Practice Plus Group - Devon OOH/CAS

Inspection report

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Overall summary

This practice is rated as Requires Improvement overall. This was the first inspection of this service.

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Requires Improvement

Are services well-led? – Requires Improvement

We carried out an announced comprehensive inspection at Practice Plus Group - Devon OOH/CAS between 10 and 20 July 2023. We were onsite at the service on 17 and 18 July 2023. (OOH-Out of Hours and CAS-Clinical Assessment Service). This was the first inspection of this service since the provider, Practice Plus Group Urgent Care Limited, registered with the Care Quality Commission to provide a service from this location in September 2022.

How we carried out the inspection

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. 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 and face to face with staff members.
- Reviewing patient records to identify issues and clarify actions taken by the provider.
- Requesting evidence from the provider.
- Requesting the completion of a staff survey document.
- Conducting site visits.

At this inspection we found:

- Practice Plus Group (PPG) faced unique challenges in delivering this newly commissioned service. In response, we saw the provider demonstrated a willingness to constantly review and shape the service by ensuring it was agile and responsive to the needs of the expanding rural population of approximately 814,500 people (doubling in spring and summer).
- The provider had clear systems to manage risk so that safety incidents were less likely to happen. However, not all risks were adequately identified, limiting the facilitation of learning and improved patient safety processes.
- The provider reviewed the effectiveness and appropriateness of the care delivered. However, there was a theme of delayed responses for patients resulting from recruitment and staffing challenges, and inappropriate referrals for assessment. Whilst actions were taken or were in progress, sustained improvement in outcomes for patients had yet to be achieved.
- The service ensured care and treatment was delivered according to evidence- based guidelines.
- Staff always treated patients with compassion, kindness, dignity and respect.

Overall summary

- There was high levels of engagement with the public, staff and external partners to receive feedback and involve them in developing sustainable high quality care.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.
- Overall governance arrangements still needed time to embed in this newly established out of hours service for Devon.
- Processes for managing risks, issues and performance did not provide assurance all risks had been identified and mitigated as far as reasonably practicable.

The areas where the provider **must** make improvements as they are in breach of regulations are:

Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care, specifically to:

- assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

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

- Provide consistency in the standard outcome wording within response letters to complaints.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC Operations Manager, a CQC Deputy Director, a GP specialist adviser, a CQC pharmacist and four CQC inspectors.

Background to Practice Plus Group - Devon OOH/CAS

Practice Plus Group - Devon OOH/CAS is the registered location for services provided by Practice Plus Group Urgent Care Limited and provides out-of-hours primary medical services to patients in Devon when GP practices are closed.

The Devon out-of-hours service is contracted locally to take any patient calls made to GP practices after 6.30pm. The out of hours service is provided between 6.30pm and 8am on weekdays and 24 hours on weekends and bank holidays. The service is run from an administrative base and nine primary care centres. The service provides the clinical assessment service (CAS) for NHS 111, the ambulance service, care homes and health care professionals, which is delivered from a base in Exeter. Clinicians working at the bases carry out telephone triaging and face to face appointments, which are booked after a telephone triage call. There are also clinicians who work remotely and carry out telephone triage and when appropriate, offer advice and referrals to other service, such as pharmacies and minor injuries units.

The service is commissioned by Devon Integrated Care Board (ICB) and covers a population of approximately 814,500 people across the county of Devon. During the spring and summer months the population more than doubles due to tourism. Nearly 25% of the population of Devon is over 65 years old and 26% live in rural areas with limited access to public transport and out of hours pharmacy provision. Practice Plus Group (PPG) provides services in a number of rural locations.

The administrative base is located at:

Stratus House, Emperor Way, Exeter EX1 3QS

The out of hours service is provided from the administrative base and nine primary care centres. Patients are triaged according to clinical need and may be invited to attend a face-to-face appointment at one of the centres (during the hours listed):

Stratus House, Emperor Way, Exeter EX1 3QS (111, CAS & OOHs Hub) – open 6pm to 11pm weekdays and 8am to 11pm at weekends)

Practice Plus Group Hospital, 20 Brest Road, Plymouth PL6 5XP – open 6pm to 11pm weekdays and 8am to 11pm at weekends

Trelawny Surgery, 45 Ham Drive, Plymouth PL2 2NJ – open 8am to 6pm at weekends only*

St Leonard's Practice, Athelstan Road, Exeter EX1 1SB– open 6.30pm to 11pm weekdays and 8am to 11pm at weekends

North Devon District Hospital, Raleigh Park, Barnstaple EX31 4JB – open from 7pm Monday to Friday and at weekends *

Tiverton Treatment Centre, Honiton Hospital, Marlpits Lane, Honiton EX14 2DE – open 9am to 6pm at weekends only*

Okehampton Treatment Centre, Okehampton Hospital, Cavell Way EX20 1PN – open 6.30pm to 11pm weekdays; 8am to 11pm at weekends *

Newton Abbot Treatment Centre, Newton Abbot Hospital, Jetty Marsh Road TQ12 2TS - open 6pm to 11pm weekdays and 8am to 11pm at weekends*

Totnes Treatment Centre, Totnes Hospital, Coronation Road, Totnes TQ9 5GH - open 6pm to 11pm weekdays and 8am to 11pm at weekends*

*Some of the primary care centres had flexible opening arrangements which was agreed with local commissioner, due to resource availability.

