Integrated Care 24 Limited – Norfolk & Wisbech

Quality Report

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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 service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Integrated Care 24 (IC24) NHS111 and out-of-hours service in Norfolk on 23 March 2017.

The service was inspected in March 2016. The inspection report was unrated and focussed on Safe and Well Led domains only. Following that inspection we issued several requirement notices to the provider to improve the service. These requirement notices related to Regulations 12 (safe care and treatment), 17 (good governance), 18 (staffing) and 19 (fit and proper persons employed). We followed these notices up during this inspection to see whether sufficient improvements had been made.

Following the inspection on 23 March 2017,overall the service is rated as Good.

Our key findings were as follows:

- The provider had a clear vision which focussed on quality and safety.
- There were systems in place to help ensure patient safety through learning from incidents and complaints about the service.
- The service was consistently meeting National Quality Requirements and locally agreed key performance indicators.The primary care centres where patients were seen had good facilities and were equipped to meet the needs of patients. Vehicles used for home visits were clean and well equipped.
- We found that the service was well-led and managed by an effective senior management team and board of directors, and their values and behaviours were shared by staff.
- The service worked with other organisations and with the local community to develop services.
- NHS 111 staff were supported in the effective use of NHS Pathways. Call review and audit was regular and robust in its application.
- The service shared experience reports with the clinical commissioning group (CCG) on a regular basis which contained information on complaints, feedback from professionals, feedback from patients, incidents and accolades.

However, there was one area of practice where the provider should make improvements.

Summary of findings

- Record details of recruitment and induction processes for clinical staff effectively in line with Schedule Three of the Health and Social Care Act 2008.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The service is rated as requires improvement for providing safe services.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- There was an effective system in place for recording, reporting and learning from significant events
- Lessons were shared to make sure action was taken to improve safety in the service.
- When things went wrong patients were informed in keeping with the duty of candour. They were given an explanation based on facts, an apology if appropriate and, wherever possible, a summary of learning from the event in the preferred method of communication by the patient. They were told about any actions to improve processes to prevent the same thing happening again.
- When patients could not be contacted at the time of their home visit or if they did not attend for their appointment, there were processes in place to follow up patients who were potentially vulnerable.
- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours. Although we did see that safeguarding training was overdue for a number of members of staff, including sessional GPs. Training for basic life support was also overdue for several sessional GPs.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The service is rated as good for providing effective services.

- Staff assessed needs and delivered care in line with current evidence based guidance.
- The service was meeting most of the National Quality Requirements (performance standards) for GP out of hours services to ensure patient needs were met in a timely way.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff but evidence of inductions was not consistently recorded. Staff we spoke with confirmed they had undergone inductions.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The service is rated as good for providing caring services.

- Feedback from the majority of patients through our comment cards and feedback collected by the provider was positive.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The service is rated as good for providing responsive services.

- Service staff reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified.
- The three sites that we visited had good facilities and the service was well equipped to treat patients and meet their needs.
- The service had systems in place to ensure patients received care and treatment in a timely way and according to the urgency of need.
- Information about how to complain was available and easy to understand and evidence showed the service responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The service is rated as good for being well-led.

- The service had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

Summary of findings

- There was a clear leadership structure and most staff felt supported by management. The service had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The provider encouraged a culture of openness and honesty. The service had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The service proactively sought feedback from staff and patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels. For example, the service took part in a pilot with the UK Sepsis Trust using a telephone triage sepsis tool and the provider had developed a clinical assessment service focussing on non urgent A&E and 999 calls.

Summary of findings

What people who use the service say

We obtained the views of patients who used the out-of-hours service through the CQC comment cards patients had completed. We received 30 comment cards, of which 27 contained positive comments about the service, the staff and the care received. Three cards contained negative comments, specifically around waiting times but also on staff behaviour and delays in treatment.

The National GP Patient Survey asks patients about their satisfaction with the out-of-hours service. These results, published in July 2016, were analysed per CCG. The service covered four main CCGs: Norwich, West Norfolk, North Norfolk and South Norfolk.

