Devon Scrutiny Committee: Devon Doctors CQC Improvement Plan

12 November 2020

Introduction

On 14-16 July 2020 the Care Quality Commission (CQC) visited Devon Doctors (the Organisation). Following the visit, six conditions and five requirements were placed upon the Organisation's registration.

This paper sets out the improvements made to date against the Conditions set out by the CQC. This paper should be read alongside the Presentation from Devon Doctors to the Scrutiny Committee.

Condition One: Generating the plan

The Board approved the CQC Improvement Plan ahead of the submission date of 11 August 2020. Updates have been provided to the Devon Doctors Board on a weekly basis as well as through the monthly Board meetings. Assurance on progress has also been provided to Devon CCG and the CQC on a weekly basis through a series of touchpoint meetings.

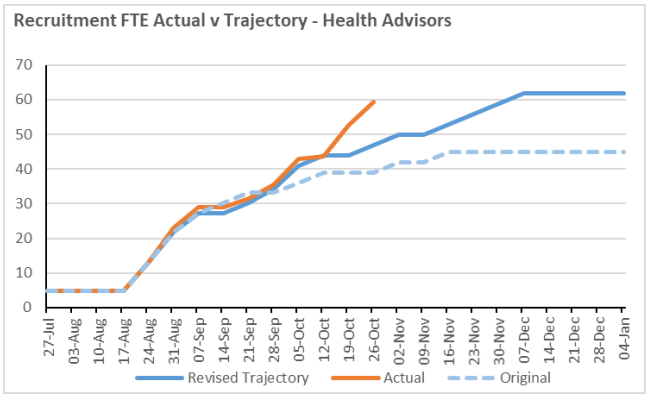
While the Organisation has not had confirmation that this Condition will be removed, there has been no challenge as to the scope or depth of the plan from either Devon CCG or the CQC.

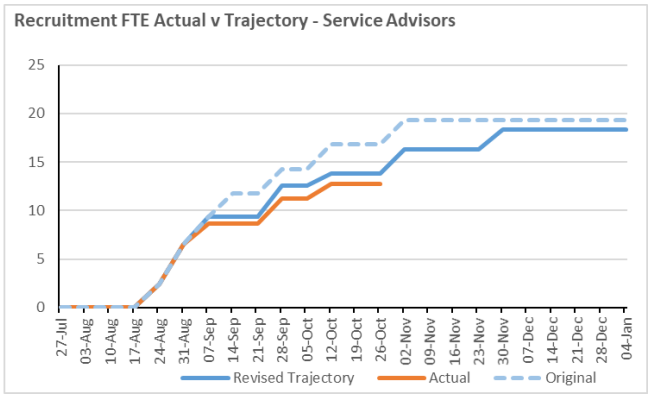
The CQC Improvement PMO meeting holds the senior responsible officers to account for delivery of the plan on a weekly basis, and reports to the Devon Doctors CQC Executive on areas of improvement and challenge before these points are escalated to the Board.

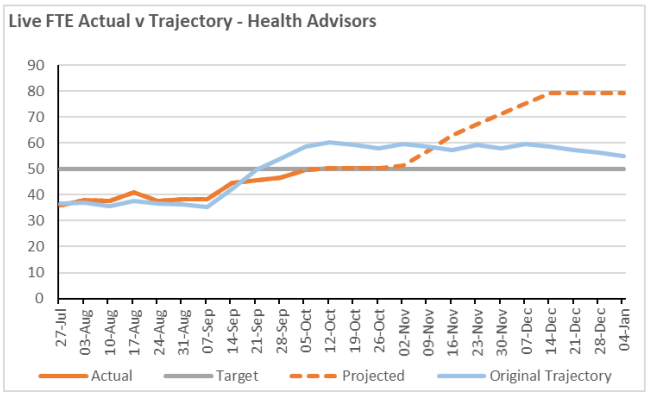
Condition Two: Improving the Devon NHS111 service

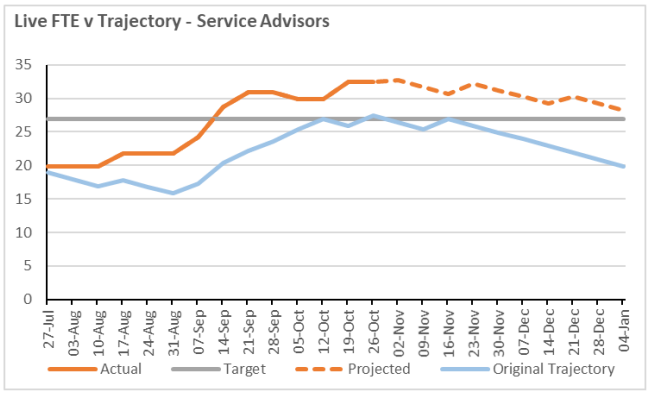
The delivery of the Organisation's NHS111 service requires sufficient well-trained health and service advisors and clinical advisors to answer the calls being made by members of the public. As such, it is essential that work is undertaken to monitor the design of the rota compared to the presentation of calls within the service, while recruiting sufficient call operatives to meet the demand.

The following graphs set out the position in relation to Recruitment and Performance. This is based on information to the end of the week commencing 19 October 2020. It should be noted that the charts below show the recruitment trajectory for both the Core 111 service and the Think111First service in Devon.