Patients access the service via the NHS 111 Service. Patients may be seen by a clinician at one of the primary care centres, receive a telephone consultation or a home visit depending on their assessed needs.

During the inspection we visited the Primary Care Centres at Exeter, Plymouth, Newton Abbot and Barnstaple. In the body of the report, we use the term 'Bases' when referring to the Primary Care Centres.

The provider is registered to provide the following regulated activities:

Transport service, triage and medical advice provided remotely

Treatment of disease, disorder or injury

Requires Improvement

Are services safe?

We rated the service as requires improvement for providing safe services because:

- There were some gaps in systems and processes for the safe handling of medicines.
- Arrangements for planning and monitoring numbers of staff working (shift fill) were under review and changes were yet to be completed to improve patient safety outcomes.
- The management of significant events did not consistently identify and mitigate all risks to ensure actions were taken; and the health and welfare of patients was maintained.

Safety systems and processes.

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

- The provider conducted safety risk assessments. It had safety policies, including Control of Substances Hazardous to Health and Health & Safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the provider as part of their induction and refresher training.
- Safety of staff was also considered by the service. There were lone worker risk assessments completed for each base. An assessment for a rurally located base that was some distance from main sites identified potential risks for lone workers. We saw roster changes had occurred to reduce this risk for staff.
- The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. Thirty-two staff responded to a CQC survey, 50% of staff responding confirmed who the named safeguarding lead was. We saw information prominently displayed in every base setting out the safeguarding process and who to contact for further advice. The same information was accessible for staff on the provider intranet page. The provider had a national safeguarding hub, responsible for but not limited to administration of safeguarding referrals to ensure these were sent to the correct local authority safeguarding board.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. For example, staff told us about a vulnerable patient living alone and carers reported concerns to the service. The clinician had submitted a safeguarding referral to ensure their situation was reviewed and further support provided where needed. Information was shared between in hours GPs and the out of hours service to ensure there was awareness of potential risks and continuity of care.
- We sampled 5 staff files and found the provider carried out required checks at the time of recruitment and required staff to declare any changes to their status on an ongoing basis when needed. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff who had their employment transferred over to Practice Plus Group from the previous provider had undergone a risk assessment for any gaps in the employment records that were handed over. Where gaps were found, information required had been requested.
- All staff had received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control (IPC). IPC audits were carried out monthly at all bases and actions were taken to address shortfalls. Bases visited were visibly clean, maintained and staff were provided with personal protective equipment.
- The premises used for service provision were clinically suitable for the assessment and treatment of patients. One base was situated within the local NHS Acute Trust, where service level agreements were in place to identify areas that the

provider was responsible for, such as ensuring clinical rooms used were left clean and tidy after staff had used them. Suitable arrangements were in place so the provider could demonstrate they had assurance from the service whose premises they used that facilities and equipment were safe and equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

- The provider had arrangements for ensuring equipment being used by self-employed medical practitioners were maintained and safe to use. GPs interviewed said they signed an annual contract to confirm this. Opportunities to have equipment calibrated to check the instruments accuracy were offered to self-employed staff but we were told this was sometimes difficult to do as this was usually carried out at the Exeter base. We spoke with the provider who told us they were reviewing these arrangements to increase accessibility for staff working at other locations.

Risks to patients.

There were systems to assess, monitor and manage risks to patient safety, which required time to fully embed.

- There were arrangements for planning and monitoring the number and mix of staff needed. A team comprising of a manager and staff rota administrators scheduled operational and clinical shifts using an application. The provider had reviewed data related to service activity and staffing levels to improve performance.
- The provider had identified times, for example at weekends and holiday periods, where agreed performance data had dropped due to increased demand. A minimum number of clinicians per core shift was created across the week for the bases and home visiting resource. The provider had a minimum requirement of 70% rota fill to meet predicted demand.
- In agreement with the Integrated Care board (ICB) the provider was introducing new duty rotas to mitigate patient safety by achieving agreed capacity and staffing targets. The new CAS rota was launched in June 2023. Staff interviewed onsite told us that this had improved performance resulting in more timely assessment of patients. Over the weekend a clinical lead or navigator on shift oversaw both the Out of Hours (OOH) and Clinical Assessment Service (CAS) queues of patients waiting for contact from a clinician. Whilst on site for the inspection, we looked at patient queues for OOHs and CAS and found no evidence of target response times being breached.

- Data seen demonstrated the provider's performance trajectory had steadily improved since starting the service. Between April and July 2023, 3145 staffing hours were filled against 3380 hours allocated. We saw no cases were handed back to in hours services on Monday mornings for the previous 4 weeks up to 3 July 2023 prior to the inspection. This meant patients referred to the out of hours service were assessed, referred and/or treated, increasing patient safety and reducing burden on other in hours services.

