Devon Doctors - 10 Manaton Court

Quality 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.

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Summary of findings

Overall summary

Devon Doctors Limited is a GP-led, out-of-hours primary care service owned by the 176 GP practices in Devon (not the individual GPs). This unique model has the benefit of having no conflicts of interest from individual GPs, and the practices can influence and take an interest in the quality of the out-of-hours service for their registered patients.

Devon Doctors Limited has one location registered with CQC at 9 -10 Manaton Court. The service operates from a central hub located at 10 Manaton Court, with 15 satellite bases co-located in acute and community hospitals across the county of Devon. Each base had a car for home visits.

We found the service was effective in meeting the wide ranging needs of people who presented at the service, and the varying levels of demand that were placed on the service. Care and treatment was audited and information about a patient was shared with their usual GP to support continuity of care between different providers.

People received a caring service. They told us they were involved in discussions about the health care they received. We found there were opportunities for people to provide feedback about the care and treatment they had received.

The service was responsive to the needs of people. Staff had access to equipment, medicines, guidance and, where possible, information about the patient to support clinical decisions and effectively respond to those in urgent need.

At all the bases, the provider co-located with other agencies such as minor injury units and A&E departments. Some equipment, such as nebulisers and resuscitation trolleys, were shared between agencies. There was a lack of audit of the emergency equipment used by Devon Doctors at the bases we visited. This, coupled with no centrally held records of the maintenance and servicing of any medical devices, meant that staff and people using the service could not be confident that equipment was safe to use.

Staff described the service as well-led. Staff at all levels felt supported and information was routinely shared with staff by email. There was good support for new members of staff. However, we found that there were limited opportunities for established staff to formally discuss issues relating to their work in a one to one meeting.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall the service was safe. However, we found that improvements were required to ensure that stock held medicines and medical devices such as nebulisers were safe for use. There was no inventory of medical devices, which meant that the servicing of these was not robustly managed.

The provider recruited local GPs who were familiar with the local health and social care services. This also supported good communication between different providers.

People were protected from abuse. There was an open culture of reporting within the organisation and staff understood their roles and responsibilities to keep people safe from avoidable harm.

Standard operating procedures and processes were in place to protect people. The provider monitored performance against standards such as The National Quality Requirements.

People told us that they felt safe. They said their needs were met in a timely manner and people were satisfied with their diagnosis and treatment.

Are services effective?

Overall the service was effective.

The provider managed demand for the service effectively. Staff had limited information about people who presented to the service, but they used what information they had effectively to prioritise and ensure people received appropriate care.

People's care and treatment was evidence-based and achieved good outcomes. There were effective clinical governance frameworks in place. The management team monitored the quality of care and were committed to improving and reviewing the effectiveness of treatment.

People told us that the service, advice and treatment had met their needs. We saw that the provider worked with other agencies and had multi-disciplinary working and arrangements in place. Information about a patient's treatment was shared with their own GP, and appropriate information was shared with relevant parties, such as the clinical commissioning groups, mental health professionals, local authority safeguarding teams, and NHS England.

This showed that the provider both supported and actively engaged in working with other stakeholders to ensure that services were delivered effectively and that people experienced positive outcomes.

Are services caring?

Overall the service was caring.

People told us they had been treated with kindness and dignity. They felt their concerns had been listened to and they had been treated in a respectful, professional and dignified way.

Clinicians told us they involved people when making decisions about their treatment, and people confirmed this. People said they had received information about their condition and were given options about the treatment.

Are services responsive to people's needs?

Overall the service was responsive to people's needs.

Summary of findings

People's individual needs were met without avoidable delay. People were given a choice of primary care centres to visit for their appointments.

The provider engaged with local commissioners and local authorities, and used local intelligence to plan its services according to the needs of local people.

There was an open culture within the organisation with a clear complaints and feedback system in place. This means that the provider involved people, their representatives and external agencies in planning its services. The provider routinely learned from people's experiences, concerns and complaints to improve the quality of care through continual audit and monitoring processess.

Are services well-led?

Overall the service was well-led.

There were robust organisational structures in place with clear lines of accountability and responsibility. The staff we spoke with were clear about their role and responsibilities. The leadership within the organisation held itself and others to account for delivering an effective service. The provider welcomed challenge, and promoted an open and fair culture.

Effective clinical governance and corporate systems had been developed to ensure a service that was safe and of a good quality.

New clinical staff received regular supervision opportunities to discuss their performance and issues relating to their role. However, this was not robust for established non-clinical staff, who had few opportunities to formally raise any issues or concerns they might have about their work.

Summary of findings

What people who use the out-of-hours service say

All the people we spoke with before and during the inspection were very satisfied with the service they received. We had not received any complaints or concerns about the service before our inspection, and we received none during our visits.