Resources – Service Advisors

Since July 2020, the organisation has recruited 12.7FTE of Service Advisors in to the CAS, with 2.2FTE leaving the business in the same period. This has been attributed to the improved training programme and an increase in the level of support within the CAS for the Service Advisors working on shift leading to improved morale.

The Service Advisor training programme was completely redesigned following concerns raised by staff that the previous approach was not sufficient for them to do their role. As well as training all of the new recruits, all members of the Service Advisor team have been retrained to enable them to confidently and safely deliver all parts of the Service Advisor role.

The result of this is that Service Advisor levels of recruitment remain above those set out as necessary within the CAS staffing model. The current level is being maintained while consideration is given to the long term operational model, and how Service Advisors can be used during peak times to support the wider 111 service.

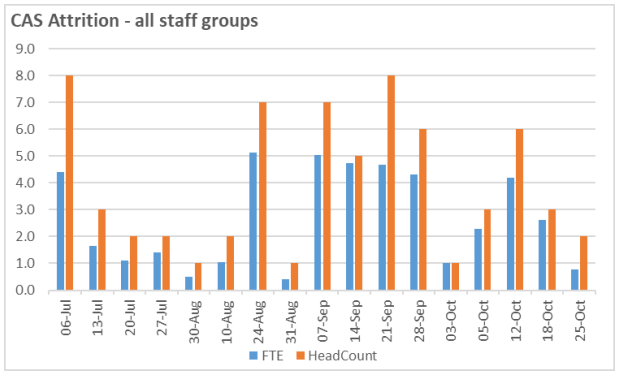
Resources – Health Advisors

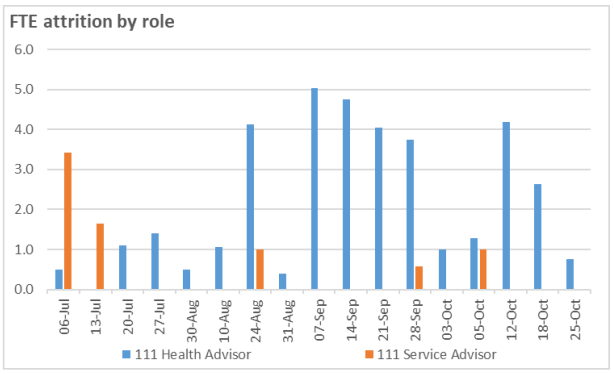
The initial analysis identified that there were significant gaps within the Health Advisor roles. Furthermore, analysis undertaken the NHS England national team has identified that the original funding envelope is insufficient in this area and that rather than aiming for a total of 68 FTE (Health Advisors and Service Advisors) we should in fact have recruited to 88FTE. We have worked collaboratively with the CCG to increase the level of funding for an initial 20 FTE during the summer of 2020. The national analysis has determined that Devon Doctors actually require 96FTE to deliver the core service based on current activity levels. As part of the mobilisation of the Think111 service we are discussing the long term funding model for the service with Devon CCG (please see below).

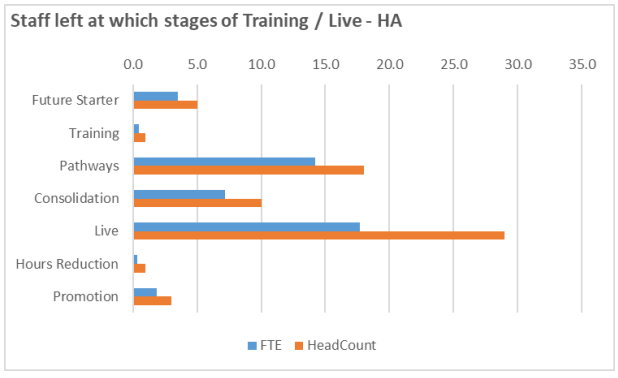
Since July 2020, the Organisation has recruited 44.0FTE (excluding the latest recruitment for Think111First in Devon) of Health Advisors in to the Devon 111 service, including 6.3FTE who were already trained. This is in line with the revised trajectory for recruitment as shown in the chart above.

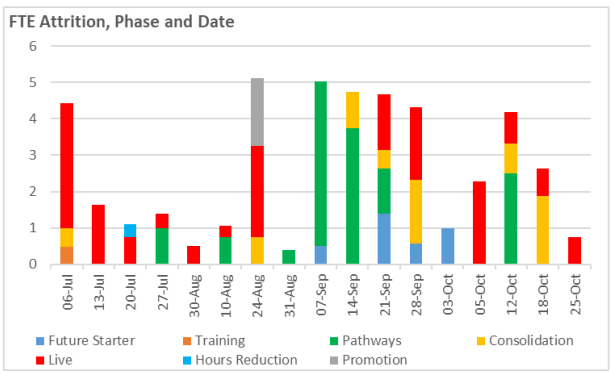
Due to the significant levels of attrition in this cohort of staff during both training, consolidation, and from the “Live” staff, the level of Health Advisors (net of those on long term sick) within the service has only increased by 14.1FTE during the same period. Overall, there are 9.0FTE fewer Health Advisors within the service at the time of writing than was projected at the start of the recruitment phase. This equates to approximately 18 members of staff as many of the rotas are less than 0.5 FTE.

The graphs below show the level of attrition within the service since July 2020. The graphs include both Service Advisor and Health Advisor attrition, but the greatest majority (80%) of the attrition below relates to Health Advisors (92% if the data from July is excluded).









