must be clear from the start and evaluation criteria built in from the beginning. This should be well communicated to all teams. IT and other support must be in place from the start.
- Organisations should give good notice of shift patterns, based on local agreements with team members.

This section should be read in conjunction with the Workforce Blueprint Mental Health and Wellbeing document, and with Appendix 3 of this guide. The information in this section was drawn largely from engagement with providers, and intends to outline how governance can support wellbeing measures. This includes keeping clear records of reasons for leaving, meeting legal requirements and best practice in terms of the

workplace environment. Building in support, such as routine breaks, as well as having clear goals and evaluation criteria to all workplace wellbeing plans is key. There are clear patient safety benefits to improving staff wellbeing; see Appendix 3.

Many IUC / NHS 111 providers have highlighted reducing attrition as an important issue. More details on the evidence around reducing attrition and improving working conditions can be found in Appendices 2 and 3.

IUC / NHS 111 can be a gateway into a career in health and social care for team members who have not previously considered it. This means that it is essential to record reasons for leaving, to separate out people who are leaving for negative reasons (stress, illness, lack of support) from people who have made a positive decision to move into management or clinical training.

Physical environment

Organisations must provide a safe, pleasant working environment for all team members. This includes reasonable adjustments for team members with disabilities, meeting all relevant health and safety legislation, and meeting other duties under the Equality Act (2010). Wherever possible, organisations should also provide protected space for breaks (both routine and as a result of a difficult call). This must not be taken over for meetings. Similarly, consideration must be given to providing space for team members

who are still breastfeeding infants to express milk, and to providing space for prayer.

A recent UNISON report made a range of recommendations for protecting the health and wellbeing of people working in call centres (UNISON Calling¹⁵). Much of this is equally relevant to IUC / NHS 111. They recommend that employers give attention to a range of physical factors in the workplace, to avoid injury and stress. They also specifically note that people who are on long night shifts require access to meals, not just refreshments, and should be encouraged to drink water rather than just tea and coffee. These recommendations may help to reduce workplace sickness, which has high costs, as well as attrition. More information about their recommendations can be found in Appendix 3, and in the full UNISON report.

Providers should consider whether they are meeting their duty to provide a healthy, safe workplace, whether issues are being recorded when they are brought up in staff meetings and 1:1s, and whether there is a need to audit safe workspaces and other issues of the physical environment.

15 UNISON Calling (2012) London: UNISON retrieved from <https://www.unison.org.uk/content/uploads/2013/06/On-line-Catalogue208653.pdf>.

Staff wellbeing

There are specific challenges to wellbeing in the IUC / NHS 111 environment, outlined in more detail in Appendix 3.

Larger organisations can take advantage of occupational health teams to provide proactive health campaigns, including mental health first aid, encouraging active commuting (if shift patterns make this safe), exercise and support for people who wish to improve their diet or drink more water. Whilst this is not directly an issue for governance, the principals of good change management and governance can be supportive. Successful interventions¹⁶ are likely to:

- Take account of the unique context of the organisation.
- Be well supported by the leadership of the organisation.
- Contain a range of measures in one package.

Wellbeing programmes introduced in the sector have included mini health checks looking at BMI, blood pressure and lifestyle factors, a Work Well programme involving personalised online health coaching and staff champions and fruit boxes for teams. This has been most successful when ideas originate with teams or are closely aligned to responses to surveys and issues raised in supervision.

Organisations that have reported problems introducing wellbeing programmes have struggled with cynicism because a project coincided with a CQC inspection, and have struggled where IT

systems have prevented access to the web-based systems and interventions due to firewall restrictions. Therefore, IT systems should be checked before programmes are launched to ensure compatibility with the new measures, and staff engagement, wherever possible face to face, prioritised. As with any change management programme, it is important to outline the goals of the project at the beginning and build in evaluation from the start, so that it can be established if the programme has worked and represented good value for money. In addition, staff engagement is key in eroding any cynicism about the purposes of the project, and ensuring that team members will welcome the outcomes, especially as discussions about diet, exercise and mental health can be seen as invasive.

Best practice in the private sector¹⁷ found that many of the best organisations are able to publish when people will be working well in advance, and are working towards better notice of shifts for their team members. This makes it easier for team members with caring commitments to plan, and allows team members to book holidays, arrange time off for weddings and other important life events, and reduces stress and attrition. Providers should work towards publishing shift patterns as far in advance as it is possible to, bearing in mind the need for flexibility.

16 Kroezen et al 2015. Recruitment and retention of health professionals across Europe: A literature review and multiple case study research. Health Policy 119, 1517–1528.

17 This information comes from engagement rather than the academic literature.

Flexible working

All team members (not just parents, carers and people with other protected characteristics) have the right to request flexible working arrangements, including reductions in hours, flexitime, compressed hours and term time working, and organisations must consider such requests reasonably. More information can be found here: <https://www.gov.uk/flexible-working>.

Flexible working can offer organisational benefits. Good team members who have dependents or difficult childcare arrangements, or who need to allow time for medical appointments, can be kept in work, rather than lost to the team. Flexible working can allow high quality team members who are studying (students and aspiring clinicians, or clinicians seeking further qualifications, for example) to drop shifts before exams and take on additional shifts at peak times when their exams are over. This can be achieved without having to incur agency costs, either by supporting flexible working arrangements in contracts or by having relatively low core hours and encouraging all team members to boost this through using a staff bank; this latter approach has been successful in the Partnership of East London Cooperatives.

