Beech House

Quality Report

Beech House, Witham Park, Waterside South
Lincoln LN5 7JH
Tel: 01522 308686
Website: www.lincolnshirecommunityhealthservices.nhs.uk

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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.

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection of Lincolnshire Community Health Services NHS Trust (LCHS) GP out-of-hours service on 2, 3, 4 and 17 August 2016.

Overall the out-of-hours service is rated as 'Inadequate'. Specifically, we found the service as 'inadequate' for providing safe and well-led services. It was 'requires improvement' for providing effective and responsive services. It was good in providing a caring service. Our key findings across all the areas we inspected were as follows:

Our key findings were as follows:

- There was no effective process in place to ensure that staff and GPs received updates on NICE guidance and safety alerts such as those issued by the Medicines and Healthcare Products Regulatory Agency and Central Alerting System.
- The trust had no oversight of safeguarding referrals made by GPs working in the out-of-hours service to ensure that referrals had been tracked and effectively followed up.
- Not all staff that undertook chaperoning duties had received appropriate training.
- Although employed staff underwent a thorough recruitment and induction process to help ensure their suitability to work in this type of healthcare environment, the process for inducting sessional GPs did not provide similar assurance.
- There was insufficient assurance to demonstrate people received effective, timely care and treatment, for example in respect of the time to commence face to face consultations at both patients place of residence and primary care centres.
- The trust had failed to react in an appropriate and timely manner to concerns raised through infection prevention and control audits.
- There were systems in place to help ensure patient safety through learning from incidents and complaints about the service.

Summary of findings

- Patients experienced a service that was delivered by dedicated, knowledgeable and caring staff. They were positive about their interactions with staff and said they were treated with compassion and dignity.
- The primary care centres where patients received care and treatment were equipped to meet the needs of patients. At one primary care centre we found that GPs used their own equipment although equipment was provided by the trust. There was no assurance that the GPs own equipment was safe and fit for purpose.
- Signage to direct patients to some out-of-hours locations were deficient or absent altogether.
- The trust had systems in place to engage with staff and obtain their views about the service and the trust.
- Although members of staff expressed positive views of the leadership at a local level and generally felt supported by them, some felt isolated and told us that the quality of service had deteriorated.
- Some GPs working in out- of- hours told us that they received little support from some senior members of the management team.
- Staff were unsure about whether they should comfort call patients who were waiting for home visits.
- The trust worked proactively with other organisations and with the local community to develop services that supported hospital admission avoidance and improved the patient experience.
- There was limited evidence of the trust seeking the views of people who used the service.

The areas where the trust needs to make improvements are:

The trust must:

- Provide assurance that GPs are inducted into the service in a manner that helps to ensure patient safety.
- Implement a system that gives the trust oversight of safeguarding referrals made by GPs whilst working in out-of-hours and assurance that referrals are being shared with other agencies appropriately.
- Have in place a process that provides assurance that staff and GPs working in out-of-hours are made aware of patient safety alerts, MHRA alerts and updated NICE guidance.
- Ensure that only those staff who had received the appropriate training undertake chaperoning duties.
- Make improvements to ensure that patients are seen at both their place of residence and primary care centres in a timely manner.
- Ensure that issues highlighted at infection prevention and control audits are actioned and remedial action implemented in a timely manner.
- Engage with the public as a means of gathering views to improve the service provided.

In addition the trust should:

- Improve signage to the out-of-hours service at primary care centres.
- The trust should obtain assurances that where GPs and practitioners using their own equipment it is safe and fit for purpose.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

Lincolnshire Community Healthcare Services NHS Trust out-of-hours service is rated as inadequate for providing safe services.

- There were clear procedures and policies that staff were aware of to enable them to recognise and act upon any serious events or incidents. Any learning was shared with staff, although there were no such process to ensure sessional GPs were similarly informed.
- Although employed staff underwent a thorough recruitment and induction process to help ensure their suitability to work in this type of healthcare environment, there was uncertainty with regard to the induction process for GPs who worked in the out-of-hours service on a sessional basis.
- There were no effective systems in place to ensure GPs and practitioners were kept up to date with patient safety alerts such as those issued by the Medicines and Healthcare Products Regulatory Agency and Central Alerting System.
- The trust had effective systems in place to manage medicines.
- The trust did not have systems in place to provide oversight of the safeguarding referrals made by GPs when working in out-of-hours.
- Chaperoning duties were carried out by staff who had not been appropriately trained.
- The service was equipped to respond to foreseeable circumstance that may affect the smooth running of the service such as adverse weather.

Are services effective?

Requires improvement

Lincolnshire Community Healthcare Services NHS Trust out-of-hours service is rated as requires improvement for providing effective services.

- The systems in place to ensure GPs and practitioners were kept up to date with best practice guidance such as National Institute for Health and Care Excellence (NICE) guidelines were not effective in ensuring patients were kept safe. Following the inspection the trust assured us that they had implemented a process to ensure communications are received and read.
- Records showed that all eligible staff had an annual appraisal in the last 12 months.
- GP and practitioner clinical audits were undertaken to help support service improvement.