Since September attrition has been greatest within the Training and Consolidation phases. Those that have recently left the service from the “Live” cohort have been relatively new recruits who had passed consolidation but had decided that the role was not suited to them after a few weeks in the service.

The high levels of attrition for Health Advisors is very concerning. A detailed review of attrition within the training cohort has been completed, in conjunction with the CCG and the Turnaround Director and as a result of this a number of key actions has been undertaken, including:

- Recruitment via REED using pre-determined rota patterns so staff are aware of the working expectation.
- Increased selection criteria before candidates are offered an interview.

- 1:1 interviews of all candidates before they are offered a placement on the 111 Pathways course.
- Corporate induction day prior to the start of the course to explain the role and to play examples of calls that could be taken to provide the breadth of experience of some of the more complex and challenging cases that could be presented.
- 15-minute introductory session with the Chief Executive Officer during the first day of the course to welcome the candidates to the role and introduce them to Devon Doctors.
- Daily touch point calls between the 111-leadership team and the trainers to identify candidates who may be struggling and agree further tuition and support.
- Increased numbers of trainers and coaches to support during the consolidation process and while the new trainees are on shift.
- Detailed exit interviews to understand why people are leaving so that further improvements can be made.

Following the introduction of the measures above, there has been a reduction in the number of trainees leaving the organisation during the training phase. The level of trainees and attrition is reviewed on a weekly basis through the PMO and Executive process so that immediate corrective actions can be put in place as required and additional courses mobilised to deal with attrition. We continue to evaluate this process to seek continual improvement. Examples of the future measures being introduced include:

- Internal end to end review of the training programme to determine whether the delivery of the mandatory training programme and consolidation process could be improved (02.11.2020).
- NHS Pathways national team to be requested to undertake a review of the quality of the training provided.
- Face to face training course to be implemented to compare quality of training to the current virtual process.
- Adastra focused sessions now implemented to ensure that recruits are able to easily navigate the system during their consolidation period.

Further training courses are being put on to address the current level of attrition and ensure that the necessary resources are in place to deliver the required service level. This is in addition to the recruitment required for Think111 (see below).

Work is also ongoing to ensure that Health Advisors are aligned to the core periods of activity (weekend mornings) to ensure that peaks in demand can be serviced without adversely impacting on either patient safety or performance.

The ongoing recruitment and retention of Health Advisors remains one of the largest challenges within the CQC Improvement Plan. In addition to the actions taken above the opening of our new contact centre in Plymouth should improve attrition further are we have the ability to recruit from a different geographical area.

Resources – Clinical Advisors

The level of Clinical Advisors within the rota remains significantly higher than required as determined by the local modelling of 111 demand. This has been funded by Devon CCG as part of the ongoing Covid-19 funding. This funding ceased on 30 September 2020 and the Organisation is in discussion with the CCG about the ongoing support of this funding to enable clinical advisors to

“front end” the 111 service in the short-term due to our health advisors being below the required FTE.

While further Clinical Advisors will be needed as part of the Think111 work, the current level of Clinical Advisors within the rota exceed the adjusted number. As such, changes to the service delivery model will need to be made if the CCG are unable to continue funding the current position. Negotiations continue.

Think111

In addition to the recruitment being undertaken for the core 111 service, the service is required to increase the number of Health/Service Advisors from 88 to 104 (approximately 50 new members of staff) by 01 December 2020 in order to deliver the anticipated increase following the first phase launch of Devon’s Think111. It is anticipated that this will then need to be increased further to 116 by 01 April 2020.

Work is already in place to deliver the required level of recruitment in line with the timescales above subject to managing the level of attrition. This is however, a monumental challenge given the short timescales for mobilisation and training of a new service.

In order to recruit the additional number of staff, focus has been switched to Plymouth, with the CCG and Local Authority providing an office space to host the service. This provides an increased pool of resources both for Think111, but also to manage future attrition within the Core service. This will also enable the Think111 service to be delivered while maintaining social distancing in the current call centres based in Exeter and Taunton.

Dental Calls

One of the biggest pressures within the CAS is created by the management of dental calls; this has been further exacerbated since the Covid-19 pandemic with fewer face to face appointments being available.

Once all urgent appointment slots have been filled, the role of the Service Advisor historically was simply to advise patients via the telephone that there are no more appointments left. This invariably led to very unhappy callers speaking to call handlers for extended periods of time. In order to remove this pressure point once the appointments are full, the service now implements an automated message providing the caller with the information provided by dental commissioners about alternative services that patients can access depending on the severity of their pain. Patients are advised that if they have red flag symptoms to attend ED, this is exactly the advice that would be given by a Dental Service Advisor. This decision has the support of the dental commissioners.

We continue to work with the local dental commissioners to stress the importance of more face to face clinical appointments. Without these being offered this chronic short fall in appointments will not be addressed.

Mental Health Calls

Devon Doctors have agreed that all crisis mental health calls (without physical complications) for patients within the Plymouth area can be passed through to the Livewell Southwest crisis management line 24 hours a day. This has reduced the impact on the 111 service of having to take

complex calls, and ensures that the patient is able to speak to a clinician specifically trained in the management of complex mental illness.

