South East Coast Ambulance Service NHS
NHS Foundation Trust

Telephone Triage Audit and Practice Development - Policy and Procedure

Contents

1 Scope

1.1. This document defines the quality assurance and practice development processes for any grade of staff working within the Emergency Operations Centre (EOC) and Integrated Urgent Care who:

- uses Clinical Decision Support Systems (CDSS),
- undertakes welfare calls
- provides 'in-line' advice to colleagues.

1.2. CDSS include NHS Pathways (NHSP), NHS Pathways Light, Manchester Triage System (MTS) and any other CDSS triage and assessment tools approved by the Trust.

1.3. The standards of use for CDSS are set out in their respective user licenses, training guidance, Trust policy and procedure and Trust Operational or Clinical Bulletin. These are the approved standards that practice will be audited against.

1.4. We reserve the right to change these procedures swiftly as occasionally required by our Pathways licence.

1.5. This document does not include no-send or clinical tail audit; these both have their own respective procedures.

2 Responsibilities

2.1. The **Chief Executive Officer** has overall responsibility for risk management, clinical safety and governance within the Trust.

2.2. The **Executive Medical Director** is the Caldicott Guardian and has overall responsibility for Clinical Governance, including the Emergency Operations Centre (EOC), within the Trust.

2.3. The **Executive Director of Nursing and Quality** has responsibility for matters relating to regulatory compliance (data protection), risk management, health and safety relating to this procedure.

2.4. The **Executive Director of Operations** has overall responsibility for Emergency Call Compliance processes within the Trust.

2.5. The **Associate Director for Integrated Care (111 & 999)** is responsible for ensuring application of processes, procedures, performance and compliance within the EOCs & IUC in the Trust.

2.6. **Consultant Clinicians** in the Medical Directorate are responsible for the professional practice and registration of all registered clinicians in the Trust (including EOC & IUC Clinicians).

2.7. The **Operating Unit Managers (OUM)** and **Senior Operations Managers (SOM)** are responsible for ensuring that the compliance and quality assurance process is taking place within the EOC and IUC and ensuring that appropriate support/actions are undertaken.

2.8. The **Senior Clinical Operations Manager Clinical (SCOM)** is responsible for ensuring that the compliance and quality assurance process is taking place within the EOC & IUC and ensuring that appropriate support/actions are undertaken.

2.9. The **Head of Clinical Audit (HCA)** has delegated responsibility to ensure the Trust is compliant with the activities set out within the scope of this procedure.

2.10. The **Clinical Audit and Quality Sub-Group (CAQSG)** is the nominated sub-group with responsibility for oversight of Clinical Audit Activities in EOC & IUC. Members of this group will work in collaboration with the **EOC & IUC Quality and Patient Safety (QUAPS)** sub-group to ensure effective delivery of audit and practice development activities.

2.11. The **Education and Training leadership team across EOC & IUC** have responsibility to ensure that lessons from audit activities are used to inform learning and development activities.

2.12. Accredited auditors and line managers of individuals who carry out telephone triage are responsible for undertaking call compliance audits within the Trust, for the delivery of timely feedback and for the creation, population and maintenance of appropriate documentation.

2.13. All EOC and IUC staff:

- Must ensure that they are familiar with the content and application of this procedure and their responsibilities contained within. Any questions on this procedure must be raised initially with the individual's line manager.

- Are responsible for using CDSS software in accordance with their training programme and Trust policy.

2.14. Registered clinicians are responsible for ensuring that they act within the scope of practice defined within the relevant CDSS license and that all other clinical practice is safe, evidence based, and patient centred.

3 Who will carry out audit?

3.1. Call audit and practice development will only be undertaken by accredited individuals who meet criteria to maintain competence, as per the user license/guidance for the relevant CDSS.

3.2. Line managers will audit 1 call per month for each member of their team. The remainder will be carried out by the respective audit function for either 111 or 999.

3.3. Individuals are responsible for maintaining their own skills and competence in audit, recognising that this involves a high level of competence in telephone triage skills, a good understanding of the relevant CDSS, understanding of local policy, advanced critical thinking skills and a confident and supportive nature.

3.4. All individuals who are accredited to audit will undertake levelling each month. Levelling may be undertaken remotely or face to face.

3.5. A register of those who are accredited to audit and their participation in levelling activities will be maintained by the respective audit function for either 111 or 999.

3.6. Those who audit as a major part of their role will have one audit per month reviewed by their line manager and/or a peer and assessed against the NHS Pathways Coach competencies (Appendix C & D).

4 What is the transition from initial training to audit?

4.1. Responsibility for training in use of a CDSS sits with the IUC training team. Supervised practice is the responsibility of operational management.