Summary of findings

- Staff worked collaboratively with other services in the delivery of patient care.
- There was evidence of continuing clinical supervision of practitioners to ensure their effectiveness in delivering safe and effective care and treatment.

Are services caring?

Good

Lincolnshire Community Healthcare Services NHS Trust out-of-hours service is rated as good for providing caring services.

- Patients said they were treated with dignity and respect by helpful and caring staff.
- Patients were satisfied that they were involved in decisions about their care and treatment.
- There was a process in place to ensure patients whose first language was not English were able to access the service through translation services.
- We heard patients being spoken with professionally, courteously and with empathy.

Are services responsive to people's needs?

Requires improvement

Lincolnshire Community Healthcare Services NHS Trust out-of-hours service is rated as requires improvement for providing responsive services.

- The service understood the needs of the population it served and engaged with the local Clinical Commissioning Group to provide services that were responsive to the needs of the population.
- The service worked collaboratively with other trusts to identify opportunities and develop schemes to improve the services patients received.
- The trust had facilities that were equipped to treat patients and meet their needs. GPs did not do home visits and some of the practitioners who did were non prescribers which had resulted in delays in patients receiving medication prescriptions. However the trust has assured us that a GP was available on call and could be called upon to do home visits as required.
- Data showed the service was consistently failing to meet National Quality Requirements (performance standards) for GP out-of-hours services in respect of the time taken to commence face to face consultations in both primary care centres and in people's homes.

Summary of findings

- Information about how to complain was available and easy to understand. .
- The service responded quickly and sensitively to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Lincolnshire Community Healthcare Services NHS Trust out-of-hours service is rated as inadequate for being well-led.

Inadequate

- People working in the out-of-hours service spoke positively about local management but expressed views that their concerns were not acknowledged, listened to or responded to at higher levels of the organisation.
- Staff morale was low in some primary care centres, with staff citing recruitment freezes, a chaotic home visiting service and excessive workloads as primary factors, but we were assured by the trust that there was no recruitment freeze.
- Recent re-structuring had resulted in a management hierarchy that was clear and easy to understand.
- There was well defined management structure with a clear and focused desire to improve the service and to be an active participant in an integrated care model and in doing so meet the urgent care needs of people at or closer to their homes.
- The trust actively and positively engaged with staff as means of identifying areas of service improvement, although staff and sessional GPs said their feedback was not listened to or acted upon.
- The trust did not have effective systems in place to govern activity and to ensure that people using the service were protected from avoidable harm or risk from harm. Some members of the senior management team were not sighted on matters contributing to patient safety such as GP safeguarding referrals, recruitment and ensuring GPs and practitioners were made aware of patient safety alerts and NICE guidance
- The trust had not undertaken any meaningful action to seek the views and experiences of patients and carers using the out-of-hours service.

Summary of findings

What people who use the service say

There was no publically accessible data available to assess peoples experience of using the out-of-hours service.

The results from the Friends and Family test were available from three of the eight out-of-hours primary care centres for January to June 2016. The sample represented a very small percentage of patients. The results were positive.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection taking place. In all total 74 cards were returned. All were positive about the standard of care received. Patients told us they had received a good service, that they were treated with respect by helpful and caring staff. Two contained negative comments regarding the cost of car parking, which we acknowledge the trust had no control over.

We spoke with six patients. They said they were given appointments quickly and they found staff polite and helpful.

Areas for improvement

Action the service MUST take to improve

- Provide assurance that GPs are recruited and inducted into the service in a manner that helps to ensure patient safety.
- Implement a system that gives the trust oversight of safeguarding referrals made by GPs whilst working in out-of-hours.
- Have in place a process that provides assurance that staff and GPs working in out-of-hours are made aware of patient safety alerts, MHRA alerts and updated NICE guidance.
- Ensure that only those staff who had received the appropriate training undertake chaperoning duties.
- Make improvements to ensure that patients are seen at both their place of residence and primary care centres in a timely manner.
- Ensure that issues highlighted at infection prevention and control audits are actioned and remedial action implemented in a timely manner
- Engage with the public as a means of gathering views to improve the service provided

Action the service SHOULD take to improve

- Improve signage to the out-of-hours service at primary care centres.
- The trust should obtain assurances that where GPs and practitioners using their own equipment it is safe and fit for purpose.
- Implement a clear policy for staff to follow in respect of 'comfort calling' patients waiting for home visits.
- Have an effective process to ensure the most up to date policies and protocols were available to staff.

Beech House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and the team included further CQC inspectors, a CQC pharmacy inspector, a GP out-of hours specialist advisor, a GP out-of-hours manager specialist advisor and urgent care nurse specialist advisors.

Background to Beech House

Lincolnshire Community Health Services NHS Trust provides GP out- of- hours services for Lincolnshire. The services are commissioned on behalf of the four Lincolnshire clinical commissioning groups by Lincolnshire West CCG. In addition the trust provides a wide spectrum of other healthcare services including, but not limited to, urgent care and walk in centres, community nursing, health visiting, community hospitals and family and healthy lifestyles services.