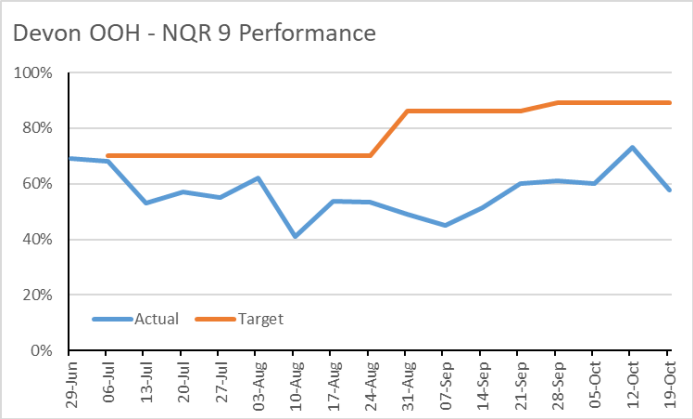
Conversations are ongoing with Devon Partnership Trust to get a similar arrangement in place for the Devon County Council footprint.

Condition Three: Improving Out of Hours Triage

Unlike the 111 service, the Out of Hours (OOH) triage model is multi-factorial and as such requires a more complex improvement plan to address the concerns identified by the Care Quality Commission.

Performance

The graphs below set out the Organisation's weekly NQR9 performance since July 2020 compared to trajectory.



During this period, activity increased during the summer months and has now returned to levels seen during June. Rota fill is also challenged during the summer months. This year was no exception despite the travel restrictions caused by Covid-19, with clinicians still taking their annual break from clinical work. The combination of increased activity and reduced rota fill has meant that performance has remained challenged. In recent weeks, the new Clinical Model combined with improving rota fill has seen an improvement in the level of performance in Devon.

Since September 2020, the Organisation has put a new operating model in place to increase the level of triage resource within the IUCS. This has resulted in a general improvement against the NQR9 target. The latest week's performance showed a reduction compared to other weeks due to reduced clinical rota fill.

In addition to core activity, the Devon service is now undertaking additional revalidation work as part of the Think111 mobilisation. While additional shifts have been put on to provide this work, it has not always been possible to fill them given the limited pool of clinicians that the service can call upon. This makes the recent upturn in performance more remarkable as the service has not only managed its own demand, but also revalidated and redirected a high proportion of ED and 999 dispositions from 111 which then can often require further work from a clinician within the IUCS.

In response to the concerns raised by the CQC, the organisation has re-evaluated its triage model and implemented two key changes:

Lead IUCS Clinician

The Lead IUCS Clinician is a new role and is operational at times of peak service pressure, (Saturday/Sunday/public holidays 08:00 – 23:00). The role is held by a number of highly experienced out of hours clinicians, who work five-hour sessions across these time periods. The Lead IUCS Clinician is supported by the on call Medical Director as required.

The Lead IUCS Clinician plays a critical role in monitoring the Devon clinical queue, ensuring that cases are correctly prioritised and that response times are appropriate and based on clinical acuity. Key areas of responsibility include:

- Monitoring of the clinical queues to ensure that patients receive a clinical response appropriate for the acuity of their presenting condition.
- Reviewing cases where worsening of the patient's condition subsequent to the original call is identified, (eg by way of patient callback or during a comfort calling'), and escalating appropriately to ensure timely clinical assessment.
- Supporting fellow clinicians on shift where clinical advice from an experienced colleague is required, (including the service's own Home Visiting Paramedics). As well as being on a dedicated telephone extension and also contactable via Adastra's internal messaging service, the Lead IUCS Clinician carries a dedicated mobile telephone to facilitate communication with clinicians in the field.
- Supporting operational colleagues where decisions around appropriate deployment of clinical resources are being made.
- Undertaking telephone consultations where there is the capacity to do so, with a focus on high priority/high acuity cases e.g. ED/999 validation, HCPs on scene, palliative cases.

The presence of a dedicated resource with oversight of the clinical queues ensures that cases requiring rapid assessment are swiftly identified and appropriate action taken to maintain the safety of individual patients. Furthermore, the support provided by the Lead IUCS Clinician to colleagues, (both clinical and operational), on shift engenders an environment that feels supportive and facilitates smooth running of the wider service.

Direct booking of telephone cases into vacant treatment centre appointments

Detailed evaluation of our service has identified that approximately 30% of clinical time during weekends is unused, primarily as a result of empty appointment slots in our treatment centres. It was also apparent that clinicians working in our treatment centres did not always pick up telephone cases in between face to face appointments despite having capacity to do so.

It was clear, therefore, that if this resource could be utilised in a more efficient manner, service performance and, consequently, the level of patient safety would increase accordingly.

As such, a decision was made to book triage "appointments" for treatment centre clinicians. Current timescales allow a clinician 20 minutes to see a patient in the treatment centre to take account of the additional time to don and doff the necessary PPE. It was, therefore, agreed that no more than three appointments would be booked for each clinician per hour, irrespective of whether this was

made up of triage, face to face, or a combination of the two. Importantly, only ‘routine’ telephone cases are booked into vacant treatment centre appointments as part of this process.

This process was initially implemented on the 3rd of October and has been running since then. Whilst the full impact of this change needs to be evaluated, there has been a clear change in the length of the clinical queue at peak times. Analysis will be produced at the end of October.

