Devon Doctors - Osprey House

Inspection report

Osprey House
Osprey Road, Sowton Industrial Estate
Exeter
EX2 7WN
Tel: 01392822345

Date of inspection visit: 7, 8 and 9 December 2020
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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 location	Inadequate
Are services safe?	Requires Improvement
Are services effective?	Inadequate
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Overall summary

We are mindful of the impact of Covid-19 pandemic on our regulatory function. We therefore took account of the exceptional circumstances arising as a result of the Covid-19 pandemic when considering what type of inspection was necessary and proportionate.

This service is rated as Inadequate overall. (Previous inspection July 2020 – the overall rating of Good, was carried over form an inspection which took place in May 2017, as the July inspection was focused and therefore unrated.)

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Inadequate

Are services caring? – Requires improvement

Are services responsive? – Requires improvement

Are services well-led? – Inadequate

We carried out a focused inspection in July 2020, in response to concerns received. After this inspection we imposed urgent conditions on the provider's registration with a timeframe to make urgent improvements in the service provided.

This inspection of Devon Doctors Limited, on 7, 8 and 9 December 2020 was a short notice announced focused inspection to follow up on the urgent conditions imposed on the provider and requirements made at our inspection in July 2020.

We looked at the following key questions: safe, effective, responsive and well-led. During the three-day inspection we found further information of concern. Therefore, we converted the inspection from focussed inspection to a full comprehensive inspection, to include the caring domain. We spoke with and interviewed a range of staff across the service, including call handlers, senior leaders, junior managers, clinicians, the chief executive officer and members of the Board. We also reviewed documents relating to the running of the service.

At this inspection we found:

- Staff were able to identify what constituted a safeguarding concern and knew what actions to take, however, not all staff had completed relevant training in line with the provider's policy.
- The provider did not consistently ensure that there were sufficient numbers of staff available to run the service, to ensure risk was minimised and the service could respond quickly to an increase in demand.
- Risks to patients were not adequately assessed, monitored or managed to maintain patient safety.
- Overall service performance was not always consistently monitored in a way that ensured patient safety.
- Systems and processes to manage risk were applied inconsistently, whilst learning was not always shared effectively and acted upon. There was a lack of clarity on how significant events and risks were identified and managed. Improvement was still needed to ensure learning and actions taken from incidents were understood and acted on by all relevant staff.
- There were risks of patients not receiving effective care or treatment.
- There were shortfalls in systems and processes that did always not enable safe and effective care to be provided.
- There were still shortfalls in some of the personal development and support provision for staff. Staff did not have appraisals or supervision sessions, to enable them to develop their skills.

Overall summary

- There was a strategy, but it had not been implemented sufficiently to ensure that a high-quality sustainable and consistent care could be provided.
- There were shortfalls in communication between senior leaders and staff groups, staff did not consider they had been fully engaged in the running of the service.
- Governance arrangements were not consistent to support the delivery of a safe, effective and well led service in a consistent manner. Limited attention had been paid to achieving and maintaining compliance with the regulations of the Health and Social Care Act 2008.
- Performance levels had shown signs of improvement and were now in line with national performance levels remained below expected contracted targets. (Due to the pandemic commissioning bodies were accepting service level performance to be in line with national performance, rather than the defined national targets).
- Staff were kind and caring and responsive to patients' needs.

Following this inspection, we took regulatory action and varied the urgent conditions placed on the service after our inspection in July 2020.Conditions are a requirement of the providers registration with the Care Quality Commission. These conditions were imposed as there were significant shortfalls in systems, which led to delays to care and treatment; call answering targets were not consistently being met; there were often adequate numbers of staff; and governance processes were not effective.

We extended the timescales for the urgent conditions to be met, as evidence gathered during this inspection showed some improvement, but it was insufficient to deem that the urgent conditions had been met.

In addition, we imposed two new urgent conditions on the provider's registration relating to taking calls from the NHS 111 national contingency service (National contingency is a systematic process available to all NHS 111 providers in England. This enables any other NHS 111 services nationally to route telephone calls of another provider during periods of high demand); and the second condition was for the provider to produce duty rotas which clearly showed which staff were scheduled to work across the service; which staff actually worked; and reasons for absence of staff.

We also made requirements related to meeting the fundamental standards; complaints handling; provision of staff training, appraisals and supervision; and health and safety.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration. Special measures will give people who use the service the reassurance that the care they get should improve.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team undertaking the site visit included a CQC Inspection Manager, a GP specialist adviser, two CQC team inspectors, a bank CQC inspector and an NHS 111 and Out of Hours specialist advisor. Three CQC team inspectors worked remotely to interview staff and review documentation.

Background to Devon Doctors - Osprey House

Devon Doctors Limited is a social enterprise group which is run by healthcare professionals and reportable to a Board of directors. The organisation does not have any stakeholders and is a non-profit organisation. Any profits from the service are invested back into the service.

Devon Doctors Limited provide an Urgent Integrated Care Service (IUCS), comprising of an out of hours GP service and an NHS 111 service, for the counties of Somerset and Devon. The service covers an area of 6,707 km2 (2,590 square miles) of which a large percentage is rural. The service provides a primary medical service for approximately 1.1 million people. This figure increases substantially in the summer months. The IUCS functions as a whole service provision.

We focussed on the service provision for the Devon NHS 111 service and the Out of Hours service for Devon and Somerset.

Devon Doctors Limited registered locations are:

Suite 1, Osprey House

Osprey Road, Sowton Industrial Estate

Exeter

EX2 7WN

and

10 Manaton Court

Manaton Close

Matford Business Park

Exeter

EX2 8PF

The website is: www.devondoctors.co.uk

We visited the bases or clinical assessment services at Osprey House, Ashford Court, Honiton, Shepton Mallet, Taunton and Newton Abbot as part of this inspection.

The service has nine treatment centres in Devon, which are open at various times throughout the week and weekends to provide the out of hours GP service. There are five treatment centres in Somerset. Devon Doctors Limited is the main contract holder and is responsible for providing the NHS 111 service and out of hours service in Devon and Somerset. The NHS 111 service for Somerset is sub-contracted to another provider. Devon Doctors Limited remains responsible for any services which it sub-contracts out as the main contract holder.

The provider is registered for the following regulated activities:

- Diagnostic and screening procedures
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury.

Staff employed by Devon Doctors Limited include; call handlers, drivers, reception staff, GPs, nurse practitioners, call centre coordinators and supporting office staff holding lead roles such as clinical governance, recruitment, rotas and medicines. Supporting staff also include communication and information governance staff. These members of staff are led by a management team overseen by a Board of directors.

The out of hours service operates between 6pm and 8am Monday to Friday, and 24 hours on Saturdays, Sundays and bank holiday. The NHS 111 aspect of the service provision operates 24 hours a day, all year round.

Requires Improvement

Are services safe?

We rated the service as requires improvement requires improvement for providing safe services.

Systems, processes and operating procedures were not always reliable or appropriate to keep patients safe.

At our inspection in July 2020 we found:

- Safeguarding was not always given sufficient priority.
- Safeguarding systems were not fully embedded, and senior leaders and managers did not always identify concerns that should be considered as safeguarding or respond quickly enough any concerns raised. There were shortfalls in the system of engaging with local safeguarding processes.
- Substantial and frequent staff shortages increased risks to patients who used the service.
- Staff did not adequately assess, monitor or manage risks to patients and opportunities to prevent or minimise harm were missed.
- Changes were made to services without due regard to the impact on patients' safety.
- Safety was not a sufficient priority.
- There was limited measurement and monitoring of safety performance. There were unacceptable levels of serious incidents, or significant or never events.
- There was little evidence of learning from events or action taken to improve safety.

At this inspection we found:

- There had been some improvements to prioritising safeguarding to minimise risk to patients. However, there continued to be shortfalls in the systems and processes.
- Staff we spoke with were able to identify what constituted a safeguarding concern and knew what actions to take, however, not all staff had completed relevant safeguarding training as per their policy.
- Limited improvement had been made to ensure there were enough staff available to run the service and that the service could respond quickly to changes in patient demand and increase staffing when needed.
- Risks to patients were not adequately assessed, monitored or managed to maintain patient safety.
- Service performance was not consistently monitored in a way that ensured patient safety at all times.
- Limited improvement had been made to ensure learning or actions taken from incidents were understood and acted on by all relevant staff.

