# Devon Doctors - Osprey House

## Inspection report

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

Date of inspection visit: 12, 13, 14 and 20 May 2021
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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 responsive to people's needs? | Requires Improvement |
| Are services well-led? | Inadequate |

# Overall summary

**Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.**

**This review was carried out in a way which enabled us to undertake the review remotely, without the need for a site visit. This was with consent from the provider and in line with all data protection and information governance requirements.**

**This included:**

- **Conducting staff interviews using video conferencing**
- **Reviewing patient records to identify issues and clarify actions taken by the provider**
- **Requesting evidence from the provider**

**This service is rated as inadequate overall. This review, undertaken in May 2021, was carried out to check compliance with the urgent conditions imposed on the service following our inspection in December 2020 and therefore we did not amend the rating.**

**At this review we reviewed the regulations and key lines of enquiry for safe, effective, responsive and well led, as these were key focus areas with risk from the last inspection. The rating for caring is based on the previous inspection in December 2020. The current rating reflects our judgment following the inspection in December 2020, when the service was rated as inadequate overall and placed into special measures.**

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 an announced focused desk-based review of Devon Doctors Limited, on 12,13,14 and 20 May 2021. We spoke with and interviewed a range of staff across the service, including call handlers, senior leaders, junior managers, clinicians, and members of the Board. We also reviewed documents relating to the running of the service and information on our systems. We received feedback from the two clinical commissioning groups who commissioned the service.

**At this focused review we found the conditions had been met and we have therefore removed them from the provider's registration:**

- The Care Quality Commission received an action plan within the specified timescale. The plan set out how the provider would ensure there were adequate numbers of suitably qualified, competent and skilled members of staff for the provision of the Out of Hours service and the NHS 111 service. The plan showed how the service intended to assess capacity and resources, and how this would be implemented to meet patients' needs.

# Overall summary

- We found work has commenced on developing a hybrid model of staffing, which included other clinicians as well as GPs.
- We found appraisals and one to one supervision sessions had been planned for and some had commenced. Those that had taken place had been welcomed by staff.
- The action plan showed the process for reviewing all significant events and complaints, and the progress made on this work.
- Evidence from executive meetings showed that this information was shared at Board level and learning was cascaded to staff. However, further work was needed to ensure this was embedded in the service.
- Systems were in place to identify deteriorating patients, and staff were aware of these.
- We found the lead clinician role had a positive impact at weekends and Bank Holidays, as they monitored the clinical queue and were able to reprioritise calls with the aim of ensuring patients received the right advice.
- Positive feedback was received from frontline staff and lead clinicians about how this role was starting to bridge the operational gap between the OOH service and the NHS 111 service.
- Safety calling (comfort calling) was in place, when advice or treatment from clinicians were delayed. Anecdotal reports from staff indicated that these were reducing and were happening within specified timescales. Data provided by the provider showed that safety calling was completed in accordance with the targets the provider had set for this.

Although the conditions were met, the service still has requirement notices from our inspection in December 2020. These covered governance systems; privacy breaches; health and safety in the service; medicine management; infection control; complaints handling; recruitment process; consent to care and treatment; and staff training. The provider submitted an action plan detailing how they would meet these requirements. The concerns found at this review are covered by the requirements made after our inspection in December 2020 and are subject to an inspection within 12 months of the report being published.

The service remains in special measures until we carry out a full comprehensive inspection within six months of the previous inspection report being published.

The areas where the provider **should** make improvements are:

- Consider implementing protected meeting times and time for learning from significant events to promote effective engagement with staff.
- Provide training as described in the action plans related to the inspection in December 2020.
- Review how significant events are documented, to enable decisions made on level of harm to be clear.
- Continue work on staffing needs and building resilience into service provision when possible.
- Provide clarity on how low harm incidents are used to drive improvements in the service provision.

**Dr Rosie Benneyworth** BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

## Our inspection team

Our review team was led by a CQC lead inspector. The team included a GP specialist adviser and a team of CQC inspectors. The team spoke with staff using video conferencing facilities and completed clinical searches and records reviews without visiting the location.

## 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 Integrated Urgent 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 1.8 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

The website is: www.devondoctors.co.uk

The service has two clinical assessment service centres at Osprey House in Exeter and Ashford in Taunton.

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?

**The rating from the inspection in December 2020 has been carried forward. The service is rated as requires improvement for providing safe services.**

One of the conditions imposed on the provider's registration included the need to implement and maintain sufficient oversight of governance process across the service. This was to include the identification, review and learning shared from significant events and serious incidents. The provider was also required to demonstrate how they intended to assess the relevant capacity and resources (in relation to service provision, including staffing), and how it intended to plan and safely deliver this to meet patients' needs.