4.2. After completing initial CDSS training, individuals will receive a minimum of 2.5 days (18.75hrs) of direct supervised practice and 2.5 days (18.75hrs) of indirect supervised practice. During indirect supervised practice the formal sign-off audits that allow the individual to progress to independent practice will be undertaken. This consists of 5 random call audits which will be undertaken by a suitably accredited individual (month 1).

4.3. To progress to independent practice, 4 out of 5 of these audits must be compliant. If the individual does not pass, they must repeat supervised practice (indirect as a minimum or both direct and indirect if required) and receive reasonable and appropriate development.

4.4. Once signed-off as independent, responsibility for ongoing audit will be passed to the EOC & IUC auditors (month 2 onwards). These teams will work conjunction with the individual's line manager to provide audit and practice development.

4.5. Note that MTS users require an additional 5 audits to be completed once independent to be fully signed off. These audits should form part of the regular audit programme (month 2 onwards).

5 How many audits will people receive?

5.1. There are two types of audit; Standard Audit (SA) and Non-Standard Audit (NSA). Audit can be either retrospective (auditing call recordings) or live (listening in and auditing side-by-side).

5.2. Standard Audit is the monthly routine audit of each user, for each type of triage they undertake. This includes CDSS, welfare calls, service adviser calls or 'in-line clinical advice' according to their 'tier'.

5.3. Those on Tier 1 will have:

Gold standard: • 1 retrospective audit • 5 side-by-side 'live' audits – it is recognised that an adapted approach is required for agile auditors and this should be managed locally. • 1 optional self-review is strongly encouraged. OR:
Silver standard (only if live audit cannot be achieved due to shift patterns or unprecedented operational demand): • 4 retrospective audits • 1 optional self-review is strongly encouraged

Tier 1 includes new staff for their first 6 months after sign-off, staff with persistent and/or significant performance issues and staff who work on a part time basis (part time used as a proxy for those who take less than 200 calls per month).

It is recognised that clinicians undertake a variety of duties and may not undertake 200 patient triages per month. In-line advice, welfare calls etc. will be counted towards the 200 calls per month minimum. However, a significant proportion of these encounters should include triage using the relevant CDSS.

5.4. Those providing operational (SEMA, EMATL and coach) or clinical 'in-line support' should have one of these calls audited per month, in addition to their tier 1 or tier 2 CDSS audits.

5.5. Those on Tier 2 will have:

Gold standard: • 1 retrospective audit • 3 side-by-side 'live' audits • 1 optional self-review is strongly encouraged. OR:
Silver standard (only if live audit cannot be achieved due to shift patterns or unprecedented operational demand): • 3 retrospective audits • 1 optional self-review is strongly encouraged

Tier 2 is for staff who are consistently performing safely and effectively.

5.6. Line managers are responsible for reviewing the tiers for their team monthly (clarification on tiers can be sought from the EOC Practice Development team or IUC audit team). If there is evidence of quality issues (e.g. non-compliant audits) an individual will return to tier 1.

5.7. As suggested by the Medical Directorate, there will be months where trend auditing will be carried out. These calls will be randomly picked around a condition or classification chosen for that month e.g. chest pain, cardiac arrest or HCP calls.

5.8. It is best practice for individuals to carry out reflective practice on their calls throughout the year which can be reviewed with line managers at monthly 1-2-1s.

5.9. Non-Standard Audit (NSA) is over and above Standard Audit. Any individual with a non-compliant call audit that contributed to a serious incident or complaint will be subject to 5 additional call audits. The 5 calls will include the call relating to the complaint or SI.

5.10. NSA will only be requested by approved staff; an EOCOUM, EOCM, EMATL, SCOM, OMC, CSN, DCCM, HATL, CCN an investigating manager, Patient Experience Team or the SI group. These requests will be logged in the audit request tracker.

5.11. The EOC Practice Development Team and IUC Audit Team will endeavour to respond to NSA requests in the following time frames.

- Audit appeals within 10 working days (defined as Monday-Friday 9.00-17.00)
- Standard audit requests within 6 working days
- SIs, urgent incident reports and priority audits for coroners/legal team etc. within 4 working days.

5.12. The outcome of NSA will be returned to the individual making the request. Feedback to the auditee should be completed as detailed below.

5.13. Individuals undertaking welfare calls should have one welfare call audited per month, in addition to their tier 1 or tier 2 CDSS audits, unless their only role is to undertake welfare calls, in which case they will be audited under either tier 1 or 2.

6 How is live audit undertaken?

6.1. Live audit should be carried out using the NHS Pathways Competency Checklist for NHSP calls or the standard audit tool for other types of call.