In all the trust employs approximately 2,500 staff.

The trust provides for a population of approximately 731,000 (Office for National Statistics data) living in Lincolnshire, dispersed across an area of 2,350 square miles, it being the second largest county in England.

Road communications can be difficult with few miles of dual carriageway and no motorways. The public transport infrastructure from the outlying villages to the county towns is generally poor.

The Lincolnshire coastal holiday destinations have a high number of transient, temporary residents coupled with high levels of deprivation.

Out-of-hours care is provided from eight primary care centres across the county. They are located at: Lincoln, Boston, Grantham, Spalding, Stamford, Louth, Skegness and Gainsborough. We visited the primary care centres at Lincoln, Boston, Grantham and Stamford together with the trusts headquarters at Beech House, Lincoln during the course of this inspection. All of the primary care centres we visited were used by other healthcare providers during the 'in-hours' period.

The out- of- hours service operates from 6.30pm to 8.00am on weekdays, and continuously from 6.30pm on a Friday evening to 8.00am on a Monday morning. It also covers Bank Holidays and provides a service for patients with urgent medical needs that cannot wait until their GP practice is next open. To access the service patients phone 111. They may then be asked to attend a primary care centre for a consultation or in some circumstance they may be seen in their home.

The NHS 111 service is provided by Care UK East of England from their call centre located in Ipswich.

In the year April 2015 to March 2016 the out-of-hours service had over 100,000 patient contacts.

GPs who work in the out-of-hours service are self-employed and work on a sessional basis. In total the service has 67 such GPs. In addition to GPs the out-of-hours employs nurses, nurse practitioners, emergency care practitioners and healthcare support workers at the primary care centres.

GPs worked from 6.30pm to 11pm. After 11 pm an 'on-call' GP was available by telephone. Between the hours of 11pm and 8am the primary care centres were staffed by practitioners supported by healthcare support workers.

A home visiting service operated and was staffed by nurse and emergency care practitioners.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the trust is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We had previously inspected this service in June 2014.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about this out-of-hours service and asked other organisations to share what they knew about the service. We also reviewed information that we had requested from the trust and other information that was available in the public domain.

We carried out an announced visit to the trusts headquarters at Beech House Lincoln on 2,3 ,4 and 17 August 2016 and visited four primary care centres at Boston and Lincoln on 3 August and Stamford and Grantham on 4 August.

We left comments cards at the primary care centres to enable patients and others to share their experiences with us.

During our visit we spoke with members of staff at the trusts headquarters and also at the four primary care centres. They included the Chair of the trust, Chief Executive Officer, Medical Director, Director of Nursing and Operations, Head of Urgent Care, GP lead, Medicines Management Officer and Safeguarding lead amongst others. We also met and spoke with GPs, nurses, nurse practitioners, emergency care practitioners healthcare support workers, receptionists as well as clinical team leaders, urgent care matrons, managers and a range of administrative staff.

We also reviewed a range of records including audits, staff files, training records and information regarding complaints and incidents.

Inadequate

Are services safe?

Our findings

Safe track record

Staff we spoke with confirmed they had access to a wide range of procedures, policies and protocols that were available on the trust's computer system that all relevant staff had access to. Many were also available in hard copy at the primary care centres. These covered a range of subjects including everyday activity and service delivery aimed at ensuring the best outcomes for patients. We saw they had been reviewed and updated where necessary on the computer system but hard copies did not always contain the most recent versions which meant that staff might not always be referring to the most up to date guidance and protocols aimed at keeping patients safe. Since the inspection the trust has told us that they have taken action to ensure that staff only refer to the most up to date policies and protocols which could be accessed on the IT system.

Staff were clear about their line of management and told us they would have no concerns about reporting any safety incidents and near misses.

Learning and improvements

The trust had an effective system in place for the reporting, recording and monitoring of significant events and complaints. There was a nominated member of staff who dealt with complaints about the service. We looked at the 29 recorded complaints for the period April 2015 to March 2016. There was good analysis of the complaints, full investigations, timely acknowledgments and full responses including apologies where necessary. We saw evidence that any learning from complaints was cascaded to staff. However we found that there was no effective system for ensuring this learning was made available to sessional GPs.

The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

We looked at the serious events that had been recorded in the year 2015/16. We saw that they had been clearly recorded and a full root cause analysis undertaken, where appropriate. Steps to prevent any re-occurrence were clearly documented and had been actioned.

Reliable safety systems and processes and practices

We reviewed personnel files of employed staff and GPs and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However there was no system to check that sessional GPs had up to date training once they had been recruited and no checks were carried out to ensure they remained on the performers list. Since the inspection we have been assured by the trust that additional measures have been put in place to ensure that all GPs are up to date with their required training.

Professional indemnity was in place for employed clinical staff and sessional GPs.

There were no effective systems in place to ensure GPs and practitioners were kept up to date with patient safety alerts such as those issued by the Medicines and Healthcare Products Regulatory Agency and Central Alerting System.

