Lincoln County Hospital

Quality Report

Lincoln County Hospital
Greetwell Road
Lincoln
LN2 5QY
Tel: 01529 220300
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.

Summary of findings

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Summary of findings

Overall summary

Lincolnshire Community Health Services NHS Trust provides out-of-hours General Practitioner (GP) services for patients living across Lincolnshire. It is registered to provide the regulated activities of diagnostic and screening procedures and the treatment of disease, disorder or injury.

The out-of-hours service conducted clinical audits 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 service was accessible to those who may have mobility issues.

We saw that leaflets to inform patients about how they might raise a complaint were only available in English, but we saw documentary evidence that the Clinical Commissioning Group had instructed that they should not be printed in other languages due to cost. The out-of-hours service had access to language line, which provided a telephone interpretation service. We were told that interpreters could be brought in if necessary. However this was very rare, as most patients either came with someone who could speak English or were able to make themselves understood.

There were systems in place to help ensure patient safety through learning from incidents, the safe management of medicines and infection prevention and control. Following our inspection we raised concerns with the provider with regard to the management of medicines. We received a swift response detailing what action would be taken to address the concerns.

Staff were trained and supported to help them recognise the signs of abuse of children and vulnerable adults and provided staff with training to heighten their awareness of domestic violence.

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. 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. They had taken action to ensure their values and behaviours were shared by staff through regular engagement.

Members of the staff team we spoke with held positive views of management and their leadership and felt well supported in their roles. They told us the senior managers were approachable and listened to any concerns or suggestions they might have to improve the level of service provided to patients. However, staff did say that it was very rare to see a senior manager at the out-of-hours service due to the hours the service operated.

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 Lincoln County 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 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 was well informed of their role and responsibilities.

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

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. They had not assured themselves that patients were cared for, or supported by GP's who were suitable to work in a healthcare environment. As a result we have told the provider that they must take action to improve.

Medication was stored in a room with poor ventilation and the temperature within this room was not being monitored. As a result medication could have reached temperatures which rendered it ineffective without the staff being aware.

The equipment within the out-of-hours department and carried on the vehicles showed the service to be well equipped and prepared for many scenarios.

Are services effective?

The out-of-hours service at Lincoln County 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

We found that 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.

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

The provider had been effective in sharing information about patient consultations with the patient's own GP practice.

There were effective arrangements in place for staffing the out-of-hours service. There were also arrangements to ensure that agency staff was adequately prepared, prior to starting work at the service.

There were effective arrangements for making referrals to other services. Particularly in relation to patients whose needs could not be met within the service, or who required further support or treatment.

Are services caring?

The out-of-hours service at Lincoln County 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 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 effect.

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 Lincoln County hospital was responsive to patient's needs. We saw that leaflets informing patients about the complaints procedure were only available in English. We saw documentary evidence that indicated that the commissioners of the service had stated that they should not be printed in other

languages due to financial implications. We were informed 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 find 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. She told us that she had met with a member of staff in private to discuss issues raised.

The provider responded to changing levels of demand for services. For example when demand for services was high during the winter months and during the holiday season. Particularly at coastal locations such as Skegness. The provider conducted regular checks on the level of service need 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 decrease in the number of 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 Lincoln County 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 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 accessible on the provider's website.

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

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 an appraisal and regular supervision.

Summary of findings

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 spoke with seven patients at the out- of- hours service. Comments we received were generally positive. Patients told us that they found the out-of-hours service accessible, and staff were approachable, efficient and professional. When asked, patients said that the waiting times were acceptable and understandable. Patients spoke positively about being kept informed by staff about what was happening. Two patients were referred for further investigation or treatment, and they said the staff had informed them what was happening and why.

The out-of-hours service was busy with a steady flow of patients throughout the evening. We asked about pain relief and patients said they were asked if they were in pain or discomfort when they arrived. Some patients were offered pain relief, although staff said this would depend on what was wrong with them, or suspected to be wrong with them.