While the new triage model has not resulted in a step change in NQR9 performance and detailed analysis of performance data is pending, early evidence suggests that the clinical queues have become shorter and response times have improved as a result of booking routine telephone cases into treatment centre slots. The productivity of our treatment centre clinicians has increased accordingly; this has also allowed our CAS and remote clinicians to focus on higher acuity cases within the clinical queues. Feedback from clinicians also suggests that the shorter clinical queues that have resulted from this new process have made the service feel significantly safer and workload feel less overwhelming. Furthermore, implementation of the Lead IUCS Clinician role has provided an additional layer of assurance regarding patient safety and has also been well received by clinical and operational colleagues for the additional benefits it brings in terms of support of colleagues on shift.

Clinician Efficiency

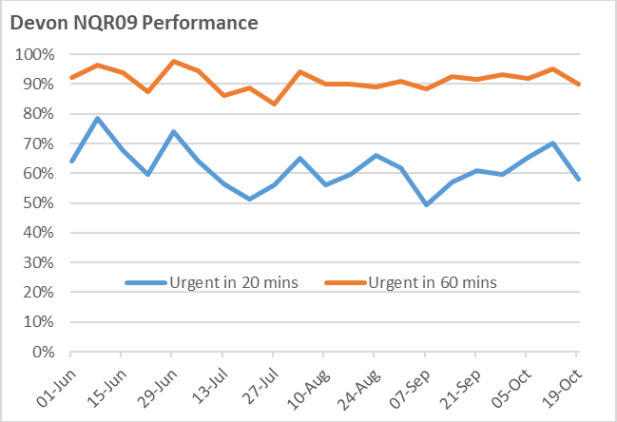
The Medical Director, supported by the Senior Clinical Management Team, have developed reporting statistics that measure the number of consultations completed on shift, the utilisation percentage, and the log on and log off times. Clinicians are then RAG rated to identify those that are consistently falling below the required standard. Individual action is taken, and a summary of this action will be presented to QAC for assurance back to the PMO / CQC Executive and the wider Board.

Disposition (DX) Based Operating Model

The current performance requirements for Devon Doctors are based on historic National Quality Requirements (NQR). These measures are now out of date and do not reflect the timescales provided by 111 through Pathways. When a patient calls 111, they are taken through a Pathways assessment that will give them one of a range of disposition codes (DX Codes). Some of these DX codes then mean that the patient is passed to the OOH service. The DX code has a target time associated to it by which time the patient should receive the necessary clinical care. The timescales range between 1 and 24 hours and have been assessed nationally as being clinically safe.

Devon CCG has agreed that Devon Doctors should transition to a DX operating model. Both organisations are currently working on a Contract Variation Order (CVO) to enable performance reporting to be formally switched over from NQR9 to an aggregate DX reporting model.

The graph below shows the level of triage performance in Devon against the current NQR9 (blue) and DX (orange) measures for urgent cases. Performance within 60 minutes remains above 90%.



Performance for routine cases within 240 minutes (a proxy for other timeframe DX codes) is 91% in Devon this week. Performance under the DX model will be reported as an amalgamation of all DX codes, although it will be possible to disaggregate them for performance management purposes.

It is anticipated that the CVO will be signed in the next couple of weeks to enable the new model to be operational during November 2020. A mobilisation plan is currently being developed to ensure that all necessary communications and system/process upgrade are made in a controlled and clear manner to minimise any adverse impact on service delivery.

Direct Booking

Due to the Covid-19 risk there is currently no direct booking of Treatment Centre appointments from 111. This means that all cases that end up in a Treatment Centre are receiving two touchpoints from within the service. This is inefficient as it creates potentially unnecessary patient contacts. When the proportion of “Contact” dispositions (those requiring face to face clinical input) being closed at triage was reviewed it was found to be between 55% and 75%. Based on this, it is more efficient for the service not to direct book patients in to Treatment Centres.

This will continue to be reviewed to determine when it is appropriate for Direct Booking to be turned back on. In the meantime, the Lead IUCS Clinician will stream patients to Treatment Centres from the Triage queue where it is clear that they will need a face to face appointment. For those that have potentially Covid symptoms they will be directed to a HOT site once operational.

HOT Sites

During the first wave of Covid-19 HOT patients were treated in four HOT sites within Devon.

The Organisation has secured HOT site funding for Devon until 01 April 2021 and is in the process of mobilising the sites in Plymouth, Torquay, Exmouth and Barnstaple ahead of the winter period and forecasted second wave. Devon CCG are requesting that weekday evening HOT site provision is mobilised. This is currently in the planning stage.

The consistent delivery of HOT provision will enable more effective streaming of Treatment Centre appointments from the triage queue as it will be possible to stream both HOT and warm patients to an appropriate location.

Clinical Recruitment

The level of clinicians working within the Devon OOH service remains a significant challenge. A recruitment paper has been produced and is being mobilised to improve the current recruitment numbers. The Organisation is working closely with Devon CCG and Devon LMC to increase the level of clinical recruitment in to the service.

Home Visiting Strategy

Patients awaiting a home visit from the OOH service are some of the most at risk within the Organisation's portfolio. Current performance against the NQR12 target for home visits raises concerns about the safety of patients, especially those waiting for an Urgent Home Visit.