All of the staff we spoke with were able to demonstrate a good working knowledge of what may constitute a safeguarding concern and how they would raise a concern. We saw that safeguarding concerns raised by the nursing and practitioner team had been directed to the appropriate authority and the outcomes had been fed back to staff where possible.

However we found in the case of GPs there was no such system in place and the trust could not identify what safeguarding referrals, if any, had been made by GPs whilst working in out-of-hours. We found that emails sent out to staff to re-enforce the system of making referrals and the process for adding to the computerised records had not included GPs.

Training records we looked at showed that staff received training at an appropriate level in safeguarding vulnerable adults and children as part of their mandatory training, which they renewed annually. All nurses and practitioners had received safeguarding children training to level two and many to level three. We could not be assured that GPs working in the out-of-service had up to date appropriate level of training. Clinicians we spoke with were aware of the Mental Capacity Act 2005, as well as consent in relation to

the children and young people, known as the Gillick and Fraser Competency Guidelines. We saw that training in this area formed part of staff induction and guidance was also available online.

Notices in the waiting rooms advised patients that chaperones were available if required. All staff who acted as chaperones had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).We found that healthcare support workers undertook chaperoning duties. When we spoke with a healthcare support worker at one primary care centre they said that although they undertook chaperoning duties they had never received any training. The trust's policy on chaperoning stated that only appropriately trained staff should undertake such duties. Since the inspection the trust had provided assurances that all staff who may be required to perform chaperoned duties will receive appropriate training.

Medicines Management

We found that the trust had a process in place for ensuring that all drugs, including controlled drugs, were ordered from an agreed stock list of medicines and delivered to the primary care centres by the supplier. There was a minimum stock level of medicines kept at each primary care centre. This was managed and 'topped up' on a weekly basis from the medicines supplier.

Staff at the primary care centres confirmed this system worked well. Nurses or a healthcare support worker put the medicines away into locked cupboards. They were also responsible for checking the expiry dates of all medicines although there was no standardised procedure for them to follow. There were different procedures at the various primary care centres. Registers that we viewed were accurate and correctly completed.

Marie Curie held the contract for Rapid Response within palliative care in Lincolnshire. Their contract did not include the provision of drugs to patients in their care. LCHS out-of-hours supported this service by ensuring that medication was available. Some GPs within the Lincolnshire area were not advocates of pre-emptive prescribing and though the trust was working with all stakeholders involved to improve this, there was a deficit in provision of both pre-emptive prescribing and appropriate community pharmacy provision. This had necessitated the trust keeping a supply of emergency drugs for patients, and a new method of supply to Marie Curie which was seen in the 'supply to patients CD register' held at primary care centres. These supplies were always in the form of an original pack, authorised by a prescription for a specific patient as defined in the standard operating procedures. Controlled drugs on LCHS premises were handled appropriately.

Patient Group Directions (PGDs) were in use for the supply of a range of medicines. There were systems for maintaining PGD documentation which included prompting for a review of each PGD three months prior to expiry and ensuring they were signed by all practitioners using them. Clinical Team Leaders also signed-off individual practitioners as being competent to use a PGD. We saw that the medicines management team were in the process of reviewing all PGDs in an effort to rationalise and reduce if possible the somewhat confusing number in existence, for example paracetamol where there were nine existing PGDs.

Medicines-related incidents were documented on an electronic risk management reporting system. There were systems for reviewing and documenting all such incidents and providing appropriate feedback to the individuals involved.

There was an internal process for the management of prescriptions which helped to ensure that reconciliation of medicines was done. In addition, physical counts of the stock were undertaken and compared to records.

At the primary care centres we visited we found that prescription pads were, secured, accounted for and managed correctly.

The trust undertook quarterly medicines audits which included processes pertaining to controlled drugs. We were made aware of one such audit that had prompted the trust to make significant changes to the manner in which controlled drugs were managed at a particular primary care centre.

We were informed that the commissioners of the service did not have a medicines management lead and provided no support or external review or audit of the trusts medicines management.

Infection prevention and control

Inadequate

Are services safe?

The Medical Director was designated as the Director of Infection Control and held overall responsibility.

The trust maintained appropriate standards of cleanliness in the primary care centres. We observed the four centres we visited to be visibly clean and tidy other than high level dust at Grantham. Staff had access to appropriate hand washing facilities, personal protective equipment, and equipment for cleaning equipment and spills of bodily fluids during the shift.

The service had a nominated infection control lead, who we spoke with, and up to date infection control policies and procedures were available to support staff. Infection control was part of the service's mandatory training. We looked at a number of infection control audits which had been undertaken by the trust during 2015 and 2016.We saw that areas for improvement were clearly highlighted along with the actions required. However when we compared the audits undertaken in July 2015, with the most recent audits that had been completed in July 2016 many issues had not been addressed.

The infection prevention and control team consisted of two members of staff who had responsibility for approximately 60 sites used by the trust in delivering its various healthcare services. They told us that covering so many different sites was challenging but that some infection prevention and control duties and responsibilities had now passed to senior staff at the primary care centres.