For Norwich CCG area:

- Patients were asked about "their overall experience of NHS service when a GP surgery was closed" to which 68% thought the service was either "very good" or "fairly good". This was in line with the national average of 67%. 14% thought the service was "fairly poor" or "very poor", compared with the national average of 14%.
- 67% of patients said they were satisfied with how quickly they received care from the out-of-hours provider compared to the national average of 62%.
- 87% of patients said they had confidence and trust ("definitely" or "to some extent") in the out-of-hours clinician they saw or spoke to compared to the national average of 86%.

For West Norfolk CCG area:

- Patients were asked about "their overall experience of NHS service when a GP surgery was closed" to which 68% thought the service was either "very good" or "fairly good". This was in line with the national average of 67%. 15% thought the service was "fairly poor" or "very poor", compared with the national average of 14%.
- 72% of patients said they were satisfied with how quickly they received care from the out-of-hours provider compared to the national average of 62%.
- 91% of patients said they had confidence and trust ("definitely" or "to some extent") in the out-of-hours clinician they saw or spoke to compared to the national average of 86%.

For North Norfolk CCG area:

- Patients were asked about "their overall experience of NHS service when a GP surgery was closed" to which 75% thought the service was either "very good" or "fairly good". This was above the national average of 67%. 15% thought the service was "fairly poor" or "very poor", compared with the national average of 14%.
- 72% of patients said they were satisfied with how quickly they received care from the out-of-hours provider compared to the national average of 62%.
- 90% of patients said they had confidence and trust ("definitely" or "to some extent") in the out-of-hours clinician they saw or spoke to compared to the national average of 86%.

For South Norfolk CCG area:

- Patients were asked about "their overall experience of NHS service when a GP surgery was closed" to which 72% thought the service was either "very good" or "fairly good". This was above the national average of 67%. 13% thought the service was "fairly poor" or "very poor", compared with the national average of 14%.
- 66% of patients said they were satisfied with how quickly they received care from the out-of-hours provider compared to the national average of 62%.
- 88% of patients said they had confidence and trust ("definitely" or "to some extent") in the out-of-hours clinician they saw or spoke to compared to the national average of 86%.

The provider also gathered patient feedback through their own means including patient experience questionaires and a text messaging feedback system. Feedback from January 2017 from 75 patients that used the Norfolk based service (the most recent result available at the time of inspection) indicated:

- 92% of respondents would recommend the service to friends and family,

Summary of findings

- 87% of respondents rated the overall service as “excellent” or “good”,
- 99% of respondents felt they were treated with dignity and respect.

Areas for improvement

Action the service SHOULD take to improve

Record details of recruitment and induction processes for clinical staff effectively in line with Schedule Three of the Health and Social Care Act 2008.

Integrated Care 24 Limited – Norfolk & Wisbech

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector**.** The team included a GP specialist adviser, a second CQC inspector, a nurse specialist adviser and two service manager specialist advisers.

Background to Integrated Care 24 Limited – Norfolk & Wisbech

The integrated NHS 111 and out-of-hours service for Norfolk and Wisbech and surrounding area is provided by Integrated Care 24 (IC24). IC24 is a social enterprise; 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 (excluding East Kent and Medway), Sussex, East Surrey, Northamptonshire 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, advanced nurse practitioners, paramedical practitioners, nurses and support staff who are directly employed or engaged on a sessional basis to deliver care to patients.

The service provides care to a population of approximately 824,000 people residing in the area and operates locally from the Care Coordination Centre in Norwich. 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.

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 Thetford and Norwich.

We inspected this service in March 2016 in an unannounced, focussed, unrated inspection which led to various requirement notices being put on the service; specifically for Regulations 12 (safe care and treatment), 17 (good governance), 18 (staffing) and 19 (fit and proper persons employed). We followed these notices up during this inspection to see whether improvements had been made.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We carried out an announced visit on 23 March 2017. During our visit we:

- Spoke with a range of staff and spoke with patients who used the service.
- Observed how patients were provided with care and talked with carers and/or family members.
- Inspected the out of hours premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.
- Looked at the vehicles used to take clinicians to consultations in patients' homes, and we reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Please note that when referring to information throughout this report, for example any reference to the National Quality Requirements data, this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the service manager of any incidents and there was a recording form available on the service's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received support, an explanation based on facts, an apology where appropriate and were told about any actions to improve processes to prevent the same thing happening again.
- The service carried out a thorough analysis of the significant events and ensured that learning from them was disseminated to staff and embedded in policy and processes. We saw evidence of a variety of forums through which learning from significant events and complaints was shared with staff. For example, a notice board, a newsletter and ad-hoc bulletins. Significant events were discussed at monthly minuted meetings and reviewed on a weekly basis by an incident review group of staff.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. The service made use of safety alert reports which highlighted new alerts, alerts under review and actions that had been taken as a result of an alert. We saw evidence that lessons were shared and action was taken to improve safety in the service. For example, following an incident involving an adverse outcome related to sepsis, the provider had shared the learning and outcomes with the whole organisation and implemented additional training to ensure staff were up to date with their knowledge of sepsis. The service also took part in a pilot with the UK Sepsis Trust using a telephone triage sepsis tool which was to be used for non-pregnant adults and children over 12 years of age with infection symptoms. This tool aimed to assist with early identification of systemic responses to infection.

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and services in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Staff demonstrated they understood their responsibilities, but when we reviewed training records we saw that safeguarding children training was overdue for four sessional GPs and safeguarding vulnerable adults for 14 sessional GPs, except for four GPs the training was overdue less than two months. When we raised this with the provider they explained that sessional staff were subcontracted and were required to comply with a service level agreement. No work could be undertaken unless the agreement had been signed. In line with the agreement sessional staff had to provide evidence of training credentials. The provider acknowledged that this had at times been difficult due to challenges in managing staff outside of employment status. They explained they had mitigating systems in place, including the checking of General Medical Council registration of all sessional GPs, which, the provider explained, provided assurance that these GPs were in the GP appraisal process. GPs were trained to child safeguarding level three. Any safeguarding concerns were proactively shared with local safeguarding organisations.
- Notices at the premises we visited advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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). Drivers, who held the access codes to medicines available to doctors on visits, had undergone checks with the DBS.
- The service maintained appropriate standards of cleanliness and hygiene. We observed the premises we visited to be clean and tidy. There was an infection control lead. There was an infection control protocol in

place and staff had received up to date training. We saw evidence that infection control audits were undertaken with actions as a result. For example, more surface wipes were made available to clean desks and telephones.

- At our inspection in March 2016 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, Disclosure and Barring Service (DBS) records and confirmations that an induction programme had been completed. During our inspection in March 2017 we saw that improvements had been made in staff file completion but some gaps remained in a variety of staff files. There was no consistency in what information was missing, for example for one member we saw that probationary period evidence was missing and for another member of staff there were no references recorded, the provider explained that some of the gaps were for staff that were transferred over from the previous provider. IC24 had attempted to obtain the necessary documents from the previous provider in these cases to no avail. We did see that the provider had complete records of DBS status of all staff. For seven members of staff the DBS checking process was ongoing but there were risk assessments in place for all of these and these staff members were not dealing with sensitive information until the process was complete. There were arrangements in place to check the registration of GPs with the General Medical Council, of paramedics with the Health and Care Professions Council and of nurses with the Nursing and Midwifery Council.

Medicines Management

During our previous inspection in March 2016 we found out of date medicines at one satellite location which showed that the system of recall was not sufficiently effective to ensure that people were not at risk of receiving out of date medicines. During our inspection in March 2017 we noted the provider had addressed these concerns and implemented effective processes to monitor and recall medicines. A pharmaceutical lead member of staff was responsible for all aspects of medicine management at the service.

- The arrangements for managing medicines at the service, including emergency medicines and vaccines, kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). In March 2016 we saw that staff did not always use the correct prescribing stationery and that improvements were needed around controlled drugs management. At our inspection in March 2017 we saw the provider had implemented a new approach that provided assurance that prescription stationary was used and tracked correctly; blank prescription forms and pads were securely stored and there were systems in place to monitor their use. 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.
- Patient Group Directions (PGDs - written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) were used by nurses / paramedics to supply or administer medicines without a prescriptions. PGDs in use had been ratified in accordance with the Medicines and Healthcare products Regulatory Agency guidance.
- The service held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had standard operating procedures in place that set out how controlled drugs were managed in accordance with the law and NHS England regulations. These included auditing and monitoring arrangements, and mechanisms for reporting and investigating discrepancies. The provider held Home Office licences to permit the possession of controlled drugs within the service at each of their locations. There were also appropriate arrangements in place for the destruction of controlled drugs.
- Processes were in place for checking medicines, including those held at the service and also medicines bags for the out of hours vehicles and arrangements were in place to ensure medicines and medical gas cylinders carried in the out of hours vehicles were stored appropriately, for example the safe storage of controlled drugs.

