Devon Doctors - 10 Manaton Court

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.

Overall summary

The service was previously inspected in January 2017 and was rated as **good** overall.

We are mindful of the impact of Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the Covid-19 pandemic when considering what type of inspection was necessary and proportionate. This was a focused inspection on the concerns we received. At the time of the inspection we spoke with the registered manager. We were informed after the inspection that the registered manager had gone on a period of extended absence and this role was being covered by another member of staff.

This service was not rated at this inspection due to it being a focused inspection.

We carried out a short notice announced focused inspection at Devon Doctors Limited on 14, 15 and 16 July 2020 in response to concerns received. We inspected specific aspects of the safe, effective and well led domains. We spoke with and interviewed a range of staff across the service, including call handlers, senior and junior managers, clinicians and the chief executive officer and members of the Board.

At this inspection we found:

- Systems to keep patients safe and safeguarded from abuse were not consistently followed or monitored to ensure risks to patients were minimised whenever possible.
- Not all staff had received up-to-date safeguarding and health and safety training appropriate to their role. Safeguarding training was provided online, but oversight and monitoring of completion was not effective. We looked at the training matrix and found that there were gaps in training being completed. Training that had been completed did not provide detail on the level of training undertaken to ensure it was in line with guidance.
- The service could not consistently demonstrate how significant events were identified; used to make improvements; or ensured relevant learning was embedded in everyday practice.
- Information to enable staff to deliver safe care and treatment to patients was not always up to date.
- Feedback from some staff included that they were not always confident that the training they received adequately prepared them for their role.
- Data related to key performance indicators for the NHS 111 service showed that the service was consistently considerably below England averages and did not achieve the required national targets. Performance against some indicators such as calls being answered in 60 seconds were regularly at levels below England averages. There was a lack of systems to ensure associated risks were mitigated for the safety of patients' health and welfare.
- The service used a recognised forecasting tool to determine staffing levels required; however, there were times when there were significant shortfalls in the number of staff on duty. These shortfalls aligned to the periods of time where the NHS 111 service performance was low.
- Leaders were unable to demonstrate that actions to address challenges to quality and sustainability were effectively put into place and monitored.
- Not all staff told us they felt supported by leaders to perform their role effectively. Staff were not fully involved in the running of the service.
- Systems and processes in place to support good governance were not fully embedded.

Following the inspection, we applied urgent conditions to the provider registration of Devon Doctors Limited. The conditions focused on systems to ensure delays to care and treatment were reduced and call answering targets were met; ensuring there were adequate staffing levels at all times and suitable governance processes across the service provision. This was in relation to the significant issues relating to patient safety, the quality of service and leadership and governance.

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 second CQC inspector, a GP specialist advisor, and a practice manager specialist advisor. In addition, four CQC inspectors worked remotely as part of the inspection team in view of Covid-19.

Background to Devon Doctors - 10 Manaton Court

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

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

Devon Doctors Limited registered location is

10 Manaton Court

Manaton Close

Matford Business Park

Exeter

EX2 8PF

The location at Manaton Court, is used for back office functions, and can also be used as a call centre if needed.

The service operates from two main clinical assessment centres (CAS):

Suite 1, Osprey House

Osprey Road, Sowton Industrial Estate

Exeter

EX2 7WN

Ashford Court,

Blackbrook Park Ave,

Taunton,

TA1 2PX

The website is:

We visited Osprey House and Ashford Court as part of this inspection. The service has nine treatment centres in Devon, which are open at various times throughout the week and weekends to provide the out of hours GP service. There are five treatment centres in Somerset.

Devon Doctors Limited is the main contract holder and is responsible for providing the NHS 111 service and out of hours service in Devon and Somerset. The NHS 111 service for Somerset is sub-contracted to another provider. The NHS 111 service for Devon was previously sub-contracted to another provider, however as of October 2019 Devon Doctors Limited took over the running of this service. Devon Doctors Limited remains responsible for any services which it sub-contracts out as the main contract holder.

The provider is registered for the following regulated activities:

Diagnostic and screening procedures

Transport services, triage and medical advice provided remotely

Treatment of disease, disorder or injury.

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

The service operates between 6pm and 8am Monday to Friday and 24 hours Saturdays, Sundays and Bank Holidays but also covers additional hours during the day on an individual contract basis. For example, when a GP practice closes for training.

Are services safe?

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

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

Safety systems and processes

The service had systems to keep patients safe and safeguarded from abuse, but these were not consistently followed or monitored to ensure risks to patients were minimised whenever possible.

- Safeguarding policies identified the safeguarding lead for the service, however, some staff did not know who the safeguarding lead was. However, all staff we spoke with were able to identify what would constitute a safeguarding concern and how to report it. Oversight of any child safeguarding referrals during shifts was the responsibility of line managers or team managers and we were informed that there was always a director on call if needed.