The recommendation to encourage flexible working does not conflict with advice to publicise shift patterns for team members far enough in advance to allow them to plan their lives, because core hours can be allocated early and then flexibility offered around this through bank arrangements.

Flexible working is challenging in the IUC / NHS 111 context, due to the hours of peak demand and staffing levels. Patients are most likely to seek help from 111 during evenings and weekends, and it is hard to see how heavy weekend working could be avoided. Many organisations report team members working 3 out of 4 weekends and 6 out of 8 bank holidays. However, this should be made clear from the recruitment stage onwards, as many organisations are doing.

It is important to note that flexible, part time and remote workers should not be discriminated against. This includes offering them the same training opportunities; they should be able to seek promotion, and should not be at greater risk of injury from inappropriate working environments. This may involve arranging assessment of their workspaces.

Remote working

Several organisations are either actively allowing clinicians to work remotely from healthcare settings or from home, or looking to introduce this in the future. This is already routine practice in some areas of medicine, and is comparable to being On Call; a team member whose input is specialist and may not be needed constantly throughout a shift, for example a pharmacist, can be contacted on a remote and on call basis for advice.

Although there are some governance issues around this, for example ensuring that spaces are appropriate for call centre work, that data security and information governance can be maintained and so on, this has been successful. It allows team members to come into a shift for specific calls as needed, or to work more flexibly at times of peak demand, whilst still having time for other roles.

So far, remote working has not been encouraged for Health Advisor roles. Working remotely would lose many of the benefits of being able to access clinical advice rapidly from floorwalkers, for example. Remote working should be encouraged for healthcare professionals who are able to work independently and who may be able to work more flexibly and supportively if they are not required on site for a full shift.

Implementing change

- Build in evaluation for all change projects from the beginning.
- Team members must be involved in change projects from the design stage through all stages to completion and evaluation. Organisations should include a diverse range of team members in this, and give consideration to any equalities issues or differential impact of change that could arise.
- Organisations should include external partners such as Local Authorities, patient groups and Third Sector/Voluntary organisations in the coproduction of improvements.
- Look for opportunities to partner organisations around research and innovation, including the potential for academic posts working with universities or Deaneries.
- Build relationships with commissioners, Academic Health Science Networks and other organisations whose mailing lists contain links to funding for research.
- Share the results of evaluations where possible through publications and where appropriate, provide incentives, to benefit the wider system.
- Form partnership boards and joint agreements across providers to support change across the workforce. CCGs, Sustainability and Transformation Partnerships and Accountable Care Services will support this, and many have existing forums that perform this role.

- Create an identified channel to raise ideas for improvements and innovations, and make sure that all team members are aware of how to do this.

Successful change depends on high levels of staff engagement, a positive relationship amongst leadership and with commissioners, and will require time to bed in. There is a large literature on change management within the NHS, which can be used as a resource¹⁸. One of the most important levers for success is a high level of staff involvement, or co-production, in change from design through to implementation. More information on this can be found in Appendix 5. Successful co-production of change should include external partners such as local authorities, third sector and voluntary organisations and patient groups.

Always include a clear definition of the intended goals, and evaluation should be considered from the start. It is far easier to either collect data on successful measures as the project happens, or to use routinely collected data as proxies, than to try to evaluate services retrospectively. If possible, include cost data in evaluations, to allow others to decide if benefits outweigh costs. According to Clarke (2016) cost benefit data for interventions is rarely reported¹⁹.

Some organisations are looking for opportunities to appoint clinical academics in the IUC / NHS 111 as an opportunity for formal research into the service. They are also forging

18 For example <http://www.nhsemployers.org/~media/Employers/Publications/Managing%20staff%20through%20change.pdf>, <https://www.nice.org.uk/media/default/about/what-we-do/into-practice/support-for-service-improvement-and-audit/how-to-change-practice-barriers-to-change.pdf>, http://theedge.nhsiq.nhs.uk/wp-content/uploads/2015/10/nhs_change_model_july2013.pdf.

19 <http://bmjopen.bmj.com/content/7/7/e014650.long>.

links with universities, and hope to provide other PhD and MSc opportunities. This could be extremely valuable. It will not be possible for all organisations to publish formal research, but best practice should be shared. Possible forums include applying for prizes (for example HSJ or Nursing Times awards), sharing through informal mechanisms such as the NHS Academy of Fabulous Stuff Website, and writing up case studies. This should not interfere with intellectual property or commercially sensitive data; drug companies and medical technology firms publish their results without damaging their commercial activities.

Commissioners, Academic Health Science Networks, Sustainability and Transformation Partnerships and non-governmental bodies such as the King's Fund and university departments may have access to funding streams, and many have mailing lists that organisations could be included on that would notify providers of opportunities.

Structures for change

Provider organisations are already involved in innovative arrangements where GPs can be shared across NHS 111, IUC and Out of Hours provision, or where team members are already rotated across roles within ambulance and primary care services. Where this crosses organisational boundaries, it can be helpful to have formal structures to govern roles, responsibilities and pay arrangements. These may include existing networks, forums including urgent care partnership boards, or new partnership arrangements. CCGs and Sustainability and Transformation Partnerships will support these arrangements. Local Authorities should also be included in partnerships.

