John Coupland Hospital, Gainsborough

Quality Report

John Coupland Community Hospital,
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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.

Summary of findings

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Summary of findings

Overall summary

Lincolnshire Community Health Services NHS Trust provided out-of-hours General Practitioner (GP) services for patients living in Lincolnshire. The service was administered from the trust's headquarters in Sleaford and patient care and treatment was provided from eight primary care centres at locations across the county. We visited the trust's headquarters on 5 June 2014 where we looked at records and information and talked with staff about issues that related to all eight locations and the service a whole. On the 7 June 2014 we visited the primary care centre at John Coupland hospital and spoke with members of staff, patients and carers and reviewed documents and matters specific to that location.

Lincolnshire Community Health services NHS Trust (referred to in this report as 'The provider') provides OOH GP services for patients living across Lincolnshire from eight locations. We have inspected the eight locations and this reports is in relation to our inspection of the location at John Coupland Community Hospital

The provider conducted clinical audit that addressed specific areas of patient care. Individual clinicians' practice was assessed on a regular basis to help ensure that patients received safe and effective care and treatment.

We found the service was effective in meeting patients' needs and the primary care centres were accessible to those who may have had mobility issues.

The reception used Language Line for interpretation purposes if required. They had a laminated sheet available in numerous languages for patients to identify the language they spoke. There was a book available specifically to assist Polish speaking patients. Lincolnshire has a large number of resident Polish migrant workers.

There were systems in place to help ensure patient safety through learning from incidents and infection prevention and control.

Staff were trained and supported to help them recognise the signs of abuse of children and vulnerable adults.

The provider had not used effective recruitment processes to assess the suitability of staff to work in this sector. We have told the provider they must improve

Patients experienced care that was delivered by dedicated and caring staff. Patients and carers we spoke with said staff displayed a kind and caring attitude and we observed patients being treated with respect and kindness whilst their dignity and confidentiality was maintained.

The provider had in place business continuity and contingency plans that would enable the service to continue to operate in the event of a failure of, for example, the information technology or telecommunication systems.

We found that the service was well-led and managed by a knowledgeable senior management team and Board of Directors at provider level. They had taken action to help ensure their values and behaviours were shared by staff through regular engagement.

At John Coupland Community Hospital out-of-hours there was only one GP on duty. The GP told us that he felt supported by the clinical lead and held positive views of the management team and their leadership. He told us the senior managers were approachable and listened to any concerns or suggestions he might have to improve the level of service provided to patients.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The out-of-hours service at John Coupland Community Hospital was safe. There was a clear process for recording patient safety incidents and concerns and the provider had taken steps to investigate such incidents and inform staff of the findings to help prevent any re-occurrence.

We saw the provider had put into place actions plans in response to concerns and saw how they had been held accountable to the trust board in delivering those plans.

There were clear policies and processes that helped to identify and protect children and vulnerable adults from harm, and staff we spoke with were well informed of their role and responsibilities.

There was clear evidence of collaborative working with other healthcare providers aimed at delivering care and treatment to patients by the most appropriate route.

We saw evidence that the provider was working with other healthcare providers in an effort to adapt the service to the needs of patients and to ensure its sustainability going forward.

The provider had not taken the appropriate steps to ensure that all staff underwent a thorough recruitment process and had not assured themselves that patients were cared for, or supported by GP's who were suitable to work in a healthcare environment and we have told the provider that they must take action to improve.

The out-of-hours (OOH) service at the hospital did not keep any medicines. Emergency medicines were held in the Minor injuries Unit (MIU) and those could be accessed by the OOH GP if required. Because of that we looked at records and found that all necessary checks had been completed and that the medicines held in MIU were in date.

Staff observed appropriate infection prevention practices. The consulting room was cleaned by the MIU cleaners according to a cleaning schedule.

Are services effective?

The out-of-hours service at John Coupland Community Hospital was effective. GPs who delivered care to patients all worked in the practices covered by the out-of-hours service. There was no use of locum or agency GPs

Summary of findings

The provider had undertaken reviews of the clinical practice of individual practitioners. This meant that poor practice could be identified and appropriate action taken to help prevent any re-occurrence.

There was evidence of robust clinical audit being undertaken but noted that in one instance the audit cycle had not been completed and reviewed on the agreed date.

The provider was effective in sharing information about patient consultations with the patients' own GP practices.

There were effective joint working arrangements with the Minor Injury Unit (MIU) which included the use of MIU reception staff to assist with appointments and with chaperone duties.

Are services caring?

The out-of-hours service at John Coupland Community Hospital was caring. We saw that patients were treated with dignity and respect and patients and carers we spoke with said staff displayed a kind and caring attitude.