The Organisation has had conversations with SWASFT about the management of mobile resources and how learning can be taken to improve performance in this area. This includes:

- Mobilising the cars as soon as the shift starts irrespective of the triage position. This will reduce the pressure on visits later in the day.
- Provide dedicated set up / down time for drivers ahead of the start of the shift so that resources are ready to go.
- All visits to be managed from the CAS via a Visit Coordinator supported by the Lead IUCS clinician, with the driver / mobile clinician not having sight of further calls. This ensures that cases are delivered based on clinical importance not geographic proximity.
- Change mobile resources to a blend of paramedics and GPs so that cases can be prioritised based on clinical need.
- Utilise mobile resources to cover calls based on clinical need not based on geography.

No further work is being undertaken in this area while the focus remains on improving patient safety and performance in relation to the triage queue. The changes set out above, with the exception of the clinical resourcing model, will be monitored using a combination of patient safety and performance metrics. The blend of resources utilised for Home Visiting will be picked up as part of the wider review of the operating model.

Condition Four/Five: Improving Governance and Quality Processes

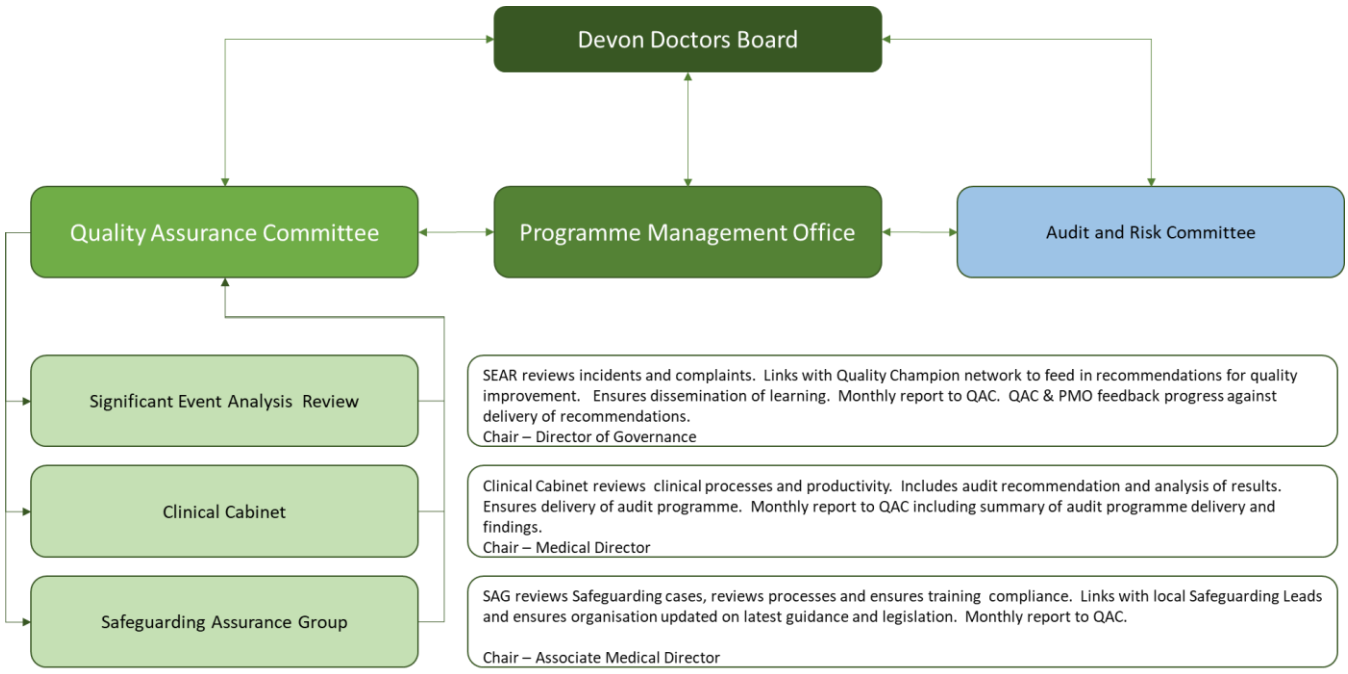
Concerns were raised by the Care Quality Commission about the efficacy of the Governance processes within Devon Doctors and the ability to implement change as a result of complaints, incidents, and serious incidents. In order to address these concerns, a full review of the Governance Framework has been undertaken and a new model of Quality and Patient Safety meetings has been implemented. These meetings are attended by a Non-Executive Director from the Board to provide independent review and challenge, as well as a direct line of reporting from/to the Board on areas of concern.

Quality Framework

The diagram below sets out the revised Governance Framework. This has been further reviewed since the previous Board meeting to take account of the additional meetings that are needed to ensure that all appropriate aspects of patient safety and quality are captured, reported, escalated, and actions taken to address areas of concern at the appropriate level within the Organisation.

The Quality Assurance Committee (QAC) receives assurance and areas for escalation from the three subgroups, each of which has a specific focus as set out in the diagram below. The QAC escalates areas for improvement to the Programme Management Office (PMO) and provides assurance to the Board. These then complete the feedback cycle through the QAC to the subgroups. This ensures that a cycle of continuous improvement is embedded throughout the organisation.

The QAC is chaired by the Medical Director and is attended by a Non-Executive member of the Board.



In addition, a review of the Governance arrangements identified that it was necessary to further embed governance processes within the wider organisation. In order to address this a network of Quality Champions was created from staff members (clinical and non-clinical) across the Organisation. The Quality Champions have two roles; firstly to share information about areas of concern from within the Organisation, and secondly to cascade learning back in to the Organisation when improvements are made.