Not all staff had received up-to-date safeguarding and safety training appropriate to their role. The safeguarding polices set out the frequency for when safeguarding training was required. It identified that staff were expected to complete annual updates and clinical staff had to undertake level three child safeguarding training every three years. However, oversight and monitoring of training was not effective. We reviewed the service's training matrix and identified that there were gaps in the recording of completed training and there was no detail on the level of training undertaken. For example:

- 19 out 139 members of staff in the Devon Integrated Care Service (IUCS) had not undertaken safeguarding training in the previous year.
- In the Somerset IUCS, three out of 58 members of staff had not completed training. The training matrix also showed that four members of staff had not completed up to date training.
- We identified that 17 out of 42 clinical members of staff were not up to date with their level three child safeguarding training in line with the service's policy, and 10 of the records on the training matrix were blank.
- We saw evidence that if a member of staff had not completed their required safeguarding training, then this would be treated as a disciplinary matter.

Staff did not consistently follow safeguarding procedures to make sure that appropriate actions and learning were identified when needed.

Examples included:

- In the past nine months an incident occurred where a patient had fallen, and contact was made with NHS 111 service and passed to the out of hours GP for a call back within two hours. This was completed and the clinician determined that an urgent home visit was required. The outcome of this visit was a possible infection and a further home visit was arranged to check on the patient's condition. During this visit the clinician did not carry out an examination, giving a reason that they had other work which needed to be completed. The patient's condition subsequently deteriorated and they died the following morning. The service's investigation concluded that there were no safeguarding issues as the

patient had died. Their investigation report showed that the clinical rota had 29% of hours unfilled and 25 home visits which needed to be made. This case was subsequently referred to the coroner.

- During the winter of 2019, a patient contacted the NHS 111 with symptoms which were similar to indigestion but could have indicated there were more serious concerns. During the call an NHS pathway relating to breathing problems was followed, and further probing questions were not asked, to ensure this was the correct pathway. A further three calls were made to the NHS 111 service as they had not received a call back from a clinician. This information was not passed to the clinician on duty. Before the clinician could call the patient back the NHS 111 service were informed that the patient had died.
- The root cause analysis report, dated 16 April 2020, concluded that the correct pathway had not been followed and the call handler should have asked more probing questions around the symptoms described and how these were potentially symptoms of a cardiac event.
- The mitigation in the root cause analysis referenced the Out of Hours Service being at OPEL3, which is where the system is under pressure. The NHS 111 service which received the call was sub-contracted out to another provider by Devon Doctors Limited to provide the service, but as the main contractor Devon Doctors retained overall responsibility for this aspect of the service provision.

Other examples included:

- An incident occurred involving a child with an injury. The service failed to follow its own policy which details that a referral should have been made to the local safeguarding authority. However, the incident happened during staff change over and was recorded as 'refer to the patient's own GP'. No further action was taken by the service.
- The service had been contacted by a care home regarding an unresponsive patient. The care home did not receive a call back from the service until seven hours after their initial contact. The outcome from their investigation did not identify any learning and concluded that no further action was required as it was identified that the patient was deceased at the point of first contact, and that the seven hour delay had not led to further exacerbation of the circumstances.

Systems to manage infection control risks in the clinical assessment service (CAS) premises did not fully protect staff who worked in the centres and those who saw patients either in their own homes or the treatment centres.

- We received information from staff members regarding the management of staff who were suspected of being, or who had tested positive for coronavirus. This information was conveyed to team leaders, managers and the service's human resources department, but was not acted upon to mitigate risk to staff, patients and external services.
- Staff said there were delays in carrying out deep cleaning of the CAS sites and no contact tracing was carried out. Staff also said that they were told by managers not to disclose this information to other staff members, or any external contacts, to enable them to seek appropriate advice and take any necessary precautions.
- Concerns had also been raised about the fitting of protective screens into out of hours cars and whether the necessary risk assessments had been carried out to ensure safety features in the cars, such as air bags, would deploy correctly in the event of an accident.
- While inspecting the CAS centres, staff told us that one-way systems and masks had only been introduced on the Friday before the inspection visit.
- Some staff told us that if their temperature was high, when they had this checked on arriving for work, they were told to sit in their cars with the air conditioning on to cool down, before returning to have their temperature checked again. Staff said that they undertook their own temperature checks and there was no oversight of this from the leadership team.

Risks to patients

The service could not fully demonstrate that the systems to assess, monitor and manage risks to patients were effective. The system for managing surges in demand was not effective and did not demonstrate that patient safety was maintained.

Staff demonstrated that they understood their responsibilities to manage emergencies and prioritise care and treatment in accordance with the patient's clinical need. However, staff shortages meant that the prioritisation of patients were not consistently achievable.

Are services safe?