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

Prior to the inspection we left comment cards to allow patients to provide feedback. Unfortunately the comment cards were not available for the inspection team, as the box had gone missing.

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.

Areas for improvement

Action the service MUST take to improve

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

Action the service COULD take to improve

The provider could ensure that clinical audits which have been undertaken are completed and reviewed on the agreed date.

When reviewing individuals' clinical practice, it would be better for the findings to be undertaken by a clinician who is unconnected with the process. This would ensure independence and confidence that clinical practice had been effectively reviewed.

The provider could provide information on how to raise a complaint in languages other than English. The service could also make it easier to access information about the complaints procedure on the provider's website.

Good practice

Our inspection team highlighted the following areas of good practice:

The provider had reduced the number of patients who had been admitted to hospital and accident and emergency departments by providing a non-emergency service running alongside the other hospital services. We saw evidence of accident and emergency divert schemes and direct access to the out-of-hours service for ambulance crews.

The provider had recognised that the out-of-hours service did not always meet the health needs of all patients, and had responded by proposing a new model of care that included all aspects of urgent medical care. The proposed model was due to go to public consultation in the near future.

Lincoln County Hospital

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team on 6 June 2014 was led by two CQC inspectors and a Special Advisor with practice management experience. We also had an Expert by Experience as part of our team who helped us to capture the experiences of patients who used the service. An Expert by Experience is a person who has personal experience of receiving care, particularly from this type of service, so they would be best placed to understand the needs and experiences of patients using the service.

Background to Lincoln County Hospital

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 landlord for the out of hours location is United Lincolnshire Hospitals NHS Trust who runs Lincoln County Hospital.

The out-of-hours service provides care to patients who require urgent medical care from GPs and nurses outside of normal GP hours.102 GP practices are covered by the service. The provider employs the services of 100 GPs who are engaged on a sessional basis to deliver care to patients. The service operates county wide from 6.30pm until 8am Monday to Thursday, and 6.30pm Friday until 8am Monday, and all public holidays. During the day the location is an independent outpatient department of the hospital unconnected to the out-of-hours service.

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

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

The service provides 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 are;

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.

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.

Detailed findings

How we carried out this inspection

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

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

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

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

Before 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.

We carried out the inspection as part of our new inspection programme to test our approach going forward. It took place with a team that consisted of CQC inspectors, a practice manager, and an expert-by-experience. An expert-by-experience is somebody who had personal knowledge of using services either as a patient or as a carer of a patient who has used similar services. We spoke with patients and members of the public who used the service to help us capture their experience.

On 6 June 2014 we carried out an announced inspection at Lincolnshire County Hospital out-of-hours service and spoke with patients who used the service. We observed how people were being cared for and talked with carers. Prior to the inspection we left comment cards to allow patients to provide feedback. Unfortunately the comment cards were not available for the inspection team, as the box had gone missing.

We also spoke with six members of staff employed by the out-of-hours service and with GPs. In addition our Expert by Experience spoke with seven patients to gain their views of the out-of-hours service.

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

We looked at the vehicles used to take clinicians to consultations in patients' homes, and we reviewed the arrangements for the safe storage and management of medicines and emergency medical equipment.

Are services safe?

Summary of findings

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 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 good evidence of collaborative working with other healthcare providers aimed at delivering care and treatment to patients by the most appropriate way.

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. They had not assured themselves that patients were cared for, or supported by GP's who were suitable to work in a healthcare environment. As a result we have told the provider that they must take action to improve.

Medication was stored in a room with poor ventilation and the temperature within this room was not being monitored. As a result medication could have reached temperatures which rendered it ineffective without the staff being aware.

The equipment within the out-of-hours department and carried on the vehicles showed the service to be well equipped and prepared for many scenarios.

Our findings

Safe patient care

The out-of-hours service was preparing to move to new premises located within the accident and emergency department. This move was due to be completed within three weeks of our inspection visit. The new premises were smaller; however they were newly equipped, and designed specifically for the out-of-hours service.

