Devon Doctors - Osprey House

Inspection report

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

Date of inspection visit: 3, 4, 5 November 2021 site visit. 12 November 2021 end of evidence gathering
Date of publication: 11/01/2022

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

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

Background to this inspection in November 2021.

In July 2020 we carried out a focused inspection in response to concerns received. After this inspection we imposed urgent conditions on the provider's registration with a timeframe to make urgent improvements in the service provided. We also made requirements related to meeting the fundamental standards: safeguarding service users from abuse and improper treatment; good governance; and staffing.

We carried out a focused inspection in December 2020 to follow up on the urgent conditions imposed and the requirements made. We looked at the following key questions: safe, effective, responsive and well-led. During the three-day inspection we found further information of concern. Therefore, we converted the inspection from focused inspection to a full comprehensive inspection, to include the caring domain.

Following the December 2020 inspection, we took regulatory action and varied the urgent conditions placed on the service. In addition, we imposed two new urgent conditions on the provider's registration. We also made requirements related to meeting the fundamental standards; complaints handling; provision of staff training, appraisals and supervision; and health and safety. We also placed the service into special measures, as the key questions of effective and well led were rated as inadequate.

We carried out an announced focused desk-based review of Devon Doctors Limited, in May 2021 to check compliance with the conditions imposed on the provider's registration. We judged that the conditions had been met and removed them from the provider's registration. The requirement notices made at our inspection in December 2020 were still in place. We also made recommendations for the provider to 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 were 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 were used to drive improvements in the service provision.

This service is rated as requires improvement overall. (Previous inspection December 2020 – Inadequate)

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

Overall summary

We carried out an announced comprehensive inspection at Devon Doctors – Osprey House on 3, 4 and 5 November 2021, to follow up on breaches of regulations and to determine whether the service could be taken out of special measures.

At this inspection we found:

- There had been improvements to prioritising safeguarding to minimise risk to patients. All staff had received training appropriate to their role.
- Staff we spoke with were able to identify what constituted a safeguarding concern and knew what actions to take.
- Work was ongoing in the recruitment of sufficient staff numbers to provide the service. There were still issues with high staff turnover, but changes had been made to the recruitment process and there was a broader range of opportunities for allied health professionals.
- Regular monitoring of staffing levels and performance occurred. The service aimed to minimise risk to patient safety whenever possible, if there were insufficient staff to operate all of the sites.
- Risks to patients were assessed, monitored and managed to maintain patient safety.
- Improvements had been made to ensure learning or actions taken from incidents were understood and acted on by all relevant staff, but this needed time to be fully embedded.
- The provider had implemented a programme of appraisals and one to ones.
- Training records showed what training had been provided and what training was required- infection control and safeguarding training was up to date. Staff reported that professional development was discussed in supervision sessions and had started to be provided.
- 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.
- 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.
- Improvements had been made in monitoring service provision and performance to improve timely access and patients were informed of any delays to care and treatment. However, there were still shortfalls which the provider was regularly monitoring and taking action when they were able to.
- The whole of the board and governance structure had been reconfigured.
- There were systems and processes to support good governance and were starting to become embedded.
- Audits of clinicians were used to measure performance and address areas which required improvement.
- Systems had been implemented to monitor learning; further development was needed to ensure these were embedded in practice.

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, including but not limited to infection control; sharing of learning from significant events and complaints; and monitoring of service performance in line with their action plan.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.

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

- Consider how policies and procedures are communicated to staff.
- Consider completing the two outstanding actions from the external health and safety inspection.
- Review processes to make sure medicines and equipment are stored securely when not in use.

Overall summary

- Review the significant event register to make sure any concerns identified from complaints received is included on the register.
- Continue to make sure staff received appraisals at regular intervals.
- Review how call handling data is displayed in clinical assessment service centres.
- Continue with their plan to make improvements using information from complaints.
- Continue to train staff to be Freedom to Speak Up Champions.

I am taking this service out of special measures, as the provider has made sufficient progress in complying with the regulations.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a CQC inspection Manager, a GP specialist adviser, and a team of CQC inspectors who carried out site visits and worked remotely interviewing staff and reviewing documentation related to the running of the service.

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(OOH) GP service and an NHS 111 service, for the counties of Somerset and Devon. The service covers an area of 10,878 km2 (4,200 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 OOH service for Devon and Somerset.

Devon Doctors Limited registered location is: 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 Ashfords in Taunton. The service has nine treatment centres in Devon, which are open at various times throughout the week and weekends to provide the OOH 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 OOH 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 and Treatment of disease, disorder or injury.

Staff employed by Devon Doctors Limited include; call handlers, drivers, reception staff, GPs, nurse practitioners and call centre coordinators. There is a team of supporting office. These members of staff are led by a management team who hold lead roles. For example, clinical governance, recruitment, rotas, medicines, communication and information governance. All staff are overseen by the Board of directors.

The OOH service operates between 6pm and 8am Monday to Friday, and 24 hours on Saturdays, Sundays and bank holidays. The NHS 111 services operates 24 hours a day, all year round.

Requires Improvement

Are services safe?

At our inspection in December 2020, we rated the service as requires improvement for providing safe services because:

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

At this inspection in November 2021 we rated the service as requires improvement for providing safe services. We found:

- There had been improvements to prioritising safeguarding to minimise risk to patients. All staff had received training appropriate to their role.
- Staff we spoke with were able to identify what constituted a safeguarding concern and knew what actions to take.
- Work was ongoing in the recruitment of sufficient staff numbers to provide the service. There were still issues with high staff turnover, but changes had been made to the recruitment process and there was a broader range of opportunities for allied health professionals. The provider was seeking information from staff who chose to leave employment, to identify where action could be taken to improve retention of staff.
- Regular monitoring of staffing levels and performance occurred. The service aimed to minimise risk to patients whenever possible, if there were insufficient staff to operate all of the sites.
- Risks to patients were assessed, monitored and managed to maintain patient safety.
- Improvements had been made to ensure learning or actions taken from incidents were understood and acted on by all relevant staff, but this needed time to be fully embedded.

Safety systems and processes

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

Staff received safety information from the provider as part of their induction and refresher training. The provider had systems to safeguard children and vulnerable adults from abuse. Policies were reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.

A total of 12 members of staff completed a survey we sent out. However, not all survey respondents were aware of who the safeguarding lead was. All 12 members of staff confirmed they had received safeguarding training appropriate to their role. One of the respondents were not aware of where the safeguarding policy was stored on the provider's systems.