During our inspection visits to the Devon Doctors bases at The Royal Devon and Exeter Hospital, 10 Manaton Court, and Tiverton Treatment Centre, we spoke with people who had used the service. In total we spoke with 22 people. We tailored our questions to the individual or their parents. There was a range of ages, from babies under one year to people over 65 years.

We asked some general questions about people's experience of the out-of-hours service. We asked whether they felt they had been listened to, whether they had been given appropriate advice about their diagnosis and treatment, whether they were satisfied with the service they received, and if they felt the service had been responsive to their needs.

People told us they were satisfied with the service they had received. People told us "I have confidence in the doctors" and "The service I have received has been efficient and polite. I feel people really do care". One parent told us "I have three small children and have used this service a number of times before. I know that my children will be seen quickly and I have every faith in the doctors. I have always been extremely satisfied."

We reviewed the 52 comment cards we received from people who had used the out-of-hours service. They all spoke highly of the service they had received. People's written comments about the service included "exceptional", "I cannot praise this service highly enough", "A wonderful responsive service, I have been in safe hands".

The provider received maximum star ratings for all categories on the Patient Opinion website albeit from one patient. There were also three positive comments on the website from patients and family members on the website. The Devon Local Medical Committee gave us positive feedback regarding the quality of care patients received from out-of-hours services. The committee reported that 98.5% of respondents rated their overall service as 'Good, Very Good or Excellent'.

Areas for improvement

Action the out-of-hours service MUST take to improve

- The provider should ensure that the safety of the equipment and trolleys it uses are audited and be able to show evidence of how it can be assured of equipment safety, calibration and quality of medical devices.

Action the out-of-hours service COULD take to improve

- Drug stocks were checked weekly by a pharmacist. Every night drugs which had been taken from the GP's bag for home visits were replaced from the main drug stock. We saw that the GPs bags was re-tagged by the car driver, however,no additional check was made against the main drug stock held. Whilst there were no reported incidents of error, this is something the provider may want to review.
- The provider should consider enabling GPs to access the BNF online when out in the cars. This would be useful for the most up-to-date information and amendments for adults and children.
- Introduce formal systems for supervision and appraisal to ensure all staff have regular opportunities to discuss their performance and role.
- Staff told us they felt that they would benefit from meetings with their peers and line manager, as this would ensure effective and consistent communication.

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice:

- 52 comment cards that had been completed by people who had used the service. All the comments we received were positive and did not raise any concerns about patient safety. Written feedback included “The service has been first class!”, “An excellent service, I have been treated with patience, kindness and dignity”, “I cannot praise this service highly enough”.
- Devon Doctors worked closely with the South West Peninsula Postgraduate Medical Education Deanery (SWPPME), which offered study sessions on triage and out-of-hours services. The provider attended the Deanery Finisher Days to actively recruitment newly qualified GPs.
- Staff throughout the service (at all levels) described an open and supportive working environment. Staff were clear about their role and responsibilities and told us about the mechanisms in place for them to feed back about the service to improve and maintain quality and safety. Staff also told us that information flowed easily. All of the staff we spoke with felt they were listened to and they could speak with any member of the management team, at any time.
- The provider had developed its own award winning ‘putting patients first’ training in customer care, which was mandatory for all staff. This meant that people using the service could be assured that they were supported by staff who had been trained in responding to people’s needs in an appropriate way.
- The provider employed local, experienced GPs who were familiar with the local population, resources and referral pathways.
- The provider undertook formal reviews of complaints and there were procedures in place to prevent, respond appropriately to, and learn from complaints. Staff knew how to support people to make a complaint or to raise a concern with managers.

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Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team also included a registered nurse who had managed an out-of-hours service, a registered nurse, an Expert by Experience, a pharmacist who was also the national lead for CQC in this area, a policy manager from CQC, and a CQC second inspector.

Background to Devon Doctors - 10 Manaton Court

Devon Doctors Ltd a is GP-led, out-of-hours primary care service. It is owned by the county's GP practices and has provided urgent out-of-hours primary care to its 1.25m residents since 1996 when it was a GP co-operative. In 2004 it became a company limited by guarantee and was commissioned by NHS Devon, NHS Plymouth, and Torbay Care Trust to provide the out-of-hours service under the new GP contract.

Devon Doctors Ltd is part of the Urgent Health UK social enterprise which has 22 members across England.

Devon has a higher population of people over 50 and a lower percentage under 40 than average. Census data shows an increasing population and a lower than average proportion of Black, Asian and minority ethnic residents.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

Before the inspection we reviewed a range of information that we held about the out-of-hours service and asked other organisations to share with us what they knew about it. We reviewed comment cards that we had asked the provider to give out to people who used the service, so that people could share with us their views and experiences of the service.

We carried out an announced inspection on 26 and 27 February 2014. These inspection visits took place at the provider's registered location of 10 Manaton Court and two of its 15 bases, one at Tiverton Treatment Centre and the other at The Royal Devon and Exeter Hospital.

