Integrated Care 24 Limited

Integrated Care 24 Limited – Norfolk & Wisbech

Inspection report

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Overall summary

We carried out a focussed inspection with 48 hours' notice at Integrated Care 24 (IC24) NHS 111 and Out-of-Hours Service on 16 March 2016.

The inspection focussed on safety and leadership at the service and took place following information of concern that had been highlighted to CQC.

Overall, we found that a number of key improvements needed to be made in order to ensure that people always received a safe effective service. However, action already taken by the new leadership indicated that the service is capable of making these improvements.

We found that:

- Systems and processes to help prevent patients being put at risk of harm were not always in place. For example, some nurses triaging patients were found to have undertaken tasks without evidence of them having had the appropriate training.
- There were delays in patients accessing both the 111 and the GP out of hours services.
- Although staff were clear about reporting incidents, near misses and concerns, scope for ongoing learning and/or improvement as a result of any incident was limited.
- Systems to record whether recruitment procedures had been followed were ineffective, meaning the service was unable to demonstrate whether staff were appropriately qualified and security checked.
- Inspectors found medicines that were out of date in some areas of the GP out-of-hours service.

However we also found:

- The service was able to identify areas for staff development and learning, as appropriate and effective clinical audits were in place.
- NHS 111 staff followed call procedures, to triage public telephone calls for medical care and emergency medical services, that helped them make safe and effective decisions when speaking to patients needing assistance.
- Reviews and audits of calls to the service were regular and robust.

CQC has told the provider it must:

Summary of findings

- Ensure all out-of-hours staff who triage patients have been adequately trained to make clinical decisions by telephone and have been assessed as competent to do so. In addition, protocols and guidelines must be implemented to guide staff to make safe and appropriate decisions with regard to how people's needs are assessed and dealt with.
- Prioritise ongoing work to investigate and tackle the causes of delays relating to patient care.
- Ensure medicines held at primary care centres are within the manufacturers' recommended expiry dates and make sure there is an effective process for managing this.
- Put systems in place to ensure that staff files and recruitment procedures are effectively recorded.
- Undertake Disclosure and Barring Service checks for all staff in a timely and orderly manner.
- Ensure sufficient and appropriately trained staff are present at all primary care centres and that contingency arrangements for staff to follow are agreed for when gaps in GP cover arise.

The provider should make the following improvements:

- Learning relating to incidents should be shared with all relevant staff to encourage a culture of on-going improvement.
- Staff should always use the correct prescription pads when prescribing medicines.
- The provider should ensure all staff receive timely mandatory training and are supported in undertaking this.
- The provider should take action to ensure all staff are aware of who the safeguarding leads are within the service.
- All controlled drugs should be ordered from a wholesaler using the correct form, in line with Regulation 14 of the Misuse of Drugs Regulations 2001.
- Ensure a robust process is in place for monitoring clinical equipment, to make sure that it is fit for purpose.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

NHS 111 staff were well trained in the use of NHS Pathways and were subject to regular audit and review of their performance to ensure its safe use. However staff working in the out-of-hours service were undertaking tasks without the support of triage protocols and guidance, or in some occasions evidence of appropriate training.

Appropriate and effective clinical audits were in place to ensure that the service could identify areas for development and learning. This applied to the NHS 111 service as well as out-of-hours There were clear procedures and policies in place across both NHS 111 and out-of-hours, that staff were aware of, to enable them to recognise and act upon any serious events or incidents. However we could not be assured that learning from such events was regularly cascaded to staff in order to help prevent a re-occurrence.

We found that the provider did not have systems in place to ensure that people seeking to work in both out-of-hours and NHS 111 were appropriately recruited to ensure their eligibility and suitability to work in a healthcare environment.

The provider had systems in place across NHS 111 and out-of-hours to identify and safeguard patients at risk of harm, however not all staff were aware of who the safeguarding lead was.

The provider did not have systems in place designed to allow continuity of the NHS 111 and out-of-hours service in the event of information technology or telephony systems failures or other foreseeable events that might affect the delivery of the service.

Some members of staff working in the out-of-hours service used their own equipment rather than that supplied by the provider.

Generally medicines were well managed although the provider could not provide any assurances that medicines, including controlled drugs, were only accessible to those authorised to do so.

Are services well-led?

The provider had a well-defined and established governance structure which encompassed a number of committees including audit, financial, clinical quality and leadership. Most members of staff we talked with spoke positively about the management of the service and said the management team was keen for staff to continually learn and improve. However some staff told us that they felt undervalued and demoralised.

The provider took an active role in engaging with other stakeholders with a view to providing integrated care. The provider undertook regular liaison with commissioners and provided regular quality reports.