- We were informed that prior to the Covid-19 lockdown in March 2020, up to 300 call backs were reallocated back to patients' own in hours GPs on Monday mornings as they had not been addressed by the service. This meant that there were considerable delays for some patients in accessing advice or treatment for healthcare needs and concerns.
- Information from complaints showed that some patients had waited up to 17 hours for contact from the service.
- On occasion, there were no clinicians or drivers available to make home visits.
- Feedback from staff included that at times clinicians were needed to take first contact calls as there were insufficient numbers of call advisors available.
- The service used a recognised staffing tool to forecast the number of staff needed, based on call data. The rota team and rota building planning lead were separate from recruitment and training teams. Staff commented that there was a lack of communication between these teams.
- A review of the rotas and staffing numbers showed that there were times when there were insufficient staff in place to meet expected demand. Staff told us that in general, there were adequate staffing levels for morning shifts, but in the evenings and weekends this was not always the case. This meant that they were not able to respond to an increase in work due to staff shortages and ensure timescales were achieved in the NHS 111 and the Out of Hours (OOH) service. In addition, staff told us the rota team and some managers were 'rigid', and they were told that if they did not like the shifts offered then they could leave.
- The service had a main rota, but also used other rotas which detailed individual staff members shift patterns. Paper copies of staff rotas we looked at did not clearly show which members of staff were on duty.
- Data we reviewed showed a high percentage of shifts for all staff roles not being filled, in particular those staff who worked on the front-line, handling calls, for example, in May 2020, we identified up to 217 unfilled hours.
- Over the period May to June 2020, staff turnover rates were between 20-25% and sickness rates were between 6-16%.
- We discussed low performance with the service and one reason given for this was that many staff had been unable to work as they had failed the temperature checks required as set out during the Covid-19 pandemic. The service attributed this to staff waiting outside the service building (as required) during a heatwave.
- Managers told us that agency staff were not used, but this was inaccurate. The service used agency staff on a regular basis, but when possible tried to employ these staff members permanently to promote continuity.
- Sessional clinical staff were used, but safeguards were not always in place to ensure patients received appropriate care and treatment. A manager told us that due to the history of limited clinical resilience in the service, sometimes a choice had to be made between no clinician or a clinician with non-compliance with performance audit standards.

Staff were aware of their responsibilities for monitoring queue times but said that at times discrepancies with the dispositions that were used and difficulties in finding the original call information on the patient record, blurred and confused the situation. (A disposition is the recommended care or treatment outcome for patients in terms of time frame and likely clinical urgency of the call.)

- Staff reported difficulties in managing call queues to ensure targets were achieved and sustained. Difficulties encountered included a lack of priority being given to palliative, end of life. This caused some staff distress as they could not support patients appropriately.
- Systems to manage patients who experienced long waits were not fit for purpose, as staff were unable to effectively put them into place. This resulted in significant delays for patients who were waiting for a call back from a clinician from the OOH service, some delays were up to 72 hours.
- We reviewed the service's complaint log from August 2019 to the time of the inspection and found that a total of 117 out of 169 complaints related to patients experiencing a delay in being called back or not receiving a call back. This resulted in patients having to contact the emergency services.
- The service's call back policy stated that a team manager should monitor breaches in call back times and implement actions to make 'comfort calls' to patients. Comfort calls were used to check that the patient's condition had not worsened and to inform them of delays in receiving a clinician call back. If a patient's condition had worsened then the service could make arrangements for a clinician to contact them as

soon as possible, or arrange another service, such as an ambulance. The policy indicated that drivers of the OOH doctors' cars should make the calls, however, there was no training provided regarding this.

- We were told by front-line staff that one reason for the delay in call back times was how calls were prioritised after contact with the NHS 111 service. The OOH service in Somerset continued to use the NHS 111 disposition time-frame for further contact. In the Devon OOH service disposition time-frames were changed to two local time-frames of a call back within 20-minutes or a call back within one-hour.
- We reviewed data relating to patients waiting for a call back which showed that there were breaches in timescales for both the OOH and NHS 111 services.
- Examples included at 7.55pm on 15 July 2020, the Devon OOH call back queue had 24 patients waiting for a call back; of these, five had breached the time-frame set and four were about to go over the time-frame set.
- Three of the within 20-minute call backs were delayed. When calls were set as within 20 minutes or sooner, it was usually due to another clinician being with a patient and needing further advice, such as a paramedic in the community.
- On 15 July 2020 at 7.55pm, the Somerset OOH call back queue showed there were seven patients waiting for a call back; only one of these calls was set as requiring a call back within 20 minutes or sooner.
- On 15 July 2020 at 8.15pm, the Somerset OOH queue had 17 patients awaiting triage; eight had breached the timescale; one was about to breach; and two were awaiting a 20 minute or sooner call back.
- On 15 July 2020 at 8.15pm, the Devon OOH queue showed that there were 24 patients awaiting triage; six had breached the timescales; seven were about to breach; and there were three waiting for a 20 minute or sooner call back.

Information to deliver safe care and treatment

Staff did not consistently have the information they needed to deliver safe care and treatment to patients, but improvements were needed to ensure it was up to date.