We spoke with the chief executive officer, the nominated individual (who was also the registered manager), operational staff and clinicians (GPs and nurse prescribers). We met with non-clinical staff such as operational assistants, call handlers, drivers and team leaders. We looked at the arrangements in place for monitoring presenting symptoms, diagnosis and treatment.

We observed how the service handled telephone calls. We spoke with people who used the service, other carers and/or family members and reviewed personal care or treatment records.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 26 February 2014 between 6.30pm to 00.30am and on 27 February 2014 between 10am and 3.20pm.

During our visit we spoke with a range of staff. We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Summary of findings

Overall the service was safe. However, improvements are required to ensure that stock held medicines and medical devices such as nebulisers are safe for use. There was no service-wide inventory of medical devices, which meant that the servicing of these was not robustly managed.

The provider recruited local GPs who were familiar with the local health and social care services. This also supported good communication between different providers.

People were protected from abuse. There was an open culture of reporting within the organisation and staff understood their roles and responsibilities to keep people safe from avoidable harm.

Standard operating procedures and processes were in place to protect people. The provider monitored performance against standards such as The National Quality Requirements.

People told us that they felt safe. They said their needs were met in a timely manner and people were satisfied with their diagnosis and treatment.

Our findings

People's views

We spoke with 22 people who were using the out-of-hours service on the day of our inspection, and read the 52 comment cards that had been completed by people who had used the service. All the comments we received were positive and did not raise any concerns about patient safety. Written feedback included "The service has been first class!", "An excellent service, I have been treated with patience, kindness and dignity", "I cannot praise this service highly enough. I have been listened to". People said they have had "total confidence in my diagnosis and treatment". Other people described the service they had received with words such as "excellent", "brilliant", "amazing and wonderful".

Medicines management

Drug stocks were checked weekly by a pharmacist but every night drugs were replaced from stock. The bags containing medicines used by GPs when visiting people in their own home were re-tagged by the car driver with no additional check made of the contents within the bag. Whilst there were no reported incidents of error, this is something the provider should review.

Cars were equipped with emergency equipment including an automatic external defibrillator (AED), drugs and oxygen. We asked the staff to explain how they ensured appropriate drugs and equipment were available for home visits. Everyone we spoke with understood the process and requirements, but we noted that on some equipment bags in the car the contents list dated back to 2012. We were advised by the pharmacist lead for the provider that this was in the process of being updated.

A GP bag was available in cars. We found that if GPs used their own equipment, there was no evidence of how the provider assured themselves of equipment calibration or quality.

Whilst out on home visits, the GP relied on a hard copy of the British National Formulary (BNF) for information about medicines. There was no mechanism for the GP to access this online, which would be useful for the most up-to-date information and amendments for adults and children.

The main stock drugs were held at the Tiverton treatment centre base which was co-located at the minor injuries unit at Tiverton Hospital. This was because the nearest and only pharmacy that had late opening hours was in Cullompton (approximately 12 miles away), which closed at 10pm. All staff (clinical and non-clinical) had access to the controlled drugs cupboard.

At the Exeter base which was co-located at the A&E dept at Royal Devon & Exeter Hospital in Exeter, we asked about the security arrangements for medicines, including controlled drugs, and where the prescription forms were kept. We were told they were all held securely in an area accessed by Northern Devon Healthcare Staff as well as the Devon Doctors staff. The code to the safe was only available to the car drivers and the operational assistants for the out-of-hours service. We asked a member of staff from the out-of-hours service to show us the controlled drugs; they used their code and were not able to access the safe.They then retrieved the override key to access the safe. They and another member of staff confirmed that this key cupboard was not kept locked and was also open during the day. They also said it could be accessed by other teams who shared the room as well as the housekeeping staff. The key

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to the controlled drugs cupboard was also kept in the digital safe, meaning that this was also not kept securely. We discussed these concerns with the provider, who confirmed that this was being addressed as a priority.

When we asked a member of staff how often the digital code was changed, they were not sure. This means that security could be compromised if this is not undertaken. We discussed with the pharmacist the security of the controlled drugs keys and received assurance that this would be looked at.

We found that there was no system for receiving prescription pads. The pharmacist told us they thought that the previous person managing prescription pads may have had a system to record when the packs were received into the bases. However, this was not recorded at the time of our inspection and was not included in the operating protocols. Assurances were given that this would be looked into as a priority.

At theTiverton and Exeter bases we asked about the emergency equipment trolleys in the area in front of the reception desk. There was confusion at both bases as to who was responsible for the oversight and monitoring of these trolleys. At the Exeter base we were told one trolley was the responsibility of Devon Doctors and the emergency trolley was the responsibility of the Northern Devon Healthcare Trust. However, we were told that either team would use the trolleys. Audits of stock for this trolley showed the last recorded date of checking items was 26 October 2013. However, the syringes in the adrenaline box had an expiry date of January 2011. This meant that people using this equipment could not be assured of the safety and suitability for use. When we pointed this out to the nurses from Northern Devon Healthcare Trust they removed these syringes and replaced them with ones that were in date.