The provider had made positive steps to meet the needs of patients from the gay, lesbian, trans-gender and bi-sexual community.

The provider demonstrated close community links and involvement in networks such as Patient Advice and Liaison Services (PALS) which offered confidential advice, support and information on health-related matters.

We saw evidence that each month a 'patient story' was presented to the Board. Patients, carers and relatives affected by a service where care delivery had failed had been encouraged to attend the meetings and share their experience with the directors to help inform them of the impact.

Patients were asked for their consent before any care or treatment was started. Patients were also kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.

Are services responsive to people's needs?

The-out-of hours service at John Coupland Community Hospital was responsive to patients' needs. We saw that the reception used Language Line for interpretation purposes if required. They had a laminated sheet available in numerous languages for patients to identify the language they spoke. There was a book available specifically to assist Polish speaking patients.

We saw that available patient information was maintained by the Minor Injuries Unit. It gave advice on how to make a complaint to

Summary of findings

Lincolnshire Community Health Services NHS Trust, advocacy support to do this and how to access information about complaints for other languages (Portuguese, Chinese, Kurdish Sorani, Lithuanian, Polish and Russian). We were told that information on how to make a complaint was available on the provider's website but upon looking at the site we were unable to locate this.

The interim Chief Executive had provided staff with their personal email address which could be used if they felt they needed to raise issues or concerns with her directly and told us they had on one occasion met with a member of staff in private to discuss issues raised.

The provider responded to changing levels of demand for services, for example in periods of high patient numbers in the winter months. The provider conducted regular checks on activity levels at the primary care centres which ensured staffing met the care needs of patients.

The provider had implemented a system of direct referrals from East Midlands Ambulance Service to the out-of-hours service which had resulted in a measurable decrease in admissions into Accident and Emergency departments.

Patients said that they had found access to the out-of-hours service easy through the 111 telephone system. The out-of-hours service was accessible to patients with restricted mobility and wheelchair users.

The out-of-hours service had taken account of patients' views, and these had been analysed with a view to making improvements to the service.

Are services well-led?

The out-of-hours service at John Coupland Community Hospital was well-led. We saw that the trust was well led by an experienced and diverse board of directors. The senior management team was knowledgeable and actively demonstrated high values and behaviours aimed at improving patient care.

The provider displayed open and transparent governance arrangements and minutes of the various Board and committee meetings were easily accessible on the provider's website.

We found that the interim Chief Executive was pro-active in seeking the views of staff. There was a programme of staff engagement events being held across the county of Lincolnshire aimed at reaching as many staff as possible.

Summary of findings

We were told staff were given the option to undertake various training opportunities pertinent to their role and were supported to improve and reflect upon their performance through annual appraisal and regular supervision.

There was a clear desire to develop and improve the level of service and the trust was working with other health care providers to improve healthcare outcomes for patients.

Summary of findings

What people who use the service say

We received nine completed comment cards regarding the out-of-hours service at John Coupland Community Hospital. All the comments were very positive from both patients and carers. The comments praised the staff for their care and compassion, cleanliness in all areas of the service and the lack of waiting times.

We spoke with four patients who had seen the out-of-hours GP. All of the patients and in one case the parent of a baby told us that the service was easy to access, waiting times were short, a clinical examination was carried out and an explanation of causes and treatment was given. All commented positively regarding the GP providing the service.

Patient surveys that had been undertaken by the provider showed that patients were happy with the care and treatment they received. Some patients had commented upon lengthy waiting times at some primary care centres whilst others had responded in positive terms about how quickly they had been seen.

Patients told us that they were happy with the care and treatment they received and felt safe

Areas for improvement

Action the service MUST take to improve

The provider must ensure that there is in place a robust and effective recruitment system to ensure that patients are cared for or supported by GP's who are qualified, skilled and experienced. Appropriate checks should be documented and the provider must ensure that the GP's are suitable to work in the out-of-hours service.

Action the service COULD take to improve

The provider could ensure they complete and review audit cycles by the agreed date.

Reviews of individual clinician's practice could be carried out independently.

The provider could provide information on how to raise a complaint in languages other than English.

The provider could improve the way information about how to complain is presented on their website.

John Coupland Hospital, Gainsborough

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team on 5 June 2014 was led by two CQC inspectors and a GP.

Our inspection on 7 June 2014 was undertaken by two CQC inspectors

Background to John Coupland Hospital, Gainsborough

The GP out-of-hours service for Lincolnshire is provided by Lincolnshire Community Health Services NHS Trust. The service is commissioned by the four Lincolnshire Clinical Commissioning Groups (CCG's), with the lead for out-of-hours services being Lincolnshire East CCG.