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. Pain relief was offered if appropriate, and staff were seen checking on patients within the waiting area before they were seen by the doctor. We also saw staff informing 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 condition the provider took action to prevent further incidents. The clinicians practice was reviewed and the provider improved the process for retrieving voice recordings of telephone calls to 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 summary of the latest National Institute for Care and Health Excellence (NICE) guidance which related to patients who experienced chest pain, stroke and acute headache.

During our inspection we saw that a patient became visibly distressed in the waiting room. Staff quickly approached the person and offered support. We saw that this patient was treated with respect and care by the staff, and they were taken to a quieter, less public area of the out of hours location. It became apparent that the patients' needs had changed, and we saw that staff were quick to offer reassurance and get them the appropriate care they needed.

The out-of-hours service had two vehicles for making home visits. We inspected both vehicles and found that each vehicle had a bag containing essential equipment and

medication. These bags were stored securely within the out-of-hours department when the vehicles were not in use. However, some equipment including medicines was left in the vehicles when they were not in use. We were told by staff that there had been a recent change of policy, and that resuscitation equipment was now left in the vehicles. We had concerns about the security of equipment and medicines left in vehicles in the hospital's public car park. We also had concerns with regard to the changes in temperature within the vehicles. These could be very warm through the day, while temperatures could drop during the night. The service operated throughout the year, and therefore different issues relating to temperature could be experienced depending on the time of year. We saw several examples of resuscitation equipment loose in a bag. This equipment including medicines that had no instruction leaflets, and had been removed from its original packaging. The absence of instructions and original packaging could make equipment and medicines difficult to identify. The absence of instructions also meant that staff were unable to reference the manufacturer's instructions for either equipment or medicines.

Following our inspection we received the following information from the provider: Information is being collated from the manufacturer for the medicines that are held in stock. This will provide clear guidance on how long a medicine can be kept outside of a normal temperature range (similar to fridge monitoring). Monitoring of the temperature will be conducted twice daily and a flow chart of actions, should the temperature reach above/below a certain range will be provided to staff. This is a short-term arrangement until the move of the out-of-hours service in to the new accommodation is completed.

Both vehicles carried oxygen; however we saw that there were no stickers to identify that oxygen was being carried on the vehicles. A check of the resuscitation equipment showed that there were different sized masks available for both adults and children, as well as various sized airways. A check of the resuscitation equipment showed that there was a plentiful supply and all of the equipment was in date. The vehicles were also equipped with nebulisers (a nebuliser is a device used to deliver medication in the form of a mist to be inhaled into the lungs). We saw that these were checked and cleaned on a regular basis.

All of the equipment in both vehicles had evidence of having been calibrated and tested to ensure that it worked correctly. Both vehicles had a hearing loop fitted, a built in Sat Nav (satellite navigation equipment), and fire extinguisher. We observed staff carrying out a daily check of both vehicles at the beginning of the shift to ensure that all of the equipment was present and in working order. The provider may find it useful to note that there were no reflective jackets for staff, and no spillage kit in either vehicle.

A review of the equipment carried on the vehicles identified that both vehicles were well equipped and prepared for many different scenarios when visiting patients at home.

Learning from incidents

We saw evidence that the provider had undertaken an investigation regarding a patient who had died after contact with the service. A full analysis had been completed and had concluded the death was not related 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 that others, such as additional telephone triage training for staff, was ongoing.

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 learning and lessons that had been taken from them.

The manager told us that when accidents or significant events had occurred these had been recorded and learning points were discussed at staff meetings. We saw examples of these in the minutes of staff meetings. If an individual member of staff had been involved the manager said the issue would be discussed in a one to one meeting.

Safeguarding

We saw that all staff received training in safeguarding children and vulnerable adults and looked at some of the training material available. The training also included training in the Mental Capacity Act and the Deprivation of Liberty Safeguards, both pieces of legislation 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 on domestic abuse. Priority was given to this training.