- Performance data for staff rota fill shared with the commissioners and CQC in June 2023 showed on average 53% of the OOH service and 87% of the CAS rotas were filled. In July 2023, data showed improvement with an average of 65% coverage of the OOHs service and 89% of CAS rotas were filled. The provider had a 'Rota Gap Escalation Policy'. Daily meetings with the local rota team were held to review any current staffing challenges, twice weekly forecasts were undertaken identifying where staffing gaps were and needed to be filled. Concerns were then escalated when additional support was required. Senior staff attended a national call every Friday, where concerns, plans and mitigations were put in place to promote patient safety.
- The escalation procedure and support network comprised of a strategic (Gold) command, tactical (Silver) command and local operational (Bronze) onsite command. An on call medical director was available 24 hours per day at weekends and bank holidays, and every weekday evening/overnight. However, some staff said significant and widespread system pressures during the winter had meant it took longer for the escalation procedure to become embedded. Information about this procedure was accessible to all staff and awareness of it being raised through various communication channels.

Requires Improvement

Are services safe?

- Staff understood their responsibilities to manage emergencies and recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. Patients were re-prioritised appropriately for care and treatment.
- Systems were in place to manage people who experienced long waits or who had been inappropriately streamed into the service. 'Comfort' patient safety calls were carried out to check people health and well-being whilst they waited for further clinical assessment.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff, the service assessed and monitored the impact on safety.

Information to deliver safe care and treatment.

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

- Individual care records were written and managed in a way that kept patients safe. Regular audits of the quality and completeness of documentation took place and staff received feedback about this. The care records we saw showed 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.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines.

There were some gaps in systems and processes for the safe handling of medicines.

- There were systems, policies and procedures for managing medicines, including medical gases, emergency medicines, equipment, and controlled drugs. Clinicians verified they would provide basic life support and could access emergency medicines. However, these were kept in a locked cupboard and/or room. At two bases located on hospital sites, clinicians used leased rooms with nearby emergency equipment trolleys belonging to the hospitals. In the event of a medical emergency, clinicians told us they would be more likely to use this as it was closer and more quickly accessed whilst waiting for the emergency team to arrive and take over care of the patient. The provider confirmed it did not have an agreement for this nor any assurance the trolley contained the necessary items or was fit for use.

- The provider told us the list of medicines available on each vehicle was agreed and approved by the local Integrated Care Board (ICB) and was reviewed regularly. This was underpinned by procedures, however we found potential gaps in how one procedure covering a medicine used in the event of end-of-life care or cardiac arrest was being applied. Staff said there were distinct challenges of working across the rural and isolated areas of Devon. We were told access issues not limited to PPG, had the potential to delay treatment of patients. To counteract this, staff said they aimed to carry this medicine but not all clinicians agreed with this approach.

- The vehicles provided by the service for the mobile clinicians, complied with protocols to safely transport equipment and medicines.

- We observed effective ordering and storage and transportation systems at the medicines store in Exeter. The policy covering this precluded staff from using a cassette if any one medicine had run out. However, we saw records where permission was granted for the cassette to continue to be used as all other medicines except one in it were in date and stocked, until the replacement was received.

Requires Improvement

Are services safe?

- The service had carried out audits of antibiotics prescribing, which identified prescribing these were in line with best practice guidelines.
- Processes were in place for checking medicines and staff kept accurate records of medicines.

Track record on safety.

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity through a structured audit programme. This helped to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system for receiving and acting on safety alerts.
- Joint reviews of incidents were carried out with partner organisations, including the local A&E department, GP out-of-hours, NHS111 service and urgent care services.

Lessons learned and improvements made.

- The service learned and made improvements when things went wrong. However, improvements were needed to ensure all potential and actual risks were identified and mitigated.
- There were systems for reviewing and investigating when things went wrong, set out in the Incident Reporting and Investigation procedure. This document provided guidance about the process for establishing whether an incident reached the threshold for declaration as a serious incident and whether it required reporting to the Integrated Care Board (ICB) and Care Quality Commission (CQC). All incidents were reported on the Datix system (Datix is a web-based patient safety recording system), where assessment and decisions following review were recorded. Monthly newsletters covered incident reporting, signposting staff to guidance, examples and support from managers.
- Themes and trends were identified, for example, delays in care, contact and not receiving a response when a patient was called. Between September 2022 and May 2023 the OOH and CAS identified six serious incidents.
- Records demonstrated a root cause analysis was carried out and actions arising were tracked locally and reviewed at a weekly governance and quality review and the monthly Quality Assurance meetings.
- Staff confirmed they understood their duty to raise concerns and report incidents and near misses. However, 32 staff responding to our CQC survey and those interviewed on site gave mixed views about how effective they felt this was in ensuring all learning was identified and acted upon from reported events.
- We sampled records for reported incidents and found investigations lacked depth and did not always document all learning and potential/actual risks which needed to be addressed. This then impacted further on missed opportunities to review and identify learning and mitigate risk:

- For example, a patient was triaged as requiring a response within 2 hours due to their health deteriorating. The patient was not contacted for 30 hours during which time, patient safety calls were recorded as being attempted several times but were unsuccessful. We found that the investigation failed to identify whether potential risks associated with the vulnerability of the person who lived alone were established at the outset and if they had been, identified learning as to how this might have triggered earlier escalation out of concern for the patient.
- Immediately following the inspection, the provider sent further information to clarify that delayed call back was a theme identified from this and other reported incidents. This finding had fed into a larger piece of work done in collaboration with the ICB, to improve quality of the service. A call audit had taken place and individual feedback given to staff. The service had raised awareness across the team about the 'Failed Contact policy'. We saw that the policy provided guidance of action to take when a patient did not respond when contact was attempted. More widely, the governance team had consulted with the local police force to confirm their policy on welfare checks and had disseminated this to the teams. The provider told us that patient safety calling had not been timely; and resulted in the re-design of the process of patient safety calling raising awareness of staff's responsibilities to do this.