All safeguarding referrals made by the service were recorded and there were details of any further action that needed to be taken. Themes from safeguarding referrals were discussed at the provider's Safeguarding Assurance Group meetings on a regular basis.

Training records showed that all relevant staff had received adult and children's safeguarding training to the appropriate level.

Requires Improvement

Are services safe?

The service worked with other agencies to support patients and protect them from neglect and abuse. When needed the service participated in safeguarding investigations. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.

The provider carried out staff checks at the time of recruitment and on an ongoing basis, where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The service used a software application on their computer system to track progress of applications made and a weekly report was produced for senior leaders, so they were aware of the staffing situation.

Infection prevention and control systems

There was a system to manage infection prevention and control (IPC). The infection control policy was reviewed in August 2021 and updated to reflect current guidance on COVID-19 infection control guidance, and included information on the new accountable director. The accountable director was the chief nurse who had started working for the organisation in June 2021.

We visited three bases and found no concerns with infection control processes and procedures. There were adequate supplies of personal protective equipment (PPE) and regular checks were made of the environment. Cleaning schedules were in place and clinicians cleaned consulting room surfaces and equipment used in between seeing patients. All bases we visited had arrangements for isolating patients if they were displaying symptoms of COVID-19 or other potentially infectious conditions.

Monthly audits were carried out at all bases. Audits covered: supply of PPE, availability of handwashing facilities and management of sharps bins. Records reviewed showed that these had taken place as planned, apart from July and August 2021 at the Barnstaple and Okehampton bases. The audit for the Exeter base showed that since August 2021 there were no clinical waste bins in consulting rooms. Clinicians used clinical sacks in their consulting rooms and disposed of them in clinical bins in a main corridor, which presented an IPC risk.

All staff received regular infection control training as part of the provider's mandatory training programme. Training records showed that at the time of the inspection there was a 95% compliance rate with mandatory training in this subject matter. Dates and times had been identified for staff to complete the necessary training, when needed. We were unable to establish if the service had an annual infection control statement.

At our inspection in December 2020, routine testing for Legionella had not been carried out in line with timescales identified in a risk assessment. (Legionella is a bacterium found in water supplies which can cause severe respiratory illness). At this inspection we found that appropriate testing had been carried out and there were no concerns identified.

Premises, facilities and equipment

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. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.

The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Requires Improvement

Are services safe?

At our inspection in December 2020, concerns were identified at the Clinical Assessment Service (CAS) centres and some bases. These related to fire safety and actions not being completed from Health and Safety inspections, carried out by an external provider. At this inspection the provider was able to demonstrate that these shortfalls had been addressed. Further Health and Safety inspections had been carried out and there were no actions identified in relations to fire safety. Two of the bases had one action each to be completed, all of the other bases achieved 90% or above compliance with the indicators.

At our inspection in December 2020, there were also concerns about a base being used as a 'hot' site to see patients with potential COVID-19, this base was no longer in use for this purpose, at the time of this inspection.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections. For example, sepsis. In line with available guidance, patients were prioritised appropriately for care and treatment and in accordance with their clinical need.

Staff told patients when to seek further help. They advised patients what to do if their condition got worse.

There were arrangements for planning and monitoring the number and mix of staff needed.

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

We reviewed rotas and found that there were still difficulties with filling planned shifts. The provider tried to mitigate shortfalls by overfilling clinical shifts in the NHS 111 aspect of the service. This meant that if needed, clinicians could 'front end' calls if non-clinical shifts were not filled. (Front ending calls is when clinicians take calls into the service and carry out the pathways assessment). For example, in the NHS 111 service planned rotas showed that they aimed to fill rotas to 60 to 70%; clinical assessment service staff to 100 to 150% and 50 to 60% health advisors. The aim included a 15% time allocation for breaks, training and administration, with 85% being productivity time answering calls.

There were several factors which were affecting recruitment to the service and subsequent performance. These included: a national shortage of clinicians, the COVID-19 pandemic and associated sickness and the need to self-isolate and new staff not completing the required Pathways trainings (either because they failed the course or chose to leave the service before training had been completed).

Measures taken by the provider to improve recruitment included: an improved process to shorten the application process and provide clarity on what the role entailed, extending initial training on Pathways from four to six weeks and finding out the reasons why staff had left employment; so that measures could be taken to address this.

The provider had an ongoing recruitment programme and used social and local media to attract staff. Work was ongoing in relation to pay and reward and incentives for staff already employed. The provider was also looking to recruit staff who would work weekends and bank holidays only.

Requires Improvement

Are services safe?

Measures being put in place to improve overall performance in the service included: managing sickness and absence to determine causative factors which could be addressed. For example, support when dealing with callers who had a mental health condition. Absence and attrition figures provided to us by the service, showed that there was an 80% absence rate of health advisors and over 100% attrition of non-clinicians. The average rate of sickness per year per person was 15 days. When possible the provider accommodated requests for changes in shift times. The provider was also reviewing how to extend remote working solutions for staff.

Staff were being consulted on changes to the staffing rotas, so that they would only work two weekends out of four, with the aim of achieving a better work life balance. In addition, staff had reported high levels of stress due to the increase in the number of calls received and the provider had a staff counselling programme.

A new team had been developed to enable shortfalls in rotas caused by short notice sickness or absence to be addressed. The team was able to make changes to the rota in 'real time' and worked from 7am to 5pm at weekends and 1pm to 11pm during the week. This team were able to review all rotas and contact staff to come into work and if needed flex the type of clinician who would be working, in accordance with set parameters. For example, having a paramedic working a home visiting shift, as long as there was an adequate number of GPs working. An example of this occurred on Monday 2 November 2021. Staff said that 100% of clinical shifts were filled in Somerset, but by 1pm on the same day this had reduced to 50% due to illness.

The service assessed and monitored the impact on safety when there were changes to services or staff.

The provider held daily operational planning calls each morning, we attended one on 5 November 2021. There were representatives from all parts of the organisation. The current situation with regard to staffing and call handling ability was discussed. At this time the service was in OPEL 3 and there was good clinical cover. (OPEL indicators are used to reflect systems pressures both nationally and on a local level, which can impact on service performance. The lowest level is 1, with the highest being 4. When a service declares OPEL 3 or 4, then escalation plans are actioned to attempt to increase capacity and minimise risk to patients). Call handling capacity was 75% and the service planned to front end calls with clinicians. The Devon OOH rota fill was at 75% and the Somerset OOH rota fill was at 89%. A further meeting was planned for 2.30pm the same afternoon to update the rota position. A spreadsheet was maintained in real time throughout the day with the current situation.