Risk issues

- Senior leaders should seek advice from legal teams or commissioners where workforce governance issues are identified.

Risk issues are to be managed in conjunction with commissioners' needs, an example being that London Ambulance Service piloted closer integration of the NHS 111 and 999 services, and found that there were differences between the Manchester Triage System (MTS) used in the 999 service and the NHS Pathways used in the NHS 111 service. In particular, the MTS was less directive and relied more heavily on staff knowledge and experience. They felt that the information and aftercare advice and information in NHS Pathways was excellent, but that NHS 111 team members were comparatively less independent and confident. These issues also provide an insight into the needs and activities of the workforce using systems.

Turnbull et al (2017²⁰) describe "risk work" in terms of how people experience and respond to risk in their everyday roles, with an emphasis on telephone assessment. They found that even "call handlers" use individual judgment and flexibility, and this leads to anxiety and responsibility. This highlights the need for training and reflection on calls.

20 Risk work in NHS 111: the everyday work of managing risk in telephone assessment using a computer decision support system Joanne Turnbull*, Jane Prichard, Catherine Pope, Simon Brook and Alison Rowsell Faculty of Health Sciences, University of Southampton, Southampton, UK(Received 28 November 2016; accepted 26 April 2017).

Conclusion

This guidance has summed up the results of literature, engagement events and surveys, evaluations of existing work taking place in the IUC / NHS 111 sector and input from senior leaders within the sector. This would not have been possible without the engagement, enthusiasm and commitments from individuals and organisations across the system.

There is a wide range of activities that are already taking place and creating positive change across the sector. These activities are varied, covering team members from first recruitment through initial induction, formal qualifications and apprenticeships, to helping team members achieve postgraduate level training. They include use of supervision, emotional support, measures to improve wellbeing and providing additional opportunities to improve skills across a diverse range of team members.

20 Risk work in NHS 111: the everyday work of managing risk in telephone assessment using a computer decision support system Joanne Turnbull*, Jane Prichard, Catherine Pope, Simon Brook and Alison Rowsell Faculty of Health Sciences, University of Southampton, Southampton, UK(Received 28 November 2016; accepted 26 April 2017).

Appendix 1: Skills and values common to all roles

The Integrated Care Framework supports the use of the six Cs as core values for all team members working in health and care:

- Care
- Compassion
- Competence
- Communication
- Courage
- Commitment

Despite the variety of roles and professional backgrounds, the competencies required of all team members include a number of values and behaviours in common²¹. These include:

- Staying calm under pressure and in uncertain situations.
- Knowing when to ask for more help and support.
- Good listening skills.
- Treating patients with empathy and respect.
- An interest in Continuous Professional Development and Learning (CPD).

There is a growing feeling that everyone in the team needs to show leadership^{22,23,24}. Systems are complicated and rely on teamwork, and so the person who notices an upset colleague and offers advice, reports a problem or takes the initiative to suggest an improvement is a leader. Healthcare is collaborative and relies on individuals within teams accepting each other's expertise, and reforms will depend on distributed leadership²⁵. A Lancet review (Careau et al 2014²⁶) argued that there is a need for health leaders who can work across health professionals and settings. The review argued that existing programmes do not adequately stress the collaborative nature of leadership. This is especially important in IUC CAS, which crosses professional groupings, and settings across primary, secondary and community care, care homes and self-care. Governance arrangements, training programmes and mentoring need to support the idea of distributed leadership.

21 <https://www.england.nhs.uk/publication/integrated-urgent-care-nhs-111-career-framework-and-competency-based-job-descriptions-skills-for-health-levels-2-7/>.

22 3: Gordon L, Rees C, Ker J, Cleland J. Using video-reflexive ethnography to capture the complexity of leadership enactment in the healthcare workplace. *AdvHealth Sci Educ Theory Pract*. 2017 Dec;22(5):1101-1121. doi:10.1007/s10459-016-9744-z. Epub 2016 Dec 30. PubMed PMID: 28039588; PubMedCentral PMCID: PMC5663839.

23 Willcocks and Wibberley, (2015). Exploring a shared leadership perspective for NHS doctors. *Leadership in Health Services*, 28:4, 345-355. <https://doi.org/10.1108/LHS-08-2014-0060>.

24 Fitzgerald, L., Ferlie, E., McGivern, G. and Buchanan, D. Distributed leadership patterns and service improvement: Evidence and argument from English healthcare. *The Leadership Quarterly*, 24:1, 227-239.

25 Willcocks and Wibberley, (2015).

26 Careau et al. (2014). Health leadership education programs, best practices, and impact on learners' knowledge, skills, attitudes, and behaviors and system change: a literature review. *Journal of Healthcare Leadership*, 6 39-50.

Appendix 2: Recruitment and retention

Reducing attrition was a strong theme in the engagement work supporting this guide. Although this is not directly related to governance, good governance can support reductions in attrition through;

- Improvements to recruitment. IUC / NHS 111 organisations have high attrition rates, especially in the first few weeks of someone being in a new role. This early attrition indicates that the people recruited may be unsuited for the role, or that they had not fully understood issues like the very high level of weekend working.
- Improving the physical environment, leading to lower physical and mental stress on team members.
- Focusing on wellbeing, which is covered in more depth in the Blueprint document on Workforce Wellbeing and Mental Health
- Offering a wide range of interesting tasks and roles.