The provider submitted an action plan demonstrating how they would address these conditions within the required timescales.

**Risks to patients**

- Staff considered there was a potential risk to patient safety during the out of hours period (OOH) on the weekends. This was due to delays in care due to capacity and available resources. Staff said that there were certain times during the week when there were not enough staff to cover shifts. These were Saturday afternoons and weekday evenings when the in hours GP practices closed and the out of hours service started. The provider was aware of this and had started work on reviewing staff skill mix and analysing shift fill to identify areas for improvement.
- Staff also informed us that on occasion not all out of hours bases were open due to staff shortage, this included drivers as well as clinical staff. In April 2021, a clinician called the clinical assessment service (CAS) as they were stressed and upset as there was limited staff cover. This meant there were delays to patients receiving care and treatment in a timely manner.
- The provider was actively recruiting staff to multiple roles within the organisation, which included clinicians. However, there were still issues with staff leaving the service, reasons included stress of the job and staff not being fully aware of what their role entailed. During this review we found that work had started to address these issues.
- The addition of a floor walker had been welcomed. (A floor worker is a member of staff who is available to provide support and advice to call handlers).This was at the request of call handlers to help improve support for patients and call advisors. There were low numbers of clinical navigators, (these members of staff assist in directing patients to the most appropriate service to meet their needs), over the weekends and lower numbers of call advisors on Saturdays. Staff said they did not feel supported at these times. Usually there was at least one clinical navigator on each shift.
- A piece of work had been carried out to analyse staffing in the service, this focused on forecasting staffing levels needed; scheduling; recruitment and training needs. In addition, as part of this work, an absence review had been carried out. Action plans were being developed to build on this work to enable the service to staff the service effectively and improve operational performance.
- The service had introduced a lead clinician role who worked from 11pm on Friday evenings to 11pm on Sunday evenings, and bank holidays. Their role was to monitor clinical queues in the CAS, and they would reprioritise calls when needed if there were concerns or an urgent need (for example, such as when they identified that a patient would need a face to face appointment or a home visit). These cases would be removed from the queue and appointments booked. One lead clinician said that there was no set template for clinicians to follow to reprioritise the clinical queue, as all the patients had been triaged and decisions relied on clinical knowledge. We did not have any details of whether this was something the provider planned to develop as the role evolved.
- Duty rotas showed that predicted rota fill was below what was required and sometimes the service operated with 50% staffing for call handlers. There was limited resilience when staff were off sick at short notice and the provider was unable to fill these roles. The provider was in the process of reviewing staffing needs and this will be monitored through our regulatory activity.

Requires Improvement

# Are services safe?

- The service carried out what they called 'safety calls' to patients whose care and treatment was delayed. This was to check whether a patient's condition had deteriorated and to inform them of the delay, for example if they were waiting for a call back from a clinician or a home visit. If a patient's condition had got worse then arrangements were made to re-prioritise their case so they would be seen sooner. However, this was not always possible due to a lack of staff in CAS centres and bases; and the rurality of the area that the out of hours service operated in, which led to long journey times. For example, on one evening in April 2021 there were limited numbers of staff available to carry out safety calls on the evening shift due to sickness.
- The provider had started to review how home visits were organised to make best use of staff availability. We received reports that on occasions some home visiting clinicians declined to carry out home visits, as they were due a break or about to finish their shift. For example, in February 2021 a GP wanted a call downgraded as it was going to breach the timescale for visiting an end of life patient, as they wanted to have their lunch before carrying out the visit. There was limited challenge from the provider to address the behaviour of this particular GP.

**Appropriate and safe use of medicines**

Improvements were needed to ensure that prescriptions issued were appropriate and records accurately reflected the amount of medicines held in bases, treatment centres and cars used for out of hours visits.

- When we reviewed the significant events log we found there were concerns around the prescribing of medicines which were potentially addictive and the management of controlled drugs (CDs) and associated records. For example, in March 2021 a patient was prescribed 100 tablets of 5mg of diazepam; and in February 2021 the CD register for the COVID-19 vehicle had been lost.
- Other incidents included the number of CDs held at bases being more than had been recorded in the CD register. The significant event log showed that this concern would have been noted when a weekly stock check was carried out. There were also other occasions when CD reconciliation at treatment centres and CDs carried in cars used for out of hours visits had gaps. The provider had not increased the frequency of checking to mitigate risk. However, they had started to look at an automated process where real-time monitoring could occur.