On the 5 November 2021 escalation calls were held with the clinical commissioning groups (CCGs). We were able to listen to these calls. In Somerset there were challenges between 4pm to midnight and incentives had been offered to staff to work in the OOH service; one of the bases at Bridgwater was being covered by a home visiting paramedic, with support from the Taunton base. There was no cover at Shepton Mallet, but cover would be provided by Yeovil.

During the night of 4 to 5 November there were 59 OOH contacts, with six patient calls handed back to their own GP at 7.30am, but these were cleared by 8am.

In the daily Devon System call on 5 November 2021 held at 11am, it was noted that there was a 17% call abandonment rate in the NHS 111 service. (Target 3% or lower of calls abandoned); the service was at OPEL 3, in terms of health advisor cover, but there were adequate numbers of clinicians to front end calls. In the OOH service at 7.30am there were five hand backs, but these had been cleared by 8.15am. There were insufficient staff to open the Honiton and Barnstaple bases in the evening, and these were to be covered by the Exeter base.

Requires Improvement

Are services safe?

Routine meetings were held twice a week with the two CCGs who commissioned the service, to discuss risks to service provision. We were able to listen to a meeting with each of the CCGs. Areas discussed included performance and progress on recruitment.

The operations team held calls with the relevant CCG area if bases had to be closed due to a lack of staff. Agreements were in place to cover the OOH bases at the acute sites in Taunton, Bridgwater, Yeovil and Shepton Mallet first. On the first day of the inspection the provider was unable to man the Okehampton and Honiton bases, and the closure of these sites was agreed with the CCGs responsible.

The service had asked for support from another provider to manage call volumes over weekends and bank holidays, but this had not been successful. A total of 20% of calls were taken by the other provider, but they experienced difficulties with managing demand and could not continue with this support.

The service was starting to work with another urgent care provider to add resilience of the NHS 111 service. Early plans included joint recruitment and partnership working, so the service could work together to meet call demand.

A weekly meeting was held to review capacity and demand in the service. We were told that there had been an average increase in demand overall of 20%, with a 40% increase in call volumes on Saturdays and 30% increase in call volumes on Sundays for the NHS 111 service. The service reported a 25% increase in workload for the OOH service. Data we had access to confirmed this.

Information to deliver safe care and treatment

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

Individual care records were written and managed in a way that kept patients safe. The care records we saw, showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Appropriate and safe use of medicines

The service had systems for appropriate and safe handling of medicines.

The systems and arrangements for managing medicines, including medical gases, emergency medicines and equipment, and controlled drugs and vaccines, minimised risks. The service kept prescription stationery securely and monitored its use. There were arrangements to ensure medicines and medical gas cylinders carried in vehicles were stored appropriately.

Improvements required from our inspection in December 2020 to ensure medicines and equipment in the vehicles used for OOH had been addressed. The provider had reviewed all medicines held at bases and in cars to ensure they were necessary and relevant to the types of conditions clinicians would be treating. The system for monitoring medicines had been strengthened and there were clear audits trails for all medicines used.

Requires Improvement

Are services safe?

We did not find any issues with how medicines and equipment were stored. However, in the Taunton bases there were five grab bags for clinicians' use, if home visits were carried out from base. These were in an unlocked room and easily accessible. Staff said this room was usually locked and entry to the building was by use of a 'smart card'.

There were processes for routine checking of medicines and staff kept accurate records. The service carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.

Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.

Arrangements for dispensing medicines kept patients safe.

Palliative care patients were able to receive access to pain relief and other medicines required to control their symptoms.

Track record on safety

There were risk assessments in relation to safety issues

At our inspections in July and December 2020 we found risk when calls were transferred from the NHS 111 part of the service to the Out of Hours service. Urgent calls were being downgraded, which posed a risk of patients not receiving appropriate care and treatment. Since our inspection in December 2020, the provider had aligned all call timeframes to those used in the NHS 111 service. This had reduced the risk of urgent call backs not being carried out within the disposition (outcomes) generated by the NHS 111 service. Staff reported that it was now easier to track calls and manage call queues.

Improvements had been made to how the service monitored and reviewed activity. This was identified as a shortfall at our inspection in December 2020. Governance arrangements had been refined and there were clearer processes to ensure that accurate information was available in real time. For example, team leaders were able to view real time call numbers and abandonment rates which assist them in organising staff to take calls. If needed clinicians would front end calls to minimise the risk of patients not receiving timely care and treatment.

Information on service performance was regularly discussed at meetings of all levels within the organisation. Minutes from meetings confirmed this. Twice daily performance meetings were held in the CAS, to review the situation in the service.

There was a system for receiving and acting on safety alerts.

Joint reviews of incidents were carried out with partner organisations, including the local hospital trusts and the clinical commissioning group.

Lessons learned and improvements made.

The service learned and made improvements when things went wrong.

There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service.

Requires Improvement

Are services safe?

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. Leaders and managers supported them when they did so. The service had 10 significant events open on its register. We reviewed four of these and found they were appropriately investigated, and any learning was identified and shared with relevant staff.

When needed if a significant incident was identified from a complaint then these were put on the service's significant event register. Examples included a complaint that was made in March 2021, involving a patient who had a kidney infection. The service identified that there were significant delays of over 12 hours in the patient receiving a call from a clinician. The time frame set for a call back was two hours. This complaint was identified as a significant event and moved to the service's significant event log and the investigation was still ongoing. However, we noted that there was no entry on the significant event log summarising this concern.

Another significant event also related to a delay to a call back within two hours from the OOH service.

- The patient contacted the NHS 111 service at 12.08am. Due to not receiving a response the patient called an ambulance at 5.17pm on the same day. The ambulance crew said they had to wait for 30 minutes to get through to the OOH service without success. Therefore, the patient was taken to hospital.
- The investigation by the service showed that a first call ended with a two-hour disposition and no further action. The call then reappeared in the clinical queue with a different case number, but still with a two-hour disposition. A comfort call was made due to the timeframe for a call back being breached, but there was no answer from the patient. A further call was made and again the patient did not answer. No further attempts were made to contact the patient. The following morning the patient's own GP was contacted to inform them of the failed contact.
- The provider's investigation showed that the patient also contacted the NHS 111 online service. This was received and was reviewed by a clinician three minutes after it was received and a two hours disposition set. The clinician noted that it was one of two cases.
- The patient called within one hour of the online consultation form being received, to chase a response to their original call, which was logged against the online consultation. This case was then cancelled four hours later as it was a duplicate case.
- The provider identified that there was a failure to follow the correct procedure when a patient was unable to be contacted; which was to contact the patient three times via telephone and long delays in making call backs. All clinicians were reminded to follow the correct procedure for contacting patients before closing the case.