Monitoring risks to patients

Risks to patients were assessed and well managed.

Requires improvement

Are services safe?

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in areas accessible to all staff that identified local health and safety representatives. The service had up to date fire risk assessments. 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. 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 and there was a service level agreement that staff were responsible for maintenance and servicing of their own equipment.
- There were systems in place to ensure the safety of the out of hours vehicles. Checks were undertaken at the beginning of each shift. Records were kept of MOT and servicing requirements. We checked the vehicles and found that records were up to date.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. We saw evidence that the rota system was effective in ensuring that there were enough staff on duty to meet expected demand. The provider made use of agency staff when required and data we reviewed indicated that between February 2016 and February 2017 the use of agency staff ranged from 17% to 33%.

Arrangements to deal with emergencies and major incidents

The service had arrangements in place to respond to emergencies and major incidents:

- There was an effective system to alert staff to any emergency.
- Staff received annual basic life support training, including use of an automated external defibrillator. Records indicated gaps in evidence of up to date basic life support training for 34 sessional GPs, with the majority being overdue less than three months. The provider informed us that not all sessional GP staff had provided up to date evidence of basic life support training but all these GPs had up to date registration status with the GMC and were on the performers list.
- The service had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The service had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The service assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best service guidelines.

- The service had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The service monitored that these guidelines were followed.

Management, monitoring and improving outcomes for people

From 1 January 2005, all providers of out-of-hours services have been required to comply with the National Quality Requirements (NQR) for out-of-hours providers. The NQR are used to show the service is safe, clinically effective and responsive. Providers are required to report monthly to the clinical commissioning group on their performance against standards which includes audits, response times to phone calls, whether telephone and face to face assessments happened within the required timescales, seeking patient feedback and actions taken to improve quality.

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 February 2016 to February 2017. This data showed the following:

NQR 4: Providers must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the contracting CCG.

The sample must be defined in such a way that it will provide sufficient data to review the clinical performance of each individual working within the service. This audit must be led by a clinician with suitable experience in providing OOH care and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service. We saw evidence that, in the period February 2016 to January 2017, performance for this indicator was 1.75% against a target of 1%.

NQR 10:

Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those patients must be passed to the most appropriate acute response (including the ambulance service) within three minutes. We saw evidence that, in the period February 2016 to February 2017, performance for this indicator was 100%.

Providers that can demonstrate that they have a clinically safe and effective system for prioritising patients, must meet the following standards:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre. We saw evidence that, in the period February 2016 to February 2017, performance for this indicator was 98%.
- Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre. We saw evidence that, in the period February 2016 to February 2017, performance for this indicator was 99%.

NQR 11: Providers must ensure that patients are treated by the clinician best equipped to meet their needs, (especially at periods of peak demand such as Saturday mornings), in the most appropriate location. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP, including where necessary, at the patient's place of residence.

- Emergency: Within 1 hour. We saw evidence that, in the period February 2016 to February 2017, average performance for this indicator was 100%.
- Urgent: Within 2 hours. We saw evidence that, in the period February 2016 to February 2017, average performance for this indicator was 93% and ranged between 84% and 96%.
- Less urgent: Within 6 hours. We saw evidence that, in the period February 2016 to February 2017, average performance for this indicator was 98% and ranged between 95% and 99%.

Good

Are services effective?

(for example, treatment is effective)

NQR 12: Face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

Emergency: within one hour.

- We saw evidence that, in the period February 2016 to February 2017, performance for face-to-face consultations at the patient's place of residence was 100%.
- We saw evidence that, in the period February 2016 to February 2017, performance for consultations at a care centre within this indicator was 100%.

Urgent: within two hours.

- We saw evidence that, in the period February 2016 to February 2017, performance for face-to-face consultations at the patient's place of residence was 89% and ranged between 69% and 100%.
- We saw evidence that, in the period February 2016 to February 2017, performance for consultations at a care centre within this indicator was 94% and ranged between 88% and 96%.

Less urgent: within six hours.