The out-of-hours service provides care to patients who required urgent medical care from a GP outside of normal GP hours.102 GP practices were covered by the service. The provider employed the services of 100 GPs who were engaged on a sessional basis to deliver care to patients. The service operated county wide from 6.30pm to 8am Monday to Thursday, 6.30pm Friday to 8am Monday, and all public holidays

John Coupland Community Hospital, Gainsborough however was only open for out-of-hours service from 10am to 2pm on Saturday, Sunday and Bank Holidays.

Initial telephone contact with the out-of-hours service is through the NHS 111 system, a service provided by another healthcare provider.

The out-of-hours service was split into three 'Business Units', which comprised the North West, East and South business units. They were geographically aligned to Lincolnshire's Clinical Commissioning Groups. The out-of-hours service in each was managed by an Urgent Care Matron.

The service provided care to a population of 723,000 residing in an area of 2,350 square miles from eight primary care centres geographically spread across the county. The eight locations were;

The County Hospital, Lincoln

John Coupland Community Hospital, Gainsborough

Grantham and District Hospital

Stamford and Rutland Hospital, Stamford

Johnson Community Hospital, Spalding

The Pilgrim Hospital, Boston

Skegness and District Hospital

County Hospital, Louth

In the year 2013/14 in excess of 100,000 patients accessed the out-of-hours service.

This inspection focused on the out-of-hours service at John Coupland Community Hospital in Gainsborough.

Detailed findings

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.

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 we visited, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Two of our inspectors and a GP specialist professional advisor carried out an announced visit to the providers headquarters on 5 June 2014. During our visit we spoke with a range of staff that included the Interim Chief Executive, The Vice Chair of the Board of Directors, the Nominated Individual and Chief Nurse, the Medicines Management Officer, Head of Safeguarding, one of the providers GP leads and a senior human resources officer. We also spoke with an Urgent Care Matron. At this visit we reviewed the provider's policies and procedures and looked at other information with regard to how the service was run and how it was performing.

On 7 June 2014 we carried out an announced inspection at John Coupland Community Hospital, Gainsborough and spoke with patients who used the service. We observed how people were being cared for and talked with carers. We reviewed nine completed comment cards on which patients, carers and members of the public had been invited to share their views and experiences of the service.

We also spoke with the GP who is the only member of the out-of-hours (OOH) service employed at the location.

We conducted a tour of the premises, looked at cleanliness and the arrangements in place to manage the risks associated with healthcare related infections.

The OOH surgery at the John Coupland Community Hospital did not keep any medicines. Emergency medicines were held in the Minor Injuries Unit (MIU) and could be accessed by the OOH GP if required. Because of that we looked at records and found that all necessary checks had been completed and were in date.

Are services safe?

Summary of findings

The out-of-hours service at John Coupland Community Hospital was safe. There was a clear process for recording patient safety incidents and concerns and the provider had taken steps to investigate such incidents and inform staff of the findings to help prevent any re-occurrence.

We saw the provider had put into place actions plans in response to concerns and saw how they had been held accountable to the trust board in delivering those plans.

There were clear policies and processes that helped to identify and protect children and vulnerable adults from harm, and staff we spoke with were well informed of their role and responsibilities.

There was clear evidence of collaborative working with other healthcare providers aimed at delivering care and treatment to patients by the most appropriate route.

We saw evidence that the provider was working with other healthcare providers in an effort to adapt the service to the needs of patients and to ensure its sustainability going forward.

The provider had not taken the appropriate steps to ensure that all staff underwent a thorough recruitment process and had not assured themselves that patients were cared for, or supported by GP's who were suitable to work in a healthcare environment and we have told the provider that they must take action to improve.

The out-of-hours (OOH) service at the hospital did not keep any medicines. Emergency medicines were held in the Minor injuries Unit (MIU) and could be accessed by the OOH GP if required. Because of that we looked at records and found that all necessary checks had been completed and that the medicines held in MIU were in date.

Staff observed appropriate infection prevention practices. The consulting room was cleaned by the MIU cleaners according to a cleaning schedule.

Our findings

Safe Patient Care

We observed that patients received care in a compassionate and caring manner from the staff. We saw that patients were treated with respect, and the staff made efforts to preserve patients' dignity and confidentiality. We also saw the staff on reception informed patients of likely waiting times, so that patients were aware of how long they had to wait to be seen.

We found that the provider took appropriate action to learn from safety incidents and informed staff of the concerns and the steps needed to help reduce the likelihood of re-occurrence. For example we saw that following a missed diagnosis of a patient with a serious heart complaint the provider took action. The clinician's practice was reviewed and the trust improved the process for retrieving voice recording of the telephone calls into the service. They also reviewed and updated the 'Red Flag' guidance for staff that was displayed and circulated to all out-of-hours locations. We viewed this guidance and saw that it provided a synopsis of the latest National Institute for Care and Health Excellence (NICE) guidance which related to patients who experienced chest pain, stroke and acute headache.