The majority of staff we spoke with and who responded to our survey said they received learning via email updates and newsletters, but this was not consistent. Two respondents to our staff survey were unaware of how to access learning and two said that no learning was shared.

The service learned from external safety events and patient safety alerts. The service had a mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

The provider took part in end to end reviews with other organisations. Learning was used to make improvements to the service.

Requires Improvement

Are services effective?

At our inspection in December 2020 we rated the service as inadequate for providing effective services. We found:

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

At this inspection in November 2021 we rated the service as requires improvement for providing effective services. We found:

- There had been continual improvements in the monitoring and oversight of effective care and treatment. However, performance at times remained below expected levels.
- The provider had implemented a programme of appraisals and one to ones.
- Training records showed what training had been provided and what training was required- infection control and safeguarding training was up to date. Staff reported that professional development was discussed in supervision sessions and had started to be provided.
- Records showed that consent had been sought appropriately.
- There were no significant events which were looked at that had issues with consent not being sought.
- A policy on the Mental capacity Act 2005 had been implemented.

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 from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. The provider monitored that these guidelines were followed.

Telephone assessments were carried out using a defined operating model. Staff were aware of the operating model which included warm transfers (where during the initial pathways assessment calls were transferred to a clinician for immediate triage).

Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. Where patients needs could not be met by the service, staff redirected them to the appropriate service.

Care and treatment was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable, such as children under five or older patients who were housebound.

We saw no evidence of discrimination when making care and treatment decisions.

There were arrangements to deal with repeat patients, this included special notes on their records and liaising when necessary with in-hours service providers to agree a coordinated approach to their care and treatment.

Requires Improvement

Are services effective?

There was a system to identify frequent callers and patients with particular needs. For example, palliative care patients. We saw that care plans, guidance and protocols were in place to provide the appropriate support.

When staff were not able to make a direct appointment on behalf of the patient, clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.

Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

Since our December 2020 inspection we have monitored closely the performance of Devon Doctors against national indicators (whilst acknowledging the challenges faced on all systems nationally as a result of the pandemic). We have observed an increase in both the performance and ongoing monitoring and oversight of care and treatment.

The service used key performance indicators (KPIs) that had been agreed with its clinical commissioning groups to monitor their performance and improve outcomes for people. The provider was required to submit call data each month to NHS England and Improvement (NHSE/I) to show the efficiency and effectiveness of providing the NHS 111 service and the OOH service.

A situation report was sent to NHSE/I and Somerset and Devon Clinical Commissioning Groups (CCG), on a weekly basis which recorded details of how many calls were received; dispositions made; length of call time and whether call backs had been made within 10 minutes when needed.

If needed, the service could monitor service performance on a daily, weekly and monthly basis. In the CAS centres there were TV screens which showed staff call volumes and alerts of incoming calls. Information on average wait time to answer and calls abandoned was also displayed, as was the number of advisors available to take calls.

There was a clinical lead available in the OOH service during the day at weekends and bank holidays, who monitored the triage queue. The clinical lead who worked at weekends and bank holidays was supernummery to the number of staff working. During weekday evenings, there was a nominated clinical lead who monitored triage queues and were included in the staffing numbers.

Since our inspection in December 2020, the service had adopted the time scales for further action set by the NHS 111 dispositions, when transferring onward care and treatment to the OOH service. This was to minimise the risk of care and treatment being delayed. Cases were sorted according to 'time to action', so clinicians actioned cases from the top of the queue which enabled effective oversight of the clinical queue and enabled comfort callers to know which patients to contact.

Arrangements for allocating and monitoring home visits in the OOH service were not always effective in ensuring that service users received timely care and treatment. We reviewed data and found between December 2020 to October 2021:

- Percentages of home visits completed within two hours (urgent) ranged between 65.80% to 77.53%. Home visits completed within six hours (routine) for the same period ranged between 59.66% and 78.63%.
- The target for both these indicators is 95% or above.

Requires Improvement

Are services effective?

If bases were required to be closed due to staff shortages, then this was discussed with the commissioners prior to it occurring. Arrangements were made to managed expected demand and reduce travel time for patients who needed to visit bases and for home visits as far as possible.

We had received reports that the service relied on 80% of agency staff, with only 20% being permanent employees. We looked at staffing for the period of December 2020 to October 2021 and found that:

- The service used locum GPs ranging between 31 and 248 hours weekly, the range of unfilled hours was 247 to 917 and the total filled GP hours ranged between 1931 to 3571 hours. (date range 30/11/20 to 18/10/21)
- The number of agency nurses used in the same time period ranged between 10 and 119 hours, unfilled hours 332 to 620 and total filled hours ranged between 850 and 1185.

Clinical assessment service (CAS) visits

When we visited the CAS bases we found that there was effective management of call queues and NHS 111 health advisors were professional in answering calls and used pathways appropriately. When needed, health advisors sought advice from clinicians and we observed warm transfers on two occasions. (Warm transfers are when clinical advice is needed immediately, and the patient is transferred to a clinician for triage).

Information displayed on the OOH screen demonstrated appropriate re-prioritisation of dispositions (outcomes) and online cases, which had been promptly reviewed and sent to a clinician to triage.

The service shared with us the performance data from December 2020 to October 2021. We looked at performance for the period between 1 October 2021 to 26 October 2021, which showed that the majority of patients who required a face to face consultation in an urgent treatment centre, were seen within the recommended timeframe identified when they were first assessed by the service.

We reviewed NHS 111 service performance data for the period April 2021 to September 2021 and saw that:

- The average percentage of calls answered within 60 seconds of the number of calls answered ranged between 10% and 65% (the target was 95% or above).
- The percentage of calls abandoned (after waiting 30 seconds) ranged between 8% and 40% (the target was less than 5%).

These figures mirrored the pattern nationally and reflected the pressure on the system as a whole due to the COVID-19 pandemic.