The Audit and Risk Committee is included in the diagram above for completeness. It sits outside of the Governance Framework and focusses specifically on corporate risk. Patient Safety and Quality risk is managed by the QAC, with the Board retaining responsibility for oversight and scrutiny of the whole Risk Register.

The initial rounds of meetings for the QAC and its subgroups have been held. The design of these groups, if they function as intended, will provide appropriate scrutiny and challenge over all aspects of patient safety and quality within the IUCS. Initial meetings have been focussed on setting up scope and purpose, and are as a result in their early c phase of delivering service change based on the outcome of complaints, incidents, Serious/Moderate incidents, and clinical audit. However, it is important to note that the level of engagement in this new Framework, alongside its design, is more robust than any previous Governance structure within the Organisation.

Call Audits

As part of the Organisation's Pathways license, Devon Doctors is required to undertake a specific call audit programme for each of the Health and Clinical Advisors within the 111 service. This has been expanded to cover all of the Service Advisors.

Audits are being completed within the required timescales with a pass rate exceeding 85%. The pass criteria are exacting and require all aspects, from empathy, documentation, condition probing and accuracy of pathway selection to be correct. A failure in one particular area will fail the whole audit irrespective of the severity.

Appropriate training and disciplinary actions if required are being taken against those that are failing audits. Assurance on the audit process is provided to the CQC Executive through the PMO.

Safeguarding and Mandatory Training

The CQC report identified that Safeguarding and Mandatory training was below the expected level for clinical and non-clinical staff. Work has been done in this area, including removing clinicians from shift, to improve the level of training within the Organisation.

At the end of September, the training figures were as follows:

Safeguarding Level 2 (non-clinical)	95% (June: 88%)
Safeguarding Level 3 (clinical)	94% (June: 72%)
Overall Mandatory Training Compliance	90% (average across all modules) – (June: 85%)

This is a marked improvement on the level of compliance when the CQC visited in July 2020 (when they would have seen the June numbers presented above).

Further work is being done to ensure that staff remain compliant with their mandatory training on a rolling basis and not just at the end of the year. This will not only improve the safety of the service provided but will also reduce the burden on staff of having to complete all of their training in one month.

Assurance Map

In order to enable the CQC Executive, Board, CCGs, and CQC to have full and transparent visibility of performance and quality during the period of improvement, the Organisation has developed an 81 metric Assurance Map. This Map is reviewed on a weekly basis at the CQC Executive and is shared with the Board, CCG and CQC on a weekly basis.

The metrics cover all aspects of the 111 and OOH service and cover all areas of performance, patient safety, and workforce.

A one-page dashboard has been produced that shows, at a glance, performance against the key headline metrics so that a balanced view of the services can be gleaned from one page. This has been shared with the Board with a request that it is reviewed and feedback provided regarding the format and content of the information provided in understanding the impact of the delivery of the CQC Improvement Plan.

Clinical Audit

At the August Board meeting, approval was given to further resource the clinical audit programme within the Organisation. Resources are now in place, with the Medical Director taking overall responsibility for the delivery of the Clinical Audit Programme, supported by the Associate Director of Quality and Governance. The outcomes and learning from clinical audit will be taken through the Clinical Cabinet and reported to the QAC, before being presented to the Board.

The regular clinical audit work (including long waits, 111 call handling, burns and bruises, controlled drug prescribing, clinician performance) are all ongoing. The additional resource identified are allowing targeted specific pieces of work to be completed.

Condition Six: Improving Patient Safety

The Care Quality Commission identified that while patients are within the OOH Triage queue, sometimes for long periods of time, appropriate measures were not in place to ensure the safety of patients while they were waiting for their clinical contact.

The measures below have been implemented solely to improve patient safety, although some will also have an impact on performance.

Lead IUCS Clinician

The Lead IUCS Clinician role set above has a significant role in improving patient safety as well as driving performance. By overseeing the clinical queue, the Lead IUCS Clinician is able to identify patients that need to be prioritised and, where there are delays, review the patients who have breached their target time and upgrade those where there are clinical concerns based on the information from 111 or the Comfort Calling process (see below).

Comfort Calling: Triage

Dedicated call handlers have been put in the rota to make calls to patients who have been waiting for a clinical call for more than two hours. This call provides assurance to the patient that they are still in the queue to be called back, checks that there has been no deterioration in the patient's condition, and provides worsening advice. In some cases, patients will advise that their condition has improved and that they no longer need a call back. In this instance a clinician within the CAS will review the case and close it if it is clinically appropriate to do so.

Currently 95% of those patients that need a comfort call are getting one within 30 minutes of it becoming due. The Patient Safety and Governance Team are also reviewing all cases that have not had a comfort call to gain assurance that no one has come to harm.

Comfort Calling: Home Visit

The mobile clinician is responsible for comfort calling patients who have breached their home visit target time. This ensures that vulnerable patients have appropriate clinical oversight from the clinician that will be visiting them, and that any worsening symptoms can be escalated as appropriate.

Long Wait Audits

The medical director undertakes a monthly audit of 25 cases that have exceeded their triage deadline to identify whether there are any instances of harm that have been caused by the delay in providing treatment. The latest audits, completed for July and August, identified 1 case where there was potential for harm to have been caused as a result of the delay in the clinical call back. On further investigation, no harm had actually been caused.

These reviews will be completed on a monthly basis as part of the patient safety processes, with the results being provided to the SEAR/QAC.

