Stamford and Rutland Hospital

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Lincolnshire Community Health Services NHS Trust provided out-of-hours General Practitioner (GP) services for patients living in Lincolnshire. The service was administered from the trust's headquarters in Sleaford and patient care and treatment was provided from eight primary care centres at locations across the county. We visited the trust's headquarters on 5 June 2014 where we looked at records and information and talked with staff about issues that related to all eight locations and the service a whole. On the 6 or 7 June 2014 we visited the primary care centre at Stamford and Rutland Hospital and spoke with members of staff, patients and carers and reviewed documents and matters specific to that location.

Lincolnshire Community Health Services NHS Trust 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 at Stamford and Rutland Hospital.

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

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

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

We found the provider did not have reliable and safe medicine management systems in place. There were no formal procedures or audits for medicines received and held. Reliable checks would ensure safe administration of medicines, and minimise the potential for error. We saw four medicine reference books, including those in the vehicle, which were out of date. This meant the GPs and other clinicians did not have the most up to date resource for prescribing although this was available on line. However, these could not be used on home visits because staff did not have access to remote electronic recording systems. Following on our visit the provider took steps to improve the medicines management systems to keep patients safe.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There was a clear process for recording patient safety incidents and concerns. 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 action plans in response to concerns and saw how they had been held accountable to the trust board in delivering those plans.

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

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

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

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

The provider did not have reliable and safe, storage and management of medicines and systems in place including labelling for medical gases.

We found infection prevention and control measures were in place in treatment rooms and hand wash facilities and instructions were available. Staff had received recent infection control training. Some sealed sterile single use medical equipment was open and fitted to equipment ready for use. This meant staff could not be sure it was safe for use.

Are services effective?

The out-of-hours service at Stamford and Rutland 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.

All GPs and advanced nurse practitioners had access to research based best practice standards to assist them in their role, apart from when they did home visits. This was because they did not have access to electronic systems whilst working remotely.

Are services caring?

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

The provider had made positive steps to meet the needs of patients from the gay, lesbian, trans-gender and bi-sexual community. The provider had been ranked in the Stonewell Healthcare Equality Index run by the charity Stonewall.

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

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

Patients told us that the GPs listened to them and asked relevant questions before considering any treatment.

Are services responsive to people's needs?

There were copies of the complaints procedure in the waiting area. This included information in six community languages about how to obtain the leaflet in those languages. We spoke with patients who said they knew about the complaints leaflet but had not had cause to make a complaint.

Summary of findings

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

The provider responded to 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 measurable decrease in admissions into Accident and Emergency departments.

Patients were able to make appointments easily, and were seen in a timely and effective way. The 111 service misdirected some patients to the Stamford and Rutland Hospital out-of hour's service. They were seen nonetheless and the staff ensured they did not receive a delay in their care.

Are services 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 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 easily accessible on the provider's website.

We found that the interim Chief Executive was pro-active in seeking the views of staff. There was a programme of staff engagement events taking place 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.

Summary of findings

What people who use the service say

We spoke with seven patients and reviewed thirteen comments cards. As part of our inspection, we sent cards for patients to use to comment on the service and a sealed box to put them in.

All were positive about their experiences of using the service. Some told us it was their first visit and others said that they used it regularly when they were concerned about the health of their children and did not feel they could wait to see their GP. Patients told us they were happy with care and treatment received and felt safe.

We also spoke with representatives of four care homes. Three homes cared for older people, some of whom were living with dementia. The fourth cared for people with sensory disabilities. They were positive about the GPs who visited their services but reported some difficulties when making initial contact with the out-of-hours service operators.

The provider had undertaken patient surveys, which 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 were seen.

Areas for improvement

Action the service MUST take to improve

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

We found the provider did not have appropriate systems for the reliable and safe administration of medicines in place. There were no formal procedures or audits for medicines received, held or dispensed. Reliable checks would ensure safe administration of medicines and minimise the potential for error.

Action the service COULD take to improve

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

Reviews of individuals' clinical practice had been completed. There was no evidence for quality assurance of the findings to be undertaken by a clinician who was unconnected with the process, which would have ensured independence and confidence that clinical practice had been effectively reviewed.