Data seen on 3 November 2021 at 6pm showed:

- 20% of calls answered within 60 seconds (102/477 calls)
- 32 % of calls abandoned 231/725 (after 30 seconds)
- Longest wait 42.54 minutes at 9am in the morning.

Data seen on 4 November 2021 at 7pm showed:

- 59% of calls answered within 60 seconds (320/543 calls)
- 18% calls abandoned after 30 seconds (117/668 calls)
- Longest wait 24:03 minutes at 09:30am in the morning
- Service Advisors on shift: 3

Requires Improvement

Are services effective?

- Health Advisors on shift: 18
- Team Leaders on shift: 6
- Clinical Advisors on shift: 6

Urgent ambulance and emergency department revalidations were undertaken by the NHS 111 service, to ensure they were appropriate. Data received from the provider showed that ambulance re-validation were consistently occurring and were above the target of 50%. Data for the period April 2021 to September 2021 showed that all ambulances had been revalidated within the appropriate timescale.

Staff commented that it could be demoralising to see details of the longest wait, which may have been hours before they arrived on their shift. We discussed this with the provider, who said they would consult with staff about the information displayed on the display screen. Team leaders said they were able to access real-time data and would inform health advisors of the current situation to reassure staff they were working well.

The provider had implemented a programme of quality improvement activity to review the effectiveness and appropriateness of the care provided. This included the call handling audits, which were required to be carried out in an integrated urgent care service.

Effective staffing

At our inspection in December 2020 there was a lack of training on managing challenging behaviours, this had now been provided to relevant staff.

In addition to pathways training being extended the provider had included a week undertaking supervised 'live' calls to enable health advisors to transition fully to working independently.

The provider said that time was allocated for mandatory training for those members of staff employed by the service. Checks were made on agency workers to ensure they had completed relevant training in their main employment.

There were mixed views on training provision and opportunities for professional development. Some staff said they had the opportunity to complete further education and prescribing courses, but others said they had only been able to access in-house training, which usually consisted of mandatory eLearning. Some staff had requested fire officer training and first aid training, but were not able to complete this, as they were told it was for managers only.

All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. This covered such topics as infection control, health and safety and fire safety.

Appraisals and support with revalidation

At our inspection in December 2020, we found that there was no system for carrying out regular one to one supervision sessions or appraisals for staff. At this inspection we found that there was an appraisal and supervision system in place.

The provider reported that all annual appraisals, apart from eight had been completed. Nine of the 13 staff who responded to our survey said they had had an appraisal in the last 12 months or regular reviews, if they have been in the company for less than twelve months. The other four said they had not received an appraisal.

Requires Improvement

Are services effective?

Team leaders said that performance data for NHS 111 services was available to them and they used this in appraisals and supervision sessions, to comment effectively on an individual member of staff's performance and highlight areas of good practice and provide support when improvements were needed. One team leader said that wellbeing of staff was important, and they always asked members of staff how they were.

Support with revalidation

Staff interviewed during the inspection said they were supported with their revalidation requirements to ensure they were on a register to practice. Five members of staff who responded to our survey said they were supported to revalidate, while two considered they did not receive any support. Other staff who responded to our survey said revalidation was not applicable to them.

The provider ensured that all staff worked within their scope of practice and had access to clinical support when required.

The provider could demonstrate how it ensured the competence of staff employed in advanced roles by audit 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. Clear guidelines had been developed which were used to manage sickness and absence. A team leader said that now that sickness rates were being effectively monitored they were able to show staff, how short notice absence affected the whole team.

Coordinating care and treatment

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

We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.

The service was able to book directly into appointments with in-hours GPs and emergency departments in the local area.

Systems had been formalised within the NHS 111 service, with specific referral protocols for patients referred to it. An electronic record of all consultations was sent to patients' own GPs so that they were aware of the need for further action.

Issues with the Directory of Services (DOS) were resolved in a timely manner. All DOS issues were managed by a dedicated team and staff were made aware of changes. (The Directory of Services contains information on local and national services which patients can be referred or signposted to for further care, treatment or advice, such as pharmacies and walk-in centres).

Helping patients to live healthier lives

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

The service identified patients who may be in need of extra support. For example, patients who were homeless.

Requires Improvement

Are services effective?

Where appropriate, staff gave people advice so they could self-care. Systems were available to facilitate this.

Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service 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. The provider monitored the process for seeking consent appropriately.

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Business continuity

There were business continuity plans in place and staff had been trained to deal with major incidents. The provider had escalation plans for all the services they provided, which detailed what actions were needed if there was an incident, such as loss of IT services. At our inspection in December 2020, we noted that the policies had not been reviewed to ensure that information was consistent. At this inspection, we saw that updated copies of these policies had been reviewed and information was consistent.

The service had used their business continuity plan when there was disruption to IT and telephone lines on two occasions. They triggered national contingency plans (this is where calls are taken by other NHS 111 service providers) and used manual paper-based processes to continue to provide the service. The service was able to continue to contact patients who had already called into the NHS 111 service and had received a disposition as the computer system recorded patient contact details.

Good

Are services caring?

At our inspection in December 2020 we rated the service as requires improvement for providing caring services because:

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

At this inspection in November 2021 we rated the service as Good for providing caring services. We found:

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.

There were arrangements and systems to support staff to respond to people with specific health care needs such as end of life care and those who had mental health needs.

Training was provided on respecting and involving patients in their care.

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 of bases informing patients this service was available. Information leaflets were available in easy read formats on request, to help patients be involved in decisions about their care.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved as needed.
- Staff signposted patients and their carers to find further information and access community and advocacy services.

Privacy and dignity

The service respected and promoted patients' privacy and dignity.

Staff respected confidentiality at all times and understood the requirements of legislation and guidance when considering consent and decision making. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Requires Improvement

Are services responsive to people's needs?

At our inspection in December 2020 we rated the service as requires improvement for providing responsive services because:

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

At this inspection in November 2021 we rated the service as requires improvement for providing responsive services. We found:

- Improvements had been made in monitoring service provision so that the service had a clear oversight of volumes of calls and staff availability. The provider was continually working to improve timely access and patients were informed of any delays to care and treatment. However, there were still shortfalls which the provider was regularly monitoring and taking action when they were able to.

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. OOH services and the NHS 111 Service have been set up to respond to calls received by the provider.

Services have been designed to respond to patients' needs for a short period and complete any care or treatment needed or refer patients to other health and social care services, if needed.

The service had a system that alerted staff to any specific safety or clinical needs of a person using the service. For example, those at the end of their life.