6.2. If “observer effect” is of concern, the live audit can be completed via remote observation (audio and screen observation).

6.3. Any developmental feedback should be given face to face after each call, for it to be considered within the next call.

6.4. The relevant competency quick guide should be utilised alongside the checklist/audit tool.

6.5. The competency checklist is not suitable for those who are new to auditing. It is essential that anyone using the competency checklist has acquired a good understanding of the full competencies for the skill set they are auditing. Note that only a clinical auditor can carry out a clinical audit.

6.6. The competency checklist does not present the user with a final score, but instead provides focus on areas for development. If a definitive score is required, for example if a call handler or clinician is on a developmental action plan, or being managed under a formal policy, the full NHS Pathways Audit Tool should be used.

6.7. If, during a call, the auditor observes any practice that poses an imminent patient safety risk, they must intervene immediately, taking over control of the call if necessary. Only if patient safety is compromised should the auditor intervene. Any need to intervene would result in a non-compliant audit.

6.8. Example scenarios requiring intervention might be:

- An EMA taking an incorrect route through the system.
- Failure to gather adequate information to answer a question or answering a question incorrectly.
- A clinician failing to gather adequate information to carry out safe validation or failing to recognise when the situation has changed or been misinterpreted.

6.9. There are several ways in which a live audit would become non-compliant.

- Competency 8 is not achieved in NHSP audit
- 4 or more competencies are not achieved
- The auditor has any concerns that practice during the call was not safe
- (Clinician only) patient not fully assessed or Senior Clinician Module not accessed.

7 How is retrospective audit undertaken?

7.1. Auditors undertaking retrospective audit should first prioritise completing audits for those who are on duty, this ensures that immediate face to face feedback can be given. All accredited auditors are considered capable of delivering face to face feedback.

7.2. Auditors undertaking retrospective audit should select the most recent available call recordings for an individual. This will ensure that the call is fresh in the individual’s mind and increase the value of feedback given. The exception to this is when the most recent calls have already been audited and no further calls have been taken in that month.

7.3. Call recordings will be accessed from the Trust-wide telephone recording system adhering to the standard set-out within:

- Information Security & Risk Management Policy
- Records Management Policy
- Data Protection Act 2018
- Common Law Duty of Confidentiality
- Caldicott Principles

7.4. All calls being assessed must be done so within a private space in order to provide confidentiality for all parties. Where this is not possible and other persons are present or within hearing range, headphones must be used to ensure appropriate compliance with information governance rules.

7.5. Audits should be undertaken as per audit training and guidance for the relevant CDSS.

When Audits Are Compliant

7.6. Wherever possible, feedback should be given face to face immediately, in a private and comfortable location. After face to face feedback, a Feedback Reflection Form should be completed by the individual and signed by both the auditor and auditee. Audits and the feedback form should be saved in the individual's audit feedback folder and emailed to the auditee and their line manager.

7.7. If it is not possible to give face to face feedback, compliant audits can be e-mailed directly to the staff member and their line manager. Face to face feedback should occur at least every six months.

7.8. Compliance figures will be entered into the relevant database by the auditor and performance reports will be produced on a monthly basis in line with agreed reporting requirements.

One or More Non-Compliant Audit

7.9. Where an NHSP audit is below 86% or an MTS audit is below 90%, it is classed as non-compliant.

7.10. Line managers are responsible for investigating issues that have caused non-compliance and developing a suitable action plan where required in collaboration with a trainer or coach. This action plan will be individually tailored according to the situation. Consideration should be given to use of NHSP short sessions, distance learning packs, hot topics and other learning resources. The line manager should also consider the use of mentoring shifts with a coach.

7.11. Where line managers are not audit trained, they should seek advice and collaborate with an experienced auditor.

7.12. In the event of a further non-compliant month, within three months of the first, a 1-2-1 will take place to discuss the causes of this. Further support offered, mindful of the resources available e.g. utilising the training department and wellbeing hub. HR support should be sought if issues relate to ongoing disciplinary or capability challenges.

7.13. The auditor should decide whether the non-compliant audit(s) are classed as low, medium or high risk. Auditors are encouraged to seek support and share this decision where required.

Low Risk	There may be several indicators partially achieved that have led to non-compliance, however, in general handling of the call was safe enough. The individual is thought to be safe to handle all calls with feedback when they are next available.
Medium Risk	There may have been a combination of indicators partially achieved or not achieved. Worsening advice may have been omitted. Indicators 8.1 or 8.2 may have been partially achieved in an NHS Pathways audit. MTS Audit Indicators 7 not documented or correct stop code not used but safe disposition reached The individual is thought to be safe to handle most calls but requires urgent feedback.
High Risk	The auditor may have identified concerns around the safety of the individual to continue taking calls. For example, providing very poor patient experience (e.g. through unprofessional communication) or providing unsafe triage, putting the patient at risk.

