Integrated Care 24 Limited – Head Office

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?	Good
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 this comprehensive inspection of IC24 NHS 111 service on 12 and 13 July 2016. NHS111 is a 24 hours a day telephone based service where patients are assessed, given advice or directed straightaway to a local service that most appropriately meets their needs. For example that could be to their own GP, an out-of-hours GP service, walk-in centre or urgent care centre, community nurse, emergency dentist, emergency department, emergency ambulance or late opening chemist, or home management advice.

IC24 provides NHS 111 services to the areas of North Essex, South Essex, Great Yarmouth and Waveney, and Norfolk and Wisbech. IC24 has three call centres that manage calls for these areas, we inspected two of these call centres at Ashford and Ipswich.

Our key findings were as follows:

- There were systems in place to help ensure patient safety through learning from incidents and complaints about the service.
- The provider had taken steps to ensure that all staff underwent a thorough recruitment and induction process to help ensure their suitability to work in this type of healthcare environment.
- Staff were supported in the effective use of NHS Pathways. Regular audits of calls to the service monitored quality and supported improvement and where issues were identified remedial action was taken and the employee was supported to improve.
- Patients experienced a service that was delivered by dedicated, knowledgeable and caring staff.
- Patients using the service were supported effectively during the telephone triage process. Consent to triage was sought and their decisions were respected. We saw that staff treated patients with compassion, and responded appropriately to their feedback.
- Clinical advice and support was readily available to health advisors when needed. Care and treatment was coordinated with other services and other providers.
- All opportunities for learning from internal incidents and complaints were used to promote learning and improvement.
- There was an overarching governance framework across the NHS 111 service, which supported the delivery of the strategy and good quality care. This included arrangements to monitor quality and identify risk.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Risk management was embedded and recognised as the responsibility of all staff.

Summary of findings

- 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 provider had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- There was a strong focus on continuous learning at all levels.

We saw several areas of outstanding practice:

- The IC24 NHS 111 management team had developed a pilot towards the 'Professionalisation' of the health advisor role within the NHS 111 Urgent Care Setting. A proactive approach to addressing attrition and retention rates of the NHS 111 health advisor workforce (a known area of high attrition rates nationally) by nationally accrediting health advisor training and the introduction of a health advisor development framework, supported by additional distance learning packages. They had worked with a local higher education institution and NHS England to develop an accredited course.
- The service was developing an innovative pilot scheme in South Essex to support people who have called NHS111 but it has been established that they are not injured and unable to get up. They were working in collaboration with a local Fire service to support these patients and reduce the requirement to send a non-emergency ambulance response.
- The provider had developed a mobile phone 'app' that allowed senior managers to access real time information relating to call handling within the call centres. This allowed senior managers to support team managers at times of unexpected pressure.

However, there was an area of practice where the provider should make an improvement.

The provider should:

- Review their safeguarding process to consider referrals being made by health advisors and the auditing of safeguarding concerns when clinicians have determined that there is no further action required.

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?

Good

The provider is rated as good for providing safe services.

- Safety was seen as a priority.
- Service performance was continuously monitored and reviewed and improvements implemented.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- All opportunities for learning from internal and external incidents were discussed to support improvement. Information about safety was valued and used to promote learning and improvement.
- Risk management was embedded and recognised as the responsibility of all staff.
- Staff took action to safeguard patients and were aware of the process to make safeguarding referrals. Calls with a safeguarding concern were “warm transferred” to a clinician to progress the issue; however if the clinician determined that there was not a safeguarding issue with the call,no audit was maintained of these situations.
- Clinical advice and support was readily available to health advisors when needed.

Are services effective?

Good

The provider is rated as good for providing effective services.

- Daily, weekly and monthly monitoring and analysis of the service achievements was measured against key performance targets and shared with the lead clinical commissioning group (CCG) members. Account was also taken of the ranges in performance in any one time period.
- Appropriate action was undertaken where variations in performance were identified. Staff were trained and rigorously monitored to ensure safe and effective use of NHS Pathways.
- Staff received annual appraisals and personal development plans were in place, and had the appropriate skills, knowledge and experience.
- Staff ensured that consent as required was obtained from people using the service and appropriately recorded. There was an effective system to ensure timely sharing of patient information with the relevant support service identified for the patient and their GP.

Summary of findings

- People's records were well managed, and, where different care records existed, information was coordinated.
- Staff used the Directory of Services and the appropriate services were selected.
- Capacity planning was a priority for the provider. The provider undertook detailed call level forecasting to enable them to ensure adequate staffing levels could be delivered.

Are services caring?

Good

The provider is rated as good for providing caring services.

- Patient survey data from April 2015 to March 2016 showed that 90% of patients were satisfied with the level of service they received.
- People using the service were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw staff treat people with kindness and respect, and maintained people's confidentiality.
- We heard staff that listened carefully to information that was being told to them, confirmed that the information they had was correct and supported and reassured callers when they were distressed.
- Staff obtained the patient's consent when it was necessary to share information or have their call listened to.