Care pathways were appropriate for patients with specific needs. For example, those at the end of their life, babies, children and young people.

The provider was aware of different communication, mobility and cultural needs and where possible organised and delivered services to meet patients' needs.

The NHS 111 service used NHS Pathways, which were regularly updated to ensure the most recent Pathways were used and the DOS was current.

The facilities and premises were appropriate for the services delivered. The service made reasonable adjustments when people found it hard to access the service. Consulting rooms were usually on the ground floor and there was level access to buildings whenever possible.

Timely access to the service

We saw evidence that Devon Doctors had made improvements in the monitoring of timeliness of patients accessing services and had plans in place to manage this.

Patients were usually able to access care and treatment from the OOH service usually within an appropriate timescale for their needs. However, at times this was not always the case.

The OOH service operated from 6pm to 8am Monday to Friday; and 6pm to 8am, over the weekends (Friday evening to Monday morning); and over all bank holidays. The NHS 111 service operated 24 hours a day, 365 days a year.

Requires Improvement

Are services responsive to people's needs?

Patients could access the OOH service by calling the NHS 111 service. The service did not routinely see walk-in patients, but there were arrangements should patients arrive without an appointment. There was a 'Walk-in' policy which clearly outlined what approach should be taken if this occurred. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.

Patients were seen by appointment only in OOH, at the time of our inspection, in response to COVID-19 all patients, who required a face to face appointment, were also triaged first by a clinician over the telephone. This was to determine whether other actions could be taken which were more appropriate, such as attendance at a minor injuries' clinic or alternative 'walk-in' services.

The service had a system to facilitate prioritisation according to clinical need, whereby more serious cases or young children could be prioritised as they arrived at bases. The reception staff had a list of emergency criteria they used to alert the clinical staff if a patient had an urgent need. The criteria included guidance on sepsis and the symptoms that would prompt an urgent response. Reception staff called patients into the premises when it was their time to see a clinician.

Where necessary patients were referred to specific sites if they were displaying symptoms of COVID-19.

The impact of unfilled clinical shifts, due to short notice absence and sickness, meant that it was not always possible to open treatment centres for patients to attend. The provider monitored what staff were available and liaised on a daily basis with commissioners if there was a need to close a treatment centre due to staff shortages.

When patients did not arrive for an appointment or they could not be contacted for a telephone consultation, there was a process to ensure their wellbeing and safety. If needed the police were called or a home visit was carried out.

Situations where a patient could not be contacted were only closed following a review by a clinician.

Patient appointments in the OOH service were generally organised on a first come first served basis although there was a system to revalidate (this means to see that they are clinically required) urgent home visits by the Lead CAS clinician.

The service engaged with people who are in vulnerable circumstances and took actions to remove barriers when people found it hard to access or use services.

Referrals and transfers to other services were undertaken in a timely way.

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

Comfort calling

The provider introduced a process in September 2020 to 'comfort call' all patients in the service's triage queue during the day at weekends and bank holidays. These were patients who had been waiting for more than two hours for a clinician call-back. This was to ensure that that a patients' condition had not worsened and to advise them of the delay. If their condition had worsened this was escalated to the lead IUCS clinician for assessment.

Requires Improvement

Are services responsive to people's needs?

Due to its success, comfort calling was introduced in October 2020 for patients awaiting a home visit. The visiting clinician would call the patient if the timescale for the visit would not be met. This enabled the clinician to triage the patient and escalate concerns if needed. It is expected that comfort calls would only be required when a service is under pressure and not a routine occurrence.

If during the comfort call the patient mentions new or worsening symptoms then call handlers would escalate this to the lead clinician to see whether a priority upgrade is needed. If a second comfort call had to be made, this was also flagged to the lead clinician for review.

There was a process if a patient did not respond to three attempts to comfort call, which included review by the lead clinician, to make recommendations for the next action to be taken, this could involve informing the police to carry out a welfare check.

The provider carried out monthly audits of comfort calls not made at weekends. A total of 25% of calls were reviewed, to identify whether there had been incidents of patient harm. We looked at the audit for September 2021 and found:

- A total of 243 cases required reviewing from the four weekends of the months of September 2021
- A total of 94 were closed after the lead clinician had reviewed them
- A total of 20 cases needed onward care.
- A total of 19 cases were sent to a treatment centre for an appointment to be made and the patient received treatment with no other care being required.
- A total of three cases were sent to a treatment centre for an appointment to be made and required further care.
- A total of 26 cases needed a home visit and there was no need for further care or treatment after that.
- A total of two cases needed a home visit and further care following the visit.
- A total of 14 patients were unable to be contacted.
- A total of 35 cases related to medicines enquiries.
- A total of 10 cases had had actions taken by the patient, a family member or carer,
- A total of four cases were passed back to the patient's own GP.
- A total of 16 cases were either referred to the district nursing team; minor injuries unit; was an expected death; or the case was closed by the patient.
- Where cases of potential harm were identified these were highlighted to the senior clinical team and the clinical governance team. It was not clear from the audit which cases these were. For example, we saw that five cases had already had an emergency 999 ambulance called. Other incidents of potential harm related to a potential ectopic pregnancy; possible COVID-19 infections; vomiting blood and abdominal pain.
- The information showed that there were delays of up to 641 minutes in comfort calling.
- All four cases which were passed back to the patients' own GP were not called back.
- Themes and trends that the provider identified included failed contact with patients before a successful contact was made; clinicians calling back to check on a patient's condition; and time spend contacting other health professionals for advice.
- It was also noted that a large number of cases had been checked by the lead clinician on duty, as part of their monitoring of the call queue.

Home visits

The provider had a system to ensure home visits were conducted, but improvements were still needed to minimise delays.

Requires Improvement

Are services responsive to people's needs?

The provider prioritised visits for vulnerable patients and had undertaken work on reviewing staffing rotas and skill mix. An action plan had been produced, which was regularly monitored. The action plan showed that there were arrangements to utilise clinical staff when bases were closed and there was ongoing recruitment to strengthen the number of staff available to undertake home visits.

The geography covered by the OOH GPs was mixed between urban and rural areas which could involve long journey times. Home visits were booked in by the OOH service and usually planned to take account of travel times and the rurality of some of the locations.

The provider also audited home visits that had been carried out, to determine where shortfalls were. An example of an audit we reviewed related to the Somerset area, between the months of April 2021 to June 2021. The purpose of the audit was to review all home visit cases, where the visit arrival time had been extended to identify whether any actual or potential harm had occurred. The timeframes used were based around a response time of 150%, or greater of the original home visit target. For example, a target arrival time of two hours where the actual arrival time was three or more hours late.