The provider had taken positive steps to improve the recruitment, training and retention of NHS 111 staff. Senior managers were visible and an integral part of the staff team. The senior management team demonstrated a clear focus on improving the service and patient experience and took positive steps to remind and reinforce those values with all staff.

There was a clear leadership and management structure and most staff we spoke with were clear who they could approach with any concerns they might have. We found significant gaps in the recruitment process and associated record keeping across both out-of-hours and NHS 111.

Summary of findings

The provider supported both clinical and non-clinical staff by providing a range of training opportunities all aimed at delivering high quality, safe care and treatment to patients. However we found that some members of staff had not received all the training appropriate to their role.

Integrated Care 24 Limited – Norfolk & Wisbech

Detailed findings

Background to this inspection

The integrated NHS 111 and out-of-hours service for Norfolk and Wisbech and surrounding area is provided by Integrated Care 24 (IC24). IC 24 is a not for profit organisation. The headquarters for IC24 is located in Ashford, Kent. IC24 operates further NHS 111, out-of-hours and a variety of other services including prison healthcare and primary care centres in other areas, namely in Kent, Sussex, East Sussex, Suffolk and Essex.

IC24 commenced delivery of the integrated NHS 111 and out-of-hours service for Norfolk and Wisbech in September 2015. The out-of-hours service operates from 6.30pm until 8am Monday to Thursday, and 6.30pm Friday until 8am Monday and all public holidays. Initial telephone contact to receive out-of-hours service is through NHS 111, part of the service provided by IC24 under the integrated contract.

NHS111 is a 24 hours-a-day telephone based service where patients are assessed, given advice or directed to a local service that most appropriately meets their needs. For example their own GP, an out-of-hours GP service, walk-in centre, urgent care centre, community nurse, emergency dentist or emergency department.

IC24 provides care to patients who require urgent medical attention from GPs and nurses outside of normal GP opening hours. They employ GPs, nurses, health care assistants and support staff who are directly employed or engaged on a sessional basis to deliver care to patients. The organisation' governance structure consists of a board of directors overseeing 'well led', 'quality', 'audit' and 'finance' sub committees.

The service provides care to a population of approximately 830,000 people residing in the area and operates locally from the Care Coordination Centre in Norwich.

Out-of-hours services in Norfolk and Wisbech area are delivered from eight primary care centres in addition to the Care Coordination Centre. These are located in Dereham, Norwich, Fakenham, Long Stratton, Wisbech, Thetford, North Walsham and Kings Lynn. As part of this inspection we visited the Care Coordination Centre in Norwich and the primary care centres in Norwich and Kings Lynn.

Information from Public Health England dating from June 2015 states that deprivation is lower than average, for example about 17.1% (24,400) children live in poverty. Life expectancy for both men and women is higher than the England average.

Are services safe?

Our findings

Safe track record and learning

This section is applicable to both NHS 111 and out-of-hours services.Safety was monitored using information from a range of sources. We were provided with a list of alerts which had been received and disseminated amongst relevant staff. The provider kept a log which reflected recent updates and alerts that had been disseminated. However the provider was unable to evidence that all staff had confirmed they read these. We looked at alerts and updates from the Medicines and Healthcare products Regulatory Agency (MHRA) and saw that information was reviewed by a nominated person and emailed to all relevant staff. There was no process in situ to ensure all staff had seen and read the updates or alerts.

The provider carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The provider had systems in place to ensure all clinical staff were kept up to date.

The service had a policy and an incident recording process which was accessible to all staff. There was a system in place for reporting and recording incidents. We reviewed records of incidents that had occurred since September 2015. There was evidence that the service had identified learning, however there was no evidence that the findings were continuously shared with relevant staff to support improvement of the service provided. Staff told us they were part of the incident process if they had been directly involved with the incident, but might not know about it if they were not involved, thus limiting the scope for on-going learning and improvement. We saw that the provider circulated information across its operations nationally that highlighted learning from incidents across different regions, especially if there were repeat incidents of a similar nature. However local dissemination of learning needed improvement.

We were assured that incidents were reviewed and dealt with appropriately. In addition, the provider was able to evidence investigation into several ongoing coroner's cases. We saw that for one of these the provider had proactively sought input from leading bodies that were potentially involved in the incident. An outcome had not yet been established at the time of our reporting.

Reliable safety systems and processes including safeguarding

Both the NHS 111 and out-of-hours service operated effective systems to manage and review risks to vulnerable children, young people and adults. Staff told us referrals were made electronically when necessary and recorded on the electronic system. There were comprehensive safeguarding policies held centrally by the provider and the correct information, including contact details, was available on site for local processes, this was directly to hand for clinicians via an electronic link. The service had a dedicated lead for safeguarding, although staff were not always aware who it was; when asked we got differing answers from staff.