A second trolley had no records to demonstrate that this was checked for expiry dates. When we randomly sampled the contents of the trolley, we found three different medicines had passed their expiry dates. Also one of the drawers of the trolley contained Ventolin 2.5mg and Ventolin 5mg nebules. The 2.5mg nebules were still sealed but the 5mg nebules had been opened and no date was recorded when the pack had been opened. The manufacturer's instructions are that opened packs should be discarded after three months.

At the Exeter base we saw that there was a failure to regularly record the checking of the resuscitation trolley. This constitutes a potential serious risk to people in need of resuscitation and was compounded by the lack of evidence that medical devices had been checked at that base. The provider must have assurance where equipment is the responsibility of another provider and have clear accountability and responsibility for the monitoring and servicing of equipment and medical devices that are their responsibility.

During this visit we looked at a complaint concerning a GP who made a home visit and had administered a nebuliser. A contributing factor in the complaint investigation was that the nebuliser was found to be faulty. In the summary of recorded learning from the incident there was no action mentioned about equipment. We found at the Exeter base, two nebulisers had not been tested for electrical safety. When we asked for assurance, the provider could give no evidence to show that adequate attention was paid to servicing and electrical safety testing of this (or any other) medical device.

Infection control

At the Tiverton treatment centre and the Exeter base we saw the availability of personal protective equipment, alcohol gel, liquid soap, spill kits etc. There were sharps bins in use in all clinical areas and clinical waste was effectively managed. There were also effective systems in place for specimen management reported by both the GP and nursing staff. An infection control link nurse from the co-located bases carried out environmental infection control audits. We were told that the provider's infection control policy was currently under review. There was no evidence of hand hygiene audits of out-of-hours staff, although the Head of Nursing reported that they would be introducing these.

The provider's policies and procedures were available for staff on the intranet, as well as links to professional websites (e.g. NICE) for information and guidance.

Safeguarding

We saw safeguarding policies and protocols on the provider's IT system, with contact numbers for relevant teams. Staff said they had annual safeguarding training and there were named safeguarding GPs for both children and vulnerable adults. Staff told us how the safeguarding process worked. Non-clinical staff would escalate to the clinical staff, and clinical staff would escalate to the GP.

Are services safe?

They also told us they would report concerns to their line manager. One GP we spoke with was not certain where the contact numbers were, but said that one of the staff would know.

When we asked staff to describe the whistleblowing procedures, they all confirmed they would speak with their team leader, a senior clinician or a member of the senior management team if they had any concerns. We were told robust procedures had been implemented to assure staff that there were processes to protect them, if they report any concerns relating to the conduct of colleagues.

Staffing and staff recruitment

People were cared for by suitably qualified, skilled and experienced staff because the provider had completed the relevant checks on staff before they started work. There was a clear recruitment and selection policy, which was kept under regular review to ensure its contents covered all of the standards as set out within the NHS Employers safer recruitment guidelines.

During this inspection we found that all relevant checks had been completed before staff commenced employment, including those with the Disclosure and Barring Service (previously known as Criminal Records Bureau) to help ensure that people who used the service were protected and safe. All the staff files we looked at had updated contracts containing terms and conditions of their employment. The provider had checked that GPs were included on the performers list, which shows their fitness to practise.The provider had checked clinicians' registration with the General Medical Council and the Nursing and Midwifery Council to ensure they were up to date and had not expired. These checks were undertaken quarterly alongside checks with the local area teams and the clinical commissioning groups to ensure that any concerns about conduct and performance would come to light and in turn be acted upon.

The nominated individual advised us that all staff were either directly employed by the service or directly contracted on a sessional basis. This meant that Devon Doctors Ltd did not use a locum agency to cover shifts. The sessional doctors undertaking shifts were mainly GPs from around the local area. This meant that people would be seen by experienced GPs who were familiar with the local health and social care services if they needed to refer patients promptly to other services.

Environment

Buildings were safe. There were systems in place for general safety and security. For example, all visitors were signed in at reception and issued with temporary identification. This procedure applied to our inspectors and the identification passes were collected at the end of the visit.

There were key pads on the doors to sensitive areas of the building or on external doors where there were no supervising staff to control access.

The provider had introduced health and safety audits, which evaluated the safety of premises at each of the bases. Half of the bases had been audited, and there were plans to undertake this for all bases.

Systems, processes and practices

There was a lot of evidence of good practice and a corporate commitment to improvement.

All the staff we spoke with said they had completed mandatory training including fire safety, information governance, safeguarding adults and children (level 3 for GPs), and equality and diversity.

A driver, operational assistant, call handlers, GPs and the head of nursing all described the process of induction of new staff and told us that this was robust and effective.