Monitoring safety and responding to risk

We found arrangements relating to health and safety were in place and once identified issues were promptly responded to by the trust.

Regulated activities took place across eight primary care centres. All of these buildings were used by other healthcare services during the 'in hours' period. There were contractual arrangements in place for the management of risks affecting the premises such as fire safety, legionella and cleaning.

Equipment was checked and calibrated to ensure that it was safe to use and working properly. However at one primary care centre we found that GPs used their own equipment although equipment was provided. The trust had no process in place to ensure GPs own equipment was safe and fit for purpose.

Although we were assured that clinical rooms and home visit equipment bags were routinely checked and restocked as required there was no common checklist or process that staff were required to follow to ensure consistency and conformity across the eight primary care centres. Home visit bags that we looked at were satisfactorily stocked.

We looked at the vehicles used on home visits. We saw service records to show that these were regularly maintained. The drivers undertook routine checks of the vehicle to ensure they were fit for purpose and to report any faults that needed to be addressed.

There were inconsistencies in ensuring that drivers were suitable and competent. Some drivers we spoke with, who were either dual role healthcare support workers/drivers or clinicians stated that other than producing a valid clean driving licence, no other checks had been carried out to establish their suitability . For example there was no driving competency assessment or check on the health or eyesight of staff. We spoke to one member of staff who had paid for their own eye test to assure themselves they were fit for the role. Another told us that they had a driving assessment with an LCHS employee who they understood was an accredited driving assessor.

In addition to the GPs providing consultations at the primary care centres, there was also a GP whose role was to access the Clinical Assessment Service list of patients awaiting assessment and make clinical judgements on the most appropriate treatment pathway for patients. This only occurred until 11pm when all GP sessions finished. After that time nurses and practitioners were responsible for managing this aspect of the service.

We found that unfilled staff vacancies at the primary care centres had resulted in an effect on meeting patient needs and that face to face consultations with GPs and practitioners both at primary care centres and in patients place of residence had been adversely affected. This posed a risk that patients who had been clinically assessed as requiring a face to face consultation within a given timeframe were left waiting for care and treatment with a potentially worsening condition.

Arrangements to deal with emergencies and major incidents

We saw that a comprehensive business continuity plan, available electronically and in hard copy format, was in place to inform staff in the event that the normal operation

Inadequate

Are services safe?

of the service was interrupted by such things as failure of power, telephony, staffing issues or loss of a primary care centre. We saw that hard copies as well as electronic copies were available allowing all staff access to it should the need arise.

Incidents such as the closure of accident and emergency departments and events including pandemic flu were taken into account and planned for.

There was a rota to ensure that there was always a senior member of the management team on call to assist in the event of a major issue.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Lincolnshire Community Health Services NHS Trust did not have systems in place to support clinical staff and GPs in keeping up to date with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines when working in out-of-hours. We saw that at some primary care centres there were folders containing such guidance, this was held and arranged at a local level and there was no consistant process for ensuring it was cascaded to all clinical staff or to GPs. There was no system to indicate which members of staff or GPs had read the guidance. Following the inspection the trust assured us that they had implemented a process to ensure communications are received and read.

We saw that the trust newsletter contained some updates but as GPs did not have access to the trust intranet they did not receive it by this means.

Management, monitoring and improving outcomes for people

The trust had undertaken the required number of clinical audit for both practitioners and GPs in line with recognised best practice and in compliance with the relevant National Quality Requirements. The Medical Director told us that he thought that they were being done using the Royal College of General Practitioner toolkit and that they were done by the two GP leads, which we confirmed to be the case.

We were provided with evidence that showed that 64 of the 67 GPs had their clinician work audited and the remaining three had dates planned for the audits to take place.

Similarly practitioners had their clinical practice audited.

Meetings were held for all staff groups. There were a number of meetings aimed at improving outcomes for patients which included clinical review meetings, medicines management meetings and senior management team meetings. Meetings for staff working in out -of-hours primary care centres were difficult to arrange and the trust acknowledged they had work to do to improve in this area.

Effective staffing

We were aware that the trust had consistently failed to meet the key performance indicator targets for conducting face to face consultations with patients both at primary care centres and in their own homes. Staff that we spoke with at the primary care centres stated that it was down to low staffing levels, staff not being recruited to fill vacancies and changes to the way that home visits were allocated as a county wide resource rather than a quadrant resource which had resulted in staff completing excessive mileages to complete visits that were behind the poor performance. For example we were told that there were five full time equivalent practitioner posts unfilled at Grantham and also vacancies at Boston and Lincoln.

The trust had a system in place for staff to receive an annual appraisal from their manager. All staff employed by the trust and working in the out-of-hours service, who were eligible for appraisal had received one in the last 12 months.

When we looked at the annual appraisal records of staff we found them to have been well considered and written, identified the subjects performance , objectives and future training and we saw evidence that staff requirements had been condsidered and implemented where appropriate.