A recent review²⁷ found that there was no consistent evidence on single recruitment and retention measures that worked, but that it was essential to be mindful of the context that people were working in (in IUC / NHS 111 this is a high pressure healthcare environment with a number of team members who are not from healthcare professional backgrounds), and that successful interventions were those that included a range of measures and were well supported by the leadership in the organisation²⁸. HEE (2017²⁹) state that retention is the most cost effective way to maintain safe staffing levels.

We should also be wary of over emphasising a reduction in attrition as a goal in its own right. The NHS 111 service recruits many team members from call centre backgrounds who may not have previously considered a career in healthcare. It can be a valuable training ground for team members who wish to pursue a career into the NHS. Several organisations have noted that they lose a substantial number of team members from all backgrounds who choose to go on to clinical training, for example to train as paramedics. These recruits, on entering the wider health community, will be well placed to promote better use and co working with IUC / NHS 111 services. It will be worth recording why team members leave, as well as how many, to separate out positive moves from team members leaving because of stress or a lack of support.

Some organisations report that they employ students. Some students are looking for temporary work, and others are looking specifically for NHS experience. Again, these team members are very likely to leave in a short time frame, but their enthusiasm and dedication can still be very valuable to the organisation.

Moving into the IUC or NHS 111 service may also allow team members who no longer wish to work directly as paramedics or nurses to maintain an NHS career and to use their expertise, especially as they approach retirement age (Derbyshire Health United: Yorkshire Ambulance Service). These team members can be especially valuable in

27 Kroezen et al 2015. Recruitment and retention of health professionals across Europe: A literature review and multiple case study research. Health Policy 119, 1517–1528.

28 Kroezen et al 2015. Recruitment and retention of health professionals across Europe: A literature review and multiple case study research. Health Policy 119, 1517–1528.

29 <https://www.hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%252c%20Shaping%20the%20Future%20%281%29.pdf>.

rotational roles (see section on job rotation below). Partnership of East London Cooperatives has had considerable success in recruiting clinicians who were unable to continue in ward based roles due to health concerns such as back pain, but wanted to continue to support patients.

The HEE workforce strategy, *Facing the Facts, Shaping the Future* (2017³⁰), describes some pilot schemes in hospital trusts, who are working to reach out to disadvantaged communities and offer apprenticeships and routes into the bands 1-4 workforce. Whilst these are not directly comparable, there may be lessons that IUC providers in these areas could draw from collaborating in future similar schemes.

30 <https://www.hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%252c%20Shaping%20the%20Future%20%281%29.pdf>.

Appendix 3: Staff wellbeing

The need to consider emotional wellbeing

All team members have significant demands placed on them by the IUC / NHS 111 environment. This is particularly acute for team members making clinical decisions, in the absence of normal back up like access to medical histories, test results or being able to see body language and physical signs like blood pressure or pallor. But all team members who are on the phones experience upset, unwell, angry or even suicidal patients, and are placed under considerable stress by this.

The specific pressures include:

- Pressures associated with making good clinical decisions, without being able to see a patient in person.
- Pressures associated with performance targets.
- Pressures associated with the emotional impact of the patient themselves; some patients are very unwell, suicidal, frightened, angry or can be abusive, and some have severe communication difficulties.
- Some providers have fed back that the call centre environment can feel isolating, and there is not the same feeling that individuals are making a difference to patients and are part of the wider health community as is commonplace in more traditional settings. This can be compounded where team

members do not have a health background and/or are not employed under NHS terms and conditions.

Line managers have a role in encouraging an understanding of the place of NHS 111 and the IUC in the wider community and in sharing positive feedback from patients and audits.

The pressures of the environment can lead to poor clinical decision making. Allan et al (2014³¹) found that nurses working in a telephone service were more conservative, more likely to refer patients to other health professionals and were also subject to failures of attention and memory, if they were subject to high levels of workplace stress. This would make them more likely to send patients to out of hour GP services or the emergency department, negating the benefits of NHS 111. Turnbull et al (2014³²) note that clinicians have relatively low control over their working environments in the IUC / NHS 111 environment, especially where they are allocated cases by Health Advisors. This can cause workplace stress (e.g. WHO 2003³³).

Team members who have roles at Skills for Health levels 2-4 do not necessarily come from an NHS background, with some being appointed as school leavers, and some who have come from commercial call handling backgrounds. Turnbull et al (2014)³⁴ found that clinical assessment by team members in this category is characterised by high levels of negotiation,

31 <http://onlinelibrary.wiley.com/doi/10.1111/bjop.12030/full>.

32 Turnbull J, Pope C, Rowsell A, Prichard J, Halford S, Jones J, et al. The work, workforce, technology and organisational implications of the '111' single point of access telephone number for urgent (non-emergency) care: a mixed-methods case study. *Health Serv Deliv Res* 2014;2(3).

33 http://www.who.int/occupational_health/publications/en/oehstress.pdf.

34 Turnbull J, Pope C, Rowsell A, Prichard J, Halford S, Jones J, et al. The work, workforce, technology and organisational implications of the '111' single point of access telephone number for urgent (non-emergency) care: a mixed-methods case study. *Health Serv Deliv Res* 2014;2(3).

communication and interpretation, and is not limited to simply using the Clinical Decision Support System programme accurately. Some may be unfamiliar with the emotional pressures that come from working with patients, for example if a patient or carer is frightened or very ill when they first call the service. They may need extra training and support in these areas, for example at induction, and some providers report that “soft skills training” has been strengthened in their induction processes to support this.