Requires Improvement

Are services safe?

- The service learned from external safety events and patient safety alerts. The service had an effective mechanism to disseminate alerts to all members of the team including sessional and agency staff. For example, a regular newsletter was sent to staff summarising important safety alerts.
- Since taking over the service, the provider had established regular engagement meetings with key stakeholders, including the local ambulance service. End-to-end reviews of patient experience with these other stakeholders took place so improvements could be made. For example, they were working to establish a seamless re-direction of patients to the most appropriate service, regardless of the initial number called, providing a consistent response and a more efficient use of resources.

Requires Improvement

Are services effective?

We rated the service as requires improvement for providing effective services because:

- There was a theme of delays in delivering effective care and treatment for patients resulting from recruitment and staff rota fill challenges. Whilst actions had been taken, sustained improvement in outcomes for patients was yet to be achieved.
- Positive changes were being made. For example, referrals received from health care professionals on site about patient falls were audited and referral criteria reviewed with other providers. This led to fewer inappropriate professional referrals being made and had a positive impact on ensuring effective assessment of patients.

Effective needs assessment, care and treatment

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, assessment tools and triage templates from the National Institute for Health and Care Excellence (NICE), National Early Warning Score (NEWS- which is used to assess patients at risk of sepsis), The British National Formulary (used to guide medicine prescribing) and used this information to help ensure that patients' needs were met. The provider monitored these guidelines were followed through clinical audit.
- Triage templates were available, however it was not mandatory for clinical staff to use them. Assurance that clinicians were assessing patients appropriately was achieved through audits, including review of the quality of information held in clinical records and listening to contact calls with patients. The audit tool used, sought assurance that the clinician checked patient age, support network, their medical history, established known disabilities and documented a discussion of their current complaint and safety advice should they become more unwell.
- Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable, for example by making home visits to them. Staff were able to access patient records and previous clinical contact with the out of hours service.
- The service was able to access summary care records and special notes for repeat callers or those who had specific health needs, such as palliative care. If this information needed to be updated, clinical staff used an authorised system to share this with the patient's own GP who was responsible for managing this process. Frequent callers to the NHS 111 service were flagged on the system and accessed by staff at the out of hours service so that appropriate support could be given to the patient.
- All patients were triaged by telephone before being offered a face-to-face appointment including those passed to them via the NHS 111 service. If appropriate, a face-to-face appointment was offered at one of the primary care bases. However, the provider had identified a theme of delayed care through analysis of complaints and incident reporting. They had an action plan to address this, which included increased recruitment to improve rota fill, reviewing appropriateness of referrals and working with other health agencies to make changes to care pathways.
- If patients had access to a computer or smart phone, staff were able to undertake video triage with the use of the GoodSam application. (The GoodSam application provides the ability for those calling services to share their location and live video from their mobile device).

Monitoring care and treatment

- All providers of out-of-hours services were required to comply with the Integrated Urgent Care Key Performance Indicators and Quality Standards 2018. The performance indicators and quality standards are used to show the service

Requires Improvement

Are services effective?

is safe, clinically effective and responsive. Providers are required to report monthly to their integrated care board (ICB) on their performance against the standards which included: audits; response times to phone calls: whether telephone and face to face assessments happened within the required timescales: seeking patient feedback: and actions taken to improve quality.

- The service also used local key performance indicators (KPIs) which were due to be signed off by the ICB to monitor their performance and improve outcomes for people. The provider shared data about its performance with ICB and Care Quality Commission (CQC) every month.
- This was a new service for Devon set up since September 2022. Specific interim targets had been agreed with the ICB. The numbers of patients referred via NHS 111 to Practice Plus Group Devon for clinical assessment and the out of hours service had gradually increased in the first 9 months of operation, with wider organisational support in place to facilitate delivery and embedding of the service.
- We looked at data sent by the provider ahead of the inspection. Data for the period from January to June 2023 demonstrated a trajectory of improvement with the service working towards target performance measures of 95%. For example:
- The percentage of urgent call backs to patients within 20 minutes had increased from71% in January to 75% in June 2023.
- The percentage of urgent and routine call backs to patients within 60 minutes increased from 48% in January to 75% in June 2023.
- The percentage of routine call backs to patients within two hours increased from 71% in January to 83% in June 2023.
- The percentage of patients who did not require an urgent response and consulted within six hours, increased from 59% in January to 79% in June 2023.

By the end of June 2023, the service had seen an increase in base visits to 40% of total consultations (2527), the highest in number and proportion since the start of the contract. Advice consultations were now under 50% of total (49%) for first time and lowest value since October 2022 demonstrating better use of face-to-face appointments for patient assessment and treatment where appropriate.