CAScade

A detailed review of CAScade is underway to determine whether the outcomes that it generates are safe, and that the pathways within the system are up to date and reflect the latest operational practices. Consideration is also being given as to the use of CAScade on an ongoing basis, or whether a full Pathways model should be used for the 111 service. A full discussion paper will be produced during the Autumn and will be presented to the Board and CCG prior to any decision being made. This is a key area of focus for the Organisation over the coming month.

Improving Culture

The CQC inspection identified a number of cultural concerns, and received feedback about aspects of the Organisation's approach to service delivery which were raised as part of the feedback process. These concerns matched feedback that had been received by the Organisation's SMT and focused on a range of cultural issues, specifically:

- Low levels of staff satisfaction, high levels of stress and work overload
- Policies and procedures do not support staff in raising concerns
- Limited approach to sharing information or seeking the views of staff
- Low staff morale due to a lack of continuity
- Lack of management team knowledge regarding IT systems
- Poor communications systems in place
- Contradictory information from different managers and across the IUCS/111 service lines
- Significant attrition
- Reports of staff feeling stressed, not valued and not listened to by management
- The ethos of 'Putting Patients First' had been lost
- Lack of consistency regarding mandatory training compliance

The list above clearly points to a service under significant pressure resulting in issues with staff engagement within the Organisation; however, our awareness is currently limited to the comments contained within the CQC report and anecdotal feedback escalated through levels of management. That said, it is accepted and understood that morale is low in a number of areas within DDG for varying reasons; not least the impact COVID-19 and numerous (but ultimately necessary) change projects immediately preceding the pandemic.

In order to address these concerns, a paper has been produced that sets out the work that will be undertaken to improve the culture within the Organisation. This work has already started with the following steps being put in place:

- An Organisation wide staff survey is currently being conducted by an independent consultancy firm (Picker) who are used to run the NHS staff survey. The results of this survey will be used to inform the wider plan.
- Increased visibility of senior leaders within the CAS and Treatment Centres
- Scheduled meetings between the Director of Operations and the Treatment Centres and CAS staff to provide an opportunity for two-way information sharing.
- On site visits by the Director of Operations and Engagement Lead to the Treatment Centres and CASs across Devon to increase visibility of the Executive and HR Team.
- Promotion of the Speak Up Guardian role to enable staff to raise concerns on a confidential basis within the Organisation.
- Training of Mental Health First Aiders to support staff within the Organisation.
- Closer engagement with UNISON and other unions to promote staff engagement and partnership working.

Further work will be undertaken during the 2020/21 winter period to develop a full cultural improvement plan on the basis of the staff survey results. The Board will be fully engaged in the development and delivery of this plan for the Organisation.

Care Quality Commission Feedback

The Care Quality Commission provided feedback to Devon Doctors on 07 October 2020 as to the level of assurance regarding the current level of improvement. This feedback identified that while improvement was being made, the CQC are expecting to see long periods of sustained and continued improvement to give them the assurance that the Organisation has delivered against the Conditions and Requirements. They noted the challenges set out above in relation to staff attrition for the delivery of the 111 service improvements and the challenges of changing behaviours and practice in relation to delivering a safer and more efficient and effective triage service.

Conclusion

Since the Care Quality Commission visited the service, the Organisation has delivered fundamental change to governance, recruitment, patient safety, and operational processes within Devon Doctors. The list of bullet points below sets out the significant amount of work that has been undertaken by the Organisation in the past three months:

- Developed a detailed and comprehensive plan and response to the CQC initial report and Conditions on Registration in compliance with the requirements of Condition One.
- Undertaken a significant level of recruitment in to 111 Health Advisors and Service Advisors roles, redesigning the recruitment and training delivery model to improve quality of call handlers within the service and reduce the attrition rate in these staff groups.
- Revised the operational triage model to improve clinical efficiency of the Out of Hours service
- Introduced monitoring of individual clinician efficiency (covering both performance and quality) within the Out of Hours service
- Reduced sickness and improved culture within the Organisation
- Developed a cultural improvement plan with an Organisation-wide staff survey currently being conducted which will then be used to inform the detailed and longer-term cultural improvement plan.

- Developed a new approach to clinical recruitment across Devon incorporating the LMC and other partner organisations
- Implemented new processes for the oversight of patients while they are experiencing delays (comfort calling and lead IUCS clinician)
- Redesigned Governance and Patient Safety processes
- Mobilised a PMO structure to have oversight of the work plan with scrutiny and challenge in partnership with CCG / CQC colleagues

The implementation of an Associate Director of Contract Assurance and a Head of PMO to oversee this programme of work has greatly helped. There are also improved governance and executive structures in place to ensure that there is appropriate rigour in overseeing performance and delivery of the improvement plan. There is a constant need to remain vigilant and continue to seek the next improvement piece.

The performance information is demonstrating early signs of performance and patient safety improvement throughout the IUCS in Devon. It is, however, important to note that there is still a significant amount of work to be completed across the Organisation to deliver a consistent and sustained level of service improvement over the coming months. We need to deliver this change while also meeting the increasing demands of seasonal illness, Covid-19, and delivering a Think 111 plan in a new location. All of this is going to be a considerable challenge for the organisation. Probably the biggest challenge our organisation has ever faced.

Dr Justin Geddes
Chief Executive Officer
October 2020