Managing Low-Risk Non-Compliance

7.14. Feedback must be given face to face, ideally by the auditor.

7.15. After face to face feedback, a Feedback Reflection Form should be completed by the individual and signed by both the auditor and auditee.

7.16. Audits and the feedback form should be saved in the individual's Microsoft Teams folder and emailed to the auditee and their line manager. The relevant tracker should be updated to document that feedback has taken place.

7.17. If the auditee is not available for face to face feedback, audits can be emailed to the line manager for routine feedback. In this case, the line manager should sign the Feedback Reflection Form.

7.18. If there are two or more ‘low risk’ non-compliant audits, a note should be added to the next month’s audit tracker detailing that the previous month was a ‘non-compliant month’ and that tier 1 audit is required in the following month.

Managing Medium-Risk Non-Compliance

7.19. Feedback must be given face to face, ideally by the auditor.

7.20. After face to face feedback, a Feedback Reflection Form should be completed by the individual and signed by both the auditor and auditee.

7.21. Audits and the feedback form should be saved in the individual’s Microsoft Teams folder and emailed to the auditee and their line manager. The relevant tracker should be updated to document that feedback has taken place.

7.22. If the auditee is not available for face to face feedback, this should be escalated to an appropriate duty manager so that rostering can be checked and an appropriate individual (ideally the auditee’s line manager) appointed to give feedback when the auditee arrives for their next shift. In this case, the line manager should sign the Feedback Reflection Form.

7.23. If there is one or more medium risk non-compliant audit, a note should be added to the next month’s audit tracker by the individual’s line manager detailing that the previous month was a ‘non-compliant month’ and that tier 1 audit it required in the following month.

Managing High-Risk Non-Compliance

7.24. The risk should be escalated immediately to a senior manager (e.g. EOCM, CSN, CCN, DCCM) – utilising the on-call manager if required.

7.25. A discussion should be held as to whether it is appropriate for the individual to be removed from practice and suitable next steps.

7.26. Agreed next steps should have accountable owners and the auditee’s line manager should be informed of these in writing.

7.27. The relevant tracker should be updated to document that feedback has taken place.

7.28. If there is one or more high risk non-compliant audit, a note should be added to the next month's audit tracker detailing that the previous month was a 'non-compliant month' and that tier 1 audit is required in the following month.

7.29. A DIF-1 should be completed for any high risk non-compliant calls.

8 Provision of Feedback

8.1. It is well recognised that fear and anxiety block learning. As such, audit must be promoted to provide a positive, safe, non-blame approach for the continuous improvement of patient outcomes, patient experience and staff experience.

8.2. All written feedback must include these four critical elements:

- Give a desired goal, i.e. what does good look like in this scenario. E.g. "it's important that we progress quickly through module 0 to rule out immediately life-threatening emergencies".

- Include the current position, using specific examples. E.g. "when you asked the heavy bleeding question, you didn't include the timeframe, this meant that a second follow-up question was required when the patient told you they had been bleeding".

- Provide advice on how to improve in future. "Remember, the best way to ask questions is as they appear in the system. This is the tried and tested phrasing to ensure we get the answer required and do not lose the clinical meaning".

- Refer to a policy or learning tool that effectively demonstrates this point.

8.3. The following principles should be followed to ensure feedback is perceived as positive and constructive (see appendix B for further information):

- Write directly and personally to the individual. E.g. "I really liked the way you…"

- Show an understanding of why the individual might have taken the course of action they did. E.g. "given that the caller had declared that there was breathlessness and difficulty speaking, I can see why you considered the stroke route…"

- Show empathy for the context of the call and the impact that this might have had on the individual. E.g. “this was a highly emotive call; you did an excellent job of controlling your voice and manner to guide the caller”.

- Strongly emphasise the positives; there will always be areas of good practice! Audit is as much about reinforcing effective practice as it is about providing development.

- Consider referencing best practice guidelines and local policy. E.g. “the NHS Pathways Call Handler Competencies recommend that we do not we mirror any rudeness, anger or frustration on the caller’s part”.

- Provide learning materials, such as ‘Hot Topics’.

- Be mindful of scenarios where an auditee is acting under the instruction of a senior colleague. Audit should focus on the practice of the individual being audited and their compliance with the competencies for their role.

- Wherever possible encourage the individual to find solutions (e.g. “What would help you remember to ask to speak to the patient?”). Help the person explore the reason for the problem areas (e.g. “When do you think it might be appropriate to rephrase questions?”).