Learning from Incidents

We saw evidence that the provider had undertaken an investigation 'into a significant event' regarding a patient who had contact with the service. A full root cause analysis had been completed and had concluded the death was not attributable to the patient's contact with the out-of-hours service. There had been some learning points from the analysis and we saw that an action plan had been drawn up that highlighted what could have been done better. We saw evidence that some of the actions had been completed and others were ongoing such as additional telephone triage training for staff.

We viewed copies of the 'Lessons Learned' document that was published quarterly and disseminated to all staff. The documents were subtitled 'Listen, learn, share' and quantified the number and types of complaints and serious incidents and the lessons that had been learned from them.

Safeguarding

We saw that all staff received training in safeguarding children and vulnerable adults and we looked at some of

the training material available. The training also encompassed training in the Mental Capacity Act and the Deprivation of Liberty Safeguards, both of which are aimed at protecting vulnerable people. We spoke with the safeguarding lead for the provider who informed us that they were currently providing all staff with training regarding domestic abuse and that this was seen as a priority training requirement.

We viewed the provider's safeguarding policies which included information on children and vulnerable adults and their chaperone policy that enabled another person to be present when a patient consulted a clinician. We also looked at the 'whistle blowing' policy that informed staff of the procedures for raising their concerns about suspected wrongdoing at work.

Members of staff we spoke with could demonstrate knowledge of safeguarding, what might constitute abuse and what their responsibilities were in raising their concerns.

The safeguarding lead we spoke with emphasised the importance of ensuring that when staff raised concerns they were updated as to the result of any investigation. They told us of the importance of keeping staff apprised of the outcomes of any referral they may have made where that was appropriate.

We saw evidence that all safeguarding concerns were shared with the local authority and notified to the CQC.

Monitoring Safety & Responding to Risk

Prior to our inspection we were provided with documents that showed how the service had responded to events and incidents. We saw that root cause analysis had been undertaken to help understand what had occurred and action plans formulated to help minimise the chances of any re-occurrence. We spoke to one of the Urgent Care Matrons who confirmed that learning from these incidents was passed down to all staff. They told us how they always raised and discussed them at our team meetings. They added that this was also an opportunity to inform staff of changes to protocols and procedures.

Medicines Management

We spoke with the Medicines Management Officer for the provider. They told us there was wide use of patient group directives (PGDs) for drugs administration using the NICE guidelines and competency framework. (A PGD, signed by a doctor and agreed by a pharmacist acts as a direction to a nurse to supply and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription)

We saw that medication errors were collated and analysed monthly and categorised by level of potential harm. Trends and concerns had then been discussed with the governance committee and acted upon.

The Medicines Management Officer told us that medicines management training had been included as a mandatory part of the staff induction process, aimed at reducing medication errors.

The out-of-hours (OOH) surgery at the John Coupland Community Hospital did not hold any medicines at all on the premises.

Cleanliness & Infection Control

The responsibility for overall cleanliness at the OOH surgery at the John Coupland Community Hospital was that of the MIU. The consulting room was cleaned by the MIU cleaners to a cleaning schedule. The infection control process between patients was explained by the GP. This included the washing of hands, wiping down of the stethoscope and changing of the paper towel on the examination couch. We saw that there was a checklist in the consulting room for infection control and clinical waste.

Staffing & Recruitment

We looked at the documents that related to the recruitment of GPs into the out-of-hours service. We found that in some cases there was no record of the references that had been sought and in other cases references were not always retained.

All GPs and GP trainees need to be registered with NHS England Area Team Medical Performers List. We saw that in some cases there was no evidence that the list had been consulted to ensure the GPs were included.

We saw that there was no system in place for the provider to ensure that GPs working in the out-of-hours service had the appropriate professional indemnity. The provider had relied upon an annual self-declaration that such cover was in place. We also saw that in some cases, Disclosure and Barring Service checks (formerly Criminal Records Bureau checks), which are carried out to disclose any previous

criminal convictions, had not been renewed by the GPs every three years. This requirement formed part of the trust's conditions for continued work in the out-of-hours service.

We judged that these issues put patients at an unacceptable level of risk from being cared for by GP's who may not have been suitable to work in the out-of-hours environment.

Dealing with Emergencies

The provider had in place business continuity and contingency plans that would enable the service to continue to operate in the event of a failure of, for example, the information technology or telecommunication systems. Hard copies of the plans and procedures were available at all locations and were also available on the provider's computer system. We saw that the provider had senior management on call and available at all times for staff to refer to in the event of a disruption to the service.