The staff and senior management team showed openness to CQC's inspection and an Independent NHS audit (Audit South West). The appointment of both the head of nursing and head of operations appeared to reflect an open culture and willingness to improve. This provided confidence that issues identified by CQC would be acted on.

Monitoring safety and responding to risk

The provider had incident reporting procedures in place for all Serious Adverse Events (SAE). The reporting of both clinical and non-clinical incidents of any level of severity, including near misses, was part of the risk management strategy. It also had monitoring arrangements for significant events analysis (SEA).

The provider reported one serious and six significant incidents in 2012/13. In November and December 2013 and January 2014, a total of 586 incidents were reported.

There was evidence of learning from action plans following all seven serious/significant events. These were monitored at corporate level. We saw evidence that following an

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information governance breach, the provider demonstrated exemplary learning and dissemination of learning, as well as partnership working with external professional bodies including the General Medical Council, Local Medical Council, GP Performers List and the Information Commissioners Office. We reviewed the provider's action plan following the death of a child in 2010. This plan showed the sharing of learning at national level at the Urgent Health UK conference in 2011 and the NHS Alliance forum in October 2011.

Clinical and non-clinical staff told us they received feedback from events they had reported. Salaried GPs had a clinical support network attended by the medical directors and Head of Nursing where clinical matters were discussed and updates given. Independent contractors (GPs) were not invited to this and this is something the provider should consider to ensure consistency and shared learning.

Clinical updates, including learning from incidents and near misses, were circulated in the monthly newsletter 'Heartbeat'. There was also a weekly email update to all staff along with 'Sharepoint', the provider's 'online' intranet, which all staff could access. The Head of Nursing also sent out email clinical updates to the nursing team.

The Head of Governance reported sending out 'webinars' with training material by email to all clinicians. Staff also confirmed that the provider ran quarterly triage workshops and undertook record keeping audits. However, these events were not mandatory and self-employed GPs signed a self-declaration of fitness to practise, supported by their annual GP appraisal. The provider had no formal checking process to provide assurance that GPs working solely out of hours were receiving sufficient clinical updates.

Assurance of the overall clinical performance of all clinicians was monitored by a quarterly feedback audit, which encompassed Adastra Information (a computer record of consultations, triage outcomes, and the percentage of calls completed at triage). Clinical performance also incoporated clinical information, including elements of the Royal College of General Practitioners Audit, patient feedback and any complaints or incidents involving that clinician. Staff reported to us that this was a helpful tool which clinicians could use at appraisal and provided corporate assurances against clinical risk.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the service was effective.

The provider managed demand for the service effectively. Staff had limited information about people who presented to the service but used what information they had effectively to prioritise and ensure people received appropriate care.

People's care and treatment was evidence-based and achieved good outcomes. There were some effective clinical governance frameworks in place. The management monitored the quality of care and were committed to improving and reviewing the effectiveness of treatment.

People told us that the service, advice and treatment had met their needs. We saw that the provider worked with other agencies and had multi-disciplinary working and arrangements in place. Information about a patient's treatment was shared with their own GP, and appropriate information was shared with relevant parties, such as the clinical commissioning groups, mental health professionals, local authority safeguarding teams, and NHS England. This meant that the provider both supported and actively engaged in working with other stakeholders to ensure that services were delivered effectively and that people experienced positive outcomes.

Our findings

Using evidence-based guidance

People received care according to national guidelines. The provider used guidelines from the National Institute for Health and Care Excellence (NICE) and best practice professional guidelines. Information relating to national guidelines had been provided to staff within the provider's clinical audit toolkit, which was available to all staff. There were senior leads within the organisation to ensure these guidelines were implemented and monitored, which ensured outcomes for people were good overall.

Urgent and emergency medicines

Before the inspection, CQC asked the Northern, Eastern and Western Devon Clinical Commissioning Group (CCG) to provide feedback about how the provider ensured that it supplyed urgent and emergency medicines effectively, and how these were made available to patients. The CCG told us that prescribing data was a standing agenda item at the provider's Medicines Management group. The CCG had recently been taking a closer look at general prescribing. Any unusual or potentially unsafe prescriptions would be flagged and discussed at the meeting. The CCG would then review the reasons for the prescribing.

The CCG and the provider have jointly worked on controlled drug prescribing for some time, and have had many discussions about the appropriateness and actions to be taken around this subject.

Staff, equipment and facilities

The provider used the Adastra patient management system, which is a robust computer software system for out-of-hours providers. If the system failed, the provider had to resort to manual notes, which were then faxed to the main base. A recent upgrade to the Adastra System had reduced the frequency of this happening.

All GPs had individual training on the Adastra system. GP registrars had also been trained in the system. We saw that staff were continually observing the Adastra tracking system to ensure an effective response to people's needs.