The provider was unable to provide us with evidence that staff had received role specific mandatory training on safeguarding. During the inspection we were shown evidence of training completion rates for different staff groups in safeguarding vulnerable adults and children which ranged from 50% to 100%. The provider provided us with a matrix after our inspection which indicated improvement was made across all staff groups on training completion. However, there was still improvement to be made as not all were at 100%. For example, urgent care practitioners' levels of training (including safeguarding vulnerable adults and children, 80% and equality and diversity, 73%) required improvement.

All clinical staff had received up to date level 2 children safeguarding training and all GPs had undergone level 3 children safeguarding training. Not all staff were familiar with Gillick principles which are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Staff we interviewed knew how to recognise signs of abuse in older people, vulnerable adults and children but were not always aware of who the safeguarding lead was.

There was a chaperone policy (a chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff told us nurses acted as chaperones and

chaperoning was undertaken by trained staff. However, we saw evidence that criminal record checks through the Disclosure and Barring Service (DBS) were not always undertaken nor investigated if delayed. We saw records that indicated that in excess of 30 members of staff had not received a timely DBS check. In several cases it had taken more than four months for the provider to follow up unreturned DBS applications. This meant that members of staff had been operating without a valid DBS certificate in place. The IC24 senior management team told us that this situation would be progressed immediately. Following our inspection we were provided with a statement that DBS checks or risk assessments for all staff were either completed or in process.

The provider was in the process of improving systems to ensure the 111 service provided was safe and used NHS Pathways to deliver that service (NHS Pathways is computer software that provides clinical content assessment for triaging telephone calls from the public, based on the symptoms they report when they call, linked to a directory of services -DoS, which best identifies the appropriate healthcare service to meet a patient's needs).

We saw that as the day progressed into the out-of-hours' period additional NHS111 staff came on duty to meet the expected increased demand on the 111 service. Waiting times for calls to be answered and the number of calls queued were clearly displayed and were constantly monitored. IC24 staff acknowledged that there have been delays in services provided to some patients by both the NHS 111 and out-of-hours services. Work was ongoing to address the underlying causes. For example, in the out-of-hours service, there had been significant delays in visits to patients receiving end of life care in their own homes. As a result, a roving car had been introduced, initially on an ad-hoc basis but this was due to progress into cover at weekends in the week after our inspection, allowing a nurse or GP with training in palliative care to see and treat these patients more quickly.

Staff at the 111 call centre were seated at 'pods' which consisted of a mix of call and clinical advisors. NHS 111 staff wore different coloured shirts to distinguish between call handlers and clinical advisors. The ratio of clinical advisors to call handlers was better than the NHS Pathways recommended minimum of 1:6. We saw that the provider used detailed forecasting and analysis to predict 111 call demand at peak times, for example bank holiday weekends. Data was available to the provider that enabled them to make considered and evidenced judgements for the expected demand. We looked at the historic forecasted demand and compared it with the actual demand and found the forecasting to be very accurate. This enabled the provider to ensure that correct numbers of staff were available.

We saw that the provider used forecasting and analysis to predict out-of-hours consultation. Limited data was available to the provider to support demand management. The provider was transparent in acknowledging that staffing levels were not always appropriate due to recruitment issues and staff shortages.

Medicines management

A pharmacy technician was responsible for all aspects of medicine management at the service and was supported by a pharmacist who was employed by the provider.Medicines were stored at a central Norwich location and supplied to base sites. These medicines were stored securely and appropriately. Expiry dates were recorded so that medicines could be recalled when out of date. We saw that orders were checked and appropriate stock control measures were in place, for example 'top up' ordering sheets from the bases. Staff at the bases told us that they had suitable stocks available and that the service was responsive to need, particularly over bank holiday weekends when service delivery managers could access the central store for additional stocks.

Expiry dates were recorded on receipt from the supplier so that medicines could be recalled when out of date. However, we saw out of date medicines at one satellite location which showed that the system of recall was not sufficiently robust to ensure that people were not at risk of receiving out of date medicines.

Medicines were supplied to patients by prescription or Patient Group Direction (PGD). We saw that PGDs had been appropriately adopted by the service to allow nurses and paramedics to administer medicines in line with legislation. Medicines for this purpose were received by the service in over-labelled packs which included the directions for use. The name of the patient and the date was added to these labels. A system of FP10P (lilac coloured) prescriptions was in use for this, however we saw that staff did not always use the correct stationery and efforts had been made to remind staff via staff meetings.