The Chief Nurse told us how their systems had been tested due to a breakdown in the hard-wired telecommunication systems and how they had referred to the contingency plan and mobile telephones to ensure the service continued to function.

Equipment

The out-of-hours surgery at the John Coupland Community Hospital did not have any emergency equipment. All equipment at the location was the responsibility of the MIU and retained in that department. In an emergency the OOH GP could have access to that equipment.

The consulting room was cleaned by the MIU cleaners according to a cleaning schedule. The maintenance of equipment, medical devices availability and safety of medical gases, medicines, standards of cleanliness, hygiene and arrangements for handling waste were all the responsibility of the MIU.

Are services effective?

(for example, treatment is effective)

Summary of findings

The out-of-hours service at John Coupland Community Hospital was effective. GPs who delivered care to patients all worked in the practices covered by the out-of-hours service. There was no use of locum or agency GPs

The provider had undertaken reviews of the clinical practice of individual practitioners. This meant that poor practice could be identified and appropriate action taken to help prevent any re-occurrence.

There was evidence of robust clinical audit being undertaken but noted that in one instance the audit cycle had not been completed and reviewed on the agreed date.

The provider was effective in sharing information about patient consultations with the patients' own GP practices.

There were effective joint working arrangements with the Minor Injury Unit (MIU) which included the use of MIU reception staff to assist with appointments and with chaperone duties.

Our findings

Promoting Best Practice

We saw that the provider had undertaken a range of clinical audits, which aimed to improve patients' care and treatment. We looked at an audit that had been carried out on urinary tract infections and had looked at the treatment records of over 2,500 patients. The audit had highlighted higher than anticipated prescribing of antibiotics, for example, amoxicillin, co-amoxiclav and cefalxin in two areas of the county. Action had been taken to reduce the incidences of prescribed antibiotics and a repeat audit to monitor the effectiveness had been due in March 2014 but had not yet been completed. We saw that a conference had been arranged for September 2014 to include a Microbiologist and GPs in order to change behaviour around the prescribing of antibiotics for patients with urinary tract infections. This showed that the provider had responded to the clinical audit it had undertaken to help improve and care and treatment for patients.

Management, monitoring and improving outcomes for people

We saw evidence that the provider reviewed clinicians' face to face consultations and telephone advice to patients. This was undertaken using random selection of cases and was scored using the Royal College of General Practitioners toolkit. Any areas of poor practice that had been highlighted and addressed with the clinicians concerned.

Triage is the process of determining the priority of patients' treatments based on the severity of their condition. We were told that an audit of telephone triaging for all staff engaged in the out-of-hours service was planned but had not yet been completed

Staffing

We looked at staffing across the out-of-hours service and saw that there was a mix of skills and experience to meet patient needs. We looked at the induction process that all new staff underwent. It included local induction at the staff member's primary care centre. The induction included details of the staffing structure and management contact details. The induction process encompassed mandatory training in fire safety, medicine management, immediate life support, moving and handling, safeguarding children and vulnerable adults, domestic abuse, hand hygiene, equality and diversity.

Are services effective?

(for example, treatment is effective)

The provider had mechanisms in place to ensure appropriate levels of supervision and annual appraisals of staff. We sampled the records of the out-of-hours staff that were working on the day of our inspection and found them to have received a yearly appraisal of their performance and work by a manager. We were told that GP appraisal was conducted by the Lead GP. We looked at a new staff training tool titled 'Your Performance Matters'. We saw that this booklet was being introduced and was individual to each member of staff. It was used to record staff training, professional learning, work achievements and development plans. The book was used to record supervisions and appraisal meetings.

Working with other services

We saw that the provider had consistently achieved full compliance with the National Quality Requirement formulated by the Department of Health to share details of patients' out-of-hours consultations with their own GP by 8am the following morning.

We saw evidence of collaborative working with the ambulance service to help reduce the number of unnecessary admissions to urgent care services. The provider was developing closer contacts with the 111 provider in an effort to improve the telephone triage and ensure that referrals to the out-of-hours service were correctly assessed as to clinical need.

We spoke with the GP at the out-of-hours (OOH) surgery at the John Coupland Community Hospital about joint working with the Minor Injury Unit (MIU). He told us and we saw that the integration with MIU was effective. The joint working arrangements included the appointment system at the location which was operated by MIU reception staff on behalf of the OOH service. The MIU also supplied staff to act as chaperones if required.

The Nurse Practitioner in the MIU explained that they had a good working relationship with the OOH service. The receptionist was employed by the MIU but would deal with patients if they did not have an appointment booked on the system. There was an arrangement in place whereby the OOH GP could use the MIU facilities if in an emergency.