- Think about whether you would be comfortable reading your comments aloud to the individual in a face to face feedback session.

8.4. An example of optimal feedback would be: “Worsening care advice helps to keep patients safe after we end the call, in this call it was forgotten. Remember to give worsening care advice at the end of each call.”

8.5. An example of sub-optimal feedback would be: “EMA didn’t give worsening advice.”

9 Audit Appeals

9.1. Compliant audits cannot be appealed; however, individuals may discuss the audit with the auditor for clarification and any amendments as required. The auditee should be given the opportunity to listen to the call.

9.2. If an auditee does not understand or agree with feedback in a non-compliant audit, they should first discuss the case with the auditor to reach shared agreement. The auditee should be given the opportunity to listen to the call.

9.3. If an agreement is not reached, the auditee must speak to their line manager for clarification on the issues to be raised.

9.4. The line manager should clarify issues where possible. If necessary, they should listen to the call and raise an appeal if concerns remain. If the auditee and the line manager cannot reach a shared agreement, the line manager must raise an appeal.

9.5. An experienced auditor will undertake this re-audit, and their decision will be final. If their score is within 10 marks and not the difference between a compliant/non-compliant audit the original audit will stand. Otherwise, this new audit will replace the original.

9.6. The outcome will be feedback to the individual by the line manager. Feedback should also be arranged for the original auditor if their audit was not upheld.

10 Audit Reporting

10.1. The HCA or nominated deputy will provide monthly data to the CAQSG and QAPS.

10.2. IUC audit components will be submitted to commissioners.

10.3. The report will contain compliance by EOC & IUC, and any local issues encountered.

11 Audit and Review

11.1. EOC & IUC audit managers will write a quarterly and annual report for the CAQSG and QAPS which will monitor compliance with the procedure and recommend and report any changes required to the procedure to the Clinical Governance Group.

11.2. All procedures have their effectiveness audited by the responsible Management Group at regular intervals, and initially six months after a new policy is approved and disseminated.

11.3. Effectiveness will be reviewed using the tools set out in the Trust's Policy and Procedure for the Development and Management of Trust Policies and Procedures (also known as the Policy on Policies).

11.4. This document will be reviewed in its entirety by the HCA every three years or sooner if new legislation, codes of practice or

national standards are introduced, or if feedback from employees indicates that the policy is not working effectively.

11.5. All changes made to this procedure will go through the governance route for development and approval as set out in the Policy on Policies.

12 Financial Checkpoint

12.1. To ensure that any financial implications of changes in policy or procedure are considered in advance of document approval, document authors are required to seek approval from the Finance Team before submitting their document for final approval.

12.2. This document has been confirmed by Finance to have no unbudgeted financial implications.

Appendix A – Telephone Triage Audit Reflection Tool

Staff Member Name		Date of Feedback	
What happened during the call - what did I do well and what didn't I do so well?			
What impact did my actions have for the patient/carer, the Trust and on me?			
What will I do differently next time?			
What actions should I complete to help me prepare for similar situations in future?			

(Actions must clear, measurable, achievable, realistic and must have a deadline for completion.)	
Review date (Normally reviewed monthly)	
Auditor Signature	
Line Manager Feedback After Actions Complete	
Line Manager Signature	
Date	
Staff Member Signature	
Date	

Important Please Read

- Please ensure the staff member is offered appropriate support ensuring access if provided to occupational health or wellbeing if required.
- If any assistance is required completing this reflection form, please contact the Practice Development team who will be happy to assist.

Appendix B – NHS Digital Guide to an Effective Coaching Session

This Guide is designed to help you prepare for a successful coaching session. This guide is not exhaustive, but rather focuses on the key elements needed to make the session productive and effective.

Preparing for the coaching session

1. Understand the situation

What has brought the member of staff into the coaching session? Have they requested the coaching session themselves after identifying areas of their practice they wish to improve upon? Or has the session been requested by a manager/team leader as a result of a complaint or poor performance? Understanding the reason for the coaching session is vital so that it can be planned appropriately. Different approaches will need to me implemented for someone who has requested coaching for personal developmental reasons compared to someone who is receiving coaching due to poor performance.

2. Choose the setting

Most coaching sessions are received more favourably if they are carried out in private. This is especially the case if a staff member is receiving coaching due to poor performance or a complaint. Ideally, a separate room away from the individual's work area is the best place to carry out a coaching session. This will help to minimise distractions and interruptions and allow any discussions to remain confidential. If a separate room cannot be obtained, coaches need to think carefully about the area they select to carry out the coaching session. Can the area be made private as private as possible? Does the coaching session need to be postponed until a private room becomes available?