Are services responsive to people's needs?

Good

The provider is rated as good for providing responsive services.

- The service had long and short-term plans in place to ensure staffing levels were sufficient to meet anticipated demand for the service.
- There was a comprehensive complaints system and all complaints were risk assessed and investigated appropriately.
- Action was taken to improve service delivery where gaps were identified.
- Care and treatment was coordinated with other services and other services or provider. There was collaboration with partners to improve urgent care pathways.
- Staff were alerted, through their computer system, to people with identified specific clinical needs, care plans and any safety issues relating to a patient.
- The service engaged with the lead clinical commissioning group to review performance, agree strategies to improve and

Summary of findings

work was undertaken to ensure the Directory of Services (DOS) was kept up to date. (The DOS is a central directory about services available to support a particular person's healthcare needs and this is local to their location.)

Are services well-led?

Good

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

- The provider had a clear vision and strategy to deliver a high quality service and promote good outcomes for people using the service. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. Staff, including those who did not work conventional office hours knew how to access senior leaders and managers.
- The provider's policies and procedures to govern activity were generally effective, appropriate and up to date. Regular governance meetings were held.
- There was an overarching governance framework which supported the delivery of the strategy and a good quality service. This included arrangements to monitor and improve quality and identify risk.
- The information used in reporting, performance management and delivering quality care and treatment was accurate, valid, reliable, timely and relevant.
- The provider was aware of and complied with the requirements of the duty of candour. The provider and managers encouraged a culture of openness and honesty. The provider had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- There was a strong focus on continuous learning and improvement at all levels.
- IC24 had developed a mobile 'phone app that allowed senior managers to access real time information relating to call handling within the call centres. This allowed senior managers to support team managers at times of unexpected pressure.

Integrated Care 24 Limited – Head Office

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspection Manager. The team included a second CQC Inspection manager, three CQC inspectors, and three specialist advisors with experience of NHS 111 services and NHS Pathways training.

Background to Integrated Care 24 Limited – Head Office

Integrated Care 24 Limited (also known as IC24) was formed in 1996, after the amalgamation of a number of the original GP Co-operatives within the South East of England area.

In 2012, they were part of the first wave of sites to provide NHS 111 services. They now operate four NHS 111 contracts.

IC24 has three different NHS 111 Care Co-ordination centres which operate 24 hours a day, seven days a week.

- Ashford; Kingston House, The Long Barrow, Orbital Park, Ashford, Kent, TN24 0GP.
- Ipswich; 12 Delta Terrace, West Road, Ransomes Europark, Ipswich, Suffolk, IP3 9FH.
- Norfolk; Reed House, Unit 2B, Peachman Way, Broadland, Business Park, Norwich, Norfolk, NR7 0WF.

There are four areas that were covered by these call centres. These are Great Yarmouth and Waveney, Norfolk and Wisbech, North Essex and South Essex. Within these areas are 11 clinical commissioning groups, 396 GP surgeries delivering care to approximately 2.8 million people. NHS 111 calls for the year 2015/16 were 723,014 with ambulances being sent to 7.8% of patients.

On the first day of our inspection there were 135 call handlers and 57 clinicians in post between the Ashford and Ipswich call centres.

This is the first comprehensive inspection of the NHS 111 service provided by IC24 at Ipswich and Ashford. A focused inspection of the Norwich call centre has been undertaken and reported separately, please refer to the CQC website.

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

To get to the heart of people's experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?

Detailed findings

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

Before visiting, we reviewed a range of information we held about the NHS 111 service and asked other organisations such as the Clinical Commissioning Groups (CCGs) to share what they knew about the service. We also reviewed the information which the provider submitted before our visit as well as other information which was in the public domain.

We carried out an announced inspection to IC24 NHS 111 service on 12 and 13 July 2016. We were unable to speak directly with patients who used the service; however we listened to calls, with patients' consent. During our visit we:

• Visited Ashford and Ipswich call centres

• Observed health advisors and clinicians carrying out their role at both locations during periods of peak activity.

• Spoke with a range of clinical and non- clinical staff, health advisors, clinicians, team managers, clinical supervisors, clinical and non-clinical coaches, senior managers, a lead trainer which included NHS Pathways training, and the clinical governance team.

• Reviewed NHS Pathways, Directory of Services (DoS) details and other documentation.