Are services safe?

Medicines management meetings were held quarterly and we saw how information was disseminated to all clinical staff by means of a clinical newsletter. Controlled drugs were securely stored and recorded appropriately at a central location and these records were checked against records held in the bases by means of photographs of the base records and prescription reconciliation. Controlled drugs were ordered from a wholesaler but the correct form was not used in line with regulation 14 of the Misuse of Drugs Regulations 2001. We were told that the wholesaler had advised the service that this was not needed; the provider should obtain its own advice on this matter.

Controlled drugs in the bases were stored securely and we saw the records of these being signed in and out when they were transferred to the cars for home visits as completed by the doctor and the driver. When away from the service these medicines were stored under coded padlock. The drivers had the codes for these padlocks. We were also told that the codes were not changed and we saw no evidence of any changes in the codes to protect the drugs.

A monthly audit of morphine prescribing was done which included the reasons for the prescription. This was used to inform the local CCG about palliative care provision and gaps in anticipatory prescribing in their area.

The standard operating procedure (SOP) for controlled drugs was dated November 2011 and did not describe the current ordering process. The SOP stated that the doctor's bag containing controlled drugs 'is kept locked at all times' but did not describe how access was to be achieved.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept.

We found that the vehicles we inspected were also clean. Consultation rooms we viewed had disposable curtains. An infection control policy and supporting procedures were in place. There was a lead responsible for infection control, however not all staff knew who this was. Staff received induction training about infection control specific to their role and should receive updates.

Most staff we spoke with told us that they had access to online infection control training. But training records we reviewed indicated that infection control training ranged from 50% to 100% for differing staff groups. For the nurse practitioner group it was indicated that infection control training was undertaken by 73% of the staff.

Equipment

Staff told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments and there were sufficient stocks of equipment and single-use items required for a variety of interventions.

Management told us that all equipment was tested and maintained regularly and we saw evidence that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We saw evidence that calibration of relevant equipment was in date. However, staff explained that they often used their own equipment which had not been calibrated as this was not the provider's property. After our inspection the provider provided us with evidence of a service level agreement that GPs were responsible for maintenance and servicing of their own equipment. However, there was no process in place during which the provider could reassure themselves this was taking place. Nor did we see evidence of contingency arrangements in case staff forgot equipment or it failed mid session.

Staffing and recruitment

A review of staff files demonstrated that staff other than GPs were not always recruited in accordance with the policy and an array of information was either incomplete or missing. For example, there were missing references, DBS records and confirmations that an induction programme had been completed. Without any effective systems in place to evidence the recruitment procedures of staff, the provider was putting patients at potential risk of being treated by inappropriately qualified or security checked staff. Drivers, who held the codes to medicines available to doctors on visits, had undergone checks with DBS. We were shown evidence that the provider was in the final stages of a process that delivered a comprehensive induction programme for out-of-hours' clinicians. This was not yet active at the time of our inspection but indicated that the provider was aware of the shortfall and had responded with a very comprehensively designed induction programme.

We saw that the training and induction process for 111 call handlers and clinical advisors was of a high calibre and

fully complied with the terms of the NHS Pathways licence agreement. We observed new staff in the training environment and spoke to call handlers who had recently completed their training. They were positive about their experience and told us of the arrangements in place to ensure that they were coached by experienced staff for a period of time before working alone by working in a 'graduation bay'. We saw that all call handlers and clinical advisors were subject of call audits and the achieved level of audit was in line with recommendations.

We looked at the files of four GPs who worked in the out-of-hours service and found that recruitment procedures and checks to ensure their suitability to work in a healthcare environment had been carried out. This included DBS checks, references, training records and evidence of professional indemnity. There were arrangements in place to check the annual registration of GPs with the General Medical Council and of nurses with the Nursing and Midwifery Council.

We reviewed rotas and staffing levels for the out-of-hours allocation and found there were repeatedly gaps in GP cover at various locations in the area. We saw that on one occasion during a recent Saturday prior to our inspection there had been a shortage of GPs in the whole area over a 24 hour period, spread over several shifts. During this period a total of 50 GP shifts were planned and six had remained uncovered. This had resulted in potential difficulties in patients being able to access the services of a GP in certain areas. The provider explained that recruitment had proven difficult, which was partly due to competing offers of shifts and benefits to GPs at other services of which we saw evidence. The out-of-hours services were commissioned to have GPs available to provide consultations to patients and to advise other clinicians whenever required. We saw evidence that there was always GP advice available over the phone if not in person. Face to face consultations were largely provided by nurse practitioners and emergency/urgent care practitioners. After our inspection the provider provided us with information that indicated that in March 2016:

- 22.6% of face to face consultations were undertaken by advanced nurse practitioners
- 55.0% of face to face consultations were undertaken by GPs
- 22.3% of face to face consultations were undertaken by urgent care practitioners

There was a programme of clinical audits to monitor quality and systems for the out-of-hours service to identify where action should be taken to improve the service. We saw that, where audits indicated arising concerns, this was fed back to staff one to one or via group communication and actions were taken, for example, the dissemination of specifically composed information guidelines for sepsis. Calls to the out-of-hours service were audited and 3% of calls had undergone audit. Calls were audited using the Royal College of General Practitioners toolkit.

Many of the staff had worked for the previous provider and had been employed by IC24 as part of a 'transfer of undertakings' (TUPE) This is where either part or all of an organisation's process and staff are transferred over to a new employer. We spoke with members of staff, clinical advisors and call handlers who worked in the NHS 111 call centre. All were positive about the provider and the service provided.

We were informed that some members of staff, predominantly in the out-of-hours service had not been satisfied with their new employer and a large number of staff had left. It was also apparent that there were still members of out-of-hours' staff working for the service who were not happy with their new employer and it was clear that this was having a disruptive effect to morale and staff retainment. We noted that the exodus of staff had diminished to the extent that in the month prior to our inspection no staff had left of their own volition. The provider recognised that staff sickness was impacting on their ability to deliver care within the set performance targets. Targeted work across clinical staff teams has succeeded in reducing staff sickness levels from 10% in November 2015 to 3% in March 2016. Sickness absence across the call handling team was acknowledged by the provider to be higher than desired and remained high at 18% in March 2016. However new rotas were introduced in March and long term sickness had been addressed.

The shortage of staff in the NHS111 call centre had meant that it had been difficult to meet the minimum requirements for such performance indicators as answering calls within 60 seconds and ten minute call backs from clinicians. Data indicated that in December 5.5% of calls were abandoned; this had improved to 4.7%

in April against a national target of no more than 5%. However, data also indicated that in December 2015 94.4% of calls had been answered within 60 seconds had reduced to 77.8% in April 2016 against a national target of 95%.

The provider had addressed one of the major reasons quoted for staff leaving, namely the shift patterns for NHS111 staff. This meant that, previously, some staff infrequently got weekends off and were required to work at very short notice. Despite the above described reduction in the percentage of answering calls within 60 seconds over the period December 2015 to April 2016 data indicated that this percentage had improved from approximately 60% to 77.8% following the introduction of new shift patterns from March to May 2016. We spoke with the Operational Service Manager who explained how they had spoken personally to every 111 call handler and 111 clinician. As a result of their feedback staff now had a choice of fixed or flexible hours' contracts which meant that planning to meet demand was easier and staff we spoke with were in favour of the change. No staff were employed on a 'zero hours' contract.

Data on NHS 111 calls since September 2015 indicated that the provider's performance for call backs within 10 minutes in December 2015 was 39.0% and in April 2016 it was 38.5%. Warm transfer rates in December 2015 were 56.4% and in April 2016 57.1%. There was no performance target in place for the provider to achieve.

When calls were received by NHS 111 they were triaged using the Pathways system by clinical advisors before being passed to the out-of-hours service. The out-of-hours' staff undertaking further telephone assessment duties did not have access to robust systems to assist them in the triage process. There was no telephone assisted software in place, nor were guidelines readily available to assist and ensure the safety of the assessment process. Nurses in the out-of-hours service were also expected to have been trained in extended skills such as history taking and minor illness. We were not provided with evidence that this was always the case. However, after our inspection the provider informed us that all new nursing staff employed were recruited with a level of additional practitioner training that is an essential criterion within the personal specification.

The service provided us with a list of support mechanisms it considered to have in place for nurses which included identification of previous experience, call audits using the Royal College of General Practitioners toolkit, shadowing opportunities of other staff and services, and direct telephone access to a GP or clinical lead. Due to poor governance of staff files we were not able to confirm which took place consistently or not. Other than mandatory training and telephone consultation audits there was a considerable lack of evidence that the above practices were effectively taking place, despite the service outlining these as available support.

The out-of-hours service would receive calls through the NHS 111 service, following which the out-of-hours service would have to act within set time frames depending on the coding given by the NHS 111 service. We looked at the National Quality Requirements (NQRs are quality standards set out for GP out-of-hours services) data the service provided us for September 2015 until January 2016. This data showed the service was not always meeting requirements.