'Special patient notes' were added to the patient record on the Adastra system. GP practices usually faxed any updated information, which GPs and community staff added to the patient record. This included a wide range of information such as 'do not attempt resuscitation' (DNAR) decisions and consent to share records.

When people had been seen by a GP, notes about their treatment and contact were sent an hour later by electronic transfer to their GP at the GP practice where they were registered. In some circumstances, call handling staff telephoned the GP practice to highlight the update. For example, if the GP wanted to ensure that particular concerns were picked up quickly.

There were times when the service was very busy, but it was quiet during the period of our visit. When we asked how the provider measured its performance against the National Quality Requirements (NQRs) on target times, we were advised that timing starts when they receive the call from NHS 111. The provider should follow this up, because the NQR timings are from initial patient contact. By monitoring its performance, the provider can see where it

Are services effective?

(for example, treatment is effective)

doesn't meet performance target times. For example, in the week commencing 10 February 2014, performance at Okehampton dropped below the NQR target performance timescale.

Multidisciplinary working and support

Staff worked well together in teams to co-ordinate care for people.

A salaried GP told us that their appraisal was organised by the local medical council. A number of non-clinical staff told us that they had never had an appraisal. The Head of Nursing, call handlers, team leaders and GPs described induction processes and told us of the assurances for checking that new staff were safe to practise after induction. Staff told us they were supported and monitored to develop their clinical skills. Not all of the staff had been employed for a year, and the provider confirmed that they were consolidating current staff support systems to bring all staff into a formal appraisal and supervision system.

There were clear lines of accountability and support. Staff knew who their line manager was and who to ask if they identified concerns or risks or if they needed further advice.

Devon Doctors worked closely with the South West Peninsula Postgraduate Medical Education Deanery (SWPPME), which offered study sessions on triage and out-of-hours services. The provider attended the Deanery Finisher Days to actively recruitment newly qualified GPs.

The provider also worked in partnership with the Deanery in placing GP registrars throughout their training into the out-of-hours rota to gain valuable experience and education.

Where employed GPs identified that they needed further training, for example, controlled drugs and palliative care, this was provided on an individual or group basis.

All non-clinical and clinical staff received further training at their work locations to ensure they were familiar with the location, the facilities available and the IT software. Training courses and workshops were regularly scheduled for:

- child protection
- protection of vulnerable adults
- intermediate life support
- paediatric life support
- telephone triage
- governance
- basic life support

Employed staff were required to attend the above training. Self-employed staff were encouraged to do so, but if they didn't they needed to show evidence in their self-declaration that they had completed the required training.

Working with other providers

People accessed the service by dialling the NHS 111 number for non-emergency care and directly with Devon Doctors call-handling staff. Following a telephone assessment of their medical condition, people were either given advice from a doctor, given an appointment to attend an out-of-hours medical centre, or were visited at home by a doctor. The provider worked closely with NHS 111 to ensure that information for people was given in an appropriate and timely manner.

The provider also had a 'professionals line' open 24 hours a day. This was a service for registered healthcare professionals such as paramedics, pharmacists, nurses in nursing homes, doctors and nurses in emergency departments and minor injury units and community nursing staff. It provided medical advice from a clinician about a specific person's needs.

Are services caring?

Summary of findings

Overall the service was caring.

People told us they had been treated with kindness and dignity. They felt their concerns had been listened to and they had been treated in a respectful, professional and dignified way.

Clinicians told us they involved people when making decisions about their treatment, and people confirmed this. People said they had received information about their condition and were given options about the treatment.

Our findings

Views of people using the service

We spoke with a number of people who were using the out-of-hours service on the day of our visit. One person described feeling "listened to and much more reassured". Another person told us that it was a "wonderful, faultless service".

We also looked at other feedback received from people about the service from our comment cards and the Patient Opinion Website. The provider received maximum star ratings for all categories on the Patient Opinion website, albeit from one patient. There were also three positive comments on the website from patients and family members. The Devon Local Medical Committee also gave positive feedback about the quality of care from out-of-hours services. The committee reported that 98.5% of respondents rated their overall service as 'Good, Very Good or Excellent'.

Compassion, dignity and empathy:

People told us the staff were kind and caring. One person told us about the emotional support they had received for a personal issue that was unconnected to their medical condition. We observed examples of compassionate care, such as a member of staff who supported a person who was upset and anxious. We also heard a 'host' (a person who books in a person for their appointment) speaking with people in a kind and caring manner.

People told us they were treated with dignity and respect. Staff introduced themselves to people and relatives. We observed staff speaking kindly and patiently. We observed that privacy was maintained. The reception areas at each base varied, some were more open than others. We were told that there was a private area available if anybody wished to discuss something in private and not be overheard.

Involvement in care and decision making

A consent policy was in place which set out how the provider involved people in their treatment choices so they could make informed decisions and give consent. The policy also included information about the person's right to withdraw consent and made reference to Fraser guidelines. These are used when assessing whether children under 16 are mature enough to make decisions without parental consent for their care. This meant staff had access to guidance to involve and help people make informed consent about their care and treatment.