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse, but improvements were needed to ensure they were effective and consistent.

- Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. Some staff were still unaware of who the safeguarding lead was for the service but were able to say who they would go to for further advice if needed.
- We reviewed training records and identified that while improvements had been made, not all staff had completed safeguarding training. It was not clear from the records when the training was going to be completed.
- We found gaps in the provision of training provided which the provider considered to be mandatory. Within the records we identified that out of 36 clinical staff based in Somerset, 15 had an up to date and complete training record. We identified that there were shortfalls in ensuring appropriate safeguarding training was completed. Seven clinicians based in Somerset had no record of completing Level three safeguarding training for children. A further 10 clinicians had no record of completing both safeguarding modules.

Requires Improvement

Are services safe?

- After the inspection the provider informed us that clinicians who had not completed relevant safeguarding training were not allowed to work until this had been undertaken.
- Of the 63 clinical staff working in Devon there were 22 who had an up to date training record. A total of 41 members of staff had an average of 5.4 modules which had not been recorded as being completed.
- We reviewed the providers safeguarding policy which stated the clinical staff must complete level three safeguarding training. During the inspection we identified 15 clinicians with no record of completing Level three safeguarding children, this did not align to the providers safeguarding policy.
- The service worked with other agencies to support patients and protect them from neglect and abuse. When needed the service participated in safeguarding investigations. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- We looked at 10 recruitment files and found that one did not have any references, and another had one. The provider's policy stated that evidence of satisfactory conduct in previous employment should be sought in the form of two references. All other required information was contained in the recruitment files. Changes to personnel filing had been made and all personnel files were being uploaded to digital format and a more effective monitoring system.
- The provider had also carried out recruitment campaigns to attract more call handlers and GPs to work in the service. A review had been carried out on why staff chose to leave the organisation. Learning from this work had been applied and included in recruit induction packs.

Infection prevention and control systems and processes were not always effective.

- There were systems and processes for managing infection control at the premises used to provide regulated activities, however some audits had not been carried out due to a staff absence.
- We noted that the risk assessment for a base used in North Devon stated that it was not suitable to be used as a site where patients with or suspected COVID-19 could attend. However, at the time of this inspection this base was still in use and patients with or suspected COVID-19 were visiting the premises. No action had been taken by the provider to mitigate risk. After the site visits the provider informed us this particular base was no longer used for patients who showing symptoms of COVID-19 or were COVID-19 positive.
- Systems to mitigate risk relating to Legionella were not conducted effectively. Legionella risk assessments had been carried out and showed that there was low risk. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The organisation that carried out the risk assessments noted that not all records were made available at one base, and risk assessments had not been kept up to date. From the records we reviewed we found testing results were not always recorded.
- There was a system to manage infection prevention and control. The provider had a policy which was last reviewed in September 2019 and updated in November 2020 to include reference to COVID-19. The policy had a named lead clinician and nurse. The policy set out that all staff should receive training on infection control processes on induction and then annually. Records of infection control training across all bases showed that at the time of inspection there was a completion rate of 73% or above. There were no records of infection control training for the Somerset IUCS (Integrated Urgent Care Service), Devon IUCS NHS 111 team staff, or the shared services team.
- Infection and prevention audits had been carried out at the providers' bases. Improvements had been made to ensure staff and people using the service were protected from COVID-19. At our inspection in July 2020 temperature checks of staff were not carried out in a safe manner. In December 2020, the provider told us that the temperatures of all staff were taken prior to starting work and anyone with a high temperature was sent home and a COVID-19 test was carried out. Staff we spoke with confirmed this.

Requires Improvement

Are services safe?

- During the inspection we saw the bases used to provide the service had suitable one-way systems and appropriate personal protection equipment, such as face masks and hand hygiene stations. Temperature checks were undertaken for all patients. If the temperature of a patient was outside normal limits then arrangements were made for them to be seen at a site, where known or potential COVID-19 cases were triaged and seen face to face.

Premises, facilities and equipment

- Appropriate checks were carried out to ensure that equipment used by the service was maintained appropriately.
- The provider ensured that equipment was safe and maintained according to manufacturers' instructions. Records showed that all relevant safety checks, such as calibration of equipment and portable appliance testing had been undertaken. There were systems for safely managing healthcare waste.
- We reviewed records relating to health and safety risk assessments for 10 of the bases where regulated activities were provided. The risk assessments covered areas such as fire safety, safe storage of medicines, and safe storage of medical gas cylinders, such as oxygen.

Some processes and procedures related to fire safety needed improvement and we found other areas where safety checks had not been completed or the providers procedures had not been followed:

- Fire safety records we looked at showed there were areas which required improvement. For example, at three bases there was no responsible member of staff nominated to ensure fire safety was maintained; there were no records of fire inspections and regular fire drills being carried out at all bases; Staff who worked in Osprey House reported that fire drills and fire alarm testing had been carried out. After the inspection the provider informed us that locality managers were responsible for fire safety at bases. However, no evidence was provided to demonstrate how the locality managers mitigate fire risk through inspection, testing or drills.
- There were arrangements for checking vehicles used in the out of hours (OOH) service to ensure they were properly maintained and safe to use. We noted at four bases non- medical equipment in OOH vehicles was not removed from display when the vehicles were unoccupied, the provider's policy stated that this should occur. External contractors had carried out base inspections and recommended a review of security arrangements for some medical and non-medical supplies and equipment.
- We identified at one of the bases, the defibrillator and emergency equipment was not accessible when a minor injuries unit was closed on weekday evenings. Staff working on site during these hours were unable to access the defibrillator and emergency equipment in an emergency.
- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health (COSHH) and Health & Safety policies, which were reviewed and communicated to staff. However, at one of the bases that we visited COSHH risk assessments were only made available on the shared computer drive. This meant they were not able to be accessed by key staff who did not have access to the computer system and there were no paper copies available.

Risks to patients

The systems to assess, monitor and manage risks to patient safety were not effective.

- Standard core rotas were used and could be produced up to 12 months in advance to assist with workforce planning. These were based on previous activity, in terms of calls received into the NHS 111 and OOH services and the outcomes of these calls, such as home visits by OOH GPs. Predictions for future staffing needs took account of annual leave and sickness.

Requires Improvement

Are services safe?

- Core rotas shared by the provider showed that there were gaps with the number of staff required. The standard core rota for week three showed that between midnight and 2pm on Saturdays and Sundays there were predicted shortfalls in clinical staffing. The provider was aware of where core rotas showed shortfalls. However, they had not taken sufficient action to ensure that when the final rota was produced that these shortfalls were addressed, to ensure there were adequate numbers of staff available to provide care and treatment.
- We analysed performance and rota information supplied by the provider prior to the inspection. We found the performance of the service was impacted during periods where the numbers of relevant staff were below the predicted required levels. During the week commencing 16 November 2020, there were significant health advisor shifts shortfalls between the hours of 11pm to 7am.
- Data shared by the provider regarding 'comfort calls' at weekends showed shortfalls in performance and improvements were still required. ('Comfort calls' are done when there is a delay to care and treatment being provided. This is to make sure a patient's condition has not got worse and informed them of the delay). The most recent data for the 5 and 6 December showing that a total of 487 'comfort calls' were required, with 343 being carried out. Of these 263 were carried out within 30 minutes, which represented 77% of the required calls being made. This did not demonstrate that systems to mitigated risks to patients were fully addressed.
- Staff told us there were arrangements for planning and monitoring the number and mix of staff needed. However, the rota planning team and operational teams were unable to work effectively with each other. At the time of this inspection, only rota planners were able to update the system and they worked core hours of 9am to 5pm on weekdays. This meant that at the weekends and out of hours there could be no real time changes made to the rotas held on the system. Instead paper copies of rotas were completed at each site, and the system updated on the next available working day. Staff said that this had led to misleading information on the number of staff available and working. Such as when a member of staff was already working a shift and was requested to cover another shift at a different site at the same time.
- We were informed by one of the leaders that rota fill for the organisation was driven by available finances, rather than forecasting of staff required.
- Staff we spoke with confirmed that when there were significant rota gaps for bases, patients were advised to attend A&E, or were handed back to in-hours GP practices, as the service was unable to provide care and treatment. On the morning of 7 December 2020, 12 patients in the Somerset area alone, were handed back to their own GP, as there were insufficient clinicians available to carry out home visits. This led to delays in patients receiving safe care and treatment in a timely manner.
- Staff reported that there continued to be times where there were no drivers or clinicians available to make home visits, or staff trained to provide video consultations. We were told that after we carried out an evening visit to an OOH base on 8 December 2020 it closed at 11pm later in the evening as no clinicians were available. The provider told us after the inspection that there were additional resources available if needed to cover shortfalls. They also described how there has never been shortfalls in home visiting resources, which meant patients with an urgent primary care need were unable to be seen.
- Since our inspection in July 2020, the service had analysed attrition rates to understand why staff left the service. In response to trends and themes identified, they reviewed their recruitment process so potential staff members understood what their role in the service entailed.
- There was an induction system for temporary staff tailored to their role.
- There were systems to manage people who experienced long waits, but these were not consistently implemented to minimise the risk of delays in treatment for patients.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment, in accordance with their clinical need.