Please note that when referring to information throughout the report this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record

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

- Significant events that met the threshold for a Serious Incident or Never Event were declared and investigated in accordance with the NHS England Serious Incident Framework 2015.
- Investigation of significant events was not confined to those that met NHS England's criteria for a Serious Incident or Never Event. The provider treated significant events including near misses as an opportunity for learning and risk reduction measures. For example a serious incident had been raised following an adverse outcome for a patient; we saw the investigation that the provider had undertaken. This included a root cause analysis, audits of the call to the NHS 111 service and whether the correct outcome had been established. The provider also conducted further audits for the staff involved to ensure the level of assessment and care was appropriate in a range of other calls as best practice. The family had been involved in the process and updated of the investigation throughout. We saw that the provider had shared the findings and any learning identified. Examples of learning from significant events included hot topic guidance which was cascaded to staff and updates in a safety bulletin. We saw a range of updates for staff including a sepsis awareness workbook and hot topic guidance for meningitis, strokes and chemical burns.
- Staff told us they would inform the team manager of any incidents and there was a recording form available on the provider'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 service/provider of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong, people were informed of the incident, received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety. Complaints, concerns, health care professional feedback, significant events and non-compliant call audits were reported on.

Overview of safety systems and processes

The service had clearly defined and embedded systems, processes and practices in place to keep people who used the service 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 person's welfare. Information was available on computer and detailed the different access pathways required for staff to use depending on the specific geographical area that the issue related to. Referrals were made by clinicians or team managers. Health advisors would obtain assistance from a clinician if they had a safeguarding concern during a call.
- Calls with a safeguarding concern were "warm transferred" to a clinician to progress the issue; however if the clinician determined that there was not a safeguarding issue with the call, no audit was maintained of these situations.
- There was a lead member of staff for safeguarding. Contributions were made to safeguarding meetings when required. In the 12 months prior to the inspection there had been 154 child safeguarding referrals and 284 adult safeguarding referrals undertaken. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. Call handlers and clinicians were trained to level two for safeguarding children.
- Clinical staff, and appropriate administrative staff, had access to people's medical or care records, this included information on patients, for example, who had an agreed "do not resuscitate" order in place and care plans for vulnerable people. Staff were clear on the arrangements for recording patient information and maintaining records. Special notes were used appropriately for people with specific conditions or needs and this made a difference to those people.

Good

Are services safe?

- Staff had had training in recognising concerning situations and followed guidance in how to respond. Clinical advice and support was readily available to staff when needed. For example we saw a health advisor able to pass a call which had concerned them to a clinician so as to ensure that the patient received the most appropriate care. Clinical and non-clinical coaches were present within the call room for staff to obtain advice if there were any concerns as to which pathway to use within the clinical decision support software.
- As soon as a call was received by a health advisor, a patient record was established including name, age and address. We heard how staff double checked information for accuracy whilst at the same time reassuring the caller. Information was recorded directly onto the computer system and all calls were recorded to enable information verification and quality management. Staff were clear on the arrangements for recording patient information and maintaining records.
- The provider used the Department of Health approved clinical decision support system NHS Pathways. (This is a set of clinical assessment questions to triage telephone calls from patients and is based on the symptoms reported when they call. The tool enabled a specially designed clinical assessment to be carried out by a trained member of staff who answered the call.) Once the clinical assessment was completed a disposition outcome and a defined timescale was identified to prioritise the patients' needs. Health advisors and clinicians call handling skills using the NHS Pathway systems were monitored regularly to ensure that dispositions reached at the end of the call were safe and appropriate.
- Staff were able to access the advice of clinicians where the patient were not satisfied or did not accept NHS Pathway outcome or disposition. Should the clinician not be available for a direct transfer (warm transfer) the patient could be placed in a 'call back' queue or health advisors could seek the advice of the clinical supervisor or team leader if they were uncertain of the management of the call.
- Health advisors and clinicians also had a coloured card (or flag) available on their work station. This allowed staff members who were having difficulty in managing a call to raise the card and receive immediate assistance.
- There were clear processes in place to manage the transfer of calls, both internally within the service, and to external providers, to ensure a safe service. Standard operating procedures were available to all staff working for IC24.
- Call response times, waiting times, abandoned call data were closely monitored throughout each shift and staff were deployed to manage demand at peak times. Clinical supervisors and team leaders had oversight of call type and calls were triaged to ensure that those callers with more urgent needs were prioritised to ensure patient safety.
- We reviewed fourteen personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Staff were provided with a safe environment in which to work. Risk assessments and actions required had been taken to ensure the safety of the premises, however since electrical safety testing was no longer required, there had not been a risk assessment completed to assure that the electrical equipment was safe. Reasonable adjustments were undertaken to ensure work stations were appropriate for individual staff members. Height adjustable work stations, specialised chairs and IT equipment were available to staff if appropriate. The call centres were clean; desks were spaced appropriately to ensure that health advisors were not distracted by other calls.

Monitoring safety and responding to risk

Risks to people using the service were assessed and well managed.

- Health advisors triaged patient calls by use of a clinical decision support system (NHS Pathways). This guided the health advisor to assess the patient based on the symptoms they reported when they called. It had an integrated directory of services (DoS) which identified appropriate services for the patient's care. Staff received comprehensive training and regular updates on NHS Pathways and their competencies were assessed prior to handling patient telephone calls independently, and continuously through regular call audits for all members of staff.