- We saw evidence that, in the period February 2016 to February 2017, performance for face-to-face consultations at the patient's place of residence was 94% and ranged between 86% and 98%.
- We saw evidence that, in the period February 2016 to February 2017, performance for consultations at a care centre within this indicator was 99% and ranged between 96% and 100%.

In 2014, NHS 111 took over responsibility from out-of-hours providers for the initial handling of all non-emergency calls. The NQRs relating to phone calls (NQR 8 and 9) therefore no longer apply to the provider. However the provider still provides some telephone advice to patients who have been booked for a telephone consultation by NHS 111. The provider monitored its speed of answering phone calls as an internal target:

- The internal target was that 95% of calls assessed by NHS 111 as being urgent should receive a call back within 30 minutes. In the period February 2016 to February 2017, the provider achieved this target for 93% of calls.
- The internal target was that 95% of calls assessed by NHS 111 as being urgent should receive a call back within 60 minutes. In the period February 2016 to February 2017, the provider achieved this target for 91% of calls.
- The internal target was that 95% of calls assessed by NHS 111 as being urgent should receive a call back within two hours. In the period February 2016 to February 2017, the provider achieved this target for 95% of calls.
- The internal target was that 95% of calls assessed by NHS 111 as being urgent should receive a call back within 6, 12 or 24 hours. In the period February 2016 to February 2017, the provider achieved these targets for 100% of calls.

There was evidence of quality improvement including clinical audit. The service undertook an audit of patient contacts on a monthly basis, this was undertaken by designated central and local audit teams. We saw evidence that during 2016 1.6% of calls were audited. Where areas of improvement had been highlighted there was a structured feedback system to clinicians. However, the service considered that any performance above 80% did not require further feedback.

- There had been a variety of other clinical audits completed so that care delivery was monitored. For example, an audit on palliative care prescriptions that were requested from the out-of-hours service in January 2017.
- The service participated in local audits, national benchmarking, accreditation and peer review and research.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The service had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff were also supported to work alongside other staff and their performance was regularly reviewed during their induction period. We were shown evidence that the provider had a comprehensive induction programme for out-of-hours' clinicians but no completed documents were available.

Good

Are services effective?

(for example, treatment is effective)

- When calls were received by NHS111 they were triaged using the Pathways system by clinical advisors before being passed to the out-of-hours service. During our inspection in March 2016 we saw that out-of-hours' staff undertaking telephone assessment duties did not have access to effective 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. During our inspection in March 2017 we saw that a specific triage training programme had been developed internally and rolled out amongst the staff. We also saw that assisted software had been introduced and was in full use.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of service development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, and clinical supervision. Clinical staff had access to an online platform that supported their professional development and which had learning available to support their appraisal and revalidation processes.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. Records indicated that some sessional GP staff had gaps in their mandatory training; predominantly, records indicated gaps in evidence of up to date basic life support training for 34 sessional GPs, with the majority being overdue less than three months. Safeguarding children training was overdue for four sessional GPs and safeguarding vulnerable adults for 14 sessional GPs, except for four GPs the training was overdue less than two months. When we raised this with the provider they explained that sessional staff were subcontracted and were required to comply with a service level agreement. No work could be undertaken unless the agreement had been signed. In line with the agreement sessional staff had to provide evidence of training credentials. The provider acknowledged that this had at times been difficult due to challenges in managing staff outside of employment status. They explained they had mitigating systems in place, including the checking of General Medical Council registration of all sessional GPs, which, the provider explained, provided assurance that these GPs were in the GP appraisal process. The provider explained that they were committed to continuous quality improvement and were regularly reviewing the process and mitigations that were in place.
- 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.

Coordinating patient care and information sharing

The provider had its own bespoke information system, which had been in operation since 1992 and was nationally assured by NHS England and the Health & Social Care Information Centre. The system was comprehensive and suitable for use with some other systems (for example, Share my Care and Summary Care Records) that were intent on information sharing with other services. However, integration with the system in use by local GP practices was not optimal and the service was reliant on special patient notes from GPs and post event messaging to ensure that information was shared effectively.

NQR 1 states that providers must report regularly to CCGs on their compliance with the Quality Requirements. We saw evidence that, in the period February 2016 to February 2017, performance for this indicator was 100%. The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system.