- Where the service was not meeting the target, the provider had put actions in place to improve performance in this area. The service used information about care and treatment to make improvements. Examples included: focussed recruitment of clinical and non-clinical staff; Review and development of new staffing rotas; Analysis of reasons for health care professional on site calls and direct access line to clinicians when advice was needed.
- The service made improvements using information from completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The service was actively involved in quality improvement activity, including wider healthcare system issues for example: The provider had collaborated with pathology laboratories to improve the timeliness of reporting blood results, so these could be actioned sooner for patients. An agreed process was in place with all NHS hospitals in Devon to enable clinicians to get advice on the most appropriate care and treatment for patients from hospital doctors. This assisted in patients being able to receive care and treatment in the most appropriate setting and reduce pressures on A&E, ambulance services; and enabled patients to be treated at home wherever possible. Where appropriate, clinicians took part in local and planned national improvement initiatives for example, through membership of the 'End of Life Steering group' with the aim of removing barriers and improved care for people at the end of their life.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff, which was managed by locality managers. This covered such topics as health and safety, familiarisation with patient records

systems, medicines management, incident reporting, car checks and clinical emergency procedures. The provider and some staff who responded to our CQC survey told us face to face Basic Life Support training had been arranged. Sessions booked were cancelled at short notice by the training provider but were rescheduled and were taking place over the period of the inspection.

- The provider ensured that all staff worked within their scope of practice and had access to clinical support when required. The wider organisation had an escalation process through which, clinical expertise could be accessed from a 24-hour on call medical director. In interviews, some staff said there had been a few occasions where they had struggled to obtain support through this process. These were during the winter period when there was widespread significant pressures across the whole health and social care system.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Practice Plus Group's learning management system contained a wide range of modules to include updated guidance, incident learning, competencies and new processes. Up to date records of skills, qualifications and training were maintained. We saw the dashboard was colour coded to denote whether a member of staff was compliant, training due or overdue. There was a high level of compliance with mandatory training. The provider was aware that staff required learning disability and basic life support training. The latter had been postponed by the training provider but was rescheduled and due to take place after the inspection. Staff accessed mandatory training modules via an online learning portal. Staff showed us their training dashboard, which gave a clear indication of whether they were compliant with the training required. We saw prompt emails were sent to staff giving them support and a clear timescale set for completion of any outstanding training.
- Staff were encouraged and given opportunities to develop, for example a paramedic was funded and had protected learning time to complete a Masters level degree and obtain a non-medical prescribing qualification.
- The provider had a system for ongoing staff support. This included one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. Since the provider had taken on the service in September 2022, they had carried out a risk assessment of all staff who transferred into employment from the previous provider. They identified gaps in appraisal and supervision and had arrangements to address this within the first 12 months of providing the service. The provider was able to demonstrate the competence of staff employed in advanced roles by audits of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. For example, we saw feedback was given about initial triage call handling; quality and completeness of documentation.

Coordinating care and treatment

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

- We saw records that showed all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. Care and treatment for patients in vulnerable circumstances was coordinated with other services, for example GPs liaised with the community nursing and urgent community care teams to provide additional support where needed. Staff communicated promptly with patient's registered GPs so they were aware of the need for further action. Staff also referred patients back to their own GP to ensure continuity of care. An electronic record of all consultations was sent to patients' own GPs, which operations managers checked had been read and actioned by the receiving service.
- There were established pathways for staff to follow to ensure callers were referred to other services for support as required, for example: A patient requiring minor illness assessment was booked directly into a clinic at their own GP practice the following morning to be assessed and treated. The service worked with patients to develop personal care plans that were shared with relevant agencies when needed.

Requires Improvement

Are services effective?

- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service ensured that care was delivered in a coordinated way and took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, transfers to other services, and dispatching ambulances for people that require them. Staff were empowered to make direct referrals and/or appointments for patients with other services.
- Issues with the Directory of Services (A Devon-wide resource that all staff could use to signpost patients to other services, for example pharmacies that were open in the out of hours periods) were resolved in a timely manner.

Helping patients to live healthier lives

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

- The service identified patients who may be in need of extra support, and provided face to face home visits where needed.
- Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.
- Risk factors, where identified, were highlighted to patients and their normal care providers so additional support could be given.
- 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 obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw patient consent to access their clinical records was documented as part of the contact notes made at the time of the initial telephone triage. Audits of consent processes were carried out to ensure that consent was always obtained and recorded.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated the service as good for caring.

Kindness, respect and compassion

Staff 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 timely support and information. Call handlers gave people who phoned into the service 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.
- The provider's trend report for September 2022 to May 2023 for patient feedback received showed most patients who responded to a survey post consultation, considered staff treated them with respect. Patients also considered they were listened to during their consultation. Comments highlighted staff were compassionate and empathic to patient needs.

Involvement in decisions about care and treatment

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, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

- Staff respected confidentiality at all times. We saw reception staff were discreet in checking personal information with patients being booked in for face to face appointments on their arrival at a Primary Care Centre.
- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately, for example by carrying out clinical audits that included listening to calls to patients to ensure all standards for safe triage and patient involvement were met.

Requires Improvement

Are services responsive to people's needs?

We rated the service as requires improvement for providing responsive services because:

- Patients were not always able to access care and treatment from the service within an appropriate timescale for their needs. Actions to address this were in progress, data demonstrated some improvements to patient access outcomes.
- Complaint outcome letters did not consistently follow the provider's standard for required content.