Good

Are services safe?

- Shift rotas were planned and implemented using the workforce management tool and staff were scheduled to work against forecasted/anticipated levels of demand. Staff skill mix was monitored twice weekly and any shortfalls highlighted and acted upon. Rotas were prepared in advance to ensure enough staff were on duty. Arrangements were in place to assist in managing staffing levels at times of high demand such as Christmas and Easter periods.
- Procedures to raise concerns about staffing and patient caller demand could be escalated by use of the escalation plan when appropriate. Clinicians were available throughout every shift to provide support to patients through the clinical decision support system and to provide real time support to health advisors. However, staff told us there were occasions when access to a clinician was difficult, which meant patients were held in a queue or received a call back from a clinician.

Arrangements to deal with emergencies and major incidents

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

- The service had a comprehensive business continuity plan in place to deal with emergencies that might interrupt the smooth running of the service. This included loss of mains power, loss of utilities, loss of staffing, evacuation of the building and loss of the Directory of Services. The plan included emergency contact numbers for staff. The service could operate if required from any of the three locations providing call handling services. We saw this resilience put into action when the telephone lines to the Norwich centre were lost due to adverse weather and the other two centres stepped in to cover their calls at a peak time This provided increased resilience and mitigated the risk of any potential loss of service.
- The provider had engaged with other services and commissioners in the development of its business continuity plan.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

IC24 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 practice guidelines.

- The service had systems in place to ensure all staff were kept up to date. Staff had access to guidelines from NICE and NHS Pathways, and used this information to deliver care and treatment that met patients' needs. The provider monitored that these guidelines were followed, if the guidelines were not followed, staff would receive feedback or training with action plans if needed. The service used, (with permission from the licensee) NHS Pathways version 11.
- All health advisors and clinicians completed a mandatory training programme to become licensed in using the NHS Pathways software. Once training had been completed both health advisors and clinicians were subject to a structured quality assurance programme. Staff were regularly audited and levelling took place with the auditors to ensure procedures were followed and standards maintained.
- We were shown evidence that call audits for staff had been completed. For example:
  - From May 2015 to May 2016 there had been 10,271 audits for non-clinical staff. Of these there had been 2,208 failed audits, 21.5%.
  - There had also been 2,557 audits of clinical staff which had resulted in 427 failed audits, 16.7%.
  - Of the total calls audited those failed are, 10% are a Green fail, 7% an Amber fail and 3% a Red fail.
  - In June 2016, 53, 542 calls were triaged by IC24, of these 1,450 were audited (2.7%), non-clinical staff in June 2016 had a pass rate of 86% (1242 calls).
  - There were 289 audits of calls managed by clinicians in June 2016; Clinicians had a pass rate of 91% (263 calls).
  - Of the total calls audited those failed are, 8% are a Green fail, 6% an Amber fail and 1% a Red fail.
- Where any gaps had been identified from the audit process, or any learning identified from an incident or investigation, discussions were had with staff at a one to one meeting. When necessary the staff member received either additional coaching or formal training, an action plan was devised to manage the process. During this time the staff member may be taken off call handling until the issue was resolved, this was determined on each individual case. There were three separate levels of "fail" for an audited call ranging from a "green" fail, which indicated that whilst the call was not managed correctly no detrimental impact could have been suffered by a patient, to a "red" fail which indicated that a negative effect could possibly have been suffered by a patient (though not stating that it actually had been). Following this process, staff would undergo an increased level of auditing, supervision and support each month until managers had been satisfied that the required standard had now been reached.
- Real time performance was monitored and action taken to ensure where performance of the service was at risk of reducing. These actions included changes in break times, contacting off duty staff members to rearrange their upcoming shift and offering overtime to staff to work on from their present shift finish time.
- When staff were not able to make a direct appointment on behalf of the patient, clear referral processes were in place and seen by the inspectors. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.
- Staff told us they had easy online access to policies, procedures, e-learning and supporting information such as Toxbase (a primary clinical toxicology database of the National Poisons Information Service) and Hot topics (NHS Pathways updates).
- Discrimination was avoided when speaking to patients who called the IC24 NHS111 service. The NHS Pathways assessment process ensured patients were supported and assessed on their needs rather than on their demographic profile. Health advisors had access to Language Line for patients who did not have English as their first language.

Management, monitoring and improving outcomes for people

The service monitored its performance through the use of the National Quality Requirements and the national Minimum Data Set, as well as compliance with the NHS Commissioning Standards. In addition the provider had established its performance monitoring arrangements and reviewed its performance each hour against the forecasted call volume.

Good

Are services effective?