This included access to required special patient notes and summary care records which detailed information provided by the person's GP. This helped the out-of-hours staff in understanding a person's need. We saw evidence that the provider kept information on the number of patients with special notes for each practice in the area. This had

Good

Are services effective?

(for example, treatment is effective)

highlighted a variance in effective completion of these notes by GP practices. This information was shared with the local CCG to drive further improvement in the completion of these notes.

- The service shared relevant information with other services in a timely way, for example when referring patients to other services.
- The provider worked collaboratively with other services. Patients who could be more appropriately seen by their registered GP or an emergency department were referred. If patients needed specialist care, the provider could refer to services providing these through referral systems in out-of-hours or via a directory of services in NHS111.
- NQR 3 states that providers must have systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness). We saw evidence that, in the period February 2016 to February 2017, performance for this indicator was 100%.

The service worked with other service providers to meet patients' needs and manage patients with complex needs.

NQR 2 states that providers must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8am the next working day.

We saw evidence that, in the period February 2016 to February 2017, 100% of the details of OOH consultations were sent to the registered GP by 8am the next day. The only patients who did not have a summary of the OOH consultation sent were those without a registered GP.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear clinical staff assessed the patient's capacity and, recorded the outcome of the assessment.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs

We obtained the views of patients who used the out-of-hours service through the CQC comment cards patients had completed. We received 30 comment cards, of which 27 contained positive comments about the service, the staff and the care received. Three cards contained negative comments, specifically around waiting times but also on staff behaviour and delays in treatment.

The National GP Patient Survey asks patients about their satisfaction with the out-of-hours service. These results, published in July 2016, were analysed per CCG. The service covered four main CCGs: Norwich, West Norfolk, North Norfolk and South Norfolk.

For Norwich CCG area:

- Patients were asked about "their overall experience of NHS service when a GP surgery was closed" to which 68% thought the service was either "very good" or "fairly good". This was in line with the national average of 67%. 14% thought the service was "fairly poor" or "very poor", compared with the national average of 14%.
- 67% of patients said they were satisfied with how quickly they received care from the out-of-hours provider compared to the national average of 62%.
- 87% of patients said they had confidence and trust ("definitely" or "to some extent") in the out-of-hours clinician they saw or spoke to compared to the national average of 86%.

For West Norfolk CCG area:

- Patients were asked about "their overall experience of NHS service when a GP surgery was closed" to which 68% thought the service was either "very good" or "fairly good". This was in line with the national average of 67%. 15% thought the service was "fairly poor" or "very poor", compared with the national average of 14%.
- 72% of patients said they were satisfied with how quickly they received care from the out-of-hours provider compared to the national average of 62%.
- 91% of patients said they had confidence and trust ("definitely" or "to some extent") in the out-of-hours clinician they saw or spoke to compared to the national average of 86%.

For North Norfolk CCG area:

- Patients were asked about "their overall experience of NHS service when a GP surgery was closed" to which 75% thought the service was either "very good" or "fairly good". This was above the national average of 67%. 15% thought the service was "fairly poor" or "very poor", compared with the national average of 14%.
- 72% of patients said they were satisfied with how quickly they received care from the out-of-hours provider compared to the national average of 62%.
- 90% of patients said they had confidence and trust ("definitely" or "to some extent") in the out-of-hours clinician they saw or spoke to compared to the national average of 86%.

For South Norfolk CCG area:

- Patients were asked about "their overall experience of NHS service when a GP surgery was closed" to which 72% thought the service was either "very good" or "fairly good". This was above the national average of 67%. 13% thought the service was "fairly poor" or "very poor", compared with the national average of 14%.
- 66% of patients said they were satisfied with how quickly they received care from the out-of-hours provider compared to the national average of 62%.
- 88% of patients said they had confidence and trust ("definitely" or "to some extent") in the out-of-hours clinician they saw or spoke to compared to the national average of 86%.

The provider also gathered patient feedback through their own means including patient experience questionaires and

Good

Are services caring?

a text message feedback system. Feedback from January 2017 from 75 patients that used the Norfolk based service (the most recent result available at the time of inspection) indicated:

- 92% of respondents would recommend the service to friends and family,
- 87% of respondents rated the overall service as "excellent" or "good",
- 99% of respondents felt they were treated with dignity and respect.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and comments on CQC comment cards indicated that patients were satisfied with their involvement in decisions about their care and treatment. Clinicians were alerted to special notes from the patient's usual GP if these were available. Special notes are a way in which the patient's usual GP can raise awareness about their patients who might need to access the out-of-hours service, such as those nearing end of life and their wishes in relation to care and treatment.