The trust had in place a process to identify and deal with poor performance of some GPs, including low productivity, and we were provided with evidence to support the assertion. We noted that during our visit to one of the primary care centres the GP did not arrive until ten minutes after they were due to commence work .The trust informed us that poor GP timekeeping was an issue that they had identified and were addressing, as it had the potential to impact on the time taken for patients to be assessed and seen.

The process for recording and accessing staff records and such things as their training and induction records was disjointed with some being held centrally and others at primary care centres. This put the trust in the position where senior managers were prevented from having a clear oversight of staff competencies and past and required training. The trust had identified this shortcoming and were taking steps to centralise record keeping in respect of staff.

Working with colleagues and other services

There were clear structures in place to monitor the performance of the out-of-hours service through contract and quality review meetings, clinical governance group meetings and the monitoring of complaints and incidents by the service commissioners.

Requires improvement

Are services effective?

(for example, treatment is effective)

Other stakeholders included the ambulance service, the acute trust , mental health services and CCGs. All met regularly to discuss performance and improve patient pathways.

Information sharing

Clinicians were able to view special patient notes (started by a patient's GP). These included such information as end of life care, people with long term conditions , those with a do not attempt cardio pulmonary resuscitation notices and frequent callers to the service.

Details of a patients contact with the out-of-hours service was sent to their own GP practice by 8am the following morning, in line with National Quality Requirements key performance indictor.

Consent to care and treatment

Clinicians sought patients' consent to care and treatment in line with legislation and guidance and had access to information such as do not attempt resuscitation orders through special patient notes where these were available so that they could take it into account when providing care and treatment.

Good

Are services caring?

Our findings

Dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and helpful to patients both at the primary care centres and on the telephone.

We noted that consultation and treatment room doors at primary care centres were closed during consultations and that conversations taking place in these rooms could not be overheard.

We found that there was some variance in what staff understood in respect of comfort calling patients while waiting for home visits. Some staff told us that they undertook comfort calls whereas others told us that they had been told that they were not to do so.

Staff were mindful of confidentiality and advised us that they would offer somewhere private if a patient wished to discuss sensitive issues or appeared distressed. However staff at one primary care centre told us that they were too busy to observe patients and note if their condition was deteriorating.

Feedback we received from patients from CQC comment cards and our conversations with six patients at primary care centres during our visit was positive.

Involvement in decisions about care and treatment

Staff we spoke with were aware that some callers needed extra help and support to help them understand or be involved in their care and treatment and this included callers who were unable to understand English well enough to be able to make an informed choice. All clinical staff had access to translation services.

Patient/carer support to cope emotionally with care and treatment

The trust had systems in place to signpost callers to other services, for example mental health services.

We found the service to be sensitive of patient needs and worked proactively to deliver care that supported them. For example working with other healthcare services to develop continuity of care between services such as district nursing and health visiting teams, mental health crisis teams and GP practices.

Patients in palliative care were issued with a dedicated telephone number to enable they or their carers to access the out-of-hours service directly and thus removing the need to call NHS111 before being directed to the out-of-hours service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Lincolnshire Community Health Services NHS Trust worked closely with the commissioner of the out- of- hours service to ensure that they were planned and delivered in line with patient needs. The various stakeholders including ambulance services and clinical commissioning groups worked with the trust to best identify and meet those needs. This was achieved by formal governance arrangements including monthly reporting on performance, quality, clinical governance and complaints and incident monitoring.

Together they had identified the need for an Integrated Clinical Assessment Service which would effectively manage all patients with urgent healthcare needs, from the point of first contact through to delivery of the care or advice needed. The result of a successful service would be to free up emergency centres to concentrate on patients that are seriously ill or injured and have immediate need for high level, specialist care. The expectation was that the Integrated Clinical Assessment Service would provide senior clinicians at the front end, talking to patients and carers directly and making decisions about their care needs and the appropriate degree of urgency based on their clinical needs.

This service became fully operable on the second day of our inspection and it was therefore inappropriate to draw any conclusions regarding its effectiveness or effect on patient safety and access to healthcare.

Tackling inequity and promoting equality

We saw that staff had received training in equality and diversity. All patients were treated on the basis of their clinical need without any reference to any disability, their race, religion, ethnic group or sexual orientation.

Access to the service

The out-of-hours service operated between 6.30pm and 8am Monday to Friday and 24 hours on a Saturday, Sunday and bank holidays. Patients accessed the service through the NHS 111 telephone number. Calls were triaged by the 111 service and patients assessed as having a need to have a face to face consultation. Following the NHS111 assessment, cases were passed to the Clinical Assessment Service where cases were held in a 'stack' that could be accessed by clinicians and a re-assessment of their needs undertaken. The clinical assessment service was not based in any one physical locality and operated as a virtual service that could be accessed from any suitably configured computer by authorised staff.

The trust used National Quality Requirement (NQR) and other quality indicators which it submitted to the Clinical Commissioning Group (CCG) to monitor the quality of the service patients received. NQRs for GP out-of-hours services were set out by the Department of Health to ensure these services were safe and clinically effective.

NQR 12 is the measure of the time taken to start a face to face consultation with a patient whether it be in the patients place of residence or primary care centre after the definitive clinical assessment has been completed. They are graded as Emergency-within one hour; Urgent-within two hours and Less urgent-within six hours.