(for example, treatment is effective)

Data for calls answered within 60 seconds (for which the national target is 95%) Showed:

For South Essex,

- April 2016, 90.3% of calls answered within 60 seconds, which was better than the England average of 87.1%, 95% of calls were answered within 70 seconds.
- May 2016, 90.97% of calls answered within 60 seconds, which was better than the England average of 88.2%, 96% of calls were answered within 70 seconds.
- June 2016, 94.73% of calls answered within 60 seconds, which was better than the England average of 90.6%, 98.4% were answered within 70 seconds.

For North Essex,

- April 2016, 89.36% of calls answered within 60 seconds, which was better than the England average of 87.1%, 94.27% of calls were answered within 70 seconds.
- May 2016, 92.26% of calls answered within 60 seconds, which was better than the England average of 88.2%, 96.85% of calls were answered within 70 seconds.
- June 2016, 95.97% of calls answered within 60 seconds, which was better than the England average of 90.6%, rising to 98.99% answered within 70 seconds.

For Great Yarmouth and Waveney,

- April 2016, 92.45% of calls answered within 60 seconds, which was better than the England average of 87.1%, 96.35% of calls were answered within 70 seconds.
- May 2016, 94.69% of calls answered within 60 seconds, which was better than the England average of 88.2%, 98.04% of calls were answered within 70 seconds.
- June 2016, 97.03% of calls answered within 60 seconds, which was better than the England average of 90.6%, rising to 99.29% answered within 70 seconds.

Data for calls abandoned (the national target is less than 5%) showed:

For South Essex,

- April 2016, 0.98% which was significantly better than the England Average of 2.8%
- May 2016, 0.72% which was significantly better than the England average of 2.5%
- June 2016, 0.28% which was significantly better than the England average of 1.8%

For North Essex,

- April 2016, 1.43% which was significantly better than the England Average of 2.8%
- May 2016, 0.65% which was significantly better than the England average of 2.5%
- June 2016, 0.25% which was significantly better than the England average of 1.8%

For Great Yarmouth and Waveney

- April 2016, 0.89% which was significantly better than the England Average of 2.8%
- May 2016, 0.44% which was significantly better than the England average of 2.5%
- June 2016, 0.14% which was significantly better than the England average of 1.8%

Data for calls back by a clinical advisor within 10 minutes showed:

For South Essex:

- April 2016, 28%, which was lower than the England average of 39.1%
- May 2016, 24%, which was lower than the England average of 40.6%
- June 2016, 25% which was lower than the England average of 39.9%

For North Essex:

- April 2016, 24%, which was lower than the England average of 39.1%
- May 2016, 24%, which was lower than the England average of 40.6%
- June 2016, 25%, which was lower than the England average of 39.9%

For Great Yarmouth and Waveney:

- April 2016, 17%, which was lower than the England average of 39.1%
- May 2016, 15%, which was lower than the England average of 40.6%
- June 2016, 15%, which was lower than the England average of 39.9%

Effective staffing

Staff had the skills, knowledge and experience to deliver an effective service.

- The provider had an induction programme for all newly appointed staff. This covered such topics as information governance, health and safety, NHS Pathways training,

Good

Are services effective?

(for example, treatment is effective)

safeguarding, call control, mental health, basic life support, performance and quality assurance processes, communication requirements and specific procedures relating to their place of work. All staff must complete relevant mandatory training e-learning modules before they can start operationally within their new role. All other modules must be completed within three months of starting employment.

- The provider could demonstrate how they ensured role-specific training and updating for relevant staff. For example safeguarding training to the appropriate levels. 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 during sessions, one-to-one meetings, appraisals, clinical supervision and facilitation and support. All staff had had an appraisal within the last 12 months, other than in exceptional circumstances (such as long-term sick leave), which were clearly documented.
- Staff received training that included: use of the clinical pathway tools, how to respond to specific patient groups, Mental Health Act, Mental Capacity Act, safeguarding for Adults and children, fire procedures, and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training. During our inspection at Ipswich a representative from the mental health charity MIND was delivering training to call handlers and clinical advisors on recognising and managing callers with mental health issues. The trainer was clear that the training was to support the staff on how to engage with the caller on the phone and to get the best information from them.
- The provider had recognised the stress that working in the NHS 111 environment created for staff and had provided access to counselling for all staff. The staff could access this service without a referral from a supervisor or manager.
- There was a shortage of clinicians that impacted on the calls back by a clinical advisor; recruitment was in place endeavouring to fill his deficient.

Working with colleagues and other services

Staff worked with other services to ensure people received co-ordinated care.

- The provider was aware of the times of peak demand and had communicated these to the ambulance service. This included the arrangements to alert the ambulance service when demand was greater than expected.
- There were arrangements in place to work with social care services including information sharing arrangements. Evidence was seen that information was easily available to ensure that the different ways that each serviced area received safeguarding referrals for vulnerable people of different age groups.
- Staff knew how to access and use patient records for information and when directives may impact on another service for example advanced care directives or do not attempt resuscitation orders.
- The provider had systems in place to identify 'frequent callers' and staff were aware of any specific response requirements.
- Information about previous calls made by patients was available so staff could access this information and discuss any relevant issues with patients and assist them in the decision making for that specific call.