Staff had a good understanding of consent and involving patients in decision making. A range of information was made available to clinical staff around capacity and decision making to support them in their work. This included up to date policies, case studies and training.

For patients who did not have English as a first language, a translation service was available if required. The provider had clear systems in place to signpost callers to other services. For example, mental health services. The service had information available to support relatives in the event of bereavement.

We found the service to be sensitive to patient needs and worked proactively to deliver care that supported them. For example, working with other providers such as district nursing teams and GP practices to develop continuity of care between services. The service undertook monthly reviews of palliative care prescriptions that werer requested.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service reviewed the needs of its local population and engaged with its commissioners to secure improvements to services where these were identified.

- Home visits were available for patients whose clinical needs resulted in difficulty attending a primary care centre.
- There were accessible facilities, a hearing loop and translation services available. Staff had rapid access to a telephone interpreter service whereby a teleconference could be set up to include the patient, interpreter and clinician.
- Reasonable adjustments had been made and action was taken to remove barriers when patients find it hard to use or access services.
- There were arrangements in place to cover equality and diversity issues and there were policies to support staff in understanding and meeting the needs of patients who may require extra support.

The provider had developed a clinical assessment service focussing on non urgent A&E and 999 calls. This was implemented in July 2016 with the aim to:

- Improve patient experience. More specifically, shorter patient jouneys and appropriate care in the right place by the right health care professional
- Reduce system impact. To identify appropriate settings of care and reduce urgency across the system to achieve a patient and cost benefit.

This process was supported with staff training and a standard operating procedure and patient feedback was also collated. The provider informed us that in the period November 2016 to February 2017 when the clinical assessment service was active (every weekend and bank holiday between 9am and 3pm) they had dealt with a total of 761 cases, for which a breakdown was available. It was concluded that if the service was implemented 24/7 a significant number (3,333) of potential ambulance and A&E dispositions could have been avoided, with considerable associated financial benefits. The service had documented several lessons learnt and amendments to the process, systems in use and training was required before full implentation was realistic.

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 UK Sepsis Trust on behalf of NHS England following national lessons learned from the death of a child in 2014. This involved using a telephone triage sepsis tool which was to be used for non-pregnant adults and children over 12 years of age with infection symptoms. This tool aimed to assist with early identification of systemic responses to infection. Staff had use of a toolkit and supporting information and were required to complete a workbook and questionaire to assess their understanding.

Access to the service

The service operated from eight primary care centres at the following times:

The Queen Elizabeth Hospital, Kings Lynn; 6.30pm to 8am daily and during weekends.

Birchwood Medical Practice, North Walsham; 6.30pm to 8am daily and during weekends.

Thetford Healthy Living Centre, Thetford; 6.30pm to 12am on weekdays and 8am to 12am in weekends.

North Cambridgeshire Community Hospital, Wisbech; 6.30pm to 8am daily and during weekends.

The Fakenham Medical Practice, Fakenham; 8am to 9pm during weekends.

Long Stratton Medical Partnership, Thurston; 8am to 9pm during weekends.

Norwich Community Hospital, Norwich; 6.30pm to 8am daily and during weekends.

Dereham Hospital, Dereham; 8am to 8pm during weekends.

Patients could access the service via NHS 111. The service did not routinely see 'walk in' patients and those that came in were told to ring NHS 111 unless they needed urgent care, in which case they would be stabilised before referring on. Staff told us of instances where this had happened (for example, in the case of an unwell child) and how the situations were appropriately handled.

There were arrangements in place for people at the end of their life so they could contact the service directly.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Feedback received from patients from the CQC comment cards and from the National Quality Requirements scores indicated that in most cases patients were seen in a timely way.

The service had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Requests for home visits received a call back from the triage GP who assessed both the most appropriate venue for the consultation and also the urgency of the need for medical attention.