The provider could improve the electronic systems for monitoring complaints. This would ensure complaints were properly investigated and resolved.

The provider could monitor medical equipment and supplies, as there were no audit or stock rotation systems in place. This increased the risk that the stock of some equipment may run out and so would not be available when required.

We found the cleaning and disinfectant products available for decontamination, were not stored securely in accordance with the trusts policies and procedures.

The provider could ensure hazard spill kits, designed to manage a variety of spills, including bodily fluids are made available in the out-of-hours vehicle. Providing these would assist with the prevention of infection.

The provider could ensure that staff follow robust policies and procedures when receiving specimen bottles of bodily fluids from patients who use the service.

Summary of findings

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 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 holistic health needs of all patients and had responded by proposing a new model of care that encompassed all aspects of urgent medical care. The proposed model was due to go to public consultation in the near future.

The provider was giving staff the opportunity to learn more about current recommended practice in dementia care. The Stamford and Rutland Hospital out-of-hours practice were giving life story resources to people with dementia and their carers. Life story work intends to enhance the care provided to patients with dementia by helping staff members understand the patient as a unique individual and how they may prefer to have their care delivered.

Stamford and Rutland Hospital

Detailed findings

Our inspection team

Our inspection team was led by:

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

Two CQC inspectors undertook our inspection on 6 June accompanied by a practice nurse.

Background to Stamford and Rutland Hospital

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

The out-of-hours service provides care to patients who required urgent medical care from a GP outside of normal GP hours.102 GP practices were covered by the service. The provider employed the services of 100 GPs who were engaged on a sessional basis to deliver care to patients. The service operated from 7pm to11pm Monday to Friday and 8am to 11pm at weekends.

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

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

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

- The County Hospital, Lincoln
- John Coupland Community Hospital, Gainsborough
- Grantham and District Hospital
- Stamford and Rutland Hospital, Stamford
- Johnson Community Hospital, Spalding
- The Pilgrim Hospital, Boston
- Skegness and District Hospital
- County Hospital, Louth

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

This inspection focused on the out-of-hours service at Stamford and Rutland Hospital.

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?

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 information of using services either as a patient or as a carer of a patient who has similar experinces. 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 Stamford and Rutland Hospital and spoke with patients who used the service. We observed how people were being cared for and talked with carers. We reviewed 13 completed comment cards on which patients, carers and members of the public had been invited to share their views and experiences of the service.

We also spoke with two members of staff who were on duty at the out-of-hours service and with one GP.

We looked at the cleanliness of the premises and the arrangements in place to manage the risks associated with healthcare associated infections.

We looked at the vehicles used to take clinicians to carry out consultations in patients' homes; and at 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. 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 action plans in response to concerns and saw how they had been held accountable to the trust board in delivering those plans.

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

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

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

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

The provider did not have reliable and safe, storage and management of medicines and systems in place including labelling for medical gases.

We found infection prevention and control measures were in place in treatment rooms and hand wash facilities and instructions were available. Staff had received recent infection control training. Some sealed sterile single use medical equipment was open and fitted to equipment ready for use. This meant staff could not be sure it was safe for use.

Our findings

Safe patient care

Patients told us and wrote on comments cards that they felt safe using the service. They said they found the environment was private, clean, tidy, and comfortable and that staff were well trained.

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

Learning from incidents

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

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

Staff members told us they discussed significant events and the learning from them in meetings or other forums.

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 encompassed training in the Mental Capacity Act and the Deprivation of

Are services safe?

Liberty Safeguards, which are aimed at protecting vulnerable people. We spoke with the safeguarding lead for the provider who informed us that they were currently providing all staff with training regarding domestic abuse and that this was seen as a priority training requirement.

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

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

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

Safeguarding information packs were available in consultation rooms and we saw they contained clear and up to date guidance on the actions staff members must take if they suspected abuse. This included abuse they may witness in different settings such as people's own homes and in care homes. The staff members knew their responsibilities to safeguard vulnerable adults and children. They knew some of the signs of and types of abuse.

We saw evidence that safeguarding concerns had been shared with the local authority and the Care Quality Commission had been notified. One safeguarding concern had not been recorded on the appropriate electronic system however; we saw that all other actions had been taken to alert the correct authorities.