**Lessons learned and improvements made**

The service learned and made improvements when things went wrong, however improvements were needed to ensure that actions were taken when themes and trends were identified.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses.
- There were adequate systems for reviewing and investigating when things went wrong, learning was shared with relevant staff; and appropriate actions were taken to mitigate risk to patients and improve safety. However, we saw improvements were needed to make sure that themes were identified,

Our review of significant events identified that improvements were needed when patients presented with abdominal pain.

- For example, in March 2021 a patient contacted the NHS 111 service with a high temperature and feeling bloated and uncomfortable. The outcome was for an out of hours (OOH) GP to call the patient back within six hours.
- The patient contacted the service again two hours later as their symptoms were worsening, again the outcome was for an OOH GP to call back within six hours. There was limited information contained in the records to demonstrate whether this call had been linked with the earlier call. The patient was contacted by an OOH GP two hours later and told they would need a home visit, but the service was busy, and the patient might need to go to A&E.

Requires Improvement

# Are services safe?

- In the early hours of the morning the patient's relative contacted the NHS 111 service to inform them that the patient's symptoms were worse. The service was unable to provide a time for when a GP might visit.
- The patient then waited for over two hours, but no visit was made, therefore the relative who was concerned took the patient to A&E where the patient was admitted and required emergency surgery and an eight-day hospital stay.
- The provider's investigation showed that the lead CAS clinician decided to set the outcome as a telephone call to the patient but did not specify a time. The call was still on the triage queue at 9.30am, over 12 hours after the original call, the following morning when a call was arranged, by which time the patient had been admitted to hospital. The significant events log did not have actions or lessons learnt recorded from this incident.
- Other examples included one in January 2021 when a delay in providing care and treatment resulted in a patient being admitted to hospital with a ruptured appendix; and another patient in February 2021 had a ruptured appendix, as the triaging clinician considered the patient was seeking strong painkillers.

We reviewed 10 complaints in detail, three of which were identified in the complaints log as being significant events. These had been transferred to the significant events log for further action and investigation. Some complaints had not been identified as a significant event, such as in February 2021 when a patient suffered from a ruptured appendix; and in March 2021 when a patient had a perforated bowel and did not receive timely care and treatment.

The provider had reviewed all significant events that were open since our inspection in December 2020 and to ensure action had been taken. They had identified that there was an issue with management of patients who had abdominal pain but had not taken any action to address this.

Information supplied to us during this review, showed that low harm incidents had limited information on identification of themes and trends and how this would be used to monitor quality of services provided.

During the inspection in December, we also found that records related to significant events and incidents had not been fully completed to demonstrate what investigations had taken place; actions taken; and lessons learnt; and how this was monitored.

At this review we saw that work had started on reviewing codes used for classifying significant events and incidents on the DATIX (an electronic incident reporting system) that the service used. One aim of the project was to provide all staff with refresher training on the DATIX system so that there was consistency with how significant events and incidents were documented. This would allow the service to run reports and enable them to identify themes and trends easily to take appropriate action.

Inadequate

# Are services effective?

**The rating from the inspection carried out in December 2020 has been carried forward. The service is rated as inadequate for providing effective services.**

Conditions imposed on the provider's registration required them to implement and put into place monitoring systems to maintain an effective system to ensure the identification and root cause analysis of any patterns or trends in low performance within the NHS 111 Devon service.

The provider submitted an action plan demonstrating how they would address these conditions within the required timescales.

**Monitoring systems**

The provider produced a weekly operations dashboard which tracked forecasted calls, with the actual amount received and staffing levels. During our inspection in December 2020, we identified weekends where there were times when the service was significantly below the national average. Staff informed us there had been a COVID-19 outbreak at one of the bases, which had impacted on service delivery. The Care Quality Commission were not informed of this at the time as required in the regulations.

Our analysis of data from the time of the inspection in December 2020 to April 2021, showed that calls into the service were usually in line with those forecast by the service. However, from April 2021 call volumes were increasing, such as over the Easter bank holiday, which was expected as it was a holiday, but the underlying trend at other times was of a steady increase in call volumes. We saw that this was replicated across similar services in England.

There was limited resilience in the service when there were surges in demand when the service had not been affected by bank holidays. We found there were periods when calls were in line with those forecast, where the service was performing below England averages and staffing rotas showed there was a shortfall in available clinicians and call handlers, as not all shifts were filled. Monitoring processes the provider had were in their infancy and not all themes and trends had been identified fully at the time of this review.

