Beech House

Inspection report

Witham Park
Waterside South
Lincoln
Lincolnshire
LN5 7JH
Tel: 01522308824
<www.xxxxxxxxxxxxxxx>

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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 location	Good
Are services safe?	**Good**

Overall summary

This service is rated as Good overall. (Previous inspection August and September 2017 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced focused inspection at Lincolnshire Community Health Services NHS Trust (LCHS) GP out-of-hours service on 10 July 2018. This inspection was carried out to follow up on a breach of regulation in relation to safe care and treatment found at our previous focused inspection in August and September 2017. At that inspection the key question of safe was rated as requires improvement and therefore this inspection focused on the key question of safe.

At this inspection we found:

- There was a process in place to ensure blank prescriptions were tracked throughout the service.
- Patient Group Directions ensured that the prescriber evaluated the risks associated with high risk medicines which were to be left in a patient's home.
- The provider now had a system in place to ensure that medicines were dispensed safely and in the appropriate packaging.
- Staffing at the Lincoln primary care centre had been reviewed to ensure that staff could observe patients in the waiting room at all times to ensure they were aware of deteriorating patients.
- The provider was progressing the implementation of a medical workforce model to ensure staffing levels across all primary care centres were at the required minimum safe staffing level. Recruitment was still ongoing.
- The risk register held clear information on the risk and impact or mitigating actions were recorded.

The areas where the provider **should** make improvements are:

- Ensure that the planned signage improvements are implemented at Lincoln primary care centre.
- Continue with the programme of recruitment to ensure staffing levels are appropriate and sustainable.

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

Our inspection team

Our inspection team consisted of a CQC inspector.

Background to Beech House

Lincolnshire Community Health Services NHS Trust (LCHS) provides GP out-of-hours services for the population of Lincolnshire. Services are commissioned on behalf of the four Lincolnshire clinical commissioning groups (CCGs) by NHS Lincolnshire West CCG. In addition, the Trust provides other healthcare services including, but not limited to, urgent care centres, community nursing, health visiting, community hospitals and children and young people's services.

The Trust employs approximately 2200 staff and provides services for a population of approximately 784,000 (Office for National Statistics data) living in Lincolnshire, dispersed across an area of 2,350 square miles, Lincolnshire is 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. The Trust employs the services of 88 self-employed GPs from local GP practices who work in the primary care centres.

Out-of-hours care is provided from eight primary care centres across the county of Lincolnshire. They are located at:

• Boston Accident & Emergency Department, Pilgrim Hospital, Sibsey Road, Boston, PE21 9QS.

• Grantham and District Hospital, 101 Manthorpe Road, Grantham, NG31 8DH.

• Louth Urgent Care Centre, Louth County Hospital, High Holme Road, Louth, LN11 0EU.

• Lincoln Accident and Emergency Department, Lincoln County Hospital, Greetwell Road, Lincoln, LN2 5QY.

• Skegness Urgent Care Centre, Skegness and District Hospital, Dorothy Avenue, Skegness, PE25 2BS.

• Minor Injuries Unit, Johnson Community Hospital, Spalding Road, Pinchbeck, Spalding, PE11 3DT.

• Stamford and Rutland Hospital, Ryehall Road, Stamford, PE9 1UA.

• Gainsborough Minor Injuries Unit, John Coupland Hospital, Ropery Road, Gainsborough, DN21 2TJ.

We visited the primary care centre at Lincoln. We also visited the Trust headquarters located at Beech House, Lincoln as part of this inspection.

The service provides a 24 hour 7 day a week provision at Lincoln A&E through an integrated urgent care service. The service provides a clinical assessment service (CAS) in alliance with East Midlands Ambulance Service and 111 which has been in operation since August 2016. CAS takes non-urgent 999 calls, referrals from 111 and directly from care homes. CAS provides; support, advice & guidance, hear and treat, via call backs to those with less urgent needs, see and treat by directing patients to primary care centres and a rapid response home visiting team all supported by multi-skilled clinical staff including GPs, urgent care practitioners and pharmacists. An urgent care streaming service provides an initial navigation for all A&E walk-in patients. Patients navigated to the primary care streaming service are clinically assessed within 15 minutes. This is provided by a mix of skilled clinicians with primary care/minor illness/minor injury expertise and skills alongside GP's.

Good

Are services safe?

At our previous comprehensive inspection in August and September 2017, we rated the service as requires improvement for providing safe services. This was because;

- The provider had not ensured that a process was in place to ensure blank prescriptions were tracked throughout the Lincoln primary care centre.
- The provider had not ensured that PGDs in relation to some medicines ensured that the prescriber evaluated high risk medicines to be left in the patient's home address or other setting and to handle it in accordance with that risk.
- The provider had not ensured that some medicines were dispensed to patients at the Lincoln primary care centre in the appropriate packaging to ensure details of expiry dates, dosage and other information was provided to patients.
- The provider had not ensured that adequate staffing levels were in place at the Lincoln primary care centre to ensure that staff based on the reception desk could observe patients in the waiting room at all times to ensure they were aware of worsening patients.
- The provider had not ensured that medicines were dispensed safely to patients at the Lincoln primary care centre.
- The provider had not ensured that staffing levels across all primary care centres were at the required minimum safe staffing level at all times as determined by the provider.