When we reviewed the overall out-of-hours NQR performance for the provider over the period from September 2015 to April 2016, not differentiating between different geographical areas, we noted the following:

- NQR data for home visit consultation within one hour showed that the service performance ranged from 58.4% to 92.4% against the national target of 95%.
- NQR data for home visit consultation within two hours showed that the service performance ranged from 69% to 99% against the national target of 95%.
- NQR data for home visit consultation within six hours showed that the service performance ranged from 83.9% to 100% against the national target of 95%.

After our inspection we were provided with data for April and May 2016 which indicated the provider's performance had improved from above data, namely:

- NQR data for home visit consultation within one hour showed that the service performance was at 88.4% (April) and 93.8% (May) against the national target of 95%.
- NQR data for home visit consultation within two hours showed that the service performance was at 93.6% (April) and 99.1% (May) against the national target of 95%.
- NQR data for home visit consultation within six hours showed that the service performance was at 99.2% (April) and 100% (May) against the national target of 95%.

Are services safe?

We reviewed the NQR data which was divided into six geographical areas ('North Norfolk', 'West Norfolk', 'South Norfolk', 'Norwich', 'Cambridgeshire and Peterborough' and 'Other') and reported accordingly per area. The following data covers all the geographical areas mentioned. For example, from September 2015 to January 2016:

- NQR data for telephone advice via a call back by a health care professional within 20 minutes showed that the service was 100% compliant.
- NQR data for telephone advice via a call back by a health care professional within 60 minutes showed that the service was 100% compliant.

This data from the months prior to our inspection indicated that, in providing calls back within set time frames, the service was performing at 100% for all areas. However, there were some variations in relation to the timeliness of face to face consultations. For example:From September 2015 to January 2016:

- NQR data for contact with the GP or other local service within two hours showed that the service's performance ranged from 89.5% in October 2015 in Cambridgeshire and Peterborough to 56.3% in December 2015 in South Norfolk. The national target was 95%, this was not met in any area during this period.
- NQR data for contact with the GP or other local service within six hours showed that the service's performance ranged from 98.4% in October 2015 in Cambridgeshire and Peterborough to 84.9% in December 2015 in Norwich. The national target was 95% and was only met on four occasions in different areas throughout this period.

For the six geographical areas there were further variations in relation to the timeliness of home visit consultations. For example:From September 2015 to January 2016:

- NQR data for home visit consultation within two hours showed that the service's performance ranged from 33.3% in November 2015 in 'other' areas to 91.3% in November 2015 in Cambridgeshire and Peterborough. The national target was 95%, this was not met in any area during this period.
- NQR data for home visit consultation within six hours showed that the service's performance ranged from 63.1% in December 2015 in Norwich to 98.1% in December 2015 in Cambridgeshire and Peterborough. The national target was 95% and was only met on one occasion in different areas throughout this period.

Arrangements to deal with emergencies and major incidents

For out-of-hours, there was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. Emergency buttons were present in the consulting and treatment rooms electronically via the computer system.

At the locations we visited the service had a defibrillator available and oxygen with adult and children's masks. Emergency medicines were accessible to staff in a secure area of the premises and all staff knew of their location. All the emergency medicines we checked were in date and fit for use.Staff received basic life support training but the provider was unable to provide us with the levels of completion for all staff. Some staff commented that the standard of this training had been poor but it could not be ascertained when this dated back to. We saw evidence of a comprehensive basic life support training programme that the provider used and was delivered by an external company.

The service had a business continuity plan in place which contained a variety of risk matrices on factors such as workforce management, supplies and infrastructure. This plan however was centralised to the provider and used across its services nationally. After our inspection the provider provided us with a locality based handbook which included contact details for staff and satellite locations specific contact details. During the inspection we were shown a separate contingency policy was introduced locally, but this only contained limited arrangements for computer system failures, telephone system failures or premises problems. After the inspection the provider sent us a comprehensive business continuity plan which had been ratified after our inspection.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

Vision and strategy

Integrated Care 24 Ltd is a 'not for profit' social enterprise which describes itself as: "committed to providing our patients and our commissioners with a variety of health and care services to around 6 million patients across a large geographical area." On our inspection we found that the provider demonstrated a clear ethos and desire to provide high quality care across both NHS 111 and out-of-hours services. The senior management team described challenges around taking over a contract in Norfolk which was delivered by another provider prior to September 2015.We found the fourteen members of staff we spoke with in the NHS111 call centre, including administrative and management staff to have high morale and they demonstrated a clear desire to provide a high class service to patients. The atmosphere was welcoming and positive and the staff we talked with were friendly and co-operative.