Consent

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and Gillick competency for children.
- The process for seeking consent was monitored through audits.
- We listened to calls to the service in both the call centres. Throughout the telephone clinical triage assessment process the health advisors checked the patient understanding of what was being asked of them. Patients were also involved in the final disposition (outcome) identified by the NHS Pathways and their wishes were respected. Should a patient refuse the final disposition their call was transferred to a clinician for further assessment.
- Access to patient medical information was in line with the patient's consent.
- Staff were also aware of when they may need to share information against the patient's wishes, such as in cases of self-harm, or where others may be at risk. For example we saw how a caller had requested that her

Good

Are services effective?

(for example, treatment is effective)

contact with the NHS111 service was not shared with her GP practice as they had a relative working there who they did not wish to be made aware of the reasons for her calling NHS111.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to people calling the service and treated them with dignity and respect.

Staff were provided with training in how to respond to a range of callers, including those who may be abusive. Our observations were that staff handled calls sensitively and with compassion. In particular we observed how a call handler dealt with a call from a caller who had serious health concerns for their elderly partner. We saw that call was dealt with effectively and efficiently, with due compassion, patience and respect for both parties involved.

Results from the surveys, feedback, and NHS Choices showed people felt they were treated with compassion, dignity and respect.

The IC24 NHS 111 service was part of the patient satisfaction survey, data from April 2015 to March 2016 noted that overall 90% of patients were satisfied with the service.

South Essex 94% of patients were satisfied with the service between April 2015 to August 2015.

North Essex 90% of patients were satisfied with the service between April 2015 to August 2015

Great Yarmouth and Waverney 86% of patients were satisfied with the service between April 2015 to August 2015.

Feedback on the NHS Choices website for the IC24 NHS 111 service was mixed. Of the four relating to the NHS 111 service, two were positive and two were negative. The comments relating to the NHS 111 service posted on the website had been responded to by IC24 which included the clinical governance team asking for further feedback and offering a number of methods to provide further feedback.

There had only been one comment relating to the IC24 NHS 111 service on the Patient Opinion website, which was positive about the care received.

Care planning and involvement in decisions about care and treatment

- Care plans, where in place, informed the service's response to people's needs, though staff also understood that people might have needs not anticipated by the care plan.
- We saw that staff took time to ensure people understood the advice they had been given, and the referral process to other services where this was needed. This included where an appointment had been made by the NHS 111 service or where a request was to be made for a future appointment.

We saw good examples of people's preferences being accounted for during calls we observed.

Patient/carer support to cope emotionally with care and treatment

We listened to how patients, or their carers, were informed of the final outcome of the NHS Pathways assessment. We observed health advisors and clinicians speaking calmly and reassuringly to patients. We also saw that the advisors repeatedly checked that the patient understood what was being asked of them and that they understood the final disposition (outcome) following the clinical assessment.

We observed staff taking time to answer questions from patients and ensuring that the callers understood the information that they had been given.

There were arrangements in place to respond to those with specific health care needs such as end of life care and those who had mental health needs. Agreed care plans were available to staff to access for specific patients to ensure that the correct care was delivered to the patient.

Health advisors and clinical advisors were clear on the standard operating procedures in place which detailed the actions they would take in the event that a patient refused the final disposition.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified.

- The service offered 24 hours a day, 365 days a week service.
- The service continually analysed the demand on services and adjusted the levels of staffing according to predicted demand. For example cover was increased on known busy periods such as weekends, bank holidays and during major sporting events. The cover was analysed in 15 minute intervals and a range of rota options where in place to ensure the best cover where possible. Examples of flexibility had been built into the system for example flexible start times, and a range of different shift lengths. These were monitored and adjusted as required.
- The service had delivered an education and awareness session to two local dementia care homes, and other health care providers including local GP providers to improve the understanding and awareness of the NHS 111 system and help identify ways to work better together, to improve information sharing and promote best practice.
- Care pathways were appropriate for patients with specific needs, for example those at the end of their life, and babies and young children. The service had a system in place that alerted staff to any specific safety or clinical needs of a patient, this included special patient notes and patient specific care plans. We observed that staff had a good understanding of the care plans.
- There were translation services available and all staff we spoke with were confident in accessing this service for callers who did not speak English. The service used text talk for patients with a hearing difficulty.

Tackling inequity and promoting equality

- The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services, for example during the induction training staff had training and awareness of a range of factors which can affect access, including scenarios to increase skills in assisting patients with communication difficulties or memory impairments. The staff undertook training to increase recognition and awareness in dementia, and other areas which can impact on care for example domestic violence and radicalisation.
- New staff received training in equality and diversity during their induction and this training was updated for all staff on an annual basis.

