Integrated Care 24 - Norfolk & Waveney

Inspection report

Reed House
Unit 2b, Peachman Way, Broadland Business Park
Norwich
NR7 0WF
Tel: 01473275973
www.ic24.org.uk

Date of inspection visit: 23 February 2022
Date of publication: 13/05/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

A summary of CQC findings on urgent and emergency care services in Norfolk and Waveney.

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. We have summarised our findings for Norfolk and Waveney below:

Provision of urgent and emergency care in Norfolk and Waveney was supported by services, stakeholders, commissioners and the local authority. The health and care system in this area lies across a large, predominantly rural, geographical area with a large proportion of the population aged over 65 years.

Compliance with CQC regulations has historically been challenging across Norfolk and Waveney, particularly in Acute, Mental Health and Adult Social Care services, many of which have been rated Requires Improvement or Inadequate.

We spoke to staff in services across primary care, urgent care, acute, ambulance services, mental health and adult social care. Staff told us of increased pressure across urgent and emergency care pathways, staffing issues and a lack of capacity in key sectors including GP and Dental practices and social care. These issues were resulting in inappropriate calls to 999 and attendances in emergency departments. There were delays in discharge for patients who were medically fit but unable to access appropriate packages of care to enable them to leave hospital.

We previously inspected mental health services in the Norfolk and Waveney area in November and December 2021 and found, due to an increase in referrals and staffing shortages, patients in the community had long waits to be seen. This led, in some cases, to patients deteriorating and requiring urgent and emergency treatment. In addition to this, some inpatient services (such as CAMHS) did not have available beds within the area. Patients were kept in urgent and emergency care settings whilst a bed was found. During inspections of acute services, we found patients unable to access appropriate and timely care to meet their mental health needs.

We inspected a number of GP practices and found some concerns in relation to access for patients trying to see or speak to their GP. We found high levels of staff absence resulting in some staff working long hours and experiencing increased pressure on their services.

To try and alleviate the increasing demand on Emergency Departments, GP streaming services had been introduced in EDs in Norfolk and Waveney. Patients who presented at the ED with problems which were deemed suitable for a primary care appointment could be referred to a co-located primary care service. In some cases, streaming services helped to prevent up to 33% of patients attending the ED.

We inspected urgent care services in the Norfolk and Waveney area and found these to be well-run. However, an on-going shortage of out of hours and urgent care appointments, particularly for urgent dental care, meant patients couldn't always be appropriately signposted by NHS111. This meant patients often presented to ED for treatment. NHS111 in Norfolk and Waveney had also experienced significant staff shortages, much of which has been due to the COVID-19 pandemic. Leaders in this service had a recovery plan in place; however, staff shortages and increased demand had resulted in significant delays in call answering and call-back times in comparison to the national targets and there was also a very high call abandonment rate, meaning people ended the call before speaking to an advisor. Whilst performance across Norfolk and Waveney did not meet national targets and people experienced significant delays, these delays were, on average, shorter than regional and national averages.

Overall summary

We inspected emergency departments (ED) in Norfolk and Waveney between December 2021 and February 2022 and found lengthy delays for people accessing emergency care. A high number of patients were waiting over 12 hours in ED resulting in overcrowding. This impacted on ambulance handovers and further delays in releasing ambulance crews into the community to respond to 999 calls.

Staff shortages have had a significant impact on social care services across Norfolk and Waveney. In addition, the provision of domiciliary care services is challenging due to the rurality of the area. At the time of our inspections, a care hotel was being utilised in Norfolk and Waveney. We spoke to healthcare professionals who had provided services to people being cared for at the hotel and found them to be safe and generally well cared for. The number of people receiving care in the hotel was small and the aim was for them to only stay for a very short amount of time before going home. This service is commissioned until the 30 April 2022, a formal evaluation will take place before any future plans are agreed.

Some social care and learning disability services in Norfolk and Waveney have struggled to achieve compliance with CQC regulations and a rating of good. Some support has been established across Norfolk and Waveney to help services improve. However, the impact of any support to date has been limited.

Staff shortages and service quality has significantly reduced capacity across social care and learning disability services in Norfolk and Waveney. This has resulted in significant delays in transferring people from hospital to their own home or an appropriate place of care. This in turn meant people who were medically fit for discharge remained in hospital delaying the admission of new patients. These delays and poor flow resulted in overcrowded EDs and an inability to transfer patients from ambulances.