Are services safe?

We viewed the providers 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 on the procedures for raising their concerns about suspected wrongdoing at work.

During our inspection we spoke with four members of staff of different grades. All of the staff said they had received training in safeguarding vulnerable adults and children. Staff said that staff at band seven (nursing grade) received safeguarding training to level three. All other staff received training to level one. All four were able to answer questions related to safeguarding adults and children. Staff members identified a file located at the reception desk, which contained the contact information for the safeguarding teams. On reviewing this file we saw that it contained contact details for both the vulnerable adults and the children's teams. The policies for both safeguarding vulnerable adults, and children were up to date and were marked for review in March 2016.

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 appraised of the outcomes of any referral they may have made where that was appropriate.

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

Monitoring safety and 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 analysis had been undertaken to help understand what had occurred, and action plans formulated to help minimise further 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 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 medicines 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 medicine 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 medicine errors.

We inspected the medicine storage and supplies; we found these were stored securely. We saw that medicines were stored in a room within a room, both of which had poor ventilation. At the time of our inspection both rooms were found to be very warm, and the temperature was not being monitored. As a result medication could have reached temperatures which rendered it ineffective without the staff being aware. We saw documentation that showed that medicine stocks were checked once a week. This was to ensure that medicines had not passed its use by date, and that there was sufficient supply. The documentation showed that the weekly check had been completed the day before our inspection and everything was found to be correct.

Cleanliness and infection control

During our inspection we found the premises to be visibly clean. We met with the cleaner who was present for the first two hours of the inspection. The cleaner explained their role, and what specific tasks they completed when working in the service. We saw that there was an infection control policy, and staff members were aware of the policy and its contents. We noted that there was a sufficient supply of cleaning materials and a colour coded system for mops and buckets. Using colour coded mops and buckets allow mops to be used only in certain areas. Such as for cleaning the toilets or a separate mop and bucket for the kitchen to help prevent the spread of infection or cross contamination.

The reception area had a large number of wing backed chairs. We noted that a number of these chairs were torn and therefore represented an infection control risk. Staff

told us that the department was due to relocate to an area in the accident and emergency department within the coming weeks, and they would have new chairs. The manager of the out-of-hours service said that the torn chairs had been notified as an issue to the manager of the outpatients department.

Staffing and recruitment

We looked at the documents that related to the recruitment of GPs into the out-of-hours service. In some cases we found there was no record of the references that had been sought and received.

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 GP's inclusion on it.

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, and 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 (formally Criminal Records Bureau checks), which are carried out to disclose any previous criminal convictions, had not been renewed by the GP's every three years. This requirement formed part of the provider'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 GPs that may not have been suitable to work in the out-of-hours service.

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. 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.

We discussed emergencies with staff. There was a panic button available for staff to summon help at the reception desk. We also saw that important information including contact telephone numbers was also available at the reception desk. Staff were aware of the information and its location in reception.

Equipment

Within the out-of-hours department we saw they had an emergency trolley. This was equipped with all of the necessary equipment for dealing with an emergency. There was a checklist for staff to check the equipment on a daily basis, and this had been completed, and signed by the staff member carrying out the checks. In addition the appropriate documentation to complete in the event of an untoward incident that required the emergency trolley was available on the trolley.

Are services effective?

(for example, treatment is effective)

Summary of findings

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.

We found that 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.

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

The provider promptly shared information about patient consultations with the patient's own GP practice.

There were effective arrangements in place for staffing the out-of-hours service. There were also arrangements to ensure that agency staff were adequately prepared prior to starting work at the service.

There were effective arrangements for making referrals to other services. Particularly in relation to patients whose needs could not be met within the service, or who required further support or treatment.

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 which 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 number 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 the prescribing of anti-biotics 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 were 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 working for the out-of-hours service was planned but had not yet been completed.