Access to the service

- The Trust was monitored against the National Minimum Data Set (MDS) and adapted National Quality Requirements (NQRs).
- The telephone system was easy to use and supported people to access advice.
- Action was taken by IC24 to reduce the length of time people had to wait for subsequent care or advice where possible, for example the estimated demand was measured against staff resourcing in 15 minute intervals to try to provide the correct staffing levels.
- People had timely access to advice, including from a health advisor or clinical advisor when appropriate.
- The service prioritised people with the most urgent needs at times of high demand. For example a senior clinician had responsibility for overseeing any calls waiting in their queues and identifying the priority of calls for clinical advice, or escalating to the 999 service if required. The senior clinician could adjust the clinicians work stream according to the calls waiting, for example increase the number of clinical advisors completing call backs and adjust the number of clinical advisors available for warm transfers. The IC24 NHS 111 service could take calls from any of the calls centres so clinical advisors could also undertake call backs waiting from the other call centres according to demand.
- Referrals and transfers to other services were undertaken in a timely way. We saw examples of referrals sent automatically through secure information systems and examples of timely referrals to different health and social care providers.
- Action was taken to minimise the number of calls that were abandoned by the caller. IC24 NHS 111 service demonstrated lower than average numbers of abandoned calls, for example the abandonment rates (from 1 May 2015 to 30 April 2016) for Great Yarmouth and Waveney were 1%, North Essex were 1.6%, South Essex were 0.9% which were all below the England target of below 5% and the England average of 3%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The provider had an effective system in place for handling complaints and concerns. Information about how to complain was available and easy to understand and evidence showed the provider responded quickly to issues raised.

We looked at three complaints received in the last 12 months and found these were dealt with in a timely way, with openness and transparency. We saw examples of the communication throughout the complaint process to involve and update the complainant on any action being undertaken. For example on one occasion the provider wrote to the complainant noting that further investigations were needed and updating of the progress to date. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of the service. For example, the clinical governance team reviewed the complaints received to see if there were any themes that could be identified and any areas of learning.

The provider responded to feedback from various CCGs to improve services, for example to develop a common policy for repeat callers

IC24 NHS 111 clinical governance team also had access to any themes identified within the wider IC24 organisation. They valued the opportunity to look at any areas for improvement.

They completed trend analysis and reviewing themes of what presenting symptoms or conditions are causing inappropriate high end dispositions such as 999/ A&E or early exits to identify appropriate learning packages.

Information from complaints, audits and feedback was used to improve services with external providers, for example concerns were raised relating to the questions in the Pathways tool for limb pain in the potential diagnosis of a serious form of infection, and lower limb swelling questions in the potential for diagnosing a deep vein thrombosis (a lower clot in a deep vein often presenting in a lower limb) the team noted an improvement was needed to the assessment tool which was shared with the Pathways software provider.

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 provider had a clear vision to provide a service that was passionate about making a difference to our patients, people and partners and deliver a high quality service.
- The service had a strategy and supporting business plans that reflected the vision and values and were regularly monitored.
- The service was looking for opportunities to develop pathways and work with other agencies to ensure work was not duplicated and share ideas and best practice.
- The service had looked at innovative ways to support the callers to the NHS 111 service to ensure the best care options were available, for example they had piloted using a pharmacist, a mental health professional and a health visitor within the NHS 111 clinical teams. From this pilot they had seen a positive impact on patients from the pharmacist role and had extended this into the staff structure.

Governance arrangements

The IC24 NHS 111 senior management team worked to ensure a consistent approach across the three IC24 call centre locations and had a shared purpose to deliver high quality patient focused care. The management team used technology to support effective communication including conference calls via skype.

There was an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- A Clinical Governance Report was produced which included statistical data relating to call activities, audits and trends. This gave an overview and assurance of the service for members of the commissioning CCGs.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- A programme of continuous clinical and internal audit, including regular call audit, was used to monitor quality and to make improvements. This included reviews to identify any areas where improvements could be made. Identified shared learning was cascaded to staff.
- The IC24 NHS 111 management team had developed a governance structure for the NHS 111 service with clear arrangements for the monitoring of all aspects of the service provided. Clinical governance procedures and reporting pathways were established and regular clinical governance meetings were undertaken by the senior management team, commissioners and national leads.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

There were arrangements in place to provide support to staff in the event of any traumatic event or serious incident. For example, during staff induction examples of potentially difficult calls or situations were discussed and staff were advised how to gain support from their line managers. Notices in the call centre environment and in communal staff areas highlighted the importance of seeking support and help if they had experienced any difficult or traumatic calls. Staff we spoke with were aware of the counselling and support services available.

Leadership, openness and transparency

There were clear lines of accountability within the service. The senior management team across the IC24 organisation had recently changed with new board members; the senior management team had been engaged in projects to ensure they were providing a whole model of integrated urgent care with a focus on high quality and performance. They were proactive in ensuring effective working relationships with other stakeholders and regularly met with the commissioning groups and other health and social care providers to try to ensure they were working together to respond to local health inequalities and ensure services were accountable and supported by strong governance processes.