Requires Improvement

Are services safe?

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Appropriate and safe use of medicines

The service did not have consistently reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, controlled drugs and vaccines, did not fully minimise risk. Improvements were needed to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately. This had also been highlighted for action by an external contractor who had carried out base inspections and produced a report with recommendations to this effect. During our review of the vehicles at the time of inspection we did not see any specific concerns related to storage of medical and non-medical supplies. Concerns were raised by staff to us about appropriate storage facilities in out of hours vehicles, in particular those for controlled drugs.
- The provider had processes for weekly and monthly checks of bags and equipment carried in vehicles used to support out of hours medical care. We found that stock held within care bags aligned to the provider's policy. However, we found high amounts medicines being carried and there was no system to track when medicines had been used or were missing. This meant the provider's system to monitor medicines may not identify if medicines were missing or unavailable when needed.
- Following the inspection, the provider told us that higher stock levels in some areas were designed to enable patients to be provided with appropriate care throughout a busy weekend shift.
- The service kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Palliative care patients were able to receive access to pain relief and other medicines required to control their symptoms. However, systems to ensure special notes were placed on patient records were not effective and updated information was not added in a timely manner to ensure that appropriate care and treatment could be provided.

Track record on safety

There were risk assessments in relation to safety issues, however, these were not consistent. Improvements were needed to maintain safety at all times.

- At our previous inspection in July 2020, the systems used by the provider meant calls were being downgraded from urgent to routine by the computer systems when transferred from the NHS 111 service to OOH. This was identified as a continued concern at our inspection in December 2020 and patients were still at risk of not receiving timely care and treatment. There was a risk that urgent call backs, would go into a queue as routine and therefore timeframes for the urgent call backs would be missed. Staff were aware of this and would monitor both computer systems, but said it was not easy to find information on the system used in the OOH.

Requires Improvement

Are services safe?

- The service monitored and reviewed activity but did not use the information effectively to understand risks to give a clear, accurate and current picture that led to safety improvements and ensure patients received safe care and treatment at all times.
- Joint reviews of some incidents were carried out with partner organisations, including the local hospital trusts and the clinical commissioning group.

Lessons learned and improvements made.

We were not assured that systems to monitor and review safety to ensure patient safety were managed effectively. Learning was not always recorded, shared and acted on.

- There was a system for recording and acting on significant events and incidents, but improvements were needed to ensure patient safety was maintained. Staff understood their duty to raise concerns and report incidents and near misses but told us that they did not always receive feedback or learning points from leaders and managers.
- The service used a weekly staff newsletter; a medical director weekly clinical update and emails to share learning from incidents. We reviewed a sample of these and saw that the weekly staff newsletters did not contain any information on learning from significant events.
- Documentation provided by the service showed there were three significant events since the previous inspection and five incidents of moderate harm. In some instances, system reports had not been included on the service's significant event register.
- We reviewed a sample of incidents which had been identified by the service. There were categories of the type of incident which ranged from 'low or no harm to catastrophic' in terms of impact on patients.
- A review of 15 low harm incidents showed that there was no set deadline for these concerns to be investigated and appropriate actions taken. We reviewed the records of an incident, which met the criteria for further investigation. The actions we saw stated information should be requested for the NHS 111 service clinical lead to carry out an internal review and provide feedback to the individual concerned. There was no evidence that this was completed in the records we reviewed.
- We noted further incidents required a discussion with the clinician about how they had handled a patient's care and relevant documents recorded. From the records we reviewed there were no records of the discussions or learning identified to monitor themes occurring.
- Examples of moderate harm included a case where there was a delay of over four hours for an urgent home visit to be carried out. The home visiting GP said they did not have the capacity to carry out the visit and that the urgent visit had been downgraded, even though there was no evidence to confirm this within the provider's investigation records. The delay was not identified until a relative of the patient contacted the service again. This resulted in significant delay to the provision of care and treatment and an emergency ambulance was called. We did not see evidence that this incident could also be considered as a safeguarding concern by the service.
- There was a lack of clarity on how an incident was categorised for the level of harm to a patient and whether a complaint should also be determined as a significant event. We reviewed the Datix system and found incidents logged by the provider were not found on significant events or complaints systems. This meant there was no investigation or actions or shared learning. We found five examples of this. The service learned from external safety events and patient safety alerts. The service had a mechanism to disseminate alerts to all members of the team including sessional and agency staff.

Inadequate

Are services effective?

We rated the service as inadequate for providing effective services.

At our inspection in July 2020 we found:

- Patients were at risk of not receiving effective care or treatment. There was a lack of consistency in the effectiveness of the care, treatment and support that patients received.
- Not all staff had the right qualifications, skills, knowledge and experience to do their job.
- Performance measures for the service were below expected targets when compared with similar services.

At this inspection we found:

- There continued to be risks of patients not receiving effective care or treatment. There were continued shortfalls in ensuring that care, treatment and support was provided effectively.
- Training for staff had improved, but there were still shortfalls identified in some areas.
- Staff did not benefit from having regular appraisals or supervision sessions, to enable them to develop their skills.
- Performance levels had shown signs of improvement and were now in line with national performance levels but were below expected contracted targets. (Due to the pandemic commissioning bodies were accepting service level performance to be in line with national performance, rather than the defined national targets).

Effective needs assessment, care and treatment

- Telephone assessments were carried out using a nationally defined operating model. However, shortfalls in the telephone assessment audit programme were identified and opportunities to drive improvement and share learning were sometimes missed.
- Information received at the time of inspection showed that there were some gaps in all audits being carried out as needed to demonstrate that staff were monitored appropriately. A total of 216 clinical advisor audits were needed, of these 171 were Tier 1 and 45 were Tier 2. A total of 39 clinical advisors were not eligible for auditing. Only 57 audits were carried out, of these 55 clinical advisors achieved the required standard. There was a total of 125 audits which had not been carried out.
- Results for service advisor audits carried out in the same period showed that there were a total of 112 audits needed, of these 96 were completed, with 83 members of staff achieving the required standard. There was a total of 16 audits which had not been completed. The number of staff whose calls need to be audited varies from month to month.
- Trends and themes identified included incorrect pathways being selected and inadequate worsening advice being given. Additional support was provided for staff to enable them to meet the expected targets.
- There was limited auditing of clinical decision making of some staff, including non-medical prescribing. Specifically in relation to assurance of clinical staffs performance and competency. The provider was unable to demonstrate how it ensured the competence of staff employed. The provider said they had a rolling audit programme of 1% of clinicians notes and feedback was provided. However, some clinical staff reported that they had not had their clinical records formally audited to ensure they contained all relevant information.
- The provider was unable to demonstrate how the information was used to identify where improvements might be needed, so that patients experienced a safe and effective service. We reviewed quarterly performance reports on clinicians performance. The reports did not provide sufficient information for clinicians to review and identify learning. We spoke with one clinician and they told us they were unaware of their own productivity in management of calls and had never been told performance times needed to be improved.