3. Outline the key issues

A coaching session can quickly become unfocused and veer off track if it becomes an open discussion into someone's general practice. Prioritising key issues helps to ensure that discussions are clear and unambiguous and remain focused on the behaviour or attitude that needs to be developed. Prioritising the key issues also helps to ensure these are dealt with without the member of staff becoming overwhelmed during the session.

4. Identify specific examples

Make notes of specific behaviours that you can use to illustrate the key points you wish to discuss. Applying specific examples, rather than using of general terms and phrases, is a far more powerful way to help a member of staff identify areas of practice that need to be developed. For example, the phrase *"You give care advice far too quickly, you need to slow down"* is too general to have any real, lasting impact.
A more powerful way of highlighting the potential impact of delivering care advice at an inappropriate pace would be to have specific examples of where this could be heard on call recordings. Listening back to calls can be a very useful tool in enabling and encouraging reflective practice.

5. Identify solutions
Coaching should always be focused on working together in order to help identify solutions that may help bring about a change in practice. However, sometimes staff members may be unable to offer their own solutions for whatever reason. It is therefore helpful for coaches to be prepared to offer suggestions or solutions to the problem if the employee is unable to generate them on their own.

During the coaching session

1. Build rapport
Smile, greet the member of staff and ask simple questions to break the ice before starting the coaching session. A coach who is open and approachable is likely to experience a more productive coaching session. However, it is important to remain professional at all times and remember that you have an essential role to play in the future development and progression of the member of staff you are coaching. This may involve tackling some sensitive and potentially unpleasant topics, especially if the coaching session is being held as a result of a complaint or a mistake having been made. A coach who adopts an overly friendly approach to the coaching session may struggle to tackle such topics or they may not be taken seriously by the member of staff they are coaching.

2. Ask open questions
Open questions require a more in-depth answer rather than just a 'yes' or 'no'. The use of open questions can be invaluable in learning more about the situation and to get the staff member's perspective on the situation. It can also lead to coaches uncovering additional and critical information that they may otherwise have not been made aware of. For example, asking the question *"Do you know how to use the Declared Screen in Pathways?"* is likely to elicit a 'yes' or 'no' answer. However asking the question *"Tell me how the Declared Screen in Pathways should be used?"* requires the staff member to provide a more detailed answer which will provide far more insight into their understanding of the use of the Declared Screen.

3. Actively listen
Active listening is essential to any effective communication. It involves being part of the whole communication and not just the passive recipient of a message. Pay attention and remain focused. Be sure to paraphrase and summarise what you heard the staff member say. This demonstrates that you have been listening and helps to avoid any misunderstandings. Active listening is covered within Core Module Part One training. Be sure to revisit the training material you received during your own training in order to refresh your memory on this important area of communication.

4. Share
Share your interpretation of the situation using relevant data, such as call audit results or IDT statistics, and call recordings where relevant. Avoid making judgments and be sure to focus on the behaviour, not on the person.

5. Explain impact
Performance issues invariably have an impact: on those who use the service, on colleagues and on overall service performance. Understanding the impact certain behaviours can have on others is a powerful way of highlighting how important individual performance is. Very often staff members believe that they are such a small cog in a huge wheel that whatever they do, both good and bad, will not matter that much - but it does!

"If you think you are too small to make a difference, try sleeping with a mosquito." – Dalai Lama XIV.

Hopefully, the coaching interventions and support that the staff member receives will be sufficient in bringing about a positive change in behaviours, attitudes and/or performance. However, it has to be noted that not all staff members will achieve the desired level of change for whatever reason, despite the best efforts of any coaching and additional support they may receive. It is also important therefore that staff members are aware that a failure to achieve the desired change in certain behaviours could result in serious consequences for them personally. These consequences will obviously vary depending on the situation that has brought someone into coaching. This can be a very uncomfortable subject for coaches to tackle. Such conversations should always be carried out with sensitivity and guidance from other departments within your service - such as HR or the management team - wherever appropriate.

6. Clarify any expectations
Explain any expectations clearly, without hedging or backing down. For example,
"You have successfully completed the Probing Toolkit and we have discussed the importance of probing where necessary, rather than taking every answer at face value. You will now be expected to demonstrate these probing skills during your live call handling."

7. Ask for input
Gain the staff member's input on how to resolve any issues wherever possible. Adopting a collaborative approach to finding a solution will work much better than merely imposing a solution.
If someone feels that they 'own' a solution they will be more committed to making it work and less resentful of something that may otherwise be perceived as a sanction or a punishment.