Listening and learning from concerns and complaints

The service had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with the NHS England guidance and their contractual obligations.
- There was a designated responsible person who co-ordinated the handling of all complaints in the service. Complaints were discussed on a weekly basis with the executive team and monthly in clinical governance meetings; trends were monitored. We saw that clinical staff were involved in the process if required and senior management reviewed any final complaints related correspondence before it was sent.
- We saw that information was available to help patients understand the complaints system.
- The service produced a quarterly report for the commissioners and shared this with the staff. Clinical newsletters available to staff included lessons learnt from complaints which were evidenced, including case studies.

NQR 6: Providers must operate a complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report anonymised details of each complaint, and the manner in which it has been dealt with, to the contracting CCG. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken. We saw evidence that, in the period February 2016 to February 2017, performance for this indicator was 100%.

Are services well-led?

Good

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

Our findings

Vision and strategy

The service had a clear vision to deliver high quality care and promote good outcomes for patients.

- The service had a mission statement and staff knew and understood the values.
- The service had an effective strategy and supporting business plans that reflected the vision and values and were regularly monitored.

Governance arrangements

The service had an overarching governance framework that supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff.
- The provider had a good understanding of their performance against National Quality Requirements. These were discussed at senior management and board level. Performance was shared with staff and the local clinical commissioning group as part of contract monitoring arrangements.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

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. The comittees consisted of local representatives as well as provider level representatives.The purpose of the various committees 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.
- Undertake regular review of the performance against the cost improvement plans, 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.
- 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.
- And to oversee organisational and workforce development, remuneration and benefits and patients/public/staff engagement.

Leadership and culture

On the day of inspection the provider of the service demonstrated they had the experience, capacity and capability to run the service and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the local leadership team were approachable and always took the time to listen to all members of staff. 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.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The organisational and local management encouraged a culture of openness and honesty. The service had systems in place to ensure that when things went wrong with care and treatment:

- The service gave affected people an explanation based on facts and an apology where appropriate, in compliance with the NHS England guidance on handling complaints.
- The service kept written records of verbal interactions as well as written correspondence.

Are services well-led?

Good

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

There was a clear leadership structure in place and staff felt supported by management.

- There were arrangements in place to ensure the staff were kept informed and up-to-date. This included a staff newsletter and other circulars that were sent around the whole organisation. For example, a hot topic circular which was a clinically focussed update for staff to refresh themselves on the contents; in February the service had shared two, one was on "Diagnosis and management of suspected deep vein thrombosis in out-of-hours" and one was on "When cellulitis is not cellulitis". The provider also sent out a quarterly newsletter to staff focussed on quality, safety and governance.
- We saw evidence that lessons were shared and action was taken to improve safety in the service. For example, following an incident involving an adverse outcome related to sepsis, the provider had shared the learning and outcomes with the whole organisation and implemented additional training to ensure staff were up to date with their knowledge of sepsis.
- Staff told us there was an open culture within the service and they had the opportunity to raise any issues and felt confident and supported in doing so.
- Staff had access to an online platform which supported their professional development and had information available to support appraisal and revalidation processes.
- Most staff we spoke with said they felt respected, valued and supported, particularly by the providers. Staff had the opportunity to contribute to the development of the service. Several members of staff we spoke with did not always feel well supported and told us the transfer process had been difficult since the provider had taken over the service in 2015. This was in line with what we found during our inspection in March 2016 but improvement had been made.

Seeking and acting on feedback from patients, the public and staff

The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The service had gathered feedback from patients through surveys and complaints received. For example, through patient questionaires and a text message feedback system.
- The service had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Governance and performance management arrangements were proactively reviewed and took account of current models of best service. The provider had a performance management support group that operated organisation wide which discussed and reviewed clinicians under investigation where local management was unable to develop this further.

NQR 5: Providers must regularly audit a random sample of patients' experiences of the service (for example 1% per quarter) and appropriate action must be taken on the results of those audits. Regular reports of these audits must be made available to the contracting CCG.

Providers must cooperate fully with CCGs in ensuring that these audits include the experiences of patients whose episode of care involved more than one provider organisation. We saw evidence that, in the period February 2016 to February 2017, performance for this indicator was 1% against a target of 1%.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service. The service team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

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- Improve patient experience. More specifically, shorter patient jouneys and appropriate care in the right place by the right health care professional
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Are services well-led?

Good

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