Inadequate

Are services effective?

- Following the inspection, the provider told us that clinicians working within the Out of Hours service are all provided with a quarterly summary of their performance. Where performance is below the level required, the clinician was required to meet with the Medical Director or Associate Medical Director to discuss their performance and agree appropriate actions to be taken. Additionally, focussed audit work was undertaken to ensure that the necessary improvement has been completed. CQC has not been able to test the effectiveness of this process.
- Patients' needs were assessed, in accordance with the operating model. This included their clinical needs and their mental and physical wellbeing. Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs in line with the outcome of the assessment operating model.
- Calls were audited in line with the NHS Pathways license for clinical and non-clinical call handlers. There were clinical auditors who monitored clinicians' call handling. Learning from these audits was also shared with staff when relevant. The non-clinical call auditors also identified trends of 'common fails' such as not giving self-care advice and not giving information on if a patient's condition worsened. These were then highlighted to all staff via meetings and newsletters.
- Any learning or development needs were identified, and additional support provided to enable staff to meet the expected targets.
- Information received at the time of inspection showed that there were some gaps in all audits being carried out as needed to demonstrate that staff were monitored appropriately.
- The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.
- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

- The provider was required to submit call data each month to NHS England and Improvement (NHSE/I) to show the efficiency and effectiveness of providing the NHS 111 Service and the Out of Hours (OOH) service.
- A situation report was sent to NHSE/I and Somerset and Devon Clinical Commissioning Groups (CCG), on a weekly basis which recorded details of how many calls were received; dispositions made; length of call time and whether call backs had been made within 10 minutes when needed.
- If needed the service could monitor service performance on a daily, weekly and monthly basis. In the Clinical Assessment Service (CAS) centres there were TV screens which showed call volumes and alerts of incoming calls. Information on average wait time to answer and calls abandoned was displayed, and the number of advisors available to take calls.
- There was a clinical lead available in the OOH service during the day at weekends and bank holidays, who monitored the triage queue. Staff reported that the lead clinician was not always available for urgent queries, such as needing to upgrade a case to get prompt treatment for a patient. Staff said this was due to lead clinicians taking on complex telephone enquiries.
- Some of the staff said that they were not aware of Think 111 which had been introduced to the service in early December 2020. (Think 111 is a newly implemented initiative for NHS 111 services, where patients are asked to use NHS 111 services first if their condition was not life threatening). This had caused confusion over some of the revalidations for emergency departments, as staff were not confident this was the correct outcome for patients.
- There was a risk to the timely care and treatment of patients, when case information was transferred from the 111 system to OOH CAS system. During the transfer of information, the case prioritisation was changed automatically and could be reduced from urgent to routine. This may lead to a patients' care and treatment being delayed.

Inadequate

Are services effective?

- Following the inspection, the provider told us that all calls were managed safely and in a timescale that was shorter or inline with NHS 111 response times. They also confirmed that from January 2021, they had changed the response times to align to the nationally agreed integrated urgent care service targets for both Somerset and Devon systems. Whilst this mitigates the risk identified during the previous two inspections, CQC has not been able to corroborate the suggested improvements.
- Clinicians told us that at times management of the clinical queue was a challenge. During the time we were speaking with them, there were 27 cases awaiting call-backs in the CAS queue, which was manageable for the number of clinicians available at that time. There were nine GPs and one advanced nurse practitioner on shift. One clinician said that they usually undertake three cases per hour but was not aware of any escalation processes if numbers of cases waiting increased.
- There was consideration given to increasing the number of lead clinicians at the CAS at Osprey House and Ashford to assist with clinical queue management, but this had not been implemented at the time of inspection.
- When a CAS navigator was on shift, they would monitor the calls queues for both services and if needed re-prioritised calls to a clinician.

We reviewed NHS 111 service performance data for the period 1 October to 7 December 2020. Improvements in Devon Doctors performance has been seen since July 2020. Between July 2020 and November 2020, there were still some significant periods where performance was not in line with national integrated urgent care service targets. Following the inspection, the provider asked us to consider the more recent performance. From December 2020, performance data was more consistent and in line with national and regional averages.

At the time of inspection:

- The average percentage of calls answered within 60 seconds of the number of calls answered ranged between 51.2% and 96.88% (the target was 95% or above).
- The percentage of calls abandoned (after waiting 30 seconds) ranged between 23.87% and 1.11% (the target was less than 5%).
- The NHS 111 service had calls where a call back within 10 minutes was required. Figures showed that the proportion of patients who received a call back within 10 minutes ranged from 2.38% to 18.41%. (the target was 95% or above).
- The NHS 111 service was not consistently meeting standards for 'warm transfers' with a range of 1.27% to 18.41% of calls identified being transferred (the standard expected is more than 95%).

Data seen on 7 December 2020 at 3.28pm showed:

- A total of 88% of calls were answered within 60 seconds; 5% of calls were abandoned after 30 seconds and the longest wait time to answer was 27.34 minutes at 9am that day.
- Urgent ambulance and emergency department revalidations were undertaken by the NHS 111 service to ensure they were appropriate. Data received from the provider showed that ambulance re-validation were consistently occurring and were above the target of 50%. Data for the period 1 October 2020 to 7 December 2020 showed that all ambulances had been revalidated within the appropriate timescale.
- The service did not have a comprehensive programme of quality improvement activity and did not routinely review the effectiveness and appropriateness of the care provided. A revised clinical audit plan had been developed in November 2020 but had not been put in place at the time of inspection. Prior to November 2020 audits that had been undertaken were ad hoc. We saw evidence that an end of life audit had previously been completed, but it did not include an action plan of next steps for the service.

Effective staffing

Inadequate

Are services effective?

Staff had the skills, knowledge and experience to carry out their roles, however records of training showed there were gaps in training provision.

- Staff told us they did not consider there was enough encouragement given around further opportunities to develop in their professional roles.
- The provider did not provide staff with ongoing support. Although there was a policy on appraisals and supervision for staff, this had not been put into place. Staff said that they had not received appraisals and one to one supervision sessions were not routinely carried out.
- All staff who had a professional qualification had undertaken relevant revalidation processes.
- The provider had an induction programme for all newly appointed staff. Staff told us that the time allocated for induction as stated in the providers policy did not always provide sufficient time to adequately prepare staff for the role they undertook and they did not consider they were fully prepared to undertake the role when they started to take 'live' calls.
- Following the inspection, the provider told us that NHS England/Improvement pathways team had reviewed the induction programme and no improvement suggestions were made. The provider had planned on carrying out induction programmes; one face to face and one virtual to assess how effective they were in preparing staff for their role. This was delayed due to staff availability to provide the training.
- A health advisor's training pack covered topics such as manual ambulance dispatch, ambulance and emergency department validation, finding a GP, failed contact and challenging callers.
- Health advisors who used NHS Pathways to triage calls, had completed training in line with NHS Pathways requirements. This included core training, consolidation of learning and shadowing 'live' calls before being signed off to take 'live' calls independently.
- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.
- Records of skills, qualifications and training were in place. However, the provider did not consistently follow their own policy. For example, all staff should have received infection control training, but this had not been completed.
- Risks to staff were not fully addressed, out of hours car drivers told us about managing conflict and aggressive behaviours whilst out on visits and the need to have training on this specific area. This concern had been identified in February 2020, but no action had been taken to provide appropriate training, the provider's policy stated that the service would take steps to provide information, training and instruction on significant hazards and risk associated with their work.
- Following the inspection, the provider told us that training for managing conflict and aggressive behaviours was available through their training tool and relevant staff have access to complete the training. We were not told about when this was implemented and how many staff had completed the training following the inspection.
- The approach for supporting and managing staff when their performance needed improvement was not effective. The provider's system relied on clinicians determining whether their own performance was below average in comparison to other clinicians and taking action themselves to improve productivity. The provider used the Royal College of General Practitioners clinical audit tool and reports were produced to show the number of consultations a clinician carried out per shift and average telephone call times.
- Some clinicians said they were given data on the time it took to perform tasks, there was no follow up if any concerns were identified, when compared with their peers.
- The medical directors update stated that actions were to monitor and identify individuals and to work with them to support and improve performance. The provider said that where clinicians fell below the necessary standard they were required to meet with the medical director or associate medical director and a performance improvement plan would be developed and monitored. Where a clinician did not have improvement to make there was no direct one to one contact made. We did not see evidence to verify this had occurred or to test how effective the process was.