- We reviewed a sample of medical records and found that clinical detail provided generally gave enough information to provide care and treatment. However, the issues with different disposition systems in place, meant relevant information was not always readily available when needed.
- Clinicians were able to access special notes and care plans of patients, which gave information on specific care and treatment that the patient was receiving. Special notes also gave instructions regarding whether a patient wished to be admitted to hospital if they were unwell. The service's log of incidents showed that on 11 July 2020 an incident had been raised as their 'special patient notes message book' had not been actioned since 8 June 2020. There were two pages of patients listed who had not been followed up with their own GP practice to request special notes to be added to their record. This would ensure that Devon Doctors Limited had all the necessary information available to meet patients' needs, when required.

Lessons learned and improvements made

The service did not always have effective systems and processes in place to monitor and review safety procedures. Improvements were needed to ensure patient safety was maintained and learning from events was effectively shared and acted on. For example, the service could not fully demonstrate how significant events were identified, used to make improvements and ensure relevant learning was embedded in everyday practice.

The process for reporting and acting on significant events was set out in the service's policy and included a risk matrix which was linked to a nationally recognised risk assessment. Staff were aware of how to raise a significant event or concern, but said they were not always clear on what constituted a significant event. Some staff thought it was determined by the medical director and other directors. There was a process in place to classify significant events, but this was not used consistently.

A weekly logbook of incidents was in place which senior managers reviewed. Incidents recorded related to all of the provider's services. We reviewed a sample of incidents that occurred in relation to the Integrated Urgent Care Service (IUCS).

Examples included:

- Concerns raised by staff regarding patients being abusive on calls.

Are services safe?

- An event where a clinician had to take over an NHS 111 service call as the call advisor was unable to confirm whether a patient was breathing and where there was a delay of seven minutes before basic life support instructions were given.
- One incident related to necessary equipment not being repaired. On 12 July 2020, it was reported that a computer in one of the OOH cars was still not working and the car was still in use. This issue had not been addressed at the time of our visit on 15 July 2020. Clinicians were not able to update patient records at the time of providing care and treatment.
- An incident occurred where there was an NHS 111 service pathways error and uncoordinated responses from the OOH service, which resulted in treatment for a patient being delayed and their condition worsened and subsequently died. We identified that there were limited action plans in place to address these issues.

Incidents which had been classified as serious included:

- A patient who had sustained an injury. No call back was made, and the patient subsequently died.
- Abnormal blood results for one patient were received by the OOH service and these were not acted on, as the call handler referred the results to the patient's own GP and closed the case on the service's system. The service identified that the call handler had taken the same action with 12 other calls. There was limited information on the significant event log to demonstrate what actions had been taken and by whom.

Incidents which had been classified as moderate included:

- A patient who was on the Covid-19 shielding list and presented with several symptoms. The patient was given antibiotics by the clinician and requested to record their blood sugars. A district nurse was requested by the clinician to provide a blood glucose monitor which they were not able to do. This was later identified by another clinician who recognised the severity of the symptoms the patient was presenting with and arranged for urgent blood tests to be carried out. The blood results were abnormal, and the patient was admitted to hospital with a serious infection, which potentially could have led to sepsis.

Since August 2019, the service had received 179 complaints. Nine had been identified by the service as incidents of high risk of harm and six had been identified by the service as incidents of moderate risk of harm. These had been recorded on the service's significant event log. However, on review we identified an additional 30 events from the complaints log which could also have been classed as either moderate or high risk of harm.

Examples included:

- Patients who had experienced a delay in triaging by a clinician and who were admitted to hospital for emergency procedures.
- A patient who was experiencing mental health issues and was at risk of self-harming. They were informed by the Devon OOH that they would not be seen due to expressing suicidal thoughts. This resulted in harm to the patient.
- A patient contacted the service on two occasions did not receive a call back. This patient was subsequently seen by their own GP and prescribed antibiotics but was then taken to hospital with a serious infection.
- A patient requested a home visit and was informed they were for older patients and those who were disabled, the patient concerned was later prescribed medication by their own GP. This complaint was not upheld by the service.

Are services effective?

Patients were at risk of not receiving effective care or treatment. There was a lack of consistency in the effectiveness of the care, treatment and support that patients received.

Not all staff had the right qualifications, skills, knowledge and experience to do their job.

Performance measures for the service were below expected targets when compared with similar services.