Strategic, system wide workforce planning and increased community provision of health and social care is needed to meet the needs of the local population. This is needed to reduce the pressure on urgent and emergency care services and to reduce the risk of harm to people living in Norfolk and Waveney.

We carried out an announced focused inspection at Integrated Care 24 Limited – Norfolk and Waveney (IC24) on 23 February 2022.

This focused inspection was carried out using our Pressure Resilience methodology which meant that we did not use all the key lines of enquiry and the report has not been rated.

The service was last inspected in June 2018 when it was rated as Good throughout.

At this inspection we found:

- The service had good systems to manage risk so that safety incidents were less likely to happen.
- Call handling performance in the NHS111 service had been sub-optimal for some time due to increased demand coupled with staff shortages. The provider had a credible plan to increase staffing to the desired levels.
- The service was performing well in meeting the targets for patients to be seen at a primary care centre, but less well for those to be seen in their place of residence.
- There was an effective system to manage infection prevention and control.
- There was an effective process of ambulance validations.
- The service respected and promoted patients' privacy and dignity.
- The service had an experienced leadership team with the capacity and skills to deliver high-quality, sustainable care.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Overall summary

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included two further CQC inspectors, a CQC Inspection Manager, and a GP specialist adviser.

Background to Integrated Care 24 - Norfolk & Waveney

The integrated NHS 111 and out-of-hours service for Norfolk and Waveney is provided by Integrated Care 24 Limited (IC24). IC24 is a Social Enterprise; a not for profit organisation with no shareholders and where any surpluses are re-invested into the service.

The headquarters for IC24 is in Ashford, Kent. IC24 operates NHS 111, out-of-hours and a variety of other services including prison healthcare and primary care centres in other areas.

IC24 commenced delivery of the integrated NHS 111 and out-of-hours service for Norfolk and Waveney in September 2015.

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.

GP out- of -hours services provide care to patients who require medical attention outside of normal GP opening hours. 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. Patients access the out of hours service via NHS 111 where the information provided is assessed and triaged and patients receive an appropriate response based on their clinical needs. This can be in the form of a clinical telephone assessment, referral to the patient's own GP, a home visit from a clinician or an appointment for the patient to attend an out- of- hours base.

The service provides care to a population of approximately 1.1 million people residing in the area and is commissioned by Norfolk and Waveney Clinical Commissioning Group. The area has three acute NHS Trusts, one NHS mental health trust and 105 NHS GP practices. The service recorded approximately 311,000 answered NHS 111 calls during the 2020-21 calendar year, of which around 50,000 resulted in either face to face primary care centre or home visit consultations by the out-of-hours service.

The NHS 111 contact centre operates from the Care Coordination Centre in Norwich. Out-of-hours services in Norfolk and Waveney area are delivered from ten primary care centres located in Dereham, Norwich, Fakenham, Long Stratton, Wisbech, Lowestoft, Beccles, Thetford, North Walsham and Kings Lynn. Not all these primary care centres are open every day during the out-of-hours period.

As part of this inspection we visited the Care Coordination Centre in Norwich and the primary care centres in Great Yarmouth, Thetford and Norwich.

The service is registered with the CQC to provide the regulated activities of Treatment of disease, disorder or injury, Transport services, triage and medical advice provided remotely, Diagnostic and screening procedures.

Inspected but not rated

Are services safe?

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training.
- The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. There was a designated safeguarding lead for both children and adults.
- The service worked with other agencies to support patients and protect them from neglect and abuse. For example, we saw there were regular in-house reviews and coordination with social services. Information was shared where it was appropriate via 'Share my care.'
- Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. However, the data from the NHS111 service showed long delays in call answering and a high incidence of abandoned calls. The provider informed us that this was due to increased call volumes and staffing shortages. IC24 had found it very difficult to recruit staff into the call centre, either as health advisors or clinical advisors. This was attributed in part to a very limited pool of prospective employees and intense competition from other employers offering similar call handling roles in the Norwich area. The virtual closure of Universities during covid lock-down further exacerbated the situation as it meant far fewer students were available to take up call handling posts. Contact centre attrition had peaked in late September 2021, following the relaxation of covid-19 restrictions, but had since then decreased steadily. IC24 were addressing the situation and had a NHS111 recovery plan in place which included a vigorous recruitment campaign, a golden hello for both clinical and non-clinical front line staff, rapid and accelerated on-boarding, and by offering some financial inducement such as incentivised time periods that recognised critical points of each day and incentivising that period for those due to work as well as those picking up overtime, retention payments and a new pay framework. In addition, there was reviewed pay framework for health advisors and increased home working opportunities for both health advisors and clinical advisors (subject to high standard call auditing).