The IC24 senior managers were clear the learning was an on-going process for everyone within the organisation and that learning was shared. We saw board minutes, lessons learnt and governance bulletins which supported this.

Operational staff were clear who to go to for guidance and support. They were clear about their line management arrangements as well as the clinical governance arrangements in place.

There were arrangements to support joint working by staff, for example through team meetings. Staff who did not work

Are services well-led?

Good

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

office hours (e.g. night shift workers) were supported in joint working and engaging with members of their team. The IC24 NHS 111 management team had recently revised the one to one meeting structure to ensure this included regular face to face meetings with team leaders.

The senior leadership team had developed an application which the managers and board members could all access on their mobile phones. This provided real time performance indicators and data for the NHS 111 service. This provided a support system for the NHS 111 management and team leaders as senior management were able to respond to any challenges or issues regarding performance. This real time information was useful in ensuring that senior managers could respond immediately to any unusual increase in call volumes and provide further support to team managers in ensuring timely access is available to the service for callers.

There were arrangements in place to provide support to staff in the event of a death or serious incident.

Public and staff engagement

The service engaged with the public through a number of methods including patient satisfaction surveys, and a range of options to give feedback or raise complaints of concerns through their website. The service had formed links with local Healthwatch groups to gain patient feedback.

The service carried our regular surveys of patients who used the service via the NHS Friends and Family test survey; this showed the patient satisfaction results for the IC24 NHS 111 service. Data from April 2015 to August 2015 showed South Essex 94% satisfaction with the service, North Essex 90%, Great Yarmouth and Waveney 86%.

The IC24 team had delivered a number of educational and awareness sessions about the IC24 NHS 111 service to a range of other stakeholders including local CCGs, local service providers, a local police representative, Healthwatch, a local palliative care provider and Age UK. They had also deliver an educational and awareness to two local dementia groups.

The new senior management team had recognised the importance of staff engagement and had introduced a number of changes over the recent year including, an annual staff survey, and a new system to support regular one to one's for staff with a supporting template which covered performance feedback including audit and welfare support. Areas of change that were developed from the staff survey included staff arranging their own rotas and a pay incentive scheme.

The recent staff survey had gained feedback on morale, key dislikes and key likes for staff as well as the chance to give feedback on other issues. We saw evidence of staff feedback following the survey and actions taken as a result. The survey had highlighted that staff reported that colleagues were supportive, there was a team spirit and it was a friendly and enjoyable place to work. This was noted as the top like by staff and that they had a feeling that they helped people, make a difference to patients and do a worthwhile job, was the second most popular response.

We saw other examples of proactive engagement with staff groups for example the staff had been involved in a consultation over the pay and conditions, staff were able to design their own rotas in some teams. Additionally the scenarios in the initial training sessions had been adjusted following staff feedback.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the service.

We saw the following examples of continuous improvement and innovation within the service:

The learning and development of staff was recognised as important for the NHS 111 service, for delivery of best practice care, for staff to feel valued and to support staff retention. The senior management team had developed a number of methods to support the staff leaning and development, including a team manager development structure which was interfaced with the NHS Leadership model for any new team managers which was also being rolled out for all the established team managers. This helped managers to focus on understanding how leadership behaviours affect the culture and climate and how staff affect the experiences of patients and

service users of the NHS 111 organisation, the quality of care provided, and the reputation of the organisation.

The IC24 NHS 111 management team had developed a pilot towards the 'Professionalisation' of the health advisor role within the NHS 111 Urgent Care Setting. A proactive approach to addressing attrition and retention rates of the NHS 111 health advisor workforce (a known area of high

Are services well-led?

Good

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

attrition rates nationally) by nationally accrediting health advisor training and the introduction of a health advisor development framework, supported by additional distance learning packages. Supporting the call handling staff to feel supported, valued and empowered and to be given the opportunity to develop and progress within their role.

The IC24 management team had led the pilot scheme to develop a clear career pathway for health advisors, linked to training and performance enabling a greater ownership of the role so that it is no longer seen as a "job" but a career with opportunities for progression. The IC 24 service had worked with a local higher education institution and NHS England to develop an accredited course. They noted that this initiative would be strengthened further if the training was rolled out nationally and also would quality assure the delivery across the country.

The service was developing an innovative pilot scheme in South Essex to support people who have called NHS111 but it has been established that they are not injured and unable to get up. They were working in collaboration with a local Fire service to support these patients and reduce the requirement to send a non-emergency ambulance response.

The service looked at ways to support new staff in their development and transition into their role, for example the service developed a 'Graduation Bay' for new health advisors with extensive support and an opportunity to experience calls in a learning environment before entering the main call centre, this was to allowing staff to grow and feel confident within their new role, guaranteeing patient safety is paramount in their practice.