The service had a range of audits to monitor service performance which included call audits, to ensure call handlers were following the processes correctly; clinician call audits; and telephone consultation breach audits, where timescales for patients to receive a call back were reviewed. Evidence provided on audits covered the period of January and February 2021.

One audit was carried out to evaluate the impact of a clinical delay on patients. A total of 40 random cases were selected, which included 10 cases of both urgent and routine breaches from each county.

During the audit period there was the introduction of disposition (Dx) mapping (outcome of the initial call assessment), where the queue worked in 'priority' order with clinicians working from the top to bottom of this queue to triage cases. There was also the introduction of the clinical assessment service (CAS) lead and revalidation of clinical cases to be upgraded and downgraded in accordance with clinical need.

Breaches were seen in failed contacts; this is when clinicians do not manage to speak with a patient at the first attempt. This meant they had to try a further two times to contact patients and this extended the timeframe until the case could be closed on the system.

**Results from this audit showed:**

Inadequate

# Are services effective?

**Devon- Routine**

One case that did not breach timeframes

One case breached without a disposition

Two patients did not agree with the disposition

Three cases the Dx was downgraded

One case was referred to a treatment centre.

Of these cases no adverse outcomes identified.

**Somerset- Routine**

Two cases did not breach timeframes

Two cases failed in their outcomes, with one of the patient's attending A&E

Three cases where the disposition were over-ridden following the assessment and two of the patients attended OGP

One case was referred to A&E

One case had an electronic prescribing system issue.

Of these cases no adverse outcomes identified.

**Devon- Urgent cases**

One was to verify a death

Three cases were upgraded due to the patient's condition getting worse

Four cases were about medicine requests

One case had a paramedic on scene

Three cases were upgraded and an emergency

No adverse outcomes were identified for all these cases.

**Somerset-Urgent cases**

One case required admission to hospital for specialist care

Inadequate

# Are services effective?

Two cases had a paramedic on scene

One case was a failed contact which resulted in an ambulance being arranged.

One case was referred to A&E

No adverse outcomes were identified.

Conclusions of this audit were that the delay in clinical contact did not contribute to an adverse outcome for patients.

Breach audits for the clinical queue for home visits and telephone consultations showed that breaches of timescales were reducing, but these were affected by staff shortages in bases. We received reports from staff of times when bases had to close due to insufficient staff being available and home visits breaching the recommended timescale. The provider was in the process of reviewing staffing needs and this will be monitored through our regulatory activity.

- The provider's audit programme did not fully detail the scope of audits to be undertaken; timeframes; or audit methodology. For example, an audit of low harm incidents stated: *"If the Team Leader is concerned that there may be potential harm to the patient then this is raised with the Head of 111 and Clinical Manager immediately, and appropriate action will be taken on the day and documented in Datix."* (an electronic incident reporting system).This did not show the number of cases found where potential harm was indicated in comparison to the number of Datix reported incidents. There was no clear process to demonstrate how levels of harm were assessed and scored in breach audits. There was a risk classification assessment tool, but the measures used to obtain the risk score were not detailed.
- It was not clear if breaches of timeframes which could lead to harm or potential harm were being reported as incidents. For example, an audit on comfort calling (safety calling) had a statement: *"Cases where potential harm is deemed possible the senior clinical management team (SCMT) are notified as well as the governance team"* was used throughout comfort call audits, there was no indication that these would also be logged on the Datix system as incidents.
- Information on lessons learned consisted of a standard set of statements which did not reflect the differences of the calls reported on.

**Effective staffing**

Conditions imposed on the provider's registration required them to set out how they would ensure there were adequate numbers of suitably qualified, competent and skilled members of staff for the provision of the Out of Hours (OOH) GP Service for Devon and Somerset and NHS 111 Devon contract. In particular for those patients awaiting a telephone assessment from the OOH service; and how the provider intended to improve performance against the key targets of call answering and call abandonment in the NHS 111 service.

The provider submitted an action plan demonstrating how they would ensure adequate numbers of suitably qualified, competent and skilled members of staff. During this review staff across all staffing groups told us of continued concerns around the number and skill mix of staff available to run the service and the pressure to achieve targets with reduced staff numbers.