Responding to and meeting people's needs

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

- Devon ICB told us patient demand for out of hours services had significantly increased in the last 12 months due to other integrated care system pressures. This was particularly seen in the Western locality of Devon. The provider collaborated with the ICB every month about the ongoing development of this service. The Devon Clinical Assessment Service and Out of Hours service was able to utilise additional support from remote clinical staff working for PPG, which the ICB told us now provided a more agile service that was responsive to peaks in patient demands.
- The provider improved services where possible in response to unmet needs. We saw several examples: Clinicians were able to access an online system - Pathways Clinical Consultation Support (PaCCs) to search services available to support patients, including booking ambulances, in hours GP and clinic appointments for immediate and follow up care. Staff shared an example demonstrating the effectiveness of this system; a patient with a minor illness was booked directly into their own GP practice appointment system to be seen in the minor illness clinic the following morning. The patient was given advice on what to do if their condition worsened or they experienced new symptoms and was able to avoid having to find transport during the evening to attend their nearest centre approximately 20 miles away from where they lived.
- The service had a system that alerted staff to any specific safety or clinical needs of a patient using the service. Clinicians were able to add comments to special patient notes to patient records, which operations managers followed up with in hours GPs to ensure concerns were actioned. Care followed national pathways for patients with specific needs, for example those at the end of their life, babies, children and young people.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service. The provider was aware of the geographical challenges in Devon and certain areas where unmet needs during day-time hours led to greater demand during the evening, overnight and at weekends. There was a fleet of 10 hybrid cars, used as a mobile resource in addition to face-to-face appointments offered at bases. Senior managers told us in interviews that cars were based at four Primary Care Centres across Devon. Patients triaged as having clinical needs and/or vulnerable and requiring home assessment were seen in their homes. We met home visiting GPs and drivers during the inspection all of whom had in depth knowledge of the county, the shortest routes and time it might take them to arrive at the patient's home. We saw patients were given an estimated time and their postcode was checked before the drivers left the centre.
- The service was responsive to the needs of people in vulnerable circumstances. Clinicians accessed additional support for patients from an urgent care response team (8am to 8pm), for example to collect a urine sample for analysis so treatment could be started. The community nursing team were also requested to carry out an initial assessment of patients who were housebound, as a backup whilst waiting for a home visit by a GP.

Timely access to the service

Patients were able to access care and treatment from the service which was on a trajectory of improvement to ensure this met the appropriate timescale for their needs.

- Patients were able to access care and treatment at a time to suit them. The service operated from Monday to Friday from 6.30pm to 8am. At weekends and bank holidays a 24-hour service was provided.

Requires Improvement

Are services responsive to people's needs?

- Patients could access the out of hours service via NHS 111. The service was not commissioned to see walk-in patients. However, the provider had a policy should any patient arrive and needed to be seen without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.
- We reviewed the key performance indicator results for April 2023 to June 2023. The performance target was set to 95%.
    - The percentage of patients receiving urgent face to face consultation at a PCC within 2 hours ranged from 59% to 67%.
    - The percentage of patients receiving routine face to face consultation at a PCC within 6 hours ranged from 78% to 85%.
    - The percentage of patients receiving urgent face to face home visit within 2 hours ranged from 48% to 52%.
    - The percentage of patients receiving routine face to face home visit within 6 hours ranged from 68% to 67%.
- Where the service was not meeting the target, the provider was aware of these areas, and we saw evidence that attempts were being made to address them in an agreed action plan with the Devon ICB.
- The management of waiting times, delays and cancellations had been improving since the new service became operational due to targeted and continuous recruitment, utilization of the organization model to use remote clinicians. Additional workstreams were underway, to facilitate greater flexibility and coverage of rotas.
- The service engaged with people who were in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services, for example, providing additional verbal contact and offering paper copies of surveys when there was a drive towards digital services.
- Patients with the most urgent needs had their care and treatment prioritised.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- The appointment system was easy to use via the NHS 111 service.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care. However, complaint outcome letters did not consistently follow the provider's standard for required content.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Between September 2022 and May 2023, the Devon Out of Hours and Clinical Assessment Service received 6 concerns and 76 complaints. Of these, 42 complaints had the theme of patient safety call back being outside of the required timescale (disposition).
- We reviewed 2 complaints and found that they were satisfactorily handled in a timely way. However, the quality of the information provided in the response letter sent to the contact was variable and did not always follow the standard format response outlined within the providers policy.
- Issues were investigated across relevant providers, and staff were able to feedback to other parts of the patient pathway where relevant.
- The service learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.

Requires Improvement

Are services well-led?

We rated the service as requires improvement for leadership because we found:

- Overall governance arrangements needed time to embed in this newly established out of hours service for Devon.
- Processes for managing risks, issues and performance did not always provide assurance that all risks having been identified and mitigated as far as reasonably practicable.
- The service was not yet meeting all performance targets, but was working to an agreed plan to reach these within 2 years.
- Reported incidents and investigations lacked depth and did not always document all potential/actual risks which needed to be addressed. This then impacted further on missed opportunities to review, identify learning and mitigate risk.
- There were some gaps in the systems and processes for the safe handling of medicines.