Effective needs assessment , care and treatment

- The NHS 111 service used the Department of Health approved NHS Pathways system (a set of clinical assessment questions to manage telephone calls from patients). The tool enabled a specially designed clinical assessment to be carried out by a trained member of staff who recorded the patients' symptoms during the call. When a clinical assessment had been completed, a disposition outcome (i.e. what the patient needed next for the care of their condition) and a defined timescale was identified to prioritise the patients' needs.
- We saw evidence that all call advisors had completed a mandatory national training programme to become licensed users of the NHS Pathways programme. Once training was completed, call advisors became subject to call quality monitoring against a set of criteria such as active listening, effective communication and skilled use of the NHS Pathways functionality. However, we identified that the training programme length differed for members of staff. For example, some staff members had six weeks of training and others eight weeks. Feedback from staff included that call handlers received three weeks call handling training, with two weeks in the graduation bay, and one-week solo call handling with supervision prior to being signed off on NHS Pathways.
- Clinical advisors then completed an additional Pathways 'Module 2' training lasting about six to eight weeks after the first level of training had been completed.
- The service had introduced refinements to how it carried out assessments on NHS 111 service calls, with the aim of getting to a disposition quicker in order to provide the correct care and treatment for patients. However, there were issues with providing formal training for staff, due to trainers being off sick. Staff said training provided consisted of listening to calls for patients aged five years and under and patients aged over 80 years. Staff told us that they were not clear on how to use the new system as they considered it did not always provide the correct disposition.
- Several concerns were raised by staff to managers regarding how the system worked in practice. For example: patients who lived in care homes being treated as needing to be assessed using the over 80 years old pathway, regardless of age. Another example related to where improvements were needed to clarify how district nurses' calls should be handled.
- Staff raised concerns to managers about palliative (end of life) care being de-prioritised, managers told staff it was no longer part of the contract, which we found was not the case. Staff said that priority was given to NHS 111 and out of hours calls. Examples of non-prioritisation of palliative care calls included an instance where a caller was in the queue for 30 minutes and during that time the patient's condition had worsened and the caller had to end the call. The caller then contacted the service again to inform them that the patient had died.

Monitoring care and treatment

The service was required to comply with the 'Integrated Urgent Care Key Performance Indicators and Quality Standards 2018', this was detailed as part of their contract with the clinical commissioning groups who commissioned the service.

The key performance indicators included areas such as the proportion of calls answered; how many calls were answered in 60 seconds; the proportion calls where a patient was called back within 10 minutes by a clinician if needed; the number of calls where a caller was given an appointment with a treatment centre; and the proportion of calls where an ambulance disposition was reached and revalidated.

We reviewed data the service provided regarding the key performance indicators for the period August 2019 to the date of inspection, focusing mainly on the performance of the NHS 111 service provided. We identified that the service was consistently below England averages and did not achieve the required targets. We were aware for the period between March to the end of May 2020 all NHS 111 services

and out of hours services were subject to unprecedented demand which impacted significantly on service provision nationally, due to Covid-19 and considered this during our inspection.

For the period January 2020 to July 2020:

Data for the percentage of calls answered in 60 seconds (target at or greater than 95%):

- The rate for Somerset was broadly in line with the national average over the time period. The rate for all NHS 111 services was impacted greatly in March 2020 when call volumes peaked due to covid-19.
- In June 2020, the Somerset data had improved to be in line with regional and England averages.
- The data relating to the Devon service did not similar improvement and was below England averages.

Data for the percentage of call abandoned (at or less than 5%):

- Somerset's call abandonment rate was in line England and regional averages throughout this period.
- Devon's rate was higher than the regional and England averages both before and after the lockdown spike.

Data from the period prior to and after the provider taking the NHS 111 service for Devon back in house in October 2019; and the provision of the NHS 111 service for Somerset; in 2019 showed that both areas were showing a deteriorating performance for call abandonment before the impact of Covid-19 measures (such as national lockdown) came into effect.

In addition, since Devon Doctors Limited took back full responsibility for the Devon NHS 111 service there had been a higher rate of triaged calls resulting in ambulance dispositions and a recommendation to attend A&E.

We reviewed data relating to call waiting times, call abandonment and discussed low performance for dates where we had identified a fall in performance. For example, on 27 June 2020 call abandonment rate was at 24.43% at its highest, compared with the England average of 4.69%.

For the same date the number of calls answered within 60 seconds at its highest was 27, 33.16%, compared with the England average of 83.18%. The service told us that the fall in performance related to staff being unable to work as they had failed their temperature checks prior to starting work and were required to self-isolate. They advised that this was due to the heatwave and staff were waiting outside before the temperature checks were conducted. This had created shortfalls in available staff which the service had not managed to fill.

Live call data collected during the inspection visit showed:

On 14 July 2020

At 10.37am:

- 66% of calls were answered in 60 seconds.
- 7% of calls were abandoned.
- The longest time to wait for a call to be answered was 12 minutes

At 6.45pm:

- 59% of calls were answered within 60 seconds
- 7% of calls were abandoned after 30 seconds
- There was no change to the longest call wait.

On 15 July 2020

At 12.36pm:

- 55% of calls were answered within 60 seconds.
- 13% of calls were abandoned after 30 seconds.
- The longest call wait was 16.04 minutes.

This data was regularly shared with the clinical commissioning group who contracted the service, as part of the contract's requirements and adherence to key performance indicators. The service had action plans in place since November 2019 to address shortfalls, but these did not fully demonstrate consistent improvement in all areas. There had been improvements in the Somerset NHS 111 service, but this was not the same in the Devon NHS 111 service.

- It is a condition of the NHS Pathways user licence and Integrated Urgent Care Key Performance Indicators that the service must regularly audit a random sample of patient contacts. The sample must include enough data to review the performance of all staff that provided care. The service randomly selected calls, and the auditors listened and scored how the call handler managed the call. Learning from these audits was also shared with staff when relevant. For example, if a call handler did not ask sufficient probing questions to ensure the correct NHS pathway was selected, or if worsening information was not given.