- The provider had started work on developing a hybrid model of staffing to recruit more advanced nurse practitioners (ANP), paramedics and pharmacists, in addition to GPs to provide more resilience and a more appropriate skill mix to meet their aim of enabling patients to receive the right care and treatment in the right place, with suitably skilled staff.
- The ANPs and paramedics that currently worked in the service were able to carry out home visits. ANPs if appropriately trained were able to carry out telephone triage and work a shift in place of a GP.

Inadequate

# Are services effective?

- The introduction of the lead clinician role was positively received by staff, and staff said they appreciated the support provided. We received reports that there were still some clinicians who worked remotely or at other bases who 'cherry picked' from the triage queue so that they only dealt with 'easy' calls. This was identified at our inspection in December 2020 and limited action had been taken by the provider to address this issue. The provider had taken limited action to address this at the time of inspection.
- Staff raised concerns regarding the booking of appointments without taking account of the different skill sets of staff. For example, when three complex cases were booked in for face to face appointments, one after the other, with an ANP in the OOH service. The clinician said that they were competent to assess these cases but would not necessarily complete the assessments in the same amount of time as a GP. In addition, they also had to manage home visits that evening and a patient who walked into the treatment centre seeking help. They were the only clinician working at the treatment centre. This situation was not identified by managers working at that time.
- We found appraisals and one to one supervision sessions had been planned for and some had commenced. Those that had taken place had been welcomed by staff.
- Performance management tools were being introduced and line managers were being provided with training on how to use them in one to one sessions, with the aim being to share ownership of performance with staff members.
- A data dashboard was being produced to capture individual, team and departmental performance. This was not currently reflective of data and therefore it was intended that it will analyse April 2021 data and analysis would be provided to the teams from May 2021 for discussions with individuals regarding their performance.
- The provider carried out performance reports on clinician activity and results were shared with each clinician. However, there was a lack of clarity on how this information was used to drive performance. Clinicians we spoke with said the information identified how they performed against their peers, and they were expected to do personal reflection and consider ways they could improve if needed. The provider was unable to demonstrate how it used the information to drive improvements and the support it gave to those who were outliers. Limited consideration had also been given to those clinicians who were triaging cases quicker than others and whether the assessments carried out were thorough. This was discussed with the registered manager at the time of this review, they said they would look at this situation and determine what action was needed.
- As part of their action plan the provider undertook a process review to ensure that all opportunities to utilise non-clinical staff were maximised. All NHS 111 staff trained in NHS Pathways cover the Community Pharmacist Consultation Service (CPCS) pathway as part of their training. All service advisors were trained in Pathways Lite prior to going live on the service. NHS Pathways system is a set of clinical assessment questions to manage telephone calls from patients. The tool enabled a specially designed clinical assessment to be carried out by a trained member of staff who recorded the patients' symptoms during the call. When a clinical assessment had been completed, a disposition outcome (i.e. what the patient needed next for the care of their condition) and a defined timescale was identified to prioritise the patients' needs.
- Training for call handlers on the NHS 111 service has been increased from four weeks to six weeks to support staff to have a better understanding of the role and to be competent when they start to take live calls. Regular evaluation was being carried out at each stage of the training, such as after the introduction to Pathways. At the time of this review, the first group of staff were undergoing this lengthened training and had yet to complete the course.
- One new member of staff said they were aware that their induction and training had been influenced by learning from our inspection in December 2020. They added that the induction and training had prepared them well for their work. They said they did not feel pressure from the number of calls as they could only deal with one at a time and they were supported by colleagues to deal with calls methodically and properly.

Requires Improvement

# Are services responsive to people's needs?

**The rating from the inspection carried out in December 2020 has been carried forward. The service is rated as requires improvement for providing responsive services.**

Conditions imposed on the provider's registration required them to set out how they would ensure that the risk and incidence of delayed assessments and appointments at the GP Out of Hours service in Devon and Somerset were properly identified and managed. In addition, to ensure that there were appropriate systems in place to monitor the condition and the risk of deterioration for all patients awaiting assessment and appointments within the GP Out of Hours service.

The provider submitted an action plan demonstrating how they would address these conditions within the required timescales.

**Responding to and meeting people's needs**

- During this review, all staff interviewed who worked on the frontline were able to describe the actions they would take if a patient contacted them and required immediate assistance. They were also able to explain what actions they would take if a patient called the service again before being contacted by a clinician for an assessment, stating that their condition was worsening.
- Staff were able to explain the process for safety calling, to inform patients that there was a delay in their care and treatment. However, there were occasions when there was not staff available to make these calls. When the safety calls were made, staff were unable to provide information on how soon a patient would be contacted by a clinician.
- The role of the lead IUCS clinician assisted in mitigating some risk of delays to care and treatment when they were working.