When we carried out this focussed inspection on 10 July 2018 we found improvements had been made.

We rated the service as good for providing safe services.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

At our inspection in August and September 2017 we found that the provider did not ensure that adequate staffing levels were in place at the Lincoln primary care centre to ensure that staff based on the reception desk could observe patients in the waiting room at all times to ensure they were aware of worsening patients.

At this inspection we were told that since May 2018 a clinician, employed by the provider had been working alongside the receptionist at the Lincoln primary care centre, signposting patients appropriately to either urgent care or A&E and also monitoring the waiting area. We were told that a new reception and waiting area within the urgent care centre had been developed in order to move away from the current arrangement of a shared reception with the A&E department. We visited the primary care centre and saw the new facilities and were told once this was completed there would be a separate urgent care entrance and patients presenting there would be streamed by the clinical navigator working alongside the receptionist. We saw that there were mirrors positioned to enable staff at the reception desk to monitor all patients in this waiting area. We were told that the reception desk would always be staffed if there were patients in the waiting area.

Also at our previous inspection we found that the provider had not ensured that staffing levels across all primary care centres were at the required minimum safe staffing level at all times but saw evidence of a proposed medical staffing model which at that time had not yet been implemented.

At this inspection we were told that the provider was still progressing towards a more sustainable workforce by employing GPs rather than using locums. The employed staff would work across urgent care which included the out of hours service. An additional four GPs had been recruited since our last inspection and all GP clinical lead positions had been filled. As part of the sustainable model, the provider had also increased the number of Advanced Clinical Practitioners and trainee Advanced Clinical Practitioners. Recruitment was still ongoing with some clinical positions still being advertised, others awaiting interview and some due to take up post.

At our previous inspection we found that the arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions required further improvement as the risk register did not provide clear information on the risk or the actual impact or mitigating actions.

At this inspection we spoke with the Quality Assurance Manager for urgent care and out of hours provision. This was a new position and they had been in post since October 2017. They told us part of their role was to monitor the risk register. We also looked at the updated risk management strategy and also relevant risk registers. One member of staff we spoke with described a risk which had

Good

Are services safe?

been identified and how it was being addressed through the risk management system which was in line with the risk management strategy. We saw that the risk register included details of impact and mitigating actions.

Appropriate and safe use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

At our inspection in August and September 2017 we found that the provider had not ensured that a process was in place to ensure blank prescriptions were tracked throughout the Lincoln primary care centre.

At this inspection we were told that the process had been reviewed and a standard operating procedure introduced in order to monitor the movement of prescriptions through the service and that locks had been installed on all printers which held prescriptions. We found that there was now an effective system in place to monitor the movement of blank prescriptions through the service, including prescriptions that were held in vehicles. Blank prescription forms were logged out from Beech House to each location and when we visited the Lincoln primary care centre we saw that blank prescriptions were held securely and there was a log in each clinical room which recorded the serial numbers of prescription forms held in the printer in that room. We were told the system was in the process of being updated to use biometric technology for increased security but this was not yet operational.

The provider had also made improvements to an existing medicines audit to provide assurance for the safe and secure handling of medicines and blank prescriptions. We saw that this revised audit had been completed in quarter four of 2017/18 and the first quarter of 2018/19.

At our inspection In August and September 2017 we found that the provider did not ensure that some medicines were dispensed to patients at the Lincoln primary care centre in the appropriate packaging to ensure details of expiry dates, dosage and other information were provided to patients. At the time of that inspection the provider immediately withdrew supplies of the affected medicines and replaced them with packets containing the full course and the necessary information.

At this inspection we spoke with the Medicines Management Lead who told us that they had worked with their medicines supplier to ensure that boxes of medicines were not split and only full boxes supplied. There was now a process in place to audit this on a quarterly basis. They had also worked with their pharmacy contract holder in respect of labelling of medicines to ensure that the labels were secure and did not obscure expiry dates. This aspect was also included in the quarterly medicines audit.

At our inspection In August and September 2017 we found that the provider did not ensure that Patient Group Directions (PGDs) in relation to some medicines ensured that the prescriber evaluated high risk medicines to be left in the patient's home address or other setting and to handle it in accordance with the risk.

At this inspection we found that this risk had been addressed. We were told that relevant PGDs had been reviewed and the wording changed to address this risk and the PGDs reissued. Additionally, training in this area had been re-introduced to the mandatory training programme and we saw the lesson plan for Medicine Management and PGD use in relation to this.