During our inspection we did not meet any patients with obvious mental health issues. However, we did discuss this with staff who said that the out-of-hours service had contacts and referral mechanisms to mental health services. We discussed what action would be taken if a patient presented with mental health issues who was in crisis. We were shown contact details for the duty mental health team. One of the GPs explained how a patient had presented recently with mental health needs. They were in need of support and the referral system to the duty team had allowed the patient to receive the support they required.

Are services effective?

(for example, treatment is effective)

Staffing

We looked at staffing across the out-of-hours service and saw that there was mix of staff 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 included 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.

The provider had mechanisms in place to ensure staff received appropriate levels of supervision and an annual appraisal. 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 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.

We discussed staff shortages and how these were covered. A specific agency was used to cover staff absence and shortages. The manager of the out-of-hours service explained how all agency staff received an induction pack before starting work at the service. Over time, this had led to a situation where agency staff had a knowledge and an understanding of the out-of-hours service before they began working there.

Working with other services

We saw that the provider had consistently achieved full compliance with the National Quality Requirement 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. This was to help reduce the number of unnecessary admissions to urgent care services. We also saw that the service was developing closer contacts with the 111 provider. This was 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.

During the inspection we saw that some patients had been directed to the out-of-hours service from the accident and emergency department. In addition, we saw one patient who required treatment being referred in the opposite direction. The accident and emergency department was situated next door. Staff in the out-of-hours department told us that there was a procedure in place for referring patients between the two departments.

Are services caring?

Summary of findings

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

The provider had 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 effect.

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 and empathy

We saw that staff treated patients with dignity and respect and patients and carers we spoke with said staff displayed a kind and caring attitude. We spoke with seven patients who all said that they found the service caring, and the staff were kind and compassionate.

There was a large reception area with an open reception desk. The reception also had a television and a children's play area with plastic toys. The reception area was well lit, and because of its size, people were able to have a degree of privacy from other patients.

We saw staff treat people with dignity and respect at all times both in the reception area and on the telephone by the 'booking agent'.

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.

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 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 prevent re-occurrence.

Involvement in decisions and consent

During the inspection we asked patients if they felt involved in their care and treatment. Six patients said that they did, and they felt they had been given the information they needed. In addition, the six patients said they had been given the opportunity to ask questions. The seventh patient said they did not feel they had been given the relevant information. However, after our Expert by Experience had finished talking with this patient they (the patient) were approached by a doctor who explained in detail what was happening.

Are services caring?

We spoke with three patients specifically about consent. All three said they were happy that they had been asked for, and had given consent, and raised no concerns.

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 the 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

We saw that leaflets informing patients about the complaints procedure were only available in English. We saw documentary evidence that indicated that the commissioners of the service had stated that they should not be printed in other languages due to financial implications. We were informed 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 find this. We noted that there was a limited supply of complaints leaflets available. Staff said that more leaflets had been requested, but they were still awaiting delivery.

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 she told us that she had met with a member of staff in private to discuss issues raised.

The provider responded to differing levels of demand for services, for example in periods of high patient numbers in the winter months and during the holiday season at coastal locations such as Skegness. 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 decrease in the number of admissions to 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, address 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. This 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 being met. 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 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. Records showed that in the year 2013/14 1661 patients had been referred directly into the out-of-hours service by the ambulance service, which might otherwise have used accident and emergency services.

The out-of-hours service operated county wide from 6.30 pm until 8 am Monday to Thursday, and from 6.30 pm Friday until 8 am Monday, and all public and bank holidays.

We observed how patients accessed the booking system for Lincolnshire out-of-hours service. Initially callers contacted the 111 system and if an appointment or visit was required the message was passed via the computer system (System One) to the booking agent. This was a Health Care Support Worker based in the out-of-hours location in Lincoln hospital. We observed the booking operator, access information for patients who required an appointment on a computer screen. The operator would call the patient and advise them of an available appointment at the nearest out-of-hours location to their

Are services responsive to people's needs?

(for example, to feedback?)

home address and book the appointment. In the case of a home visit being required the operator would again contact the patient and pass their details to the visiting out-of-hours practitioner.