As of January 2022, they had 0.71 staff for every 1 whole time equivalent budgeted for. The recruitment drive, the recovery plan outlined above and changes to the NHS111 licence meant that IC24 predicted that they were on track to a full head count by May 2022. The commissioning clinical commissioning group (CCG) provided us with assurances that they had worked collaboratively to monitor and manage the situation.

Inspected but not rated

Are services safe?

- There was an effective system in place for dealing with surges in demand through workforce and rota management. Where surges in demand arose through increased telephone activity, IC24 were able to utilise their other NHS111 call centres to meet demand.
- There was an effective induction system for all staff, tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need. Significant staffing shortages meant that people calling NHS111 were left waiting for their calls to be answered far longer than the provider aspired to, but the data showed the percentage of calls answered within 60 seconds had steadily increased since October 2021.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Examples were the use of data sharing via electronic post event messaging to both the patients GP and to acute services, summary care records and 'share my care' to social services.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- Joint reviews of incidents were carried out with partner organisations, including the local A&E department and ambulance services.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. These included the use of reviews to identify themes and a regular clinical newsletter.
- The service learned from external safety events and patient safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff. The process was overseen by the regional clinical lead.
- Joint reviews of incidents were carried out with partner organisations, including the local A&E department and ambulance services.

Inspected but not rated

Are services effective?

Monitoring care and treatment

The service had a comprehensive programme of quality improvement activity and routinely received the effectiveness and appropriateness of the care provided.

- There were areas where the service was outside of the target range for an indicator. However, the provider was aware of these areas and we saw evidence that attempts were being made to address them.
- The percentage of calls into the NHS 111 service not answered within 60 seconds had been high since April 2021 and had been consistently high over time but was seen to be steadily improving. It closely tracked the level of performance when compared to both the East of England and national averages but was now better than both.
- The call abandonment rate (where a call is abandoned by the caller) remains high and the worse in the East of England. On the day before our inspection the abandonment rate was 26.2%, compared to the national average of 12.4% and a target of 3%. The call abandonment rate had been above the national average over a protracted period.
- In one area the service was performing well. Clinical call back times from the clinical assessment service were significantly lower than both the East of England and national averages and had been so since June 2021. This had been achieved despite the challenges faced in recruitment and retention of clinicians.
- Where the service was not meeting the target, the provider had put actions in place to improve performance in this area. Lack of staff in the care coordination centre was given as the primary cause of the sub-optimal performance. We were given assurances that the provider was on track to have a full complement of call handlers by May 2022.
- The service was not always meeting its locally agreed targets as set by its commissioner in respect of the out-of-hours service.
- In January 2022 94.2% of patients with a disposition to have a face to face appointment were seen within two hours at a primary care centre and for those with a disposition of six hours it was 97.6%. The target for both indicators is 95%.
- In the same period, patients with a disposition to be seen at home within two hours was 80.4% and for a six-hour disposition it was 90.6%. The target for both indicators is 95%.
- The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.

- For example, we saw that the provider had undertaken an audit of dental calls into the NHS111 service. The closure of dental services at the start of the pandemic saw the number of dental related calls rise from 1,084 in March 2020 to 2,473 in April, an increase of 128% in a month. The volume of dental related calls remained high throughout the pandemic period, only returning to pre-pandemic levels in December 2021.

The clinical commissioning group told us that dental provision was a challenge for Norfolk and Waveney along with the rest of the region. Norfolk and Waveney commissioners and IC24 had met with the NHSE specialised Dental Commissioners on several occasions and they were invited to attend call audit. There was some provision available on the directory of services, but it was 'patchy'. However, a recent Dental Strategy has been released which is looking at improving access as services return to business as usual after the pandemic. IC24 have expressed an interest in being part of a pilot socialised from the National Team that would enable standing up of the dental pathway on pathways light that would enable health care advisors and service advisors to take calls.

Regional and local and Norfolk and Waveney Quality Surveillance Group (QSG) are aware of the challenges experienced with dental provision, and there was to be a presentation of the NHSE Dental strategy at the next local QSG in March 2022.