8. Set a goal
Working collaboratively, set a specific, reasonable goal. For example: *"Aim to reduce ambulance sorting rates to <20% over the next month."* The goal needs to be reasonable and achievable within the agreed timescale.

9. Action Plan
Put an action plan together that outlines the steps needed to reach the goal. The plan should include:

- any goals
- how they will be achieved
- completion dates
- who will do what
- any further meetings to check on progress and offer additional assistance if required

10. Summarise the session
Summarise what went on during the session to ensure that both you and the staff member have a clear understanding of what will happen next. Ask the member of staff to repeat what you have agreed to ensure that there is no room for misunderstanding or confusion.

After the Meeting

1. Documentation
Ensure that all relevant documentation is completed after every coaching session. Good documentation is crucial and needs to be recorded accurately and contemporaneously: (e.g. as soon as possible after the coaching session). Keep any notes that you may have taken during the coaching session on file to show what you discussed and to help outline your thought processes for any decisions that were made. Documentation should always be signed, by both the coach and the staff member, and dated. Copies of any relevant documentation should also be made available to the member of staff. Remember, if it's not recorded, it may as well never have happened!

2. Keep any promises
Coaches should ensure that they always follow through on any promises that may have been made during the coaching session (e.g. arranging any additional training, removing obstacles, providing resources).
These should all have been recorded in the action plan therefore they need to be actioned in order to uphold the coaches part of the plan.

3. Monitor progress
Coaches should monitor the staff member's progress ahead of any follow-up sessions. The only way to measure the success of a coaching intervention and subsequent action plan is by careful monitoring of progress within the agreed timescales.

4. Additional support
Offer any additional assistance, support, or advice if it is identified as being appropriate when progress is reviewed. However, it is important to ensure that a staff member is not 'over coached' to the point where failure to achieve any agreed goals would be virtually impossible. This would not be a true reflection of an individual's progress and could result in a staff member being set up to fail once they are expected to perform their role without intense support.

5. Recognise success

Acknowledge and celebrate success. Very often coaching is viewed as some form of punishment for a mistake or a transgression from the agreed norm of a role. However the true ethos of coaching focuses on self-improvement and personal development. It is important therefore that successes are celebrated and achievements are acknowledged. Change does not just happen by itself – someone has to work hard at bringing that change about.

6. Be honest about any failure to progress

Failure to identify a member of staff who had not demonstrated sufficient competence could result in very serious consequences: for those who use your service, the staff member, the coach and for your service as a whole. It can be difficult for coaches to feedback less than positive information regarding a staff member's progress, knowing that it could have some very serious consequences for that person. There could be the temptation to 'give the benefit of the doubt' to someone who is a lovely person but who has not met the desired level of progress. Or to sign someone out of coaching in order to avoid an awkward conversation and a potentially confrontational situation with someone who may consider you to be a friend. However, the consequences of failing to fail a member of staff who has not demonstrated sufficient competence could be potentially devastating, especially for those who use your service.

Coaches should never feel obligated to sign a staff member out of coaching if they have not achieved the agreed level of progress set out in their action plan.

Appendix C – NHS Digital Coach Competencies

Competency 1: Effective Planning and Delivery of Coaching Interventions

1.1 Takes a thorough and logical approach to planning of any coaching activity

- Adequate consideration is given to the intended learning outcomes and how best to achieve these
- The workload involved in delivering coaching is managed appropriately
- Appropriate strategies are utilised (e.g. buddying, self-reflection, peer audit, observation, role-play, revision of hot topics/distance learning pack/case studies)
- Any necessary resources are prepared in advance, such as competency self-reflection tools, hot topics etc.

1.2. Demonstrates effective coaching strategies

- The content of any coaching session adequately addresses the intended learning outcomes
- Demonstrates skill in deploying the chosen coaching activities (e.g. buddying, case studies, role play etc.)
- The coaching session is logical, progressing from familiar concepts to less familiar concepts
- Paces coaching sessions appropriately (e.g. does not labour simple concepts and allows adequate time for more complex areas)
- Links are made to other areas of learning where appropriate

Competency 2: Skilled Communication

2.1 Has an engaging style of communication

- Demonstrates enthusiasm for the subject matter
- Effectively maintains the balance between formality and informality
- Uses humour appropriately
- Uses examples appropriately
- Uses non-verbal communication skilfully. This includes but is not confined to: eye contact, proximity, voice tone, voice pitch and gestures

2.2 Communicates effectively in 1 to 1 settings

- Can convey all relevant concepts **confidently, clearly and effectively** in a 1 to 1 setting
- Adapts communication if the situation demands it (e.g. for someone struggling to understand)