At the John Coupland Community Hospital there was a Nurse led rehabilitation unit of 23 beds (Scotter Ward) two of which were palliative care beds. There was a formalised agreement in place that the OOH GP would provide cover for the unit when available.

Are services caring?

Summary of findings

The out-of-hours service at John Coupland Community Hospital was caring. We saw that patients were treated with dignity and respect and patients and carers we spoke with said staff displayed a kind and caring attitude.

The provider had made positive steps to meet the needs of patients from the gay, lesbian, trans-gender and bi-sexual community.

The provider demonstrated close community links and involvement in networks such as Patient Advice and Liaison Services (PALS) which offered confidential advice, support and information on health-related matters.

We saw evidence that each month a 'patient story' was presented to the Board. Patients, carers and relatives affected by a service where care delivery had failed had been encouraged to attend the meetings and share their experience with the directors to help inform them of the impact.

Patients were asked for their consent before any care or treatment was started. Patients were also kept informed with regard to their care and treatment throughout their visit to the out-of-hours service.

Our findings

Respect, Dignity, Compassion & Empathy

We saw that patients were treated with dignity and respect and patients and carers we spoke with said staff displayed a kind and caring attitude.

We saw that the staff at the out-of-hours (OOH) service at John Coupland Community Hospital were kind and had a caring, compassionate attitude and demonstrated a positive relationship with people who used the service and those close to them. We saw them spending time talking to people, or those close to them. People valued their relationship with staff and experienced effective interactions with them. There was a mutual respect.

Confidentiality was respected at all times when delivering care, in discussions with people and those close to them and in any written records or communication. This included patients being able to talk in confidence with reception staff and in the consultation room used by the OOH GP.

We spoke with four patients some of who were accompanied by relatives who had received care at the service. They all without exception told us that the OOH GP asked the reason for the visit, carried out a full examination if required and explained any treatment that was needed. Medication was prescribed and the dosage and frequency fully explained at the time. The patients and relatives told us that because of the GP's manner they fully understood what was going to happen and why at each stage of their treatment and care.

We saw that the provider had had been ranked 16 out of 40 in the Stonewall Healthcare Equality Index. Run by the charity Stonewall, the index was aimed at helping organisations to benchmark and track their progress on equality for their gay, lesbian and bisexual patients and service users.

40 healthcare organisations entered the Index, providing services to patients across all regions of England. The provider was assessed against criteria including policy and practice, engagement and communication, health promotion and staff training.

We saw written evidence and heard from senior staff that each month a 'patient story' was presented to the Board. Patients, carers and relatives affected by a service where

Are services caring?

care delivery had failed had been encouraged to attend the meetings and share their experience. This helped to ensure that at a very senior level, management and the Board were made aware of the impact on patients, their relatives and carers and were better able to respond and make changes to help prevent re-occurrence.

Involvement in decisions and consent

We saw that the OOH GP involved patients who used the service and those close to them as partners in their own care. Patients who used the service told us that they felt involved in planning their care, choosing and making decisions about their care and treatment and were supported to do so where necessary. In one consultation the parents of a young child we spoke with told us that the GP spoke with their young child directly, not the parents They explained that the GP had asked for consent prior to any examination or treatment. This showed that the GP took a child focused approach and involved the young patient in decisions about their own care

We saw that the provider's website was informative and described the out-of-hours service and the location at which care and treatment was available and that the information was available in a wide range of languages. This helped to ensure that diverse population groups living within the county, such as migrant workers from eastern Europe, were able to understand the treatment options available to them from the out-of-hours service.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The-out-of hours service at John Coupland Community Hospital was responsive to patients' needs. We saw that the reception used Language Line for interpretation purposes if required. They had a laminated sheet available in numerous languages for patients to identify the language they spoke. There was a book available specifically to assist Polish speaking patients.

We saw that available patient information was maintained by the Minor Injuries Unit. It gave advice on how to make a complaint to Lincolnshire Community Health Services NHS Trust, advocacy support to do this and how to access information about complaints for other languages (Portuguese, Chinese, Kurdish Sorani, Lithuanian, Polish and Russian). We were told that instructions on how to make a complaint was available on the provider's website but upon looking at the site we were unable to locate this.

The interim Chief Executive had provided staff with their personal email address which could be used if they felt they needed to raise issues or concerns with her directly and told us they had on one occasion met with a member of staff in private to discuss issues raised.

The provider responded to changing levels of demand for services, for example in periods of high patient numbers in the winter months. The provider conducted regular checks on activity levels at the primary care centres which ensured staffing met the care needs of patients.

The provider had implemented a system of direct referrals from East Midlands Ambulance Service to the out-of-hours service which had resulted in a measurable decrease in admissions into Accident and Emergency departments.