Trust and communication

We observed and listened in on calls from people who needed care, and health professionals who had used the dedicated registered healthcare professionals line. At all times we found the call handlers were very helpful and gave clear advice on what to do, particularly for people if they remained unwell. We saw that GPs gave ample time to people, listening to their concerns and asking appropriate questions and checking if they understood what had been discussed with them. People told us they felt they had been well treated and were able to discuss treatment options. One person told us they had used the service a few months ago for one of their children. They were pleased with the service as the out-of-hours GP had diagnosed a health problem that their own GP had missed.

An examination of GP records showed that staff had discussed people's care with them, giving sound advice and safety considerations.

We saw that the provider routinely asked people about their experience of using the out-of-hours service. A person who had received a home visit gave feedback on a questionnaire which stated "The doctor arrived promptly, was courteous and respectful putting me at ease during an intimate investigation to confirm the cause of haemorrhage was not linked to my condition (oesophageal cancer). Doctor reassured me". The person rated the care experience as 'excellent' and added "I am very pleased with the service I received-thank you". This person also stated that "the initial call handler was competent and reassuring".

Are services caring?

The provider had developed its own award winning 'putting patients first' training in customer care, which was mandatory for all staff. The second module was being rolled out for staff. This meant that people using the service could be assured that they were supported by staff who had been trained in responding to people's needs in an appropriate way.

Understanding treatment and support

People we spoke with described being treated with respect and dignity when using the service. One person told us "The staff have been helpful". We observed reception staff speaking with people in a friendly and helpful manner. We saw them discretely checking with people who might have difficulty completing the 'patient form'.

We saw from the summary of complaints that any complaints about staff attitude had been raised with the member of staff. This demonstrated that the provider was committed to providing a caring service.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the service was responsive to people's needs.

People's individual needs were met without avoidable delay. People were given a choice of primary care centres to visit for their appointments.

The provider engaged with local commissioners and local authorities, and used local intelligence to plan its services according to the needs of local people.

There was an open culture within the organisation with a clear complaints and feedback system in place. This meant that the provider involved people, their representatives and external agencies in planning its services, and routinely learned from people's experiences, concerns and complaints to improve the quality of care.

Our findings

Meeting people's needs

We were told the service had a system to receive 'special patient notes' for people who were vulnerable because of conditions such as needing palliative care, mental health needs or where there were safeguarding concerns. This meant when a person with such a condition called the service, staff would be alerted to their medical history. This enabled staff to respond more effectively to the person's needs. The system also alerted staff when people used the service regularly. The person's own GP was informed when they had any contact with the service. This was provided by 8am the next day and meant GPs were aware of any issues which might need following up and ensured continuity of care.

The provider had robust arrangements in place to ensure that people on the end of life care pathway were supported and their palliative care needs were met in a timely and caring way in line with their assessed needs. They had an end of life care register to quickly identify relevant patients and their needs. We spoke with some district nurses who were not employed by Devon Doctors Ltd. The nurses told us that there was "excellent" communication between themselves and the staff, and they all worked well together to ensure that the people using the service were "first and foremost" in the time and attention received.

We spoke with staff about the management of people with mental ill health who may be at their most vulnerable when attending the service. The nominated individual told us the staff were good at identifying mental health problems that needed to be seen urgently. Clinicians and call handling staff were able to describe the pathways for people in a mental health crisis. We were also told that the community mental health team provided a service on weekends and contacted people in known mental health distress to provide reassurances and prevent crisis. This provided some assurance that the service would be able to respond appropriately to support people at crisis point in relation to their mental health and wellbeing.

The provider also operated a service for people who were known to other agencies, such as the police and social services, as being violent.

Access to services (regardless of background)

The provider had a clear website that informed people any information about the provider, their policies and procedures, etc. could be produced in different formats in line with individual communication needs. We were also informed that for those people whose first language was not English the use of Language Line (an interpretation service) was available.

Vulnerable patients and capacity

We looked at the policy for consent to treatment and saw that it was in line with guidance from the Department of Health. Although the policy referred to lack of capacity to consent to treatment, it did not refer staff to the Mental Capacity Act 2005 Code of Practice. This sets out guidance on assessing capacity in Chapter 4. In relation to possible photographic records, the policy referred to a further research governance policy. Keeping human tissue and photographic or video recording is not normally required in clinical practice out of hours. However, if there was a research programme that required this, full details of consent requirements were in the Devon Doctors Research Governance Policy.

Staff told us they spent time discussing treatment options and plans with people. They were aware of consent procedures. If people needed additional help and/or support, the call handlers were able to access specialist teams such as the community mental health teams and emergency out-of-hours community care and local authority safeguarding teams.

Are services responsive to people's needs?

