NHS
South East Coast Ambulance Service
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), 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 operating policies and procedures and Trust Operational and/or Clinical Bulletins. These are the approved standards that practice will be audited against.

1.4. The Trust reserves the right to change these procedures swiftly as occasionally required by the NHS Pathways licence.

1.5. This document does not include no-send, clinical tail audit or PACCS audit; these 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 **Chief Medical Officer** 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 **Clinical Operations Manager for Integrated Care and Clinical Lead for Integrated Care** 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 **Clinical Operations Manager for Integrated Care** and **Clinical Lead for Integrated Care** are 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 Health Informatics and Records** 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 999 & 111 IUC System Governance 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. It is best practice that line managers will audit one 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 once each quarter. 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.

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

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 live calls).

5.2. Standard Audit is the monthly routine audit of each user, for each type of triage they undertake. This includes CDSS, service adviser calls, 'in-line advice' and any other CDSS triage and assessment tools approved by the Trust according to their 'tier'.

5.3. Those on Tier One will have:

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

5.4 Tier One includes new staff for their first six 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 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.

5.5 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 One or Tier Two CDSS audits.

5.6 Those on Tier Two will have:

Gold standard: 5.6.1 One retrospective audit 5.6.2 Two 'live' audits 5.6.3 One optional self-review is strongly encouraged. OR:
Silver standard (only if live audit cannot be achieved due to shift patterns or unprecedented operational demand): 5.6.4 Three retrospective audits 5.6.5 One optional self-review is strongly encouraged

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

5.8 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) line managers may request an individual to return to Tier One.

5.9 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.

5.10 Non-Standard Audits (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 six working days

- Investigations, urgent incident reports and priority audits for coroners/legal team etc. within four 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.

6 How is live audit undertaken?

6.1 Live audit is carried out using the NHS Pathways Live Audit Tool for NHSP calls or the standard audit tool for other types of call.

6.2 The live audit can be completed via remote observation (audio and screen observation) at the time of the call.

6.3 Any developmental feedback should be given face to face after the audits are completed unless any serious practice concerns are recognised, and immediate feedback is needed.

6.4 The relevant competency quick guide should be utilised alongside the Live Audit Tool.

6.5 The Live Audit Tool is not suitable for those who are new to auditing. It is essential that anyone using the Live Audit Tool 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 Live Audit Tool 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 There are several ways in which a live audit would become non-compliant.

- Competency eight is not achieved in NHSP audit
- Four 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 CDSS 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 Call recordings will be accessed from the Trusts 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

7.3 All calls being assessed must be done so within a private space 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.

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

When Audits Are Compliant

7.5 Wherever possible, feedback should be given face to face immediately, in a private and comfortable location.

7.6 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.

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

One or More Non-Compliant Audit

7.8 Where an NHSP audit is below 86% it is classed as non-compliant.

7.9 Line managers are responsible for investigating issues that have caused non-compliance and if required developing a suitable action

plan. They may work in collaboration with a trainer or coach to support the development of this plan. 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.

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

7.11 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. Indicators 8.1 or 8.2 may have been partially achieved in an NHS Pathways audit. 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

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

7.13 If the auditee is not available for face-to-face feedback, audits can be emailed to the line manager for routine feedback.

Managing Medium-Risk Non-Compliance

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

7.15 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.

Managing High-Risk Non-Compliance

7.16 The risk should be escalated immediately to a senior manager (e.g. EOCM, CSN, CCN, DCCM).

7.17 The line manager will be responsible for reviewing the working pattern for the staff member and ensuring the audit is fed back on that or the next shift.

7.18 The manager will be responsible for reviewing the audit and ensuring the appropriate support plan is in place for the staff member to assure learning.

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

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.

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 they are not audit trained, they should request a suitable trained member of staff to listen to the call and reaudit the

call to submit for appeal. If the auditee and the line manager cannot reach a shared agreement, the line manager must raise an appeal.

9.5 Two independent experienced auditors will undertake this re-audit, it will then be reviewed by an EOC Practice Development Manager, 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, a level call 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.

9.7 To appeal a clinical audit. 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.

9.8 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.

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

9.10 Within the request for an appeal, it should be noted what it is that is being appealed. If it is possible for a re-audit to be completed this should be submitted with the appeal instead.

9.11 Two independent experienced auditors will undertake this re-audit, it will then be reviewed by an EOC Practice Development Manager or equivalent and their decision will be final. If the re-audit scores are within 10 marks and not the difference between a compliant/non-compliant audit the original audit will stand. Otherwise, a levelled call will replace the original.

9.12 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 EOC Practice Development Managers or nominated deputy will provide data to the CAQSG and IUCSGG as required.

10.2 IUC audit components will be submitted to commissioners.

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

11 Audit and Review

11.1 EOC managers will develop an annual report for the CAQSG and IUCSGG which will monitor compliance with the procedure.

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 EOC Practice Development Managers 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 This document has been confirmed by Finance to have no unbudgeted financial implications.

13 Equality Analysis

13.1 The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the Human Rights Act and to meeting the Equality Act 2010, which identifies the following nine protected characteristics: Age, Disability,

Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature, then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

13.2 Equality Analysis (EA) is a tool aimed at improving the quality of our services by ensuring that individuals and teams think carefully about the likely impact of their work on different communities or groups. It involves anticipating the consequences of the Trust's policies, functions and services on different communities and making sure that any negative consequences are eliminated or minimised, whilst opportunities for promoting equality are maximised.

14 Data Privacy Impact Assessment

14.1 This activity is encapsulated via the Trusts DPIA for the processing of patient clinical records as per the 'Sharing audit compliance and outcome information to clinical staff and their management teams' DPIA, that was approved July 2023; and updated further in November 2023 to include EOC colleagues (Emergency Medical Advisors [EMAs]), Private Ambulance Providers (PAPs), Community First Responders (CFRs) and staff responders using GoodSam.

15 Associated Documentation

15.1 EOC Call Handling Procedure

15.2 IUC Local Operating Procedures

15.3 Capability Policy & Procedure

15.4 NHS Pathways Licence Agreement

15.5 Information Governance Policy

15.6 Data Quality Policy