**Timely access to the service**

Patients were able to access care and treatment from the service, but this was not always within an appropriate timescale for their needs.

During this review we had reports of patients waiting for over an hour on the NHS 111 service dental phonelines and up to 60 people queuing to access the NHS 111 service.

The provider had changed the way it organised urgent and routine disposition (Dx) codes with patients in January 2021 the service now used within 30 minutes for urgent call-backs and within two, six, 12 or 24 hours for routine call-backs. Previously these were set at within 20-minute (urgent) and within 60-minute (routine) clinician call back,

The provider's initial analysis showed Dx code mapping of cases from NHS 111 to the GP Out of Hours part of the Integrated Urgent Care Service, against previous measures was comparable. Cases were ranked according to 'next action by', which showed the order in which they needed to be dealt with. This meant that cases were organised in clinical priority in the queue. Clinicians were then expected to work down the queue in order of clinical priority. This did not always happen; we were told of instances where clinicians who were not working in the Clinical Assessment Service (CAS) would choose calls that they thought would be quicker to deal with. This did not occur when there was a lead CAS clinician on duty. Early conclusions by the provider were that the service was under pressure overnight and on Saturday afternoons, due to staff shortages. The provider was in the process of reviewing rotas and staff skill mix and was planning to address the shortfalls through this.

Requires Improvement

# Are services responsive to people's needs?

During the week before this review undertaken in May 2021, we received information which said that on the evening of 6 May 2021 between 7pm to 11pm there were no GPs at four treatment centres in Somerset and only one nurse in another centre in Somerset. Therefore, three of the treatment centres were closed leaving two open. There were also reports of a GP on another evening ordering food instead of triaging and seeing patients. This delayed the care and treatment of a patient who had abdominal pain. When the GP saw the patient an hour later they were advised to go to A&E. A similar incident had occurred during the day when a patient presented with abdominal pain and advice was apparently sought from a non-medical colleague about what to do. The patient was sent to a hospital for treatment, after already travelling over 25 miles to be seen at the treatment centre. The provider was in the process of reviewing staffing needs and this will be monitored through our regulatory activity.

Inadequate

# Are services well-led?

**The rating from the inspection carried out in December 2020 has been carried forward. The service is rated as inadequate for providing well-led services.**

Following our inspection in December 2020 we varied the urgent conditions placed on the service after our inspection in July 2020 and extended the timescales for compliance.

Conditions which related to the provision of the Out of Hours (OOH) service related to shortfalls in oversight of governance systems. In particular, those regarding the quality and safety of the Out of Hours (OOH) GP service; systems used to identify, review and share learning from significant events; lack of scrutiny and challenge on performance at Board level; lack of identification and root cause analysis of any patterns or trends in low performance within the OOH service, in relation to delays in patients receiving safe and timely care.

In addition, the provider was required to demonstrate how they would ensure there were adequate numbers of suitably qualified, competent and skilled members of staff for the provision of the OOH GP Service for Devon and Somerset. This included how the provider intended to plan and safety deliver services to meet patients' needs. In particular in relation to patients awaiting a telephone assessment from the OOH GP service and those patients at risk of having delayed assessments and appointments.

Conditions related to the provision of the NHS 111 service related to shortfalls in the oversight of governance systems. In particular those regarding the quality and safety of the NHS 111 Service in Devon; review and sharing of learning from significant events; lack of scrutiny and challenge on performance at Board level; lack of identification and root cause analysis of any patterns or trends in low performance within the NHS 111 Devon service in relation to the number/ percentage of calls being abandoned and the number/percentage of calls being answered within 60 seconds.

In addition, the provider was required to demonstrate how they would ensure there were adequate numbers of suitably qualified, competent and skilled members of staff for the provision of the NHS 111 Devon contract, across all provider sites. This included how the provider intended to plan and safely deliver services to meet patients' needs, in relation to a reduction in the number/percentage of calls to the NHS 111 service being abandoned and an increase in the number/ percentage of calls to the NHS 111 service answered within 60 seconds.