Patients said that they had found access to the out-of-hours service easy through the 111 telephone system. The out-of-hours service was accessible to patients with restricted mobility and wheelchair users.

The out-of-hours service had taken account of patients' views, and these had been analysed with a view to making improvements to the service.

Our findings

Responding to and meeting people's needs

The provider used the 'OK to Ask' Make Every Contact Count (MECC) campaign which helped to improve the health and wellbeing of patients, the public and staff. The scheme aimed to encourage staff and patients to engage in conversations about any area of health, addressed key lifestyle areas and improved health and wellbeing.

The provider had engaged with staff through training to help them recognise the signs and heighten their awareness of domestic violence, which enabled staff to direct people, where appropriate to additional resources to meet their needs.

Access to the service

The provider worked with other healthcare providers to ensure patients' needs were met. The provider had implemented a system of direct referrals from East Midlands Ambulance Service to the out-of-hours which had resulted in a measurable decrease in admissions into Accident and Emergency departments. The ambulance service was provided with a direct dial telephone number to enable them to contact the out-of-hours service without the need to go through the 111 system. Evidence we saw showed that in the year 2013/14 1661 patients had been referred directly into the out-of-hours service by the ambulance service, when they might have otherwise used accident and emergency services.

The out-of-hours service operated county wide from 6.30pm to 8am Monday – Thursday, 6.30pm Friday to 8am Monday, and all public and bank holidays. The John Coupland Community Hospital, Gainsborough out-of-hours service was accessible to patients from 10am to 2pm on Saturday, Sunday and Bank Holidays. Outside of those hours patients were offered face to face consultations at other locations.

One patient we spoke with told us that they did not access the out-of-hours via the 111 system but just walked in. They were delighted that the receptionist could get her an appointment. They told us that they found the doctor to be very kind and that all symptoms had been discussed in detail prior to any examination. This person was very pleased with the service they had received.

One patient with a very young baby who was poorly told us about their experience of the initial call to the service and

Are services responsive to people's needs?

(for example, to feedback?)

the arrangements for an appointment. She reported that his had been a seamless process and that the thorough examination of her child had been thorough and reassuring. She was very satisfied with the OOH service.

Another patient told us that there had been no issues accessing both the 111 and OOH systems. He was very happy with the service, the doctor was very good and he had seen him before. He asked him why he was there carried out an examination and talked to him regarding his condition and treatment. The patient stated this service was better than his own surgery where he had problems booking appointments.

In one consultation the parents of a young child we spoke with told us that the GP spoke with their young child directly, not the parents They explained that the GP had asked for consent prior to any examination or treatment. This showed that the GP took a child focused approach and involved the young patient in decisions about their own care. .

Concerns & Complaints

We saw that the provider had a system for dealing with complaints about the service and we saw evidence that any complaints received had been investigated and where necessary action had been taken. They had been dealt with in line with the provider's policy.

We saw that available patient information was maintained by the Minor Injuries Unit. It included information on how to make a complaint to Lincolnshire Community Health Services NHS Trust, advocacy support to do this and how to access information about complaints for other languages (Portuguese, Chinese, Kurdish Sorani, Lithuanian, Polish and Russian).

We were told that an instruction on how to make a complaint was available on the provider's website but upon looking at the site we were unable to locate this.

We asked each of the patients if they had ever had to make a complaint. The patients said they had never had to make a complaint about the out-of-hours service. We asked if they would know how to, should they wish to make a complaint. All of the patients had seen the posters relating to PALS (Patient Advice and Liaison service.) When asked, none of the patients thought making a complaint would be a problem, although all of the patients were keen to stress they were very happy with the service they had received.

Are services well-led?

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

Summary of findings

The out-of-hours service at John Coupland Community Hospital was well-led. We saw that the trust was well led by an experienced and diverse board of directors. The senior management team was knowledgeable and actively demonstrated high values and behaviours aimed at improving patient care.

The provider displayed open and transparent governance arrangements and minutes of the various Board and committee meetings were easily accessible on the provider's website.

We found that the interim Chief Executive was pro-active in seeking the views of staff. There was a programme of staff engagement events being held across the county of Lincolnshire aimed at reaching as many staff as possible.

We were told staff were given the option to undertake various training opportunities pertinent to their role and were supported to improve and reflect upon their performance through annual appraisal and regular supervision.

There was a clear desire to develop and improve the level of service and the trust was working with other health care providers to improve healthcare outcomes for patients.

Our findings

Leadership & Culture

We found that the service was well led by a dedicated team of experienced senior managers who reported to a Board of Directors who were drawn from a range of backgrounds, including healthcare and public service. The Board displayed high values and held senior managers to account. There was an emphasis on quality outcomes for patients; this was evidenced by the records of meetings that were available to view on the provider's website.