Coordinating care and treatment systems and processes were not always effective.

Inadequate

Are services effective?

- Other allied health professionals such as the ambulance service and district nurses had a direct line to speak with a clinician. The expectation was these would be responded to within 30 minutes, as in some cases a paramedic could be waiting with a patient to receive advice. Staff told us this was not always achieved.
- The way the service was organised meant that there were multiple stages some patients had to go through before they received care and treatment. For example, a patient could speak with a service advisor, a health advisor, a clinical assessor before being referred onto the CAS.
- Outcomes from triaging data we reviewed indicated that up to 50% of clinical call backs needed were urgent, which when compared to the expected outcomes was high. This could potentially result in a delay to effective care and treatment for patients. The provider had started working on changing performance measures for this indicator. The indicators in use at the time of this inspection only had two outcome measures of urgent or routine. A more sophisticated measurement was being put into place, which allowed for more accurate outcomes timeframes to be put into place.
- The provider had not always taken appropriate action to ensure urgent cases were appropriately identified and managed effectively. The National Quality Requirements (NQR) 12 standard for patients attending urgent face to face appointments of within two hours was not consistently met. In some cases, delays were attributed to appointments being booked within the specific timeframe, but patients were not always called in for their appointment on time. A senior leader told us they had identified that clinicians had not been trained to accurately code on how soon a patient should be seen, and to include details on whether it was urgent or not. At the time of the inspection the provider was unable to demonstrate that appropriate action had been taken to provide clinicians with this training.
- Coordinated care was not always efficiently planned, with clinicians being allocated home visits, when another clinician was nearer to the patients address.
- Patients under five years old and those over 80 years of age had specific assessments undertaken.

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- The service had formalised systems with the NHS 111 service with specific referral protocols for patients referred to the service. An electronic record of all consultations was sent to patients' own GPs.
- Issues with the Directory of Services (DOS) were resolved in a timely manner. All DOS issues were managed by a dedicated team and staff were made aware of changes.(The Directory of Services contains information on local and national services which patients can be referred or signposted to for further care, treatment or advice, such as pharmacies and walk-in centres).

Helping patients to live healthier lives

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

- The service identified patients who may need extra support.
- Where appropriate, staff usually gave people advice so they could self-care. Systems were available to facilitate this.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

- The service did not have a policy on the Mental Capacity Act (MCA) 2005, training was provided for employed staff on the MCA 2005, but there were no checks to see if it was used and recorded on patient records. After the inspection the provider informed us a separate MCA 2005 policy had been developed and put into place, as the relevant information had been contained in other policies. We will check this at our next inspection.

Inadequate

Are services effective?

- Audits of clinicians' records were carried out, which included checking for patient's consent, however, results from all the audits undertaken were not collated to provide an overall view of the performance of clinicians, to enable any shortfalls to be identified. Clinicians said that they did not always receive feedback on audit activity.
- The message greeting callers for the NHS 111 service alerted that continuing with the call showed that they gave consent to discuss their concerns with a call handler. When needed consent was also recorded on the computer system, for example when passing the call to a clinician or the caller was not the patient.
- Access to patient medical information was in line with the patient's consent.
- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

Business continuity

- There were business continuity plans and staff had been trained to deal with major incidents. The provider had escalation plans for all the services they provided. However, we noted policies were not always reviewed in a timely way, there were discrepancies in these plans and a lack of evidence to demonstrate that testing of operations had been carried out.
- Following the inspection, the provider advised us that electronic copies of the policies they had provided us were available on share point and the review dates were set for dates in 2021. We will review this at our next inspection.

Requires Improvement

Are services caring?

We rated the service as requires improvement for caring.

Staff treated patients with compassion, however there were shortfalls in making sure that call backs were carried out in a timely manner and patients were fully involved in decision making.

Kindness, respect and compassion

Staff usually treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients support and clear information. There were arrangements and systems to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs. Training was provided on respecting and involving patients in their care.
- Call handlers demonstrated a compassionate and caring manner whilst taking calls, appropriate reassurance was provided when needed during calls.
- We received feedback from the local Healthwatch service from a survey they carried out between 5 October 2020 and 20 November 2020, about the NHS 111 service provision, results showed that the accuracy and quality of the service patients received was not consistent.

A total of 186 patients from Devon, Plymouth, Somerset and Torbay completed the survey.

Key messages were:

- 41% (76) of patients rated their experience of using the NHS 111 service as 'very good'.
- 24% (44) of respondents waited longer than three hours for an arranged call-back.
- 20% (38) of patients never received an arranged call-back.
- 76% (141) of patients said that their call was answered in a timely manner.
- The most common response to the question: 'In your opinion how could the NHS 111 service be improved?' was 'improved training for call operators.'
- 8% (12) of patients said that they had to call 999 or visit an emergency department due to inadequate responses from the NHS 111 teams.
- 8% of comments to the question: 'Is there anything else you would like to tell us?' said that calling NHS 111 was quicker or better than access to their registered GP surgery.

The provider carried out their own patient experience surveys, headline results for the period 1 January 2020 to 4 December 2020 showed:

- 90% of patients understood the call handler
- 90% of patients were reassured and listened to.
- 95% of patients understood the information about what would happen after the call ended.
- There were mixed comments about the attitude of staff, with some comments saying that clinicians were rude.

Positive aspects of the survey included when patients were asked what they liked about the NHS 111 service a total of 155 patients responded to this question and almost half of the comments were about the good attitude of staff including words such as 'helpful, polite, friendly and professional.

Involvement in decisions about care and treatment

Requires Improvement

Are services caring?

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas of bases informing patients this service was available. Information leaflets were available in easy read formats on request, to help patients be involved in decisions about their care.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved as needed. However, on occasion we saw that wishes of relatives were placed above those of a patient, for example when determining whether a patient required admission to hospital.
- Staff signposted patients and their carers find further information and access community and advocacy services.

Privacy and dignity

The service did not consistently respect and promote patients' privacy and dignity.

- We reviewed the provider's information governance policy and found that information contained within the policy referenced when staff should consider the need to report data protection breaches to the Information Commissioners Officer. There was a lack of understanding and need to investigate and report such matters.
- Patients' confidentiality was not consistently respected by staff. Two separate incidents of potential data breaches were reported in October 2020, one direct to the provider and one to the Care Quality Commission (CQC). The concerns involved a member of staff who worked for the service using patient contact details received during calls to contact them outside of the work environment without their consent. The concerns reported to the provider were investigated internally, but not reported to the police or Information Commissioners Office (ICO). The concerns received by CQC were reported to the police and ICO by the provider following intervention from CQC.
- Staff did not always support patients to make decisions. Records showed family members were consulted about care and treatment, however it was not always clear whether a patient had been fully involved in these discussions. The service did not have a system to demonstrate that they monitored the process for seeking consent appropriately.

Requires Improvement

Are services responsive to people's needs?

We rated the service as requires improvement for providing responsive services.

There were shortfalls in ensuring that patients received timely access to the services provided and patients were informed of any delays to care and treatment.

Responding to and meeting people's needs

Out of Hours (OOH) services and the NHS 111 Service have been set up to respond to calls received by the provider. Services have been designed to respond to patients' needs for a short period and complete any care or treatment needed or refer patients to other health and social care services, if needed.

- The service had a system that alerted staff to any specific safety or clinical needs of a person using the service. If these special notes were missing, such as end of life care directions, these were put into a specific book for action. However, staff told us there was a delay in this process being followed as changes to the team responsible had led to the process becoming less effective. Patients were at risk of not receiving appropriate care and treatment due to this.
- The provider was aware of different communication, mobility and cultural needs and where possible organised and delivered services to meet patients' needs.
- The NHS 111 service used NHS Pathways, which were regularly updated to ensure the most recent Pathways were used and the Directory of Services was current.
- The facilities and premises were appropriate for the services delivered, apart from one base which was not recommended to be used for patients who were COVID-19 positive or potentially had the virus and was still in use at the time of this inspection.
- The service made reasonable adjustments when people found it hard to access the service. Consulting rooms were usually on the ground floor and there was level access to buildings whenever possible.