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

The practice kept a range of equipment and supplies to enable its staff members to respond to the most common of emergencies. The equipment included a defibrillator (used to respond to cardiac arrest), a suction machine (used to help keep airways clear) and ambu bags (used to help resuscitate patients). The emergency equipment and supplies were easily accessible for emergency purposes.

Medicines management

We spoke with the Medicines Management Officer for the provider. They told us there was wide use of patient group directives (PGDs) for drugs administration using the NICE guidelines and competency framework. A PGD, signed by a doctor and agreed by a pharmacist acts as a direction to a nurse to supply 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.

The provider told us that medicines management training had been included as a mandatory part of the staff induction process, aimed at reducing medication errors. We saw that medication errors were collated and analysed monthly and categorised by level of potential harm. Trends and concerns had then been discussed with the governance committee and acted on.

We saw that there was a plentiful supply of medical equipment and supplies available but there was no audit or stock rotation system in place. This increased the risk that the stock of some equipment may run out and so would not be available when required. We found that there were safe arrangements for the storage of medicines and all of the drugs we checked were in date. However, there were no auditing or stock rotation systems in place to monitor supplies. Stock control is necessary to maintain appropriate stock levels and to prevent expiry or theft.

We checked medicine cupboards and found all medicines to be in date and stored safely. Staff at the out-of-hours service were unable to tell us what medicines they had available on the premises. We did not see evidence of any audits of the number of medicines available. We were told us that any medicines dispensed were immediately reordered. We saw examples of completed medicine

ordering forms. These showed that the dispensing pharmacist checked the medicines. We did not see evidence that the medicines were checked on arrival at the hospital. We found there were no records where staff had recorded the arrival of the medicine or could demonstrate the available stock level of any medicine on the unit, with the exception of controlled drugs.

We saw one medicine was available in two different doses however, there was little to distinguish one boxed dose of medicine from the other. This increased the risk that patients may be given the incorrect medicine.

There were occasions when it was necessary for a GP to provide small doses of medicine to a patient so that they could commence their treatment as soon as possible. We saw this happening during our inspection and found that safe practice was not being followed in line with the trusts policy for the dispensing of medicines. Small amounts of medicine were being removed from their original packaging and were dispensed in an envelope and not in a re-closable safety container with full safety instructions.

We saw written copies of the medication policies and procedures. These did not include an instruction to audit stocks of medicines and they did not advise staff how to ensure the stock was rotated so that it was used in date order. Staff we spoke with confirmed they did not have a formal procedure for stock rotation or audit. When we asked a member of staff how they would know what medicines should be available they told us they would know by looking in the medicine cupboard at what medicines were needed. This meant safe systems were not in place and may affect the patients' care and treatment. However, the provider took steps after the inspection to make improvements to the medicine management systems.

Cleanliness and infection control

A named staff member was the lead for infection control at the practice. We checked the premises and found that the waiting rooms and consultation rooms were clean and well organised. We found that the walls in one storage room used for medical equipment were not intact as they had flaking paint and plaster, which would make this area difficult to keep clean. Hand sanitising liquids were available and posters were on display showing good hand hygiene procedures. Supplies of aprons and disposable gloves had been placed about the premises for ease of access. There was a replacement schedule for privacy curtains around the examination couches. Cleaning and disinfectant products were available for decontamination of equipment and the environment. We saw that two rooms contained hazardous cleaning products which were not stored securely. This presented a risk to people who used the service and others.

We found that the single use sterile medical packs for the suction machine and the ambu bags had been open and were not therefore sterile for use. We notified the staff about this and they were changed before the end of our inspection.

We observed on staff member accepting a specimen bottle by hand from a patient at reception. They did not follow standard precautions to ensure disposable gloves were worn. This increased the risk of exposure to bodily fluids and the risk of cross contamination.

The vehicle used to take clinicians to consultations and those used to transport patients to the treatment centre were seen to be clean. Hazard spill kits, designed to manage a variety of spills, including bodily fluids were not available in the vehicle. This meant patients may not be adequately protected against the risk of infection.

Staffing and recruitment

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

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

We saw that there was no system in place for the provider to ensure that GP's 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 trust's conditions for continued work in the out-of-hours service.