**Leadership capacity and capability**

- During this review undertaken in May 2021, we saw minutes from meetings which showed that the senior management team recognised that the service being placed into special measures was an appropriate action by CQC and acknowledged the struggles they faced and sought advice and support from the clinical commissioning groups and other external stakeholders to assist with developing an action plan. The service also considered that asking for help from external organisations such as clinical commissioning groups had assisted in starting to close the gap between governance and operations teams.
- An action plan demonstrating how the provider would address the conditions was submitted within the required timescales. The action plans showed how the provider would implement and monitor progress on achieving compliance, with details of action required. When there were risks of timescales not being met there were reasons noted for unexpected delays. We found that on occasion progress on meeting the actions was not clearly defined. For example, actual achievement data was not clearly set out in each document. In particular, quantitative performance data was absent despite 'success measures' being defined and included. Our findings from this review was consistent with interviews with staff, who indicated that whilst improved and better focused governance structures had been established, it was early in the process of implementing improvement plans and there was significant work to be completed.

Inadequate

# Are services well-led?

- Leaders understood issues and priorities relating to the quality and future of services. They were starting to address the challenges. For example, minutes of meetings showed that they were aware the service had been working in silos, where different parts of the organisation were working separately to others, and information was not being shared effectively. We noted during the inspection undertaken in December 2020, that there was a disconnect between the CAS and bases where treatment and care were provided. This was particularly noticeable in the Somerset area and had been identified by senior leaders. During this review, undertaken in May 2021 work was commencing regarding how best to engage staff working in these areas and ensure that their concerns with shortfalls in service provision were acted upon. For example, such as when there were insufficient staff to provide a safe service, as a result of bases not being able to operate effectively.
- Twice daily conference calls were held between service teams to adapt to the demands of the day and review activity carried out during the evenings. This enabled the service to proactively request national contingency for the NHS 111 service, to assist with managing call volumes.
- Minutes of Board meetings showed that non-executive directors were providing 'critical friend' advice on how the service was operating and making suggestions for improvement. One example given was for the senior leaders not to just focus on changing the organisation structure and plans, but to connect with staff and develop active listening, so staff are involved in making the necessary improvements and promote effective communication at all levels of the organisation.
- Discussions held in meetings included staff wellbeing, appropriate support for frontline workers and enabling staff to speak openly and honestly about service provision; in order to improve service performance.
- During this review we had mixed reports of senior leaders being visible and approachable. Staff said their immediate line managers were supportive, but some did not see senior leaders in bases used by the service.
- Regular leadership rounds had commenced where senior leaders would visit staff to gain an understanding of positive and negative aspects of working on the front line. Areas highlighted for improvement included improving the safety of triage queue, as there were still concerns with evenings and Saturday afternoons. Positive feedback of staff being supported was the roll out of the appraisal system. Staff said they welcomed this, and it gave them an opportunity to discuss development needs. One member of staff said that when they requested additional training this had been provided, and they were better prepared to carry out their role.

**Governance arrangements**

Following our inspection in December 2020 the provider had reorganised their governance structure and committee meetings held to streamline responsibilities and promote effective communication. The committees covered areas such as risk and safety, quality, safeguarding and performance, along with senior leadership meetings.

During this review undertaken in May 2021, we found that:

- Safety calling (comfort calling) was in place, anecdotal reports from staff indicated that these were reducing, and were happening within specified timescales. Data provided showed that safety calling was completed in accordance with the targets which the provider had set for this.
- Areas discussed at these meetings included safety calling and the need to reduce these so that they would only be used by exception rather than being an accepted way of working.
- There were systems which enabled the service to predict staff requirements based on predicted call volumes. The system also enabled the provider to see how changes in staffing numbers would affect service performance. Twice weekly meetings were held by the rota team and operations team to identify any concerns about rota fill.
- Work had commenced on recruitment, training and induction processes to improve retention of staff and reduce staff attrition with the aim of building resilience in service provision. The service had extended NHS 111 service Pathways

training from four weeks to six weeks and included regular evaluation at set points in the training, for example after introduction to the Pathway system. The induction programme for new staff who worked in NHS 111 Service this included staff who worked on the frontline speaking with potential employees and opportunities to listen to the types of calls that they would be dealing with.