Timely access to the service

Patients were able not always able to access care and treatment from the service usually within an appropriate timescale for their needs. Patients with the most urgent needs did not always have their care and treatment prioritised.

- The OOH service operated from 6pm to 8am Monday to Friday; and 6pm to 8am, over the weekends (Friday evening to Monday morning); and over all bank holidays. The NHS 111 service operated 24 hours a day, 365 days a year.
- Patients could access the out of hours service by calling the NHS 111 service. The service did not routinely see walk-in patients, but arrangements were in place should patients arrive without an appointment. There was a 'Walk-in' policy which clearly outlined what approach should be taken if this occurred. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.
- Patients were seen by appointment only in OOH, at the time of our inspection, in response to COVID-19 all patients who required a face to face appointment were also triaged first by a clinician over the telephone. This was to determine whether other actions could be taken which were more appropriate, such as attendance at a minor injuries' clinic or alternative 'walk-in' services.
- The service had a system to facilitate prioritisation according to clinical need whereby more serious cases or young children could be prioritised as they arrived at bases. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response. Reception staff called patients into the premises when it was their time to see a clinician.
- Where necessary patients were referred to specific sites if they were displaying symptoms of COVID-19.

Requires Improvement

Are services responsive to people's needs?

The provider did not have an effective system to ensure home visits were conducted in a timely way.

- When needed home visits could be arranged for patients. However, prior to this inspection the service had received complaints about delays to home visits. We had also independently received reports of home visits not being completed during the out of hours period and were handed back to in hours GP services to complete, this meant there was a delay to care and treatment for patients.
- Following the inspection, the provider told us they prioritised home visits for vulnerable patients. Sometimes cases were passed back to GP practices but these were patients who have been triaged and assessed as low risk. However, the provider accepted that improvements were needed.
- Information received from the provider showed examples of home visits which were delayed or not undertaken included 13 visits booked for the Yeovil/Ashford area on the 5 December 2020. Six of which were not carried out within the required timescale; with some visits not being made until almost seven hours after the appointed time. On 6 December 2020, there were five home visits booked for the Bridgwater vehicle which were not carried out within the allotted timescales. The provider explained the main reason for the delay was due to low capacity of clinicians available. However, we also noted that delays to some visits were due to a more urgent visit needing to take priority.
- There was a lack of clarity on why travel times had resulted in delays to home visits. The geography covered by the OOH GPs was mixed between urban and rural areas which could involve long journey times. Home visits were booked in by the Out of Hours (OOH) Service and usually planned to take account of travel times and the rurality of some of the locations.
- Improvements to the categorisation of home visits was being reviewed by the provider at the time of inspection. Leaders told us they were focussing on the provision of home visits, as they recognised that these patients were often vulnerable. A pilot system to revalidate (this means to see that they are clinically required) urgent home visits by the lead Integrated Urgent Care Service clinician had been initiated to improve on this.
- When patients did not arrive for an appointment or they could not be contacted for a telephone consultation, there was a process to ensure their wellbeing and safety. If needed the police were called or a home visit was carried out. Situations where a patient could not be contacted were only closed following a review by a clinician.

Systems to manage patients waiting a long time for an assessment or treatment and to support people while they waited, were not always effective.

Comfort calling

- The provider introduced a process in September 2020 to 'comfort call' all patients in the NHS 111 service's triage queue during the day at weekends and bank holidays. These were patients who had been waiting for more than two hours for a clinician call-back. This was to ensure that that a patients' condition had not worsened and to advise them of the delay. If their condition had worsened this was escalated to the lead IUCS clinician for assessment. It is expected that 'comfort calls' are only required when a service is under pressure and not a routine occurrence.
- We reviewed the providers call back and home visiting performance and found that there were still some issues which had not been fully resolved from our previous inspection in July 2020.
- Information from the provider showed that for the three weekends prior to 7 October 2020, there were shortfalls in ensuring all comfort calls were made. On one weekend a total of 500 comfort calls were needed, of these 21 calls were not made.
- The most recent data for the 5 and 6 December showing that a total of 487 'comfort calls' were required, with 343 being carried out. Of these 263 were carried out within 30 minutes, which represented 77% of the required calls being made. This did not demonstrate that systems to mitigated risks to patients were fully addressed.
- 'Comfort calling' was introduced in October 2020 for patients awaiting a home visit. The visiting clinician would call the patient if the timescale for the visit would not be met. This enabled the clinician to triage the patient and escalate concerns if needed. At the time of this inspection the service was developing a method of recording these calls.

Requires Improvement

Are services responsive to people's needs?

Service performance

- Information about service performance was reviewed and collated. We noted there had been improvements in performance for the NHS 111 service in Devon. There had been a drop in performance below national averages during the period 1 October to 30 November 2020, but recent figures from 1 December 2020 to 6 December 2020 showed that the service was performing in line with national performance averages for calls answered in 60 seconds.
- For the same period there had been an improvement in the last week of November 2020 to 6 December 2020 for the percentage of calls abandoned where the NHS 111 service was starting to be in line with national performance averages.
- The provider had identified that outcomes resulting in the need for an emergency ambulance were above expected and the service was in the process of auditing disposition which resulted in the need for an emergency ambulance. Information we looked at for the month of November 2020 showed there was a total of 4810 dispositions, of which 2678 were deemed to be category 3 or 4, which meant an ambulance was needed within 120 or 180 minutes. Of these 2504 were revalidated and 198 were upgraded to a higher category and 1452 were downgraded to a lower category. (The target for this indicator is 50% or above for revalidation which the service met).

Information from a Healthwatch survey.

After our inspection in July 2020, Healthwatch Somerset (HWS) and Healthwatch in Devon, Plymouth and Torbay (HWDPT) worked in partnership with the CQC and invited members of the public to tell them what they think of the services provided by Devon Doctors Ltd. CQC worked in line with the Healthwatch teams in Somerset and Devon to undertake a survey on the 111 service in both areas. This was completed between 5 October 2020 and 20 November 2020. A total of 186 patients completed the survey during this time. Some of the feedback relates to the Somerset NHS 111 service provision, which was not inspected. Devon Doctors has the overall responsibility for this contract.

Results showed:

Less than a fifth of callers, had their needs resolved by the NHS 111 service over the phone.

- 56% of patients were passed to another service.
- 25% of patients contacted another service themselves.
- One comment received by Healthwatch and quoted in their public report said: '*There was a huge wait for the call-back and subsequent visit. I was told one hour for the initial call back and waited four. I then waited over another eight hours for the GP to visit - gone 2am on Sunday morning at this point.*

Information from the provider's patient experience survey for the OOH service showed: the total of respondents was 1806.

- 52% of patients who responded were told when a clinician would arrive, the service only informed 19% of these patients of a delay.
- 66% of patients who responded were given a timeframe for them to receive a call back from a clinician; of these 58% were called back within the stated timeframe.
- Referrals and transfers to other services were undertaken. Details of patients who had contacted the NHS 111 service were sent to their GP by 8am the following morning and referrals to other services such as social services were made via secure information systems.

Positive comments received included patients being understood ,reassured and listened to.by call handlers. A total of 69% of respondents considered that the time taken for the call to be dealt with and passed to a clinician was excellent. A total of 95% of respondents understood the information about what would happen after the call.

Requires Improvement

Are services responsive to people's needs?

Listening and learning from concerns and complaints

There were delays in responding to complaints and concerns. Information from complaints was not consistently used to improve the quality of care provided.