The role of Schwartz Rounds

Schwartz Centre Rounds are a “group reflective practice forum that provides an opportunity for people from all disciplines to reflect on the emotional aspects of their work” (Point of Care Foundation 2017³⁵). The benefits include eroding barriers between professionals, and reminding team members of their shared purpose in helping patients. They are not widely used in IUC or NHS 111 settings, although it has been trialled in some areas for healthcare professionals. Findings from George (2016³⁶) suggest that Schwartz rounds may indirectly improve patient care by preventing declines in empathy and stopping workers dehumanising patients; the research was not conducted in a remote setting but dehumanisation may be a greater risk where patients are not seen directly. The study also found an important mediating

role for line managers in containing emotion, and influencing the support that team members offered each other.

Some organisations have trialled this. Whilst some are offering this at all levels, some organisations have indicated that they have limited it healthcare professionals. We would advise it is not limited in this way. Although talking about emotions is a new skill for many team members, especially from a call centre background, team members at Skills for Health Levels 2-4 also encounter emotionally demanding calls. This can include dealing with a patient who is angry, frightened or mentally ill. They may not spontaneously offer their experiences in other forums for support. In addition, they are also valuable professionals in their own rights – “expert non-clinicians” – who will have their own insights to offer. In particular, organisations that do involve team members at all levels have pointed out that their Health Advisors come from the local area and have deep insight into the lives of local patients and therefore into wider determinants of health. They should be supported to take part in Schwartz rounds or other team meetings, as important members of the team.

35 <https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/>.

36 George (2016). Stress in NHS staff triggers defensive inward-focussing and an associated loss of connection with colleagues: this is reversed by Schwartz Rounds. *Journal of Compassionate Health Care* (2016) 3:9 *Health Care* (2016) 3:9DOI 10.1186/s40639-016-0025-8.

Physical environment

Unison³⁷ made a range of recommendations for improving team member wellbeing. Whilst written from the perspective of a union, it contains good advice on how to keep team members healthy and protect them from workplace harm.

In particular, it recommended that employers should:

- Maintain good air quality, including considering the impact of fumes from recent refurbishments, and consider filtering the air or encouraging living plants.
- Maintain a constant comfortable temperature, and avoid placing any worker in a draught, which can cause serious musculo-skeletal problems.
- Check lighting is at a comfortable level, without glare or dark spots, and encourage frequent eye checks for employees.
- Take measures to protect workers' hearing from constant background noise; this might include carpeting hard floors, and using noise cancelling headsets, or working to ensure that team members know how to position their microphones so that they can speak softly. UNISON also talk about recognising that "acoustic shock" – the pain experienced by a phone operator when they have sudden feedback or other loud noise on a phone line – is a legitimate work related injury.
- Provide proper assessment of the ergonomics of workspaces. This includes teaching team members how to set up their workspace safely if they are hot desking (and ensuring that they do so), and assessing the workstations of any worker working remotely or from home.
- Grant permission for team members to personalise their workspaces, to enhance a feeling of comfort and control in the workplace.
- Ensure that there is adequate security for workers leaving late at night or very early in the morning.
- Encourage breaks and stretching. UNISON advises a stretch every 20 minutes and a significant change in activity every 50-60 minutes, in line with HSE advice. Multiple short breaks are seen as more effective than a smaller number of longer breaks.
- Allow free access to toilets; encourage the consumption of water, and access to canteens or facilities to heat food (e.g. a microwave) if team members are working all night. Workers must not be penalised for needing toilet breaks.

37 UNISON Calling (2012) London: UNISON retrieved from <https://www.unison.org.uk/content/uploads/2013/06/On-line-Catalogue208653.pdf>.