However, we found areas of positive leadership, culture and improvement:

- There was compassionate, inclusive and effective leadership at all levels.
- The provider had systems to continue to deliver services, respond to risk and meet patients' needs.
- There was a demonstrated commitment to using performance data and information proactively to drive and support decision making.
- The provider involved the public, staff and external partners to sustain high quality and sustainable care.
- There were evidence of systems and processes for learning, continuous improvement and innovation.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to improve and deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. Devon Integrated Commissioning Board (ICB) told us the provider had initiated regular engagement meetings with them and other stakeholders across the integrated healthcare system.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. The provider had created the operational manager role, with staff aligned to the four localities within Devon. Staff confirmed the locality manager worked with them 2-3 times a week at a base and were able to quickly resolve or escalate any issues arising.
- Senior management was accessible throughout the operational period, with an on-call system that staff were able to use.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. Leaders accessed essentials courses and training for managers in finance, coaching skills, governance, project management, clinical skills. Immediately after the inspection, the provider clarified that key staff undertaking investigations were due to start a competency-based root, cause, analysis training in May 2023 and a further course planned for November 2023.

Vision and strategy

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

Requires Improvement

Are services well-led?

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities. The initial priority for the provider when they started the service was to review the current situation and implement a service development plan to address shortfalls in service provision, such as staff shortages, which impacted on their ability to provide the service and respond to patient need. The development plan had been shared and agreed with the commissioners of the service.
- The service developed its vision, values and strategy jointly with patients, staff and external partners. For example, the provider was working with Healthwatch and held external engagement events across Devon to hear people's views about what they wanted from the out of hours service.
- Staff were aware of and understood how the provider wanted the service to develop and were aware of the vision, values and strategy and their role in achieving this. We received 32 CQC staff surveys and spoke with staff during our site visits. Staff told us they saw improvements. For example they felt listened to and engaged in developing the service to provide a high-quality sustainable service.
- The strategy was in line with health and social priorities across the region. The provider planned services to meet the needs of the local population.
- The provider monitored progress against delivery of the strategy.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. The provider had a 'You said, we did' newsletter each month, with examples where staff had made suggestions that had been actioned. These included the provision of IT facilitating remote access to the British National Formularly and NHS mail system, for example enabling immediate referrals to be made. Staff were proud to work for the service, which they said was improving month by month.
- The service focused on the needs of patients, we saw examples of staff going above and beyond to support patients across the county by utilising their in-depth knowledge of the rural and isolated communities to do so. For example, facilitating the transfer of a patient to hospital who did not have access to transport.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values, for example by managing non-compliance with required mandatory training.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Engagement meetings with commissioners were initiated by the provider and included reporting on specific significant incidents, identification of themes and any actions taken. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. The majority had confidence that these would be addressed. Some staff who responded to our staff survey said that when they did raise concerns, they did not always receive feedback about actions taken. We spoke with the senior leadership team about this and were shown how reporting systems included the option for the member of staff to request feedback. They recognised that this could be missed by staff and had already implemented actions to improve communication with staff who raised concerns.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were enabled to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff. Staff were supported when they were involved in a traumatic incident, complaint or investigation.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Requires Improvement

Are services well-led?

- There were positive relationships between staff and teams.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out. However, feedback from staff in 32 surveys and staff interviews was mixed about whether these were yet understood, followed or effective when we inspected the service. The provider demonstrated through its engagement with staff that they were working with them to embed the structures, processes and systems.
- The governance and management of partnerships, joint working arrangements and shared services was underway in promoting interactive and co-ordinated person-centred care. For example, the provider worked collaboratively to review and refine referrals received for assessment from the ambulance service to ensure these were appropriate for the skill mix in the Clinical Assessment Service.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Leaders had established proper policies, procedures and activities to ensure safety and after a challenging first six months, now had increased capacity and resources to undertake audits to assure themselves that they were operating as intended.

Managing risks, issues and performance

We saw some examples where risks, issues and performance were managed, these included:

- There was audit trail demonstrating policies and procedures were reviewed regularly and when important guidance changed.
- Clinical supervision, appraisal and training of staff and temporary staff, including students on placement was evidenced.
- Clinical audit was used to support evidence-based treatment and care. For example, we saw adherence to National Institute of Clinical Excellence (NICE) guidance had been audited.
- The provider had processes to manage current and future performance of the service. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of the Medicines and Healthcare products Regulatory Agency (MHRA) alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators. Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local Integrated Care Board as part of contract monitoring arrangements.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.
- The provider had plans in place and had trained staff for major incidents.
- The provider implemented service developments and where efficiency changes were made, this was with input from clinicians to understand the impact on the quality of care.
- There was an induction system for temporary staff tailored to their role. Some staff responding to the CQC survey highlighted there was a lengthy period between appointment of new staff and start date. The provider verified with evidence that this was frequently due to waiting for an applicant to provide the information requested. The provider had this on its risk register and had taken action to address the issue affecting the onboarding process of new staff. The provider piloted an online application system, which enabled new staff to upload their evidence of qualifications and training. When we inspected, the provider had ratified permanent use of the online application following the successful pilot of it.

Requires Improvement

Are services well-led?