- Information about how to make a complaint or raise concerns was available.
- The service had received 26 complaints since our inspection in July 2020. The complaint policy and procedures informed complainants of the process that would be followed. However, there was no information on how long their investigation would take and when a complainant would receive a final outcome letter. Information contained within complaints records showed that the provider usually aimed to respond with the final outcome within 50 working days. We saw that there were delays in responding to complainants. The provider was unable to demonstrate why this occurred or how they had considered making improvement.
- We reviewed 10 complaints in detail and found that they were not consistently handled in a timely way in line with the provider's policy. For example, one concern received via social media in August 2020 related to chest pain and a delay in receiving a call back. This concern was not fully investigated until October 2020, and not within 50 days as stated in the provider's complaints policy.
- The service was not always able to demonstrate how lessons learned from individual concerns and complaints were put into place. The provider's policy stated that learning would be shared via emails and newsletters to staff, and during one to one supervision sessions. However, there was no process to ensure that the information had been received read and acted upon. Staff said they did not always read emails and staff newsletters. Recent newsletters provided to us did not contain any information about learning from complaints. Staff reported that they did not receive supervision sessions on a regular basis.
- Documents we reviewed showed that themes, trends of concerns and complaints were recorded. For example, delays to receiving 'comfort calls' when care or treatment was delayed; or addressing concerns around staff attitude. However, there was limited analysis or evidence of actions, to ensure that the risk of similar situations occurring again were reduced as far as possible.

Inadequate

Are services well-led?

We rated the service as inadequate for leadership.

At our inspection in July 2020 we found:

- The approach to service delivery and improvement was reactive and focused on short-term issues.
- The strategy was not underpinned by detailed, realistic plans and objectives to deliver a high-quality sustainable service.
- Staff did not understand how their role contributed to achieving the strategy.
- The sustainable delivery of quality care was put at risk by financial challenge. There was limited understanding around the importance of culture.
- There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported or appreciated. There was poor collaboration between teams and areas of conflict.
- When staff raised concerns the culture, policies and procedures did not provide adequate support for them to do so.
- There was a limited approach to sharing information with and obtaining the views of staff. The arrangements for governance and performance management were not fully clear and did not operate effectively.
- Risks, issues and poor performance were not always dealt with appropriately or quickly enough.
- The risk management approach was applied inconsistently.
- The service did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they start to be addressed.

At this inspection we found:

- There was a strategy, but it had not been developed sufficiently to ensure that a high-quality sustainable service could be provided consistently.
- There was continued insufficient challenge and scrutiny from the Devon Doctors Executive Board.
- Governance arrangements did not support the delivery of a safe, effective and well led service in a consistent manner.
- Whilst we found some improvements had been noticed by staff in the visibility of the leadership team shortfalls in communication between senior leaders and staff groups remained, and limited progress had been made in engaging staff to gain their views about how the service was being delivered
- Systems and processes to manage risk were still applied inconsistently and learning was not always shared effectively and acted upon. There was a lack of clarity on how significant events and risk were identified and managed.
- The level of concerns identified by the Care Quality Commission, at the July and December 2020 inspections, demonstrated leadership teams lack of understanding in regards to achieving and maintaining compliance with the regulations of the Health and Social Care Act 2008.

Leadership capacity and capability

- At our last inspection in July 2020 we identified challenges with leadership capacity and skills; an action plan was put into place to respond. Although there was an action plan to meet the regulatory improvements needed from our previous inspection in July 2020, insufficient progress had been made to ensure there was high-quality, sustainable care provided. There were shortfalls in demonstrating that actions taken had addressed systemic issues within the organisation.
- During this inspection we found that insufficient progress had been made, against the areas identified at our July inspection, which meant that there were still risks to ensuring that a safe and effective service was delivered.
- There had been no changes made to the board of Devon Doctors, since our previous inspection. The board consisted of mainly GPs and constructive challenge on service performance was limited. The board lacked external oversight and scrutiny.

Inadequate

Are services well-led?

- There had been significant changes in the management structure since our previous inspection, but some staff we spoke with considered that there were too many senior leaders and insufficient middle managers to support staff who worked on the frontline. Staff said that at times they were unable to access manager support in a timely manner.
- The provider recognised that there were weaknesses in the operational leadership and sought external support from the clinical commissioning groups in November 2020. An improvement programme had commenced, but at the time of inspection we were not assured that the changes were embedded or sustainable.
- Since our inspection in July 2020, the service had appointed a new registered manager. Improvements were needed to ensure that all leaders and staff who worked in the organisation were aware of the need to understand and comply with the Health and Social Care Act 2008 regulations; to ensure the health, safety and welfare of patients at all times.
- Sufficient support and time had not been allocated for the registered manager to carry out their role and have proper oversight of how the service was meeting the regulations.
- Senior management were accessible via an on-call system that staff were able to use. However, staff reported a disconnect between leaders and frontline staff. Efforts had been made by the provider for senior leader to visit bases, but these were time and place limited.

Vision and strategy

- The service had a vision and strategy to deliver high quality care and promote good outcomes for patients. The provider acknowledged that improvements were needed to ensure the vision and strategy were understood by all staff. Some improvements had been made with developing the vison, values and strategy jointly with patients, staff and external partners, since our inspection in July 2020.
- Improvements were needed to ensure that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values. At the December inspection, staff continued to report that they were not always consulted about the strategy and able to make suggestions to improve how the service was operated.

Culture

Improvements were needed to develop a culture to support the delivery of high-quality sustainable care.

- Cultural improvements were apparent at the time of this inspection. However, culture changes and improvements needed time to embed. At the time of inspection, it was too early to assess the effectiveness of the changes made.
- Staff did not always feel respected, supported and valued. Staff told us there was still a disconnect between frontline staff and managers. Staff considered there had been improvements in the Call Assessment Service (CAS) bases and they said the introduction of a lead Integrated Urgent Care Service (IUCS) clinician at weekends was a valuable addition to support available. However, staff said there were still issues with getting advice promptly.
- Staff who told us that they had experience of working in the 111 service said they felt that senior leaders lacked the knowledge to run a 111 service. These people also said they were frustrated that their experience was not considered when making change and improvements were needed. One such example related to the different IT systems being unable to 'communicate with each other' to that all relevant information could be passed between the NHS 111 service and the Out of Hours (OOH) provision which would mitigate risks in the patient pathway.
- Staff also considered that senior leaders took a reactive approach to making changes and would instigate change when other agencies identified areas for improvement, this included the inspection report produced by CQC in August 2020 and contract monitoring activities by the clinical commissioning groups.
- Openness, honesty and transparency were not always demonstrated when responding to incidents and complaints. We asked the service about how it managed duty of candour and access to external scrutiny, to ensure decisions

around handling of concerns were independently verified. A member of staff informed us that they would share examples with another GP practice, which did not provide a direct comparator; undertake a review with another data protection officer from another organisation and with one of the CCGs; and share strategic learning through an Information Governance Network. However, there were no records maintained by the provider to demonstrate this.

- We noted that leaders and board meetings had discussed the skill mix of the organisation and recognised the need to use allied health professionals more, this was in the early stages of development.
- Evidence we identified demonstrated that efforts had been made to improve staff morale and this included the introduction of wellbeing areas in CAS bases. This provided a space for staff to access information on wellbeing and have a quiet space to reflect.

Governance arrangements

- A member of the leadership team told how the clinical commissioning groups (CCG), who commissioned the service, were not always assured around the governance processes that were operating. Work undertaken with the CCGs had identified eight areas where improvements were needed, this included monitoring of moderate and minor incidents. At the time of this inspection improvement work had not been started.
- The provider had a number of committees to monitor service provision. We found there was a lack of clarity on how these committees worked together to ensure risks to patients were mitigated; how performance data was used to drive improvements and how the provider could assure that significant events and complaints were handled and learning was identified and action taken when needed.
- Since our inspection in July 2020, there had been limited improvements in the provider's system for managing significant event and complaints. There was a continued lack of clarity on how significant events were classified and limited evidence to demonstrate that all actions following an incident had been completed. Not all incidents reported on the Datix system were considered or investigated as significant events.
- The polices related to incident reporting were not consistent with the provider's processes and contained out of date information. This meant opportunities to learn, take appropriate actions and identify themes and trends were missed.
- Records showed that themes and trends of concerns and complaints were recorded, but there were no clear action plans that demonstrated how improvements were actioned and completed. There was limited information on how feedback was shared at individual and organisational level and how the service sought assurance that changes and learning had taken place.
- We reviewed a selection of the provider's policies and procedures to support the running of the service. There was a process to review all policies and procedures either every two or three years.
- The provider said that their Safeguarding Assurance Committee, had been reinstated as part of their new governance framework following a pause at the start of the COVID-19 pandemic. This was to ensure that there was senior clinical oversight of all safeguarding matters within the organisation. However, the provider was unable to demonstrate clearly how any learning or actions required to mitigate risk to patients were effectively shared with the wider organisation. GPs told us they were not invited to the service's safeguarding assurance group but did attend the local Royal College of General Practitioners safeguarding meetings.
- A clinical audit programme report had been developed in November 2020 but had not been put into place at the time of this inspection.