Our conversations with call centre staff demonstrated that they had bought into the provider's vision to provide high quality care and service to patients. The provider clearly demonstrated that they had identified and accepted the issues surrounding staffing and had taken positive steps to recruit and retain staff. Measures included call handlers being assessed and attaining Qualifications and Credit Framework (former NVQ) level 2 qualifications. This had been done to provide call handlers with a recognised and portable qualification and help improve their self-worth. It was hoped that by enhancing the status of call handlers they would feel more valued and would be less likely to move on after a relatively short period of time.

Governance arrangements

Governance meetings were held at the provider's executive level and there were several committees that the provider had introduced to oversee different governance elements:

- Audit committee. The purpose of this committee was 'to review and ensure the maintenance of an effective system of integrated governance and financial internal control across the whole of the organisation's activities'.
- Financial committee. The purpose of this committee was to be 'a vehicle for a detailed review of the performance against the cost improvement plan, to ensure the monthly financial reporting to the Board met the needs of the board to fulfil its governance role in the most effective manner and to provide an additional layer of oversight'.
- Central clinical quality committee. The purpose of this committee was to 'assure the board that an effective strategy for the maintenance and improvement of clinical quality was in place and that there were appropriate and effective mechanisms which were used to ensure safe and effective care for patients in line with local and national standards'. The central clinical quality committee was a provider wide initiative that was informed by the locality clinical quality group.
- 'Well led' committee. The purpose of this committee was to oversee 'leadership and organisational development, workforce development, remuneration and benefits and patients/public/staff engagement'.

The provider had a range of policies and procedures in place to govern activity and these were available to staff. We were not provided with any evidence that confirmed staff had read the policies but staff we spoke with were able to explain the content when asked. The policies appeared to be provider based and were not always directed specifically to the inspected geographical area. We saw that members of staff were provided with a staff handbook which consisted of over 280 pages and contained corporate policies and procedures.

There was a clear staffing structure and staff were aware of their own roles and responsibilities. However staff were not always aware of the responsibilities of the senior leadership team, for example some staff we spoke with didn't know who the safeguarding lead was. This included a very senior member of staff we spoke with who was unaware who the lead was.

We found that the process and procedures relating to ensuring effective and safe staff recruitment and record keeping were inadequate. In four of the staff files we looked at, there was no evidence that pre-employment references had been sought or received and no DBS checks had been undertaken for staff other than GPs. When looking at the records of the pre-employment interviews we saw that one interviewer had marked a candidate as unsuccessful and another interviewer was undecided. There was no explanation as to why this candidate had been employed following this assessment.Contract review meetings were held with commissioners to discuss performance against

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

the contracts. We also saw evidence that the provider had supported a local council during a recent outbreak of Norovirus. The provider had made good recommendations and shared their experiences.

The provider had also instigated a variety of internal and external stake holder meetings through an organised approach. We saw evidence that these meetings took place regularly and that actions and outcomes were tracked, updated and achieved in a timely manner. In many cases of stake holder engagement the initiative had come from IC24 since they had taken on the operation of the services in September 2015.For example IC24 were the lead agency on the Integrated NHS 111 and out-of-hours Stakeholder Project Board which involved over 20 external healthcare providers and charitable organisation including East Anglian Air Ambulance, MIND (mental health), The Benjamin Foundation (homelessness), The Big C (cancer) and NANSA (physical sensory and learning disabilities).The provider attended the local System Resilience Group, and copies of minutes and agendas were held internally. These meetings were attended by a wide variety of health commissioning, providing and advising bodies locally and held at different sites on a monthly basis. The minutes we viewed showed discussion on system wide concerns and some instances of collaborative working. We saw evidence of detailed communication and engagement plans for services in the area.

Leadership, openness and transparency/ Seeking and acting on feedback from patients, public and staff

There was visible local leadership with clearly defined operational and clinical lead roles in the structure. Some of the responsibilities for service management were managed at provider level, based in a different geographical area, but we saw that communication and involvement with the local leadership was effective. Most staff told us they felt valued by the leadership team and felt engaged in the service provision and future development of the service. Nearly all staff we spoke with told us they felt well supported by their direct management and felt confident they could raise concerns. Some staff we spoke with did not share these views and felt unsupported and uninformed about changes since the provider had taken on the service in September 2015. We presented this to the board and local management team who explained the steps they had taken to support staff. The board recognised that staff morale and staff sickness were key challenges within the out-of-hours service in particular. Actions taken to address this included a fortnightly newsletter, suggestions box, issue tracker, clinical newsletter and progress updates on improvement plans for staff. The board also recognised that staff turnover was an issue in late 2015 and early 2016, following a period of negative media coverage. However, we saw evidence that no clinical staff had left the service since December 2015 and call handler staff turnover was low in March 2016 (below 5%). This indicates the positive impact of the leadership team's targeted work around staff retention. Furthermore, external applications to the call handler role had increased threefold between February and April 2016, enabling the service to maintain a steady call handling workforce within the 111 service.