During our inspection we found staff at all levels to be honest and open.

Senior management and the Vice Chair of the Board of Directors told us that the service needed to radically change to meet the increasing and changing demands placed upon it and to take into account patients' holistic care needs. We were told how a project plan had been developed with a new vision on how the out-of-hours service could be delivered more effectively and responsively in an urgent care setting. This plan would be shortly going to consultation.

The provider had continued to play an active role in the Lincolnshire Sustainable Services Review, aimed at re-shaping the healthcare landscape in the county and bringing together all interested parties involved in healthcare provision.

Governance Arrangements

We saw clear governance arrangements that encouraged openness and constructive challenge. There was a clear management structure with the out-of hours provision being managed at a local level by the Urgent Care Matron within each of the geographical areas.

We saw evidence that telephone conferencing took place twice a week, and more often if required, to provide a position statement in relation to staffing of the service. The conferences included any perceived risks and incidents which could impact on providing a quality and equitable service across the county. The meeting was chaired by the Senior Matron or deputy and representatives of the Urgent Care Matron, Clinical Team Lead and administration for all of the geographical business units were expected to attend. This confirm and challenge process provided assurance that the service was being risk managed.

Are services well-led?

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

Staff were given the opportunity to undertake training in addition to the provider's mandatory training, aimed at developing the individual and improving outcomes for patients. Additional training for clinical staff included dementia awareness, sick and injured children, bowel care and minor illness management. However the GP at John Coupland Community Hospital Gainsborough told us that all his training had been supplied through his own GP practice not the out-of-hours provider.

All clinical staff received their training in a two day block of face to face training and corporate and non-clinical staff received one days training. There was a positive reliance on face to face training as staff had expressed their preference for this type of input, but some training was also available on-line. Managers continually reviewed attendance and non- attendance at mandatory training was followed up to ensure it was completed.

Systems to monitor and improve quality & improvement

The National Quality Requirements (NQR) was formulated by the Department of Health to share details of patients' out-of-hours consultations with their own GP by 8am the following morning. These were designed to ensure that GP out-of-hours services were safe, clinically effective and delivered in a way that gave the patient a positive experience. The provider was consistently meeting full compliance with all of the requirements with the exception of NQR 12, which stated that face to face consultations must be started within one hour for emergencies, two hours for urgent and six hours for less urgent.

The trust had undertaken an audit to try and resolve these issues. It had been identified that the 111 service provider had incorrectly assessed the clinical needs of some patients resulting in there being a higher number of cases than would be expected being assessed as requiring urgent face to face consultation. The provider was working with the 111 provider to try and ensure that patients received the appropriate assessment of their needs.

Patient Experience & Involvement

We saw evidence that that the provider used a variety of methods to capture the experiences of patients using the out-of-hours service. These included patient satisfaction questionnaires that had been given to every patient when they attended a primary care centre and also the providers own random selection of patients.

We viewed the results of these questionnaires and found that the results were overwhelmingly positive for the service. Patients had commented upon the short waiting times from arriving at the primary care centre to seeing a doctor and also on the way they had been treated with respect and compassion.

One senior member of staff told us they took time to visit the out-of-hours service and talked to patients about their experience and such things as waiting times.

Staff engagement & Involvement

We found that the service was open and transparent and encouraged staff engagement. We saw evidence that there were regular meetings held for staff at various locations to enable as many staff as possible the opportunity to attend. Regular team meetings at a local level were held to enable staff to engage with managers. These meetings gave staff the opportunity to raise issues that affected patient care. One senior member of staff told us how they made sure that individuals were appraised of any developments or issues raised at meetings by speaking to them on a one- to-one basis in the event they not been at the meeting.

Learning & Improvement

We reviewed the minutes of the Quality and Risk Committee for the previous 12 months and saw that there was a clear emphasis on quality and improvement. Matters having an effect on quality, safety and the patient experience had been discussed in depth and action taken where necessary. Standing items on the meeting agenda included compliance with the National Quality Requirements for out-of-hours GP services.

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	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers** The provider must ensure that there is in place a robust and effective recruitment system to ensure that patients are cared for or supported by GP's who are qualified, skilled and experienced. Appropriate checks should be documented and the provider must ensure that the GP's are suitable to work in the out-of-hours service

Regulated activity	Regulation
Diagnostic and screening procedures	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers** The provider must ensure that there is in place a robust and effective recruitment system to ensure that patients are cared for or supported by GP's who are qualified, skilled and experienced. Appropriate checks should be documented and the provider must ensure that the GP's are suitable to work in the out-of-hours service