Managing risks, issues and performance

- The service monitored and reviewed activity but did not use the information effectively to understand risks to give a clear, accurate and current picture that led to safety improvements.
- There were processes for managing risks, issues and performance, but these did not give sufficient assurance that they were effectively put into place.

Inadequate

Are services well-led?

- Operational oversight and forecasting documents related to staffing were shared with the CAS coordinators ahead of weekends. Staff reported issues with the way staffing rotas were produced and monitored. There were times when the rotas showed shortfalls and limited action had been taken by the provider to address this. Rotas did not clearly demonstrate who was rostered to work, who actually worked and the reasons for absence.
- There was a manager on call for the service, but the coordinators considered this did not provide them with enough management support at busy times due to the fact the manager was not at one of the CAS bases and only contactable by telephone. This potentially delayed staff from getting appropriate support when there were staffing issues which could affect patient care.
- The provider had made progress with recruiting to staff vacancies, for example, service and health advisors, but there continued to be a high turnover of health advisors up until the time of the inspection.
- Information about service performance was reviewed and collated. During October and November 2020 the performance of the provider remained inconsistent and whilst there were some improvements seen at this time these had not been seen for sustained periods.
- In November 2020 the provider revised their plan for meeting NHS 111 service performance targets, which were agreed with the CCG. Performance was measured against the revised targets and national performance measures.
- The service had introduced a 'comfort calling' process to identify patients who had been waiting over two hours for a call back from a clinician. However, the system was not operating effectively at the time of the inspection.

Appropriate and accurate information

The service did not always act on appropriate and accurate information.

- Quality and operational information was not consistently used to ensure and improve performance. Performance improvement was considered in short term episodes rather than a longer term consistent and sustainable performance. The provider's quality systems to improve patients care and experience were not fully developed and implemented effectively, ensure patients received safe and effective care and treatment.
- Quality and sustainability were discussed in relevant meetings but not all staff had sufficient access to information in relation to improvements that were needed.
- Performance information was reported and monitored, but management and staff were not consistently held to account. Productivity of staff was measured, but there were limited actions taken by the provider to improve staff performance.
- The service had information technology systems to monitor care, but appropriate actions were not always taken to improve quality of care.
- The service submitted data but did not always notify incidents to the Care Quality Commission when needed. There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

- Since our previous inspection the provider has engaged and worked collaboratively with commissioners to secure improvements to services.
- The service sought feedback from patients, the public, staff and external partners to support sustainable services, but systems were not effective to always ensure feedback was acted upon in a timely manner.
- There were arrangements to enable staff to speak up through a Freedom to Speak Up Guardian. However, the guardian had not received specific training for this and there were limited internal arrangements to enable staff to speak up anonymously.
- Following the inspection, the provider told us they had Freedom to Speak Up training booked for the week of the CQC December inspection. This was cancelled due to the inspection and rebooked.

Inadequate

Are services well-led?

- Feedback was provided to staff either via email or newsletters. The provider did not have a system to monitor whether the information had been read and understood by all relevant staff. Staff said they sometimes did not always read updates as they were overwhelmed with information at times.
- Meetings for different staff groups were not regularly held. Staff said there had been team meetings, but they were difficult to organise due to the pandemic. Staff who worked in the OOH part of the service said meetings had commenced.
- At the time of inspection, a provider staff survey was underway, with the results due in February 2021. The survey was accessible for staff who were employed by the service directly, but not for sessional staff.
- The programme of staff 121s and supervision was very limited. Staff reported not having regular 121s or meetings with their manager. This further limited the opportunity for staff to provide feedback to their employer.
- The registered manager had carried out base visits to meet and engage with staff. The provider said they planned to continue with these visits.

Continuous improvement and innovation

- There were limited systems and processes for learning, continuous improvement and innovation.
- Whilst we saw evidence of continuous learning and improvement, but this did not cover all levels within the service. Feedback was sent out to relevant staff, but leaders were unable to demonstrate whether this information had been used to promote learning and improvement across all staff groups.
- Staff said they wanted to be involved in improving the service but felt they were not offered the opportunity to offer suggestions and support developments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** **Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular:** • Limited regard had been given to ensuring that the registered manager had adequate time to fulfil their legal obligations under the Health and Social Care Act 2014. • Systems for continuous learning and improvement did not operate effectively, this included but is not limited to: • Information from clinicians' performance and audits of service users' records was not used effectively to improve service performance and ensure care and treatment was provided in a safe way. • Themes and trends from significant events were not effectively shared with staff, there were limited arrangements to cascade learning. There were no monitoring systems to ensure that learning required had been understood and acted upon. **Regulation 17(1)**

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Requirement notices

How the regulation was not being met

The registered person had failed to ensure that any and all complaints received were investigated and that necessary and proportionate action was taken in response to any failure identified by the complaint or investigation. In particular:

- There were delays in responding to and investigating complaints and there was a lack of clarity on when a complaint should also be treated as a significant incident.

Regulation 16(1)

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • Risk assessment had been carried out on the premises and facilities used, but action had not been taken in response to identified risks. With particular regard to fire safety and used of sites designated as 'hot' sites for service users who were potentially infectious. • 'Comfort calls' had been introduced but these were not consistently carried out to ensure that risk to service users was mitigated as far as practicably possible. • Arrangements for allocating and monitoring home visits in the Out of Hours service were not effective in ensuring that service users received timely care and treatment. • Calls into the service could not be effectively monitored in 'real time' to ensure that risks were minimised. **There was no proper and safe management of medicines. In particular:**

This section is primarily information for the provider

Requirement notices

- Storage for medical gas cylinders and controlled drugs were inadequate.
- Usage of medicines in the form of tablets in boxes were not consistently monitored, to ensure they were being used appropriately.

There was limited assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular:

- Legionella risk assessments had been carried out, but routine testing was not completed within the timescales recommended by the risk assessment.

There was additional evidence that safe care and treatment was not being provided. In particular:

- Specific information for service users care was not transferred onto their records in a timely manner, to ensure that all necessary information was available to provide appropriate safe care and treatment.

Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 HSCA (RA) Regulations 2014 Care and treatment of service users must only be provided with the consent of the relevant person. **How the regulation was not being met** **The registered person had failed to act in accordance with the Mental Capacity Act 2005 when providing care and treatment to service users who are 16 or over and unable to give consent because they lack capacity to do. In particular:** • Decisions had been made on behalf of a service user without proper assessment of the person and consultation with relevant persons. • The provider did not have a policy on the Mental Capacity Act 2005 which set out what processes were to be followed when providing care and treatment.

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Requirement notices

Regulation 11 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 HSCA (RA) Regulations 2014 Service users must be treated with dignity and respect. **The registered person had not ensured the privacy of service users. In particular:** • Concerns received from staff and a service user about privacy breaches had not been notified to relevant authorities in a timely manner and assumptions were made as to the outcome of the concern, prior to a full and through investigation. **Regulation 10(1)**

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** **The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:** • The provider had not obtained evidence of satisfactory conduct in previous conduct. **Regulation 19(3)**

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

How the regulation was not being met:

The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

- Staff had not received appraisals or supervision in line with the provider's policy.
- Training considered mandatory by the service was not consistently monitored to ensure that it was completed within a timely manner. This included infection control and safeguarding adults and children.
- The service did not ensure that training provided met the needs of staff to enable to perform their duties. This included training on managing aggressive behaviours.
- Staff reported there were limited opportunities for professional development.

Regulation 18(2)