Are services effective?

- A standard operating procedure was in place for service advisor call audits, who used a local system implemented by Devon Doctors Limited, known as CAScade, which was a prioritisation support tool; with the service's computer system being used to document and refer each case. This system was separate to the NHS pathways system.
- Data provided by Devon Doctors Limited showed there had been a decline in the number of audits carried out during the months of January 2020 to April 2020. However, at the time of inspection all call audits were up to date.

Effective staffing

The service used a recognised forecasting tool to determine staffing levels required, based on previous call handling data and peaks in demand identified in previous months, for example on bank holidays and weekends.

We reviewed data provided and found there were times when there were shortfalls in the number of staff on duty. This had led to delays in providing care and treatment in a timely manner.

For example:

- On 2 May 2020, between the hours of 7am and 7am on 3 May 2020 (Saturday to Sunday), the forecast showed that 399.5 health advisor (HA) hours and 325 clinical advisor (CA) hours were needed. Of the 399.5 HA hours required only 182.5 were filled, this was a deficit of 217 hours. Of the 325 CA hours required only 253.5 were filled, this was a deficit of 71 hours.
- We also found that there was a reliance on agency staff to cover gaps in the rotas. For example, for the period 2 May 2020 to 3 May 2020, four of the six HAs on shift, were agency staff.
- There was a deficit of 121.5 hours of HAs on 4 May 2020; a deficit of 78 hours of HAs on 5 May 2020; and, on 9 May 2020, there was a deficit of 140.75 hours, which was a Saturday after a bank holiday.
- CA deficits included on 4 May 2020 there was a deficit of 44.5 hours; and a deficit of 51 hours on 5 May 2020; with a deficit of 101.5 hours on 9 May 2020.
- It was not clear from the rotas why there were deficits, as staff sickness and annual leave were not recorded on rotas.
- The service was able to use clinicians who were working remotely to manage spikes in demand.

Training

The service had a training policy in place in which identified mandatory training and the frequencies in which training should be completed. Mandatory training included: fire safety; equality and diversity; infection control; and respecting and involving service users. The service had a training module entitled 'Putting Patients First' which aligned with their vision and values; however, this was not deemed to be a mandatory training module.

- The overall competition rate for all training across the out of hours and NHS 111 services ranged from 55% to 100%, with shortfalls in areas such as cyber security, information governance and safeguarding.
- The training matrix identified that in the Devon Integrated Urgent Care service (IUCS) out of 140 members of staff, 13 members of staff had not started fire safety training and two members of staff had failed the training. One member of staff who had failed the training module on fire safety, had not completed any other mandatory training. A total of 39 members of staff had aspects of mandatory training which had not been started.

Training in the Somerset IUCS had been completed on a more regular basis, with only two members of staff out of 59 not starting any of their mandatory training. A total of 14 members of staff had aspects of mandatory training which had not been started.

Are services well-led?

The approach to service delivery and improvement was reactive and focused on short-term issues.

- **The strategy was not underpinned by detailed, realistic plans and objectives to deliver a high-quality sustainable service.**
- **Staff did not understand how their role contributed to achieving the strategy.**
- **The sustainable delivery of quality care was put at risk by financial challenge.**

There was limited understanding of the importance of culture.

- **There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not feel respected, valued, supported or appreciated. There was poor collaboration between teams and areas of conflict.**
- **When staff raised concerns the culture, policies and procedures did not provide adequate support for them to do so.**
- **There was a limited approach to sharing information with and obtaining the views of staff.**

The arrangements for governance and performance management were not fully clear and did not operate effectively.

- **Risks, issues and poor performance were not always dealt with appropriately or quickly enough.**
- **The risk management approach was applied inconsistently.**
- **The service did not react sufficiently to risks identified through internal processes, but often relied on external parties to identify key risks before they start to be addressed.**

Leadership capacity and capability

Leaders could not fully demonstrate that they had the capacity and skills to deliver high quality sustainable care. Although leaders had identified actions to address challenges to quality and sustainability, they were unable to demonstrate that these were effectively put into place and monitored. Action plans were implemented in May 2020 to improve overall performance, however, these did not specify clearly how and when changes would be put into place and no timescale for completion had been identified.

The service had a defined organisational structure, but there was evidence of different staff teams working in silos. For example, feedback we received included that the recruitment team and staff rota team did not work together when planning skill mix and staffing levels. Staff said that leaders were not always visible and there was a reliance on use of emails and newsletters to cascade information. Feedback from staff included that there was a chain of command but no chain of communication and disconnection from the organisation. The leadership acknowledged there was disconnect, cultural and relationship challenges in the leadership team and the wider organisation.