Appendix 4: Career pathways

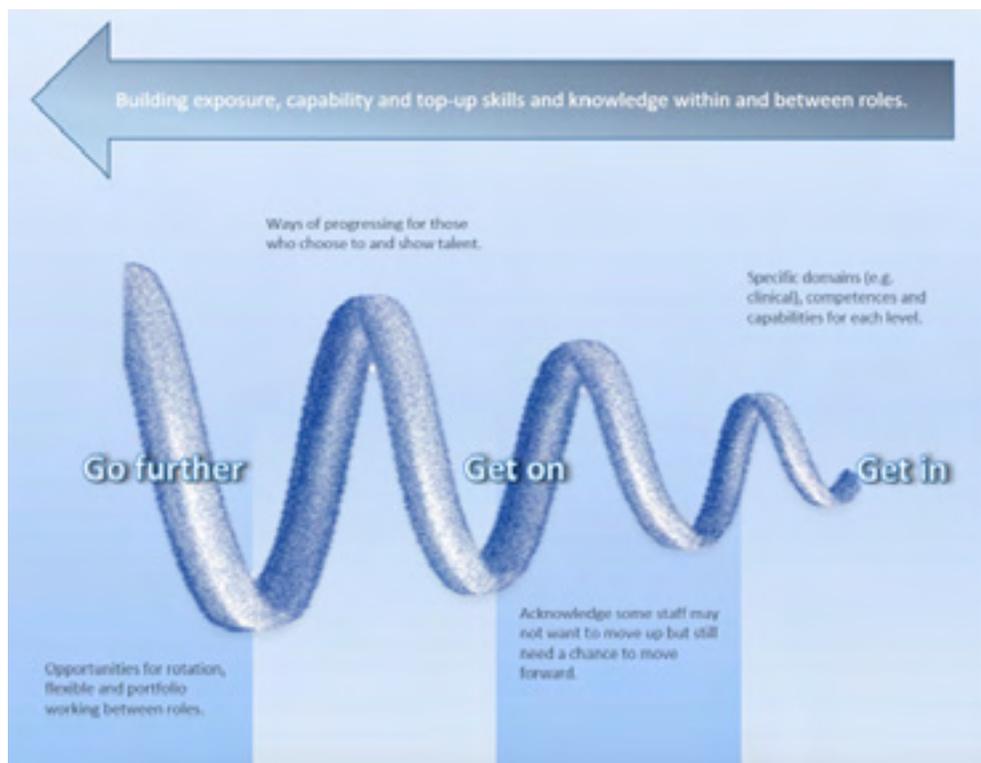
- Line managers must work with team members to identify where there are apprenticeship routes open to team members (see also the Workforce Blueprint Apprenticeship Scheme).
- Supervisors should support team members to gain the entrance requirements for further or higher education, and wherever possible allow study leave for exams and assignment deadlines.
- Line managers should offer interested team members mentorship and shadowing opportunities.
- Line managers should support team members in identifying projects, job rotations and tasks that will allow them to gain promotion, or widen their existing skills within their current roles.
- Organisations should work with organisations such as the Local Action Workforce Boards to identify opportunities for rotational roles, broader roles, and for advice on how to harmonise conditions for team members and identify which organisation is responsible for their official line management and any registration requirements.

Although not strictly a governance issue, many organisations that engaged with the development of this guide provided information that one of the most important issues for their teams were good career paths. One provider in the Midlands told us that they had sought out good practice in the private sector and found that the best organisations had clear paths through supervision and into management for their call handlers.

There is a range of potential career paths:

- Team members with specific healthcare professional backgrounds, for example nurses and pharmacists, may seek to get roles at the next Agenda for Change band. This would require taking on additional tasks, responsibilities and decision-making.
- Team members from healthcare professional backgrounds may also be seeking opportunities to move into management.
- Other healthcare professionals may have reasons to want to stop working in acute settings, for example because they have developed health problems that would make being an ambulance paramedic impossible, or because they are approaching retirement and would like to reduce their hours to part time
- Team members from non-healthcare backgrounds may develop an interest in clinical training, for example moving into paramedic or nursing training.
- Team members from non-healthcare backgrounds may develop an interest in becoming supervisors, or training in management roles in General Management, HR, Finance, Organisational Development or IT.
- Any team member may decide that they are happy in their current role but wish to take on additional tasks and responsibilities for interest and development, for example becoming a coach or buddy for new team members, taking part in an improvement project or developing a research interest.

These can be summarised in the diagram below; getting the right people in, helping them get on and helping them to go further if they wish to.



Skills for Health Level 2-4: Into clinical training

Some team members working at level 2-4 develop an interest in clinical training. Apprenticeship routes into nursing have been expanded, and offer one potential route into practice, for example. There are also formal university courses that offer access to adult learners. The Blueprint contains a specific document detailing the potential benefits of apprenticeships for a wide range of roles.

Barriers to this can include whether or not team members at levels 2-4 have the right qualifications to access university courses. For example one IUC provider notes that many people who enter Service Advisor roles may have come straight after their GCSEs or from other workplaces, and do not have the A Levels usually required by universities. They have reported that the Emergency Care Assistant role can be hard to access in their area for this reason.

Team members with an interest in accessing clinical training should be supported through the process of gaining entrance qualifications wherever possible. They should be supported in finding opportunities and, if operational pressures allow, organisations should offer study leave for exams or key assignment deadlines. Providers can also allow time off the floor for mentorship and shadowing health professionals, and managers can help identify willing mentors and providers who offer shadowing. This should not be an issue for non-NHS providers as NHS providers will be able to offer shadowing opportunities using existing arrangements for outside observers.

Skills for Health Level 2-4: Into management and supervision

Some organisations have highlighted the need for a career path for team members who wish promotion but are not interested in clinical training.

Several organisations have already got good track records of promoting their team leaders from their own teams, which provides a career pathway and also benefits the organisation because the new team leader can start their role quickly, and is already familiar with local working practices and organisational values. There are a range of qualifications and apprenticeships available for team members at this level, which can develop their management and leadership skills and allow them to be better supervisors and leaders. The Blueprint has a section on apprenticeships, which can provide more information on benefits and on how to identify suitable roles and tasks.

Non-clinical management roles span up to Skills for Health Levels 6 and 7, and this allows progression for many team members if they are interested in them.

Skills for Health Level 5-9: Career progression

Some team members, especially healthcare professionals, may choose to maintain portfolio careers, working some hours in 111 and some in other settings. For example dental nurses may retain some hours in practices. This requires careful scheduling of shifts and reduces the ability to flex up teams to meet demand, but maintains staff confidence in face-to-face care, and allows a flow of information in and out of the organisation and the wider health economy. For example, North West Ambulance Service have the capacity to rotate team members in and out of roles in the wider ambulance service. London Ambulance Service seconded 999 team members into the 111 service to assess how to reduce multiple handoffs between the services and improve patient experience, with positive improvements in awareness and work practices, although that was a temporary arrangement. Other organisations report that they are not yet offering rotational roles, but where they have a range of services, some of which work closer to office hours, they are considering rotating team members to reduce the proportion of their shifts that fall during anti-social hours.