- NHS Pathways was in place for the NHS111 service with up to date training and licence.
- A dedicated telephone line for healthcare professionals, distributed to parties via the CCG, was in place to the clinical assessment service. The dedicated line avoided the need to go through the NHS111 system.

Inspected but not rated

Are services effective?

Coordinating care and treatment

Staff worked together and worked well with other organisations to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. The clinical workforce was shown to be effective and had a positive impact, with 2,672 or 68.6% of validations being downgraded to a lower acuity outcome.
- Patients received coordinated and person-centred care. The service communicated promptly with patient's registered GP's so that the GP was aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care, where necessary. There were established pathways for staff to follow to ensure callers were referred to other services for support as required, for example mental health.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and considered the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and appointments for patients with other services.
- Issues with the Directory of Services were resolved in a timely manner.

Helping patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- The service identified patients who may need extra support, including those presenting with mental health issues.
- Where appropriate, staff gave people advice so they could self-care. Systems, including NHS Pathways were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given through the timely notification of a patients contact with the service, provided they gave consent to do so.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.
- The provider monitored the process for seeking consent appropriately.

Inspected but not rated

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff were mindful of patients' personal, cultural, social and religious needs.
- The service gave patients timely support and information. Call handlers gave people who phoned into the service clear information. There were arrangements and systems in place to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs.
- We spent time in the care coordination centre and head staff on calls displaying an understanding and non-judgmental attitude to callers.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff always respected confidentiality.

Inspected but not rated

Are services responsive to people's needs?

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of its population and tailored services in response to those needs. For example, the provider had a process for reviewing the homeless and traveller communities.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service through the use of summary care records and access to 'Share My Care' aimed at data sharing, coordinating and collaboration in end of life care.
- Care pathways were appropriate for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.
- The service was responsive to the needs of people in vulnerable circumstances. There was a policy in place for the review of patients with acute mental illness and suicidal ideation.
- The service made reasonable adjustments when people found it hard to access the service for example those with a hearing impairment and whose first language was not English.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients were able to access care and treatment at a time to suit them. The NHS111 service operated 24 hours a day, on every day of the year.
- Patients could access the out- of- hours service via NHS 111. The service did not see walk-in patients and a 'Walk-in' policy was in place which clearly outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response. The receptionists informed patients about anticipated waiting times.

- Patients generally had timely access to initial assessment, test results, diagnosis and treatment in the out-of-hours service. The latest data we had showed that;

In January 2022 94.2% of patients with a disposition to have a face to face appointment were seen within two hours at a primary care centre and for those with a disposition of six hours it was 97.6%. The target for both indicators is 95%.

In the same period, patients with a disposition to be seen at home within two hours was 80.4% and for a six-hour disposition it was 90.6%. The target for both indicators is 95%.

- Where the service was not meeting the target, the provider was aware of these areas and we saw evidence that attempts were being made to address them.

- Waiting times, delays and cancellations were minimal and managed appropriately. Where people were waiting a long time for an assessment or treatment there were arrangements in place to manage the waiting list and to support people while they waited for example though observation to ensure that deteriorating patients were identified.

- Patients with the most urgent needs had their care and treatment prioritised using NHS Pathways assessment tool.

Inspected but not rated

Are services responsive to people's needs?

- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Inspected but not rated

Are services well-led?

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the service strategy and address risks to it. The provider was planning active involvement in the Integrated Care System review.
- The provider had a good grasp of the issues facing integrated urgent care and had good interaction with acute accident and emergency, secondary care and ambulance services.
- They were knowledgeable about issues and priorities relating to the quality and future of services. The staffing shortages in the care coordination centre was a good example of how the provider had identified the challenges to the service and had taken positive action to address them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use. Staff we spoke with confirmed this to be the case.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. This included investigation and learning from serious events and review of performance across the service.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local CCG as part of contract monitoring arrangements. The commissioners of the service told us that the provider was open and frank regarding performance and had engaged throughout in the management of the difficulties it faced during the pandemic in terms of call performance.

Inspected but not rated

Are services well-led?

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. For example, we saw that the provider had conducted an audit regarding dental access. One of the recommendations was that the local directory of services (DoS) lead investigate why urgent dental centres did not appear on the DoS.
- The providers had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.