Vision and strategy

The service's vision was to put patients first by providing exceptional care. There was a strategic plan in place to deliver an Integrated Urgent Care Service (IUCS), aligned and integrated with the NHS 111 service, to improve the patient journey and to make sure patients were able to access the relevant care and treatment they required in as few steps as possible. However, the supporting strategy did not fully engage staff and patients. Some staff we spoke with told us they were consulted about the strategy, whilst others told us they felt their views were ignored

Culture

- The board comprised mainly GPs and they were responsible for overseeing service provision with an emphasis on clinical outcomes and patient safety; and providing constructive challenge to leaders about operations. Clinicians working for the service did not consider it to be unsafe. However, there were areas where safety could be compromised, for example increases in call numbers, but clinicians considered these were dealt with effectively. Clinicians who worked on the front-line in CAS considered that on occasion messages or concerns did not always reach board members.
- Some senior members of staff considered that morale was improving in the service and efforts were being made to promote staff well-being, but measures to address this were only in the planning stage. There were no actions in place to put into place arrangements to facilitate full engagement of staff to improve the culture in the organisation.

Are services well-led?

- Feedback from staff across different teams considered there was low staff morale due to lack of continuity; lack of awareness of management team knowledge about the IT systems and processes in place; and communication systems in place.
- There were reports that on occasion a manager would provide information on working practices, which would then be contradicted by the next manager on shift.
- Staff who handled calls into the service reported significant differences from IUCS and NHS 111 service support staff in how to process calls and said the situation was getting increasingly confused.
- Staff reported that changes had been made to the rota and they were told that if they did not like the changes then they could leave. This apparently resulted in a number of staff leaving. It was reported to us that seven members of staff left on one day.
- Concerns were raised about the lack of 'comfort calls' being made and the significant delays in getting back to patients when needed, for example clinician call backs, some of which had resulted in poor outcomes for patients. Directors of Devon Doctors Limited said this was in part due to existing funding constraints and differences in payment by commissioners for the NHS 111 service for Devon and the NHS 111 service in Somerset. us. They added that they had applied for extra funding from the clinical commissioning group in Devon in order to increase the number of hours available to take calls.
- Staff reported feeling stressed, not valued and not listened to by managers and the organisation. Staff reported told us that when they raised concerns they did not routinely get given feedback on whether any actions had been taken.
- Comments from staff interviews included that they considered the ethos of putting patients first was no longer true of the service as areas like end of life calls were no longer seen as a priority and the team which dealt with them had been disbanded; and the new CAScade system gave unsafe dispositions, such as a baby suffering a head injury, would not have the disposition of attending A&E.
- We saw evidence that staff were informed that if they did not complete mandatory training then disciplinary action would be taken. In some examples we saw staff received this email even though they had completed the training.

Governance arrangements

- Senior leaders reported to us that they had 10 weeks to get the NHS 111 service for Devon in place prior to August 2019. There was evidence that the provider had been the main contract holder for this aspect of the service since October 2016 and were required to oversee the performance of the provider they had sub-contracted to, as they were ultimately responsible for the running of the NHS 111 service.

There were responsibilities, roles and systems of accountability to support governance and management, however, these were inadequate and were not effective to ensure patients' health, safety and welfare was maintained. For example:

- A monthly report was compiled for the clinical commissioning groups (CCG) who contracted the service. However, there were many areas that were not assured and performance over time had not improved or declined, since August 2019. For example, providing clinical assessment within 20 minutes and validating emergency ambulance dispositions. The board was able to approve and sanction fixes to improve the service provision, but this was not always achieved.
- Staff reported to us that there were ineffective call queue management systems, which had contributed to poor performance and delays in care and treatment. They said that some clinicians would avoid what they perceived to be the more difficult calls, such as patients with mental health needs, rather than start at the top of the queue and work through it in time order to minimise delays.
- Systems to monitor training provision were not effective and did not ensure that training identified mandatory by the service was completed and refreshed when need. The service's training matrix showed there were gaps in training being completed, such as fire safety and safeguarding. Staff who undertook NHS 111 pathways training said that at times they felt this was rushed.

Managing risks, issues and performance

The service's system for managing significant events and complaints was not effective. The service used national guidance for categorising significant events and near misses.

- All incidents recorded were investigated, and required actions were signed off by the Board and submitted to

clinical commissioning groups when relevant. Learning from significant events generated an action plan, and all actions were monitored monthly by the governance group and list of outstanding actions updated and reported to the Board, but these were not shared widely with all relevant staff.