We reviewed the applicable NQR 12 for the period January to June 2016 and found that the service had failed to meet the key performance indicator (KPI) of 95% in every month in every category for home visits.

Within one hour;

January-not reported February 20% March 20% April 12.5% May- not reported June 10%

Within two hours;

January 31.3%, February 43%, March 48.6%, April 58.3%, May 46.3%, June 59.5%

Within six hours;

January 77.3%, February 77%, March 68%, April 84.9%, May 79.5%, June 83.6%

For face to face consultations at primary care centres the performance against the KPI of 95% was;

Within one hour;

January-not reported, February 66.7%, March 50%, April 20%, May-not reported, June 50%

Within two hours;

January 78.7%, February 82.5%, March 76.1%, April 86.9%, May 84.1%, June 89.3%

Within six hours;

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

January 98.3%, February 98.3%,March 98.6%, April 98.8%, May 99.3%, June 98.8%

We spoke with staff at the primary care centres regarding the time taken to complete home visits in particular, and without exception they stated that it was down to low staffing levels, staff not being recruited to fill vacancies and changes to the way that home visits were allocated as a county wide resource rather than a quadrant resource which had resulted in staff completing excessive mileages to complete visits. For example, one member of staff told us that 300 miles a shift was not uncommon and another said that 200 miles was a regular occurrence. Given the geography and quality of the road network in the county covering these mileages represented a large proportion of a shift. We were cited one example of a visiting team travelling from Grantham to Stamford and back three times in one evening, when there was a car available at Stamford but with no staff to crew it. We also heard of examples of cars travelling from Grantham to Skegness to complete visits, a distance of 52 miles and taking approximately 90 minutes. Some staff told us that excessive driving during the course of a 13 hour shift was in their opinion dangerous and did not promote safe and effective care and treatment of patients. We raised this issue with the trust who acknowledged the case of the vehicle travelling from Grantham to Boston but stated that it was an appropriate use of the resource as it had not been allocated any calls at the time.

The service deploys GPs until 11pm when they all finish their shifts. A duty GP is then available by telephone to support the work of the nurse and emergency care practitioners until 8am. Following the inspection the trust assured us that the duty GP was available to complete home visits as required.

There was no use of locum GPs although there had been a reliance on agency nurses and practitioners due to difficulties in recruiting staff. We saw that the use of agency staff had been reduced significantly on economic grounds but staff at the primary care centres told us that this had a negative effect on the delivery of care and treatment with insufficient staff available to ensure a full service was maintained.

We noted that there was no signage to the out-of-hours primary care centre at Stamford and Rutland Hospital and the inspectors visiting the centre encountered difficulty in locating it. Staff told us that this had been raised with management but nothing had been done about it. They said that during the hours of darkness patients were guided to the out-of-hours area as it was the only building with lights on. At Grantham and District Hospital there was no external signage to direct people.

We did not receive any negative feedback from the patients we spoke with or the feedback cards we received about waiting times to see a clinician or practitioners at the primary care centres.

Listening and learning from concerns and complaints

We looked at the records of the complaints received about the out-of-hours service in the period April 2015 to March 2016 and saw they had been correctly recorded, investigated and responded to. The investigations included, where appropriate, an apology to the complainant.

Analysis of the complaints had been completed but this did not show that any one theme was significantly higher than others. Learning from complaints was evident and individual members of staff concerned in the complaint were involved. Where necessary action was taken to prevent any re-occurrence by means of additional support, training, supervision or reflection.

The level of complaints was comparable to similar GP out-of-hours services.

Records clearly showed that the trust fulfilled its duty of candour and people were told when they were affected by something that went wrong. We saw that letters of apology had been sent where it was appropriate.

Are services well-led?

Inadequate

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

Our findings

The delivery of high-quality care is not assured by the leadership, governance or culture in place.

Vision and strategy

Lincolnshire Community Health Services NHS Trust told us that they put quality, safety and good patient outcomes as a top priority with the vision and values being clear to all staff through their promotion of a campaign aimed at all staff called 'The LCHS Way'

The senior management had re-enforced the messages though staff engagement events and continuing staff communications.

However we found that the trust had not demonstrated that it had taken positive action to tackle the very low performance in patients receiving face to face consultations both at their place of residence and primary care centres, which led to the safety of patients being put at risk as they were not recieving care and treatment in a timely manner and in accordance with their clinical needs assessment.

Staff we spoke with clearly understood that quality and safety were paramount but those at the primary care centres were concerned that the service was not working as efficiently as it should due to staffing shortages.

Governance arrangements

The trust had governance arrangements in place and a number of committees were responsible for service delivery. These included: finance and performance committee, quality and risk committee and remuneration committee. The lines of responsibility and reporting were clear and unequivocal. However we found there was no effective system for identifying, capturing and managing issues and risks. Significant issues that threatened the delivery of safe and effective care were not identified or adequately managed. For example there was no oversight of the safeguarding referral systems of sessional GPs and there had been no positive action taken to improve the poor performance of the service in meeting patient consultation timescales.Senior members of the management team were not sighted on matters contributing to patient safety such as the process for ensuring staff and GPs were made aware of patient safety alerts, NICE guidance and MHRA alerts. Equally we did not receive assurance that all sessional GPs working in the out-of-hours service had been recruited in manner that promoted patient safety or had undertaken all of the necessary training.