These opportunities can both deepen their existing role (see below), and can provide experience, which may be useful when moving to the next post in their profession, or to a management position. Team members should maintain records of what they have done, as part of their CPD portfolios, which will support them identifying and achieving opportunities.

In order to enhance recruitment and retention of team members, Vocare have identified a need to define potential career pathways with clinical pathways, and increase the level of activity variation within roles. They also saw an opportunity to meet weaknesses in their own service by developing workers into new roles. They developed Clinical Assessment Services as hubs, with the purpose of managing cases that were more complex. Team members were seconded into the centres, with the secondment including a requirement to complete 7.5 hours a week of academic study and an additional 15 hours of consolidated study hours. The people seconded to the CAS showed a reduction in their disposition rates to the emergency department and to 999, they rated their confidence in dealing with calls 16% higher than people outside the study, and call audits showed improvements in call quality. It is too early to quantify an impact on retention.

All team members: Deepening and widening roles

Not all team members at any level are interested in changing their current role. These team members still deserve good opportunities to develop their skills and interests. This could include being given responsibilities to train or buddy new team members being able to take part in front line improvement projects, or roles as coaches for the service. Research opportunities are another potential area for team members to develop their skills.

Job rotations can also support all team members in deepening and widening their existing skills. This is often thought of in terms of clinical rotations, but non clinical team members can also be encouraged to identify rotational roles, for example into HR or Finance assistant posts or into Ambulance or Primary Care providers.

North West Ambulance Service NHS Trust has the capacity to rotate people in and out of roles in the wider ambulance service. London Ambulance Service seconded 999 staff into the 111 service to assess how to reduce multiple handoffs between the services and improve patient experience, with positive improvements in awareness and work practices, although that was a temporary arrangement.

The Manchester Triage Service routinely have days available to staff to use for shadowing other services. In order to do this, team members must demonstrate that they are acquiring knowledge and feeding it back to the team. This encourages a sense of being part of the NHS family and a better knowledge of the wider health community.

Other organisations report that they are not yet offering rotational roles, but where they have a range of services, some of which work closer to office hours, they are considering rotating people to reduce the proportion of their shifts that fall during anti-social hours.

This is not an option that is equally available to all providers. Small providers in particular report that this can pose severe scheduling problems, and that their KPIs can prevent this. However, close working with the rest of the health economy could support job rotation efforts. Short rotations between the NHS 111 environment, face-to-face IUC roles, the ED and ambulance or primary care settings could support maintaining face to face skills, and understanding how other organisations judge risk. It could support revalidation where skills have been harder to evidence within the 111 setting, and promote better knowledge and understanding of 111 in the wider community and the wider community within 111. As yet, this is not included in formal job plans in most providers, but could be in the future.

Smaller organisations may also be able to be creative about offering opportunities to gain skills as project managers, or to take on tasks that in larger organisations may be given to organisational development specialists, research leads or within HR. This will allow team members to gain broader leadership skills that could support them in feeling more valued and seeking career progression if they want it.

The new Local Workforce Action Boards serve the same regional areas as the Sustainability and Transformation Partnerships³⁸ and they may provide a forum for discussing rotations or secondments. Although there would be obvious contractual issues to address, it will be worth considering ways to overcome these, as the advantages to both the IUC CAS and the wider economy will be large.

38 <https://www.hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%252c%20Shaping%20the%20Future%20%V281%29.pdf>.

Appendix 5: Co-production

Co-production involves working with employees, patients and carers to highlight the most important areas for improvement and suggest and implement solutions to problems. Whilst not directly referencing co-production, HEE's new workforce strategy acknowledges that productivity improvements can only be delivered with a fully engaged workforce (HEE 2017 *ibid.*). It may involve co-design, co evaluation and co-implementation. It can help improve the work done in healthcare settings, including 111, by:

- Making sure that we are not coming up with “a good solution to the wrong problem”, which can lead to costly projects not helping the actual problems in the workplace.
- Making sure that patients and team members are fully involved, and care about the success of a project.
- Leading to real learning, especially for senior team members who may not fully understand the pressures and issues facing front line team members or the public.
- Encouraging reflection on work processes and the impact of work habits and behaviours on the public.
- Drawing attention to factors that can be ignored in classic service improvement, for example the time that a change takes, or the emotional investment team members or the public may put into a set of actions.
- Make team members and the public feel more powerful in the change process, which in turn boosts the likelihood of the project working.

Its disadvantages include that it can be slow and costly, especially if large numbers of patients are involved, and in terms of complex change in large organisations, it can take time to develop useful improvement suggestions and then put them into action.

There is some evidence (e.g. Felipe et al 2017) that co-production is often focused on “small, practical” problems that may not seem like big barriers to senior leadership, but that actually have a major impact on front line staff and patients. Fixing these issues can be extremely helpful for reducing stress and improving care.