- Whilst investigations were carried out, learning from complaints was not embedded in practice to ensure risk to patients were minimised. Themes were identified from complaints included long delays in call backs being made, and a lack of comfort calls. These issues have not been addressed fully and we noted repetition of themes over the period of August 2019 to the date of the inspection. We also found that the analysis into themes from complaints did not assess whether the concerns raised constituted a significant event and required further investigation.
- The service could not demonstrate how their monitoring of performance had mitigated risks effectively and led to improvements. Overall performance for the Devon NHS 111 service had been consistently below regional and England averages from August 2019 to the time of inspection. However, the NHS 111 service for Somerset's performance, although poor initially in August 2019, had improved by the time of the inspection and was now in line with regional and England averages. This part of the service had been sub-contracted out to a different provider.
- We were given assurance that the performance dashboards and data for the service were used to oversee service performance. However, the service could not effectively demonstrate a proactive approach to mitigating risk and sustainment of improvements. We noted that staffing levels had a pattern of insufficient numbers of staff available to handle calls and triaging. We identified that response times particularly decreased between 7am to 11am.
- We were informed that changes had been made to the recruitment processes, with the aim of improving staff retention. This included offering set shifts to staff when they started working for the service. However, this contradicted feedback received from staff who told us that they considered the rota system to be rigid and they were told they could find alternative employment if they were not satisfied with the shifts offered.
- The service used a four-stage system known as the Operational Pressure Escalation Levels (OPEL) process to manage service provision depending on the level, seriousness and impact on patient flow through local health systems. At each stage there were specific actions to be taken in order to manage an increase in demand. When needed at the highest level (level 4), the service could escalate concerns to a national level and drawn on support by using national contingency plans, where a proportion of the calls would be allocated to other NHS 111 service providers in England. This was to allow the service to manage demand and provide a period in which they could return to a business as usual level.
- Staff reported that the highest level was rarely used, and it needed to have the chief executive, chief operating officer or chief strategy officer declaring OPEL level 4 and there were situations where they considered it should have been declared but was not. The service had inserted its own pre-level OPEL 4, which they sought to use to bridge the gap between OPEL 3 and OPEL 4.
- The escalation plan for the Devon out of hours service stated that car drivers, for GPs who undertook home visits, were to carry out comfort calls to patients whose care and treatment may be delayed. The service did not have comprehensive systems to support staff effectively for them to conduct comfort calls as part of the escalation plan. For example, while staff had access to guidance, there was limited information on what to do it a patient's condition had deteriorated.

Systems to support improvements through the use of audits were not effective. The service carried out quarterly breach audits on clinical call back queues to identify where improvements were needed. They selected 50 cases and reviewed call response times, and whether these were met, and if there was potential for harm.

The target times were:

- Emergency target response time 3mins;
- Urgent target response 20mins;
- Routine target 1 hour.

The audit for October to December 2019 showed:

Emergency cases:

- 3 cases;
- Average breach 53 minutes;
- Longest 1.23 hours.

Urgent cases

- 28 cases;
- Average breach 3.24 hours;

- Longest 18.03 hours.

We identified potential harm for one case. The initial call was followed by a call back by the patient due to their worsening condition approximately three hours following their initial call. This was not brought to the attention of a clinician and not flagged on the system. Following the second call made by the patient, there was an additional delay of approximately three to four hours before a call was made. This resulted in a breach of 6 hours, 59 minutes and 55 seconds, by which emergency services had already been contacted.

Routine cases

- 19 cases;
- Average breach 5.49 hours;
- Longest 16.38 hours.

No adverse outcomes identified. One call related to a potential infection and risk of harm was deemed to be low.

The audit for January to March 2020

Emergency cases

- 2 cases;
- Average breach 13 minutes.

Urgent cases

- 30 cases;
- average breach 2.17 hours;
- Longest breach 18.12 hours.

One case identified as potential harm relating to poisoning in a child.

Routine cases

- 18 cases;
- Average breach 6.34 hours;
- Longest 18.20.

No adverse outcomes identified.

This data showed that there were still inherent risks with the service, as performance had deteriorated over time.

Engagement with staff

The service did not involve staff to support high-quality sustainable services. There were systems in place to raise concerns or suggest improvements, but these were limited. For example, if a member of staff wanted to whistle blow, then the policy stated that they would have to do so in writing and their concerns would have to go through three levels of managers, before being brought to the attention of senior leaders. Staff reported not being able to raise concerns anonymously. Members of staff who had witnessed inappropriate behaviours such as bullying, said they had been told to keep quiet by managers.

The service had a Freedom to Speak Up Ambassador, who had held this responsibility for two years, but this person had not received specific training in order to carry out this role. Staff were encouraged to speak to their Ambassador via weekly 'phone-ins' and/or via use of suggestion boxes.

Front-line staff considered they were not involved in developing systems and processes used in the service. For example, the CAScade system where feedback was provided on inconsistencies with the system and improvements needed to ensure the system would be used in a consistent manner by all staff.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:** The registered person had failed to establish systems to prevent abuse. In particular: There were delays in identifying and reporting safeguarding concerns. Not all staff had received appropriate training to the required level in line with published guidance **This was in breach of Regulation 13(1) & 13(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. In particular: Staff were not provided with sufficient opportunities to feedback on how the service was provided and developed.

This section is primarily information for the provider

Requirement notices

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 Treatment of disease, disorder or injury Transport services, triage and medical advice provided remotely	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: Training considered mandatory by the service was not consistently monitored to ensure that it was completed within a timely manner. The service did not ensure that training provide met the needs of staff to enable to perform their duties. **This was in breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**