- The provider was aware of the challenges to recruitment which included shortage of GPs and had started to review staff skill mix, with the aim of employing more advanced nurse practitioners and paramedics. The provider was planning to look at how home visits were booked and the feasibility of a single clinical queue for Devon and Somerset.
- The service considered that data collected was being used differently since our inspection in December 2020 to inform the senior management team of pressures and challenges to the system. They considered they had a clearer understanding of key performance indicators and used root cause analysis to understand causes for performance drops.
- The action plan submitted to us following our inspection in December 2020, stated that all senior leaders' staff would receive root cause analysis training to enable them to monitor service performance. We requested evidence of this and were supplied with copies of two certificates of training carried out by senior leaders in November 2019.
- The action plan showed the process for reviewing all significant events and the progress made on this work. However, there shortfalls the provider being able to demonstrate what actions had been taken to address concerns and how these were to be monitored; due to the records not being completed fully. Staff said they had not been trained fully in the use of the DATIX (an electronic incident reporting system) system used for reporting significant events and incidents.
- The provider was aware of times when service performance decreased, but actions taken had not improved resilience of the service if staff were off sick at short notice or rotas were not filled to the forecasted levels. For example, in April 2021 the NHS 111 service received 9,331 calls inbound against a forecast number of 7,314, minutes of meetings referenced budgetary constraints. (Commissioners contract NHS 111 services to manage a set number of calls based on previous demand, therefore when demand increases, funding does not increase in line with this until a contract is reviewed.) Minutes stated that the provider considered that there were two options. One of which was to request more funding from commissioners. If this was not possible consideration should be given to agreeing a reduction in the performance target. There was also discussion around the rota fill being at 76%, which was not sufficient to manage call volume and some call handlers were still in training, which meant they were unable to take live calls.
- Improvements were still needed to ensure that learning was shared effectively with all relevant staff members as systems in place had not changed since our previous inspections in July 2020 and December 2020.
- At the Board meeting in April 2021 there was discussion around a decrease in performance of the service, in particular regarding the NHS 111 service and that the provider had subcontracted out a proportion of the NHS 111 service calls to another provider over weekends, to assist with managing call volumes. This support was due to start at the end of April 2021, and at the time of this review, had been in operation for two weeks. There was limited improvement in service performance due to an increase nationally in calls being received by all NHS 111 services across England, which had affected the subcontractor's ability to take the percentage of calls agreed.
- Performance of the NHS 111 service, since our inspection in December 2021, was usually in line with national averages. We noted that in January and February 2021 calls answered within 60 seconds on occasion was 20-30% below England averages; and call abandonment rates were also below England averages. We discussed this with the provider and were told that there had been caused by a COVID-19 outbreak in one of the clinical assessment service (CAS) centres. This resulted in a high number of call handlers having to self-isolate. We were not informed of this as required by the regulations.

**Managing risks, issues and performance**.

- Staff reported that there were still concerns with working with rota teams and human resources. They were unable to contact rota team staff during the evenings and weekends to adjust staffing rotas to reflect who was actually on shift. They also said they were actively discouraged from contacting either of these teams within working hours. The

provider did have mechanisms for reviewing and adjusting rotas out of usual working hours, but team leaders were unable to make real-time changes to rotas to reflect the current staff who were working. Issues with human resources related to delays in new staff commencing employment. One member of staff said they had to supply the same documentation three times before starting employment, as the first two sets of documentation had been lost.

- The medical directors' clinical update dated 12 March 202, provided information on service performance and included details on home visit arrival time, and guidance on how visits would be logged to enable consistency across the OOH service provision. The update also highlighted areas for improvement, such as making sure that three attempts should be made to contact a patient when they were expecting a clinical callback. There was limited information on how this would be monitored. The piece highlighted that in some instances clinical judgement should be used if appropriate, such as if not contacting the patient would pose a risk.

**Engagement with staff**

- Staff reported mixed engagement with managers and leaders across the organisation and across different departments. Staff at the CAS in Taunton said they felt disconnected from the CAS at Osprey and considered that they did not see senior leaders regularly.
- Arrangements to share learning with staff had not changed since our inspection in December 2020, with a reliance on written communication. Some team meetings had started but staff said they were not given protected time away from taking calls to attend. Senior leaderships rounds were carried out which provided frontline staff with an opportunity to speak directly with leaders on issues of concern. We had reports of information being provided by email and staff not having sufficient time to read the emails. Staff said they would appreciate role specific communications.
- Meetings had begun to happen with union representatives, and these were viewed positively by leaders and union members and provided a platform for staff's shared concerns to be discussed. Minutes of the meetings demonstrated that the chief executive was listening to what staff had to say and acknowledged that change was needed, which they would do their best to achieve.
- Staff said they would welcome positive feedback as well as areas for improvements when their call audits were carried out and when general feedback on performance was provided. There were still some staff who said that sharing of learning from significant events and incidents did not happen.
- There were mixed responses when staff were asked about feeling valued by the organisation, some staff reported that morale was low, and they were fatigued by the workload and the COVID-19 pandemic. Some staff said they reported concerns to line managers but did not receive information on whether action had been taken. The majority of staff said they were supported by line managers.