Results from the home visiting audit showed:

- A total of 22 urgent home visit breaches were identified (home visit to take place within two hours). Of these, 16 were not identified as resulting in potential harm; and six were identified in resulting as potential patient harm.
- Timescales for the breaches were measured as the original timeframe, plus the actual arrival time. Therefore, if a visit occurred one hour after the planned time this would be measured as plus one hour over the original time.
- Reasons for potential harm included the clinician having to call 999 on arrival at the patient's home. The highest delay in carrying out a home visit was 5.51 hours, with the shortest delay being 3.18 hours.
- A total of nine routine home visit breaches were identified (home visit to take place within six hours). None of these delayed visits resulted in harm to patients. The longest delay in carrying out routine home visits was 9.23hours , with the shortest delay being 5.44 hours.
- Factors which affected extended breaches cases included the geographical distances visiting doctors had to travel.
- The six cases identified as potential harm had been passed to the clinical governance team to find out what the outcome was for the patient and whether this needed to be recorded as a significant event.
- Themes and trends were being used to refine and improve existing processes, with the aim of improving response times.

Lessons learnt from audits carried out included looking at the comfort calls weekly report to determine whether there were particular times where most comfort calls were needed and therefore adjustments were needed to the shift patterns to increase the number of clinicians available.

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. Information about how to make a complaint or raise concerns was available.

At our inspection in December 2020 we found there were delays in responding to complaints. At the time of this inspection we found processes had been put in place to address this. We saw that outstanding complaint responses had been reduced from 160 to 30, over a period of six months.

Requires Improvement

Are services responsive to people's needs?

We reviewed 20 complaints and found that managing and responding to concerns and complaints was improving. Complaints which had been responded to in the three months prior to the inspection, demonstrated the end to end procedure to respond to complaints within 50 working days.

Information from complaints was starting to be consistently used to improve the quality of care provided. Minutes of meetings held showed that learning from complaints was a regular agenda item. Learning was also shared via newsletters, emails and in one to one sessions. Although, some staff were unaware of where the policy was held and said they did not receive updates.

Requires Improvement

Are services well-led?

At our inspection in December 2020 we rated the service as inadequate for providing well-led services because:

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

At this inspection in November 2021 we rated the service as requires improvement for providing well-led services. We found:

- The whole of the board and governance structure had been reconfigured.
- There were systems and processes to support good governance and these were starting to become embedded.
- Audits of clinicians were used to measure performance and address areas which required improvement.
- Systems had been implemented to monitor learning; further development was needed to ensure these were embedded in practice.

Leadership capacity and capability

At our previous inspections in July and December 2020, there were significant shortfalls in leadership capacity and skills to ensure that high-quality sustainable care was provided consistently.

The provider developed and actioned an improvement plan, which covered all areas which required improvement and longer term aims to improve culture within the organisation.

We were provided with the most recent review of the plan, dated October 2021 which showed progress had been made in defining individual senior leaders' responsibilities and communicating these changes with staff. There were clear lines of accountability and information on how different parts of the service worked together.

The board of the organisation now included non- executive directors, who provided scrutiny and challenge to the executive directors on service performance. The provider had sought support from the commissioners of the service to implement the improvement plan and had regular meetings with them to monitor progress.

Changes were being implemented in a planned manner, to enable effective ongoing monitoring and realistic timeframes had been identified to enable changes to be embedded. For example, work was ongoing in relation staffing skill mix and rota planning in response to increased activity and pressures on the health and social care system due to the COVID-19 pandemic.

Requires Improvement

Are services well-led?

Improvements were still needed to communication between frontline staff and senior leaders, but staff spoken with and those who responded to our staff survey, said that communication with their line managers had improved since our previous inspections.

Communication had started to be addressed with senior leaders being linked to specific bases. The senior leaders undertook visits to the bases to talk with staff who worked in them. The purpose of these visits was to gather staff views and feedback on service provision and what the organisation was like to work for. Information from these visits was shared with the board on a regular basis. Minutes from meetings confirmed this.

During the provider presentation at the start of this inspection, the provider said they were now using more qualitative data, alongside quantitive data to gain an overview of service provision.

The provider had processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Members of staff who responded to our survey and those we spoke with at the site visits were more positive about interactions with their immediate line managers. A total of 10 out of 12 respondents said their line manager provided support with wellbeing and workload. Two respondents did not consider that they were supported in the workplace. Comments made included that some managers had favourite staff and spent more time in supporting them, rather than the whole staff team.

Senior management was accessible throughout the operational period, with an on call system that staff were able to use.

Vision and strategy

The service had a vision and strategy to deliver high quality care and promote good outcomes for patients. This vision and strategy was understood by senior leaders, but some staff said that they did not feel they were engaged in the delivery of this. Some staff who worked in bases told us there were issues with effective communication. The provider had put in place webinars with the chief executive, regular updates by email and other opportunities for staff to suggest improvements to service provision.

Staff were also able to speak with their immediate line managers about how the service was developing. Some leaders commented that there was some resistance in adapting to change by staff and a sense that whatever changes were made, there potentially would be a small number of staff who would not be satisfied with changes. The provider had implemented an appraisal system which was linked to the core values of the organisation and this provided a regular opportunity for discussion around the vision and strategy.

Staff feedback on career development had been listened to by the provider, and work had commenced on looking at how staff would be able to progress in the organisation. For example, a health advisor progressing to be a team leader.

Part of the strategy was to increase staff retention and find a larger site for the NHS 111 part of the service to enable sufficient numbers of staff to be employed, as the current premises did not have sufficient capacity for the amount of health advisors needed to enable the service to improve service performance. The recruitment team said that they had suitable candidates who could start work, but due to space limitations this had not been possible.

Culture

Requires Improvement

Are services well-led?

Progress had been made on developing a culture of high-quality sustainable care. This was starting to be embedded in everyday practice.

The provider was aware of the impact of COVID-19. If staff had to self isolate, they ensured staff did not return to work before their self isolation period had ended. The provider was also aware of the impact on the mental health and wellbeing of staff, due to increased call volumes and wait times for callers. There was an employee assistance programme, with access to counselling services. In addition, staff were asked in their supervision sessions about their wellbeing.