The provider had implemented the professional management support group (PMSG) which was aimed at providing additional support to staff and systems. The provider had held out-of-hours staff meetings in the six month prior to the inspection. These meetings were held at the base locations over a two week period, taking the meetings to the staff. By attending the different locations the management team were not asking staff to travel an inconvenient distance to a single meeting at head office. Not all staff were always able to attend as clinical staff worked unsocial hours but we saw records that at least 20 out-of-hours staff had attended. The minutes of the out-of-hours base meetings indicated a bias towards information giving. There was evidence that staff concerns were collated in advance and fed back in person in a “you said, we did” format. Examples included questions from staff asking how to communicate with managers, concerns about non-clinical staff being asked to handle drugs and uniform matters.

The board members explained the main method for disseminating information to staff was via email and through newsletters. We saw one example of an email that had been sent to staff and staff newsletters were commenced in February 2016 with issue one and an issue two dated March 2016. These contained a mixture of social and performance information that gave staff a clear and unbiased overview of the service’s performance. Staff we spoke with provided a variety of opinions on outcomes of the meetings; some staff explained that no changes were made as a result of the meetings where other staff complimented the openness and engagement of the leadership through these meetings.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

We spoke with GPs in the service who confirmed that they had access to, and were aware of, an internal database containing clinical guidance and information. Some information was shared via email. For example, "Hot Topics" which reflected on lessons learnt or other safety data relevant to GP care as well as bulletins with easily missed topics to ensure GPs were aware of these.

The service intended to gather patient feedback on an on-going quarterly basis in cooperation with local HealthWatch services but this was not yet active at the time of our inspection.

Continuous improvement

Staff we spoke with felt they had opportunities to attend courses and other development opportunities, for example nurse seminars and they were supported to attend these. It was a challenge for staff to attend all training due to the hours they worked.

E-learning was available for staff and the service monitored mandatory training levels. The monitoring of the mandatory training indicated significant shortages in completion. We were shown an undated matrix that indicated staff mandatory training levels were between 50% and 100%. The provider told us that the system to monitor mandatory training was not updated and provided us with a matrix after our inspection which indicated improvement was made across all staff groups on training completion. However, there was still improvement to be made as not all were at 100%. For example, urgent care practitioners' levels of training (including safeguarding vulnerable adults and children, 80% and equality and diversity, 73%) required improvement.

We were shown evidence that the provider was in the final stages of a process that delivered a comprehensive induction programme for clinicians. This was not yet active at the time of our inspection but indicated that the provider was aware of the shortfall and had responded with a comprehensively designed induction programme.

The provider had developed its own internal information system called CLEO, which had been in operation since 1992 and is nationally assured by NHS England and the Health & Social Care Information Centre. The system was comprehensive and suitable for use with other systems that were intent on information sharing with other services. For example, Medical Interoperability Gateway (MIG) which was not yet fully operational due to on-going commissioner discussions and suitability with other systems that were in use across the local health economy; and Share My Care, which had been operational since 2002. This indicated that the provider was forward thinking on information sharing. CLEO provided a variety of support mechanisms for the provider to maintain an overview of performance. For example, for GP prescribing it provided an audit overview and feedback from the patient's practice.

The provider acted as a testing site for NHS Pathways. As a result updates and learning were shared across 111 providers. For example, a pilot on a new sepsis question set developed with the Sepsis Trust on behalf of NHS England following national lessons learned from the death of a child in 2014.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Protocols, guidelines and appropriate training were not always in place to support and guide staff who make clinical decisions.** **Patients were sometimes at risk due to delays in accessing care from both the OOH and 111 service.** **Controlled drugs were not obtained or stored during transportation in line with current legislation. Suitable procedures were not in place to ensure that medicines were not kept past their expiry dates.**

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered person was not protecting service users against the risks associated with maintaining securely an accurate, complete record in relation to persons employed in the carrying on of the regulated activities.**

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **We found that the registered person was not protecting service users against the risks associated with maintaining sufficient numbers of qualified, competent, skilled and experienced staff.**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

We found that the registered person was not protecting service users against the risks associated with ineffectively operated recruitment procedures to ensure that the persons employed meet the conditions set out in Regulation 19.

We found that the registered person was not protecting service users against the risks associated with the lack of availability of information in relation to each person employed - the information specified in Schedule 3.