In the case of a computer failure, we were told there was a backup system. This consisted of a secure Fax system located in the out-of-hours department. This would be used and backed up on to the computer when the system was up and running.

The booking agent was constantly monitoring the volume of calls and time taken to respond to the calls. This was recorded automatically on the computer system.

Of the seven patients we spoke with, six said that they had found access to the out-of-hours service easy. The seventh person had telephoned the 111 service had been passed around and kept waiting on the telephone. They said that once they had arrived at the out-of-hours department things had improved considerably.

The out-of-hours service was based in a ground floor building close to the accident and emergency department. There was a level access and good signage to show where the department was located. Within the department the reception area was spacious, and was accessible to patients in a wheelchair or with restricted mobility.

Discussions with a GP who was working at the out-of-hours service identified that there was a broad cross section of the population attending the service. The GP acknowledged that there were limits to their knowledge and experience, but stressed that there were good links and contacts with other agencies. Particularly, if a patient should have needs outside of the scope of the out-of-hours service. One member of staff was a qualified learning disability nurse and we were told they took the lead should any patients with a learning disability attend the service.

Concerns and complaints

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

We saw that leaflets informing patients about the complaints procedure were only available in English. We saw documentary evidence that indicated that the commissioners of the service had stated that they should not be printed in other languages on financial grounds. We were informed 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 find 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. The responses to this question varied, although all of the patients who were unsure, said they would phone the hospital's main switchboard and ask to be directed to the correct person. Some patients were aware of the complaints leaflets, and 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.

The manager showed us the Patient satisfaction questionnaire quarterly analysis for January to March 2014. Most of the responses were scored as excellent or good, with a small percentage scoring poor. Where negative comments had been recorded, we saw there was an action plan. We also saw how progress with the action plan was checked and monitored through staff meetings, to ensure targets were met.

Are services well-led?

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

Summary of findings

We saw that the trust was well led by an experienced and diverse Board of Directors. The senior management team was knowledgeable and reflected 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 accessible on the provider's website.

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

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 and culture

We found that the service was well led by a dedicated team of experienced senior managers who reported to a Board of Directors. They 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 which 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' care needs. We were told how a project plan had been developed. This set out a new vision on how the out-of-hours service, could be delivered more effectively and responsively in an urgent care setting. We were told this would be going to consultation shortly.

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.

We spoke with the manager for the out-of-hours service in Lincoln who was new in post. The manager outlined the areas of improvement that had been identified and discussed how these were being achieved. We saw the minutes of staff meetings and individual support sessions, which identified that there was a shared vision.

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. This was to provide a position statement in relation to staffing of the service. The conferences also included any perceived risks and incidents which could impact on providing a quality

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. All of the geographical business units were expected to attend. This confirmed and challenged the process, and provided assurance that the service was being risk managed.

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.

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 and improvement

The National Quality Requirements (NQR) 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 and 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 overwhelming positive for the service. Patients had commented upon the short waiting times from arriving at the primary care centre to seeing a doctor, and the way they had been treated with respect and compassion.

We saw that patient representatives had been used to conduct the '15 Steps Challenge' at Louth Urgent Care Centre. The 15 Steps Challenge is a nationally recognised toolkit to help look at care through the eyes of patients and relatives. It is aimed at helping the provider to hear what good looks like, and what could be improved.

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 and 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 which had been held 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 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 and 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.

The manager of the service explained that since coming into post many of the management systems within the service had been reviewed. This had seen more regular meetings with staff on both a group and individual basis.

Are services well-led?

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

There was a clear emphasis on improving the service, and additional staff training had been provided. The manager showed us the meeting minutes and training information to support that the actions identified had taken place.

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
Diagnostic and screening procedures	Regulation 21

Regulated activity	Regulation
	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. Regulation 21 (a)(b)(c)

Regulated activity	Regulation
Treatment of disease, disorder or injury	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. Regulation 21 (a)(b)(c)