Recommendations from Appendix 4: Career Pathways

Area	Recommendation
Career Pathways	Line managers must work with team members to identify where there are apprenticeship routes open to team members (see also the Apprenticeship section of the Blueprint)
	Supervisors should support team members to gain the entrance requirements for further or higher education, and wherever possible allow study leave for exams and assignment deadlines
	Line managers should offer interested team members mentorship and shadowing opportunities
	Line managers should support team members in identifying projects, job rotations and tasks that will allow them to gain promotion, or widen their existing skills within their current roles.
	Organisations should work with organisations such as the Local Action Workforce Boards to identify opportunities for rotational roles, broader roles, and for advice on how to harmonise conditions for team members and identify which organisation is responsible for their official line management and any registration requirements.

Acknowledgments

The authors wish to express their gratitude to all the individuals who gave up time to discuss the issues in this guide with us, during November and December 2017. Without their generosity, this guide would not have been possible.

First name	Surname	Job title	Company
Aisha	Chaudhary	UEC Transformation Lead	NHS England South
Andy	Summerbell	Head of Emergency Preparedness, Resilience and Response and Lead for Urgent Emergency Care	NHS England CNE
Asmah	Salim	Project support officer	NHS England
Bob	Fellows	Head of Professional Development	The College of Paramedics
Breda	Watson	Project Officer	Health Education England
Catherine	Connor	Senior Contracts Manager	South, Central and West Commissioning Support Unit
Christine	Johnson	Clinical Lead	NHS England
Colin	Simmons	111 Programme Director	Costal West Sussex CCG
Daniel	Mason	Yorkshire & Humber CCGs IUEC Lead	Yorkshire & Humber CCGs
Delphine	Abbott	Stakeholder engagement and communication manager	NHS England
Donna	Poole	Deputy Head of Clinical Education transformation	Health Education England, Kent, Surrey and Sussex
Emma	Cox	Programme Manager - UEC	Surrey Heartlands STP
Fleur	Kitsell	Associate Director for Workforce Transformation	Health Education England
Gareth	Stuttard	Deputy Medical Adviser IUC	NHS England
Gerry	Egan	Chief Executive	College of Paramedics
Jackie	Bell	Head of Urgent Care	North West Ambulance Service

First name	Surname	Job title	Company
Jacqueline	Calladine	Divisional DoS Lead East Midlands	North Derbyshire CCG
Jacqui	McBurnie	Senior Programme Manager	NHS England
Jamie	Bateman	NHS 111 IUC Workforce Development Programme. Programme Support Administrator	Health Education England
Jenny	Doxey	Medical Director	Derbyshire Health United
Jim	Quinn	IUC Workforce Governance Guide Author	Nottinghamshire Urgent and Emergency Care Partnership
John	Black	Medical Director	South Central Ambulance Service NHS FT
Jonathan	Davis	Head of HR, Training and Development	Partnership of East London Cooperatives
Jonathan	Leach	GP	Davenal House Surgery Bromsgrove
Jonathan	Jeanes	Director	Jeanes Consulting Ltd
Kat	Noble	Associate Medical Director	North West Ambulance Service
Karen	Roberts	Project Manager	Yorkshire Ambulance Service
Karin	Orman	Professional Practice Manager	Royal College of Occupational Therapists
Kerry	Exley	Senior Project Manager	Sussex NHS 111 Transformation Team
Leaf	Mobbs	Director of Urgent Care and Integration	Yorkshire Ambulance Service
Lisa	Houghton	Directory of Services Officer	Isle of Wight Ambulance Service
Michaelene	Holder-March	Director of Governance, Nursing and Quality	Partnership of East London Cooperatives
Michela	Littlewood-Prince	Head of Nursing	Yorkshire Ambulance Service
Michelle	Reader	Director of Quality and Business Development	Medvivo
Mike	Baiey	Workforce Transformation Lead	Health Education England, Kent, Surrey and Sussex
Mike	Burgess	Workforce and Education Transformation Lead	Health Education England

First name	Surname	Job title	Company
Michael	Hewitt	IUC Workforce Governance Guide Author / Nottingham Trent University	Nottinghamshire Urgent and Emergency Care Partnership
Rachel	Robinson	Chief Nurse	IC24
Raju	Valasapalli	Medical Director	VoCare
Rosie	Courtney	Workforce Transformation Lead	Health Education England, Kent, Surrey and Sussex
Ross	Hamilton	Programme Manager	South, Central and West. Commissioning Support Unit
Ruth	Allanson	111 / IUC Operations Programme Manager	NHS England
Sarah	Johnson	Clinical Lead	NHS England
Sarah	Bentley	IUC NHS Workforce Development Programme. Project Manager	Health Education England
Sharon	Harrison	National Programme manager, National Workforce Transformation	Health Education England
Simon	Browes	IUC Workforce Governance Guide Author	Nottinghamshire Urgent and Emergency Care Partnership
Stuart	Baird	Workforce Transformation Lead	Heath Education England
Sue	Hall	IUC Workforce Development Programme Manager	NHS England
Suzanne	Birt	Senior Programme Lead	Dorset CCG
Usha	Kaushal	NHS 111 Pharmacy Advisor NHSE	NHSE / NHS 111 Yorkshire Ambulance Service
Wendy	Preston	Head of Nursing Practice	Royal College of Nursing

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net.

© NHS March 2018.

NHS England Publications Gateway Reference: 07791

For more information about the Integrated Urgent Care / NHS 111 Workforce Blueprint, click [here](#).