2.3 Creates a supportive environment that encourages learning

- Encourages and praises learners appropriately
- Manages learners' mistakes skilfully using them as positive opportunities for learning
- Provides additional support to learners when required

Competency 3: Effective Feedback Skills

3.1 Is skilled in providing constructive feedback

- Fully accepts their responsibility to give feedback when errors, misunderstandings or poor practice occur
- Creates the appropriate atmosphere/environment for giving feedback depending on the circumstances, considering issues such as privacy, dignity etc.
- Provides feedback according to recognised good practice, for example it should be:

  - Specific and where possible supported by example(s)
  - Timely
  - Balanced
  - Owned; the person who made the observation should ideally be the one that feeds back

- The recipient's receptiveness for feedback is taken account of (i.e. buckets, tumblers, thimbles.)
- Involves the learner in the feedback process (e.g. by checking out their understanding of the feedback and negotiating a way forward)

3.2 Applies the competencies effectively when auditing calls/feeding back issues related to practice

- Practice shows a good awareness of the NHS Pathways competencies
- Issues are categorised/commented on under the appropriate competency and indicator
- The quick guide is always used as an aide memoir to call audit, and the detailed competency document is used when required

Competency 4: Demonstrates Appropriate Subject Knowledge

4.1 Demonstrates a sound understanding of the underlying principles of telephone triage using NHS Pathways

- Can describe the purpose of telephone triage
- Can analyse the risks and benefits of telephone triage
- Can effectively discuss the underlying philosophy of NHS Pathways and how this relates to safe telephone triage

4.2 Demonstrates a sound understanding of NHS Pathways content and structure

- Navigates the system in a consistent and safe manner and can support others to do the same
- Recognises and manages misconceptions or areas of confusion regarding the system skilfully

Competency 5: Effectively Assesses Learning

5.1 Ensures that learning is assessed appropriately

- Affords time and space within a coaching session to assess learning
- Assesses learning appropriately depending on the issue(s) being coached (e.g. observation of psychomotor skills or question and answer session for cognitive learning).
- Applies the chosen assessment method skilfully

5.2 Acts appropriately on assessment results

- Assessment is seen as part of a cyclical process, rather than a means to an end. Appropriate actions are implemented where indicated.

Competency 6: Demonstrates Professionalism

6.1 Manages equality and diversity with skill

- Treats everyone with respect irrespective of any differences
- Treats everyone fairly and recognises that being fair does not necessarily mean treating everyone the same
- Ensures that everyone receives the support they need to achieve to their full potential

6.2 Works collaboratively and co-operatively with colleagues

- Takes on a fair workload
- Shows respect and care for colleagues
- Shares information with colleagues appropriately
- Able to compromise where necessary
- Maintains commitments to colleagues
- Is able to overcome any personality differences

6.3 Demonstrate a positive attitude to NHS Pathways

- Discusses all aspects of the system and the way it is deployed realistically and positively
- Utilises appropriate problem-solving techniques, such as the parking lot, to manage system focused issues that arise.

6.4 Has a positive approach to receiving feedback

- Actively listens to feedback given
- Is willing to consider feedback given
- Is able to adapt their approach in response to feedback where required
- Takes responsibility for own actions and decisions
- Acknowledges own mistakes in an adult fashion.

Key

Full achievement: demonstrated to an excellent standard or the indicator did not apply to the circumstances

Partial achievement: adequately demonstrated and any issues identified in relation to this competency did not affect the overall effectiveness of the session/intervention.

Not achieved: not adequately demonstrated and the issues identified detracted from the overall effectiveness of the session/intervention.

				F	P	N	Comments
Competency		Indicators					
1	Effective Planning and Delivery of Coaching Interventions	1	Takes a thorough and logical approach to planning of any coaching activity				
		2	Demonstrates effective coaching strategies				
2	Skilled Communication	1	Has an engaging style of communication				

		2	Communicates effectively in 1 to 1 settings				
		3	Creates a supportive environment that encourages learning				
3	Effective Feedback Skills	1	Is skilled in providing constructive feedback				
		2	Applies the competencies effectively when auditing calls/feeding back issues related to practice				

4	Demonstrates Appropriate Subject Knowledge	1	Demonstrates a sound understanding of the underlying principles of telephone triage using NHS Pathways				
		2	Demonstrates a sound understanding of NHS Pathways content and structure				
5	Effectively Assesses Learning	1	Ensures that learning is assessed appropriately				
		2	Acts appropriately on assessment results				
6	Demonstrates Professionalism	1	Manages equality and diversity with skill				

		2	Works collaboratively and co-operatively with colleagues				
		3	Demonstrates a positive attitude to NHS Pathways				
		4	Has a positive approach to receiving feedback				