The systems in place to govern activity and to ensure that people using the service were protected from avoidable harm or risk from harm were ineffective. The process for recording and accessing staff records and such things as their training and induction records was disjointed with some being held centrally and others at primary care centres. This put the trust in the position where senior managers were prevented from having a clear oversight of staff competencies and past and required training. The trust had identified this shortcoming and were taking steps to centralise record keeping in respect of staff.

The trust had made the required statutory notifications to the Care Quality Commission.

Leadership, openness and transparency

The trust was led by an experienced management team who were supported by a board of directors with wide ranging experience including crime and justice, commercial and business strategy, finance, third sector, acute and urgent care provision and cultural and workforce transformation.

Staff that we spoke with told us that senior management were visible and confirmed that the Chief Executive Officer had visited in the out-of-hours period. Although people working in the service were generally satisfied and thought local management was good both employed staff and sessional GPs told us that some senior members of the management team did not seem willing to listen or respond to their concerns, in particular their concerns about the workload, staff vacancies not being filled and the difficulties in ensuring patients were seen in a timely manner.

Public and staff engagement

There was minimal engagement with people who use services or the public. The service did not respond to what people who use services or the public say.

There were no effective systems in place to seek the views of people using the out-of-hours service. National Quality Requirement 4 states that the provider should seek the views of a random selection of 1% of people using the out-of-hours service. In the case of the trust, that would

Are services well-led?

Inadequate

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

equate to approximately 1,000 people per year or 250 people per quarter. We saw that the trust had used the Friends and Family Test at three primary care centres from October 2015 to March 2016 but that only 64 people had been consulted, each had replied. The trust had also undertaken the Friends and Family Test at their urgent care centres at Skegness and Louth but they were unable to provide us with any indication of how many of the 131 responses related to out-of-hours.

The trust had appointed a new provider to undertake the Friends and Family surveys and we viewed the report for July 2016. Although the report stated that 240 patients had been surveyed, it did not specifically target people using the out-of-hours service but related to Urgent Care as a whole. The results were therefore of very limited use in assessing the quality of service people received in out-of-hours.

We viewed the results of the staff survey that took place in October and November 2015, that was open to all staff and in which 54.3% of LCHS staff took part. It was not specific to staff working in out-of-hours.This represented an increase of 5.8% over the previous year's survey. The trust moved from being rated 'below average' for overall staff engagement in 2013, to a rating of 'above average' in 2014. Other accolades had followed, including being listed in the 'Top 100 Great Places to Work' by the Health Services Journal (HSJ) in 2015 and also being shortlisted by the same organisation in their prestigious annual awards in the category of Staff Engagement. More recently, the trust was asked to speak at the HSJ Value in Healthcare Congress in May 2016 around its work on Staff Engagement.

The senior managers, including the Chief Executive had conducted 60 two hour long 'staff conferences' at various locations throughout the county to engage with staff in the future direction of travel for the trust.

The Chief Executive Officer sent all staff a weekly email to update them on developments and held a monthly telephone conference that was open to all staff and was also recorded and available for those that wished to hear it. A monthly 'team brief' was circulated to keep staff appraised of news and developments. Staff also had direct access to the CEO via 'Ask Andrew' email account.

We found staff morale was low in some primary care centres, with staff shortages, a chaotic home visiting service and excessive workloads cited as a primary factors by the staff we spoke with.

The trust had a Whistleblowing policy that had an equality impact assessment tool template attached.

The trust published a quarterly staff newsletter, 'Update' that was well presented, professional looking and covered a range of subject areas including staff news and social events as well as performance statistics and other material affecting the staff and service delivery.

Continuous improvement

The trust had recently appointed a Band 8 practitioner to further develop and enhance the skills, training and mentorship available to clinical staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have assurance that GPs working in the out-of-hours service were inducted in a manner that helped to ensure patient safety. The provider did not have oversight of any safeguarding referrals made by GPs while working in out-of-hours or assurance that they were being shared with the appropriate agencies. Not all staff who acted as chaperones had received the appropriate training. The registered person had not taken steps to ensure that issues highlighted as a result of infection prevention and control audits were actioned and implemented in a timely manner. This was in breach of Regulation 12 (1) and (2)(a)(b)(c) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person did not have in place a system to ensure that relevant staff and GPs were kept appraised of guidance from National Institute for Health and Care Excellence, MHRA alerts and patient safety alerts. The provider did not have in place an effective system that enabled patients to be seen at both their homes and primary care centres in a timely manner.

This section is primarily information for the provider

Requirement notices

The provider did not have effective systems in place to engage and seek feedback from users of the out-of-hours service.

This was in breach of Regulation 17(1) and (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.