(for example, to feedback?)

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. One clinician explained that wherever possible staff would speak with the person who needed advice and support, or to the patient's representative. If this was not possible the clinician confirmed all nurses and doctors made a clinical decision in the best interest of the person who used the service.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

Overall the service was well-led.

There were robust organisational structures in place with clear lines of accountability and responsibility. The staff we spoke with were clear about their role and responsibilities. The leadership within the organisation held itself and others to account for the delivery of an effective service. The provider welcomed challenge, and promoted an open and fair culture.

Sound clinical governance and corporate systems had been developed to ensure a service that was safe and of a good quality.

New clinical staff received regular supervision opportunities to discuss their performance and issues relating to their role. However, this was not robust for all established non-clinical staff, who had few planned opportunities to formally raise any issues or concerns they might have about their work.

Our findings

Staff told us they had no concerns and felt generally well supported by their employer. They knew how to raise concerns and told us they could go to someone other than their line manager if that was more appropriate. All the staff we spoke with had positive views of the management and comments included "I can speak with anyone within the management team and feel I am well supported", "Whilst formal arrangements are not in place for a meeting on a one-to-one basis with my team leader, I know that I can email them at any time and they will contact me to discuss any issues or concerns I may have".

The GPs we spoke with said they received regular performance reporting and this had made them think about their practice and they had made some changes as a result.

Governance arrangements

There were management systems in place to monitor the quality of the service provided. Quarterly reports were provided to clinical commissioning groups. This included performance information, clinical and strategic management.

Devon Doctors Limited underwent a regular cycle of audit from the independent body, NHS Audit South West. The provider was measured against a range of national and internal standards. The results of the audits and actions taken were reported in the quarterly reports to the Board.

Leadership within the organisation had been recently strengthened by the appointment of a head of nursing and head of operations. The governance structure had also been recently reviewed. However, there was limited evidence of effective leadership operationally at the Tiverton base we visited. This was based on interviews with two non-clinical staff who, despite long periods of employment, reported that they had never had an appraisal and did not have planned meetings with their manager. The safety issues described at this base reflect this issue, although service-wide conclusions cannot be drawn from this.

There was strong evidence of engagement with the Devon CCG and GP surgeries described by the senior management team. This was enhanced by the fact that Devon Doctors Limited is owned by surgeries within the CCG and the GPs working in the out-of-hours service are local. There has been no locum use in 20012/13, which was a further strength benefiting the people who use the service.

One of the aims stated in the provider's Strategic Plan was to "put patient safety at the foremost of everything we do". Efforts to do this were evident in:

- Review of governance framework and demonstrable learning from serious incidents; regular clinical audit of clinician performance and themed clinical audits e.g. diclofenac/bruising.
- Appointment of heads of nursing and operations.
- Development of a rota (shift) system to ensure adequate staff on duty at all times.
- Use of NHS South West to independently audit Devon Doctors Limited.
- Strong engagement with patients.

Leadership and culture

Devon Doctors Limited is one of the largest social enterprise organisations in the South West. All its profits are reinvested into improving services for patients, which has seen it consistently benchmarked as one of the country's leading providers of out-of-hours GP services by the Primary Care Foundation.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Patient experiences, staff involvement and engagement

There was evidence of regular random patient experience audits as part of the National Quality Requirements for this type of service.

Staff told us there was a good team approach and staff were motivated to provide good quality care. All staff confirmed they received a good level of support from the organisation's senior management team.

People we spoke with were complimentary about the staff who they had spoken with and those they had met.

Staff were clear about their role and responsibilities and told us about the mechanisms in place for them to feed back about the service to improve and maintain quality and safety.

We were told there was a staff forum and recently the staff were surveyed for their opinions about the service. We were told this was a positive survey. It gave staff the opportunity to voice their views and to offer ideas or suggestions about the service. One member of staff said "Everyone is very approachable. The doctors we use come regularly, we know them well".

Staff also told us that information flowed easily. All of the staff we spoke with felt they were listened to and they could speak with any member of the management team, at any time. They felt there was an open culture. Non-clinical staff told us that regular team meetings with peers and line mangers did not take place and they felt that they would benefit from this to ensure effective and consistent communication.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Regulation 16: Safety, availability and suitability of equipment** (1) The registered person must make suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is— a) properly maintained and suitable for its purpose; and (b) used correctly. (2) The registered person must ensure that equipment is available in sufficient quantities in order to ensure the safety of service users and meet their assessed needs. (4) For the purposes of this regulation— (a) “equipment” includes a medical device; and (b) “medical device” has the same meaning as in the Medical Devices Regulations 2002. **How the regulation was not being met:** People who use services and others were not protected against the risks associated with unsafe or unsuitable equipment, as there was no service-wide inventory. The provider was not able to show evidence of how it can be assured of equipment safety, calibration and quality of medical devices. This meant that the servicing of these was not robustly managed.