We asked staff what it was like to work at the service and whether they had noticed any improvements since our previous inspections. There were some members of staff who considered that there were still issues with not being supported or listened to, and changes being either too slow or too fast.

Positive comments included that staff and managers were supportive and caring and they had seen improvements since our previous inspections. Examples included different teams working more closely together; and an improvement in governance structures so that service performance was clear, and risks could be easily identified and minimised. Some staff said that they had received support during periods of illness.

Some staff said that there was still a disconnect between bases, which they considered had resulted in a 'them and us' situation.

Other comments included having a clear plan to improve and the right people employed to deliver the strategy.

Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

The service focused on the needs of patients.

Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

The Freedom to Speak Up Guardian had received appropriate training to carry out their role. They also had access to a web portal, where staff could report concerns anonymously if they were concerned about being identified. Plans were being put into place to train members of staff to be Freedom to Speak Up Champions in the workplace, to enable staff to discuss concerns more easily. Improvements were still needed to provide reassurance to staff that issue raised would be acted on.

There were processes for providing all staff with the development they need, although work needed to be continued to ensure these processes were embedded. The majority of staff had received an appraisal and were up to date with their training requirements. However, we noted that some refresher training had become due again. The provider was working on plans to make sure there was a rolling programme of staff training and development. Staff were usually supported to meet the requirements of professional revalidation where necessary.

Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work, but this needed to be consistent across all staff groups.

There was a strong emphasis on the safety and well-being of all staff.

Requires Improvement

Are services well-led?

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.

Governance arrangements

There were systems and processes to support good governance and were starting to become embedded.

The whole of the board and governance structure had been reconfigured since our inspection in December 2020. The provider had a number of committees to monitor service provision. The provider was able to demonstrate how these committees worked together, through regular meetings' to ensure risks to patients were mitigated; how performance data was used to drive improvements; how the provider could be assured that significant events and complaints were handled and learning was identified and action taken when needed.

Comments made by staff about governance structure included that they considered these were becoming more streamlined. For example, 'frequent callers' were dealt with by the NHS 111 team, who liaised with the patient's own GP, rather than the governance team carrying out this activity.

All policies and procedures used to support the running of the service had been reviewed in line with the providers set timeframes. This was to make sure that the information contained in them was current and relevant. When needed Standard Operating Procedures were developed and implemented.

At our inspection in December 2020 we noted the provider did not have a separate policy on the Mental Capacity Act 2005, this was now in place and information contained within the policy was relevant.

The processes for managing complaints and significant events had been strengthened and the provider was able to identify themes and trends. We found that significant events and complaints that had been dealt with in the three months prior to this inspection had been investigated appropriately and thoroughly. There was clear information to demonstrate that the provider's policy had been followed and where needed, Duty of Candour had been applied.

Since our inspection in December 2020 audits had been carried out on areas such as: early exiting of calls; management of potential sepsis and management of abdominal pain. As these were areas where improvements were needed to minimise risk to patients. Learning had been shared with staff via newsletters, emails and case studies in the medical directors briefing.

The provider had planned a comprehensive audit programme for 2022 which included clinical audits, call handlers' audits and environmental audits.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.

Requires Improvement

Are services well-led?

At the providers July 2021 Audit Committee meeting it was decided to fully review the service's risk register, to make sure it reflected the organisation's risk matrix as set out in the Risk Management Policy. From this we saw that a total of 88 entries were reviewed and re-scored in line with the organisation's risk register. This was carried out to enable the provider to monitor risk more effectively.

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 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 CCGs 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 providers had plans and had trained staff for major incidents.

The significant event reporting system had been redesigned, and all incidents were captured on the DATIX system (which is an electronic reporting system that enables the provider to run data reports to identify themes and trends and use information to improve service performance). All new significant events were emailed to the senior management team, with 'read receipts' to monitor that the information had been accessed. A weekly report was made of any complaints or significant events which were either new or in progress. Information from these weekly reports was incorporated into a themes and trend report which was presented to the board on a monthly basis. When needed any immediate learning and actions needed was disseminated to relevant staff. For example, if the concern related to a clinician, then the clinicians would be removed from working to allow an investigation to take place.

Learning was also shared through a bimonthly quality newsletter; focussed newsletters, such as one for sepsis identification and management; and quality webinars. However, not all staff said that they received this information.

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 when possible.

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, 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.

The service submitted data or notifications to external organisations as required.

Requires Improvement

Are services well-led?

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.

Staff were able to contact the Freedom to Speak Up Guardian anonymously, should they wish to report any concerns.

Feedback was provided to staff through a range of procedures, however, some staff said that they did not always receive this. For example, seven respondents to our staff survey said they had received information on learning needed, but three said they had not.

The provider had carried out a staff survey in January 2021, concerns identified included staffing levels and communication. These views had been incorporated into the service's overarching action plan. The survey was in the process of being repeated at the time of this inspection.

Patient views had not been easy to capture due to the COVID-19 pandemic and the need to reduce footfall in out of hours services. Information from a local Healthwatch survey, which highlighted issues with access and delays to care, had been used in the provider's improvement action plan.

The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

There was a focus on continuous learning and improvement within the service. Staff knew about improvement methods and had the skills to use them.

The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements; however, this needed some improvement to make sure all staff were engaged in the process.

Leaders and managers supported staff to take time out to review individual and team objectives, processes and performance.

Improvements made since our previous inspection included enhanced clinical validation for routine ambulances, with nearly 1005 of ambulance dispositions being revalidated to ensure they were appropriate and necessary. This had resulted in downgraded 30% of ambulance referrals and 60% of A&E attendances, without compromising patients, health and safety, or care and treatment.

Remote working which the service set up had resulted in an additional 300 hours of clinical advisor resource being made available.

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
Treatment of disease, disorder or injury Diagnostic and screening procedures Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were systems and processes to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk, but these needed to be consistently implemented. In particular: • Infection control processes were not consistently followed at all bases. • The registered person was unable to demonstrate that an annual infection control report was in place. • There were mixed reports from staff on how learning form significant events and complaints was shared. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. The service provider had failed to ensure that persons employed were enabled, where appropriate, to obtain further qualifications appropriate to the work they performed. In particular:

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Requirement notices

- There were mixed reports from staff on training provision and opportunities for professional development. Some staff said they had the opportunity to complete further education and prescribing courses, but others said they had only been able to access in-house training, which usually consisted of mandatory eLearning. Some staff had requested fire officer training and first aid training, but were not able to complete this, as they were told it was for managers only.

This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.