However, we found the providers systems and processes to assess the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks still needed time to embed in this new service. For example:

- The organisational risk register detailed the complexity and challenges with recruitment, and the impact this then had on rota fill and delayed call backs to patients. The provider had an agreed action plan in place with the commissioners, which was monitored twice weekly. Data demonstrated some progress with improving staff rota fill, however the service was not yet meeting all performance targets.
- There was a comprehensive process to identify, understand, monitor and address current and future risks including risks to patient safety. However, we found reported incidents and investigations lacked depth and did not always document all potential/actual risks which needed to be addressed. This then impacted further on missed opportunities to review, identify learning and mitigate risk.
- There were some gaps in the systems and processes for the safe handling of medicines.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information, which was reported and monitored by the provider and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service used information technology systems to monitor and improve the quality of care. For example, quality assurance of clinical audits included listening to patient contact calls recorded for training purposes. The 'GoodSam' application enabled staff to complete video triage with patients calling services to share their location and live video from their mobile device.
- The service submitted data or notifications to external organisations as required. However, in July 2023 the provider identified through its governance arrangements that the quality and performance report packs sent to stakeholders did not follow the required standard. They reported this to us and the ICB and made corrections to rectify data about performance in the July 2023 report pack.
- 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

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.

  Staff were able to describe to us the systems in place to give feedback. There was a Freedom to Speak Up Guardian and process. Four staff were currently receiving training to be Freedom to Speak Up Ambassadors. Staff who worked remotely confirmed they were able to provide feedback through email, remote meetings and were updated on changes via operational and clinical update newsletters.

Requires Improvement

Are services well-led?

- The provider carried out two all staff surveys since September 2022. We saw evidence of the most recent staff survey and how the findings were fed back to staff. We also saw staff engagement in responding to these findings, for example operational managers were aligned to Primary Care Centres (PCCs), working onsite 2-3 times each week providing support to staff. Monthly staff meetings took place at the PCCs. A staff forum was set up, with representation of all staff groups across the service and was autonomous. A well-being strategy was implemented with staff representatives being trained as mental health first aiders to provide additional support to their colleagues.
- The service was transparent, collaborative and open with stakeholders about performance: Weekly and monthly meetings with commissioners were initiated by the provider to report on performance. Agreed improvement plans were discussed. The provider had asked Healthwatch for feedback about the quality of its written responses to patients when things went wrong to identify what improvements could be made.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the service. For example, Advanced Nurse Practitioners (ANPs) and Paramedics were supported both in time and financially to achieve Masters Degree level qualifications to extend their practice.
- Staff knew about improvement methods and had the skills to use them. For example 8 employee roadshow events had taken place where staff were encouraged to raise concerns and offer solutions to improve the service for patients.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. From this, themes for improvement were identified and actions taken to improve the service for patients, including collaboration with other stakeholders. For example:

Delays

- The provider conducted Patient Safety Calling where operational staff called patients when there was a delay to their clinical call back. Calls included an apology for the delay, worsening information and basic safety netting advice. The Patient Safety Calling policy was updated to ensure effective processes were followed to maintain patient safety.
- To reduce delays, the service had increased the number of clinicians by making greater use of Paramedics and Advanced Nurse Practitioners (ANPs). The provider was also working with Exeter University to deliver the new Advanced Care Practitioner (ACP) training syllabus to existing Nurse and Paramedic Urgent Care Practitioners.

Community Pharmacy

- Since taking over responsibility for the service, the provider identified the distribution and opening times of pharmacies across the county was varied. Few pharmacies provided out of hours opening and many having to close without notice due to staffing issues. The provider met regularly with Devon ICB and the local pharmaceutical committee to discuss pharmacy provision plans.
- The electronic prescribing system was implemented to ensure patients prescriptions were sent directly to a pharmacy of their choice.

Patients missing calls

- Comments were received about patients being unable to reach the phone, missing a call at night or that the patient did not recognise the number.
- The provider updated its procedure for non-attendance and no reply situations, setting out triggers and actions to take including the involvement of emergency services like the police to request a welfare check of vulnerable patient.

Requires Improvement

Are services well-led?

Paper patient surveys

- The provider had a good rate of responses from text surveys sent to patients. However, the quality improvement process identified that it could be failing to capture feedback from some groups of patients, especially older patients and those who did not use mobile phones. A paper survey was introduced enabling more patients to give their feedback to the service.
- Leaders and managers had implemented a reward scheme enabling staff to take time out to review individual and team objectives, processes and performance.
- The provider demonstrated actions to embed a strong culture of innovation. This was evidenced by the improvements made in the first nine months of the new Devon Out of Hours and Clinical Assessment System service. There were systems to support improvement and innovation work. Collaborative working with other stakeholders was at the centre of these and examples seen were, regular engagement with the local ambulance service and community nursing teams to strengthen the care and support of vulnerable patients.

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
Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Systems and processes to assess the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks still required time to fully embed: • There were some gaps in the systems and processes for the safe handling of medicines. • Arrangements for planning and monitoring numbers of staff working (shift fill) were in place but the service had not yet achieved full staffing provide the service. • The service learned and made improvements when things went wrong. However, improvements were needed to ensure all potential and actual risks were identified and thoroughly investigated to mitigate these. • Patients were not always able to access care and treatment from the service within an appropriate timescale for their needs. Actions to address this were in progress, data demonstrated some improvements to patient access outcomes. This was in breach of Regulation 17 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.