Are services safe?

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

The provider used a rota tool to forecast and schedule GPs to predicted demand for the service. GPs used the tool to register their availability for different shifts. We saw that the required clinical shifts were well covered however there were no arrangements in place for a stand by GP to work in the event of sickness or other events.

Dealing with Emergencies

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

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

We saw an emergency continuity plan and one staff member we interviewed knew how to report the risk of such an event happening so that actions could be taken to protect patients and others.

Equipment

We saw that the treatment centre was accessible to people with restricted mobility such as wheelchair users and that those areas, which were accessed by patients, were in good condition. We saw there were systems in place to assess risks at the practice and to test emergency equipment such as the fire system.

We looked at the vehicles used to take doctors to consultations in patients' homes and saw that they were in good condition and regularly maintained. The equipment, which was carried in the vehicles for use by a GP to manage medical emergencies was maintained and checked regularly.

Are services effective?

(for example, treatment is effective)

Summary of findings

The out-of-hours service at Stamford and Rutland 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.

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.

All GPs and advanced nurse practitioners had access to research based best practice standards to assist them in their role, apart from when they did home visits. This was because they did not have access to electronic systems whilst working remotely.

Our findings

Promoting best practice

The out-of-hours GPs worked to guidelines from the National Institute for Health and Care Excellence (NICE). We saw that the provider had undertaken a range of clinical audits, which aimed to improve patients' care and treatment. We looked at an audit that had been carried out on urinary tract infections and had looked at the treatment records of over 2,500 patients. The audit had highlighted higher than anticipated prescribing of antibiotics, for example, amoxicillin, co-amoxiclav and cefalxin in two areas of the county. Action had been taken to reduce the incidences of prescribed antibiotics. A repeat audit to monitor the effectiveness had been due in March 2014 but had not yet been completed.

We saw that a conference had been arranged for September 2014 to include a Microbiologist and GPs in order to change behaviour around the prescribing of antibiotics for patients with urinary tract infections. This showed that the provider had responded to the clinical audit it had undertaken to help improve and care and treatment for patients.

Management, monitoring and improving outcomes for people

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

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

Staffing

We looked at staffing across the out-of-hours service and saw that there was mix of skills and experience to meet patient needs. We looked the induction process that all new staff underwent. It included local induction at the staff member's primary care centre. The induction included details of the staffing structure and management contact details. The induction process encompassed mandatory

Are services effective?

(for example, treatment is effective)

training in fire safety, medicine management, immediate life support, moving and handling, safeguarding children and vulnerable adults, domestic abuse, hand hygiene and equality and diversity.

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

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

The service had close working relationship with other healthcare and social care providers such as social services, the mental health crisis team and district nursing out-of-hours team. We saw that arrangements were made for one patient to see the out-of-hours GP because of information the service had from another healthcare service. Close collaboration between these different agencies helped to ensure that patients were given the best opportunity to experience 'joined up' health and social care.

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 displayed a kind and caring attitude.

The provider had made positive steps to meet the needs of patients from the gay, lesbian, trans-gender and bi-sexual community. The provider had been ranked in the Stonewell Healthcare Equality Index run by the charity Stonewall.

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

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

Patients told us that the GPs listened to them and asked relevant questions before considering any treatment.

Our findings

Respect, dignity, compassion and empathy

We saw that patients were treated with dignity and respect and patients and carers we spoke with said staff displayed a kind and caring attitude. We observed the staff providing a professional and compassionate approach to patients who arrived at the service. One patient had been sent to the service by mistake however they were quickly reassured that they would be seen. Another two patients arrived in a visibly distressed state. The staff member covering reception immediately put them at ease and we observed that the GP responded appropriately to their distress providing a kind and personalised approach. After seeing the GP, we noted that patients looked relieved and calmer. Patients told us they felt they had been listened to, and that their treatment and care met their needs. We saw that appropriate emotional support was provided to people escorting patients to the practice.

Patients we spoke with told us they felt well cared for and that they were treated with dignity and respect. This was also noted on patient comment cards. Patients using the service noted that staff were kind and listened to them about any on-going conditions and treatment. One person who had attended the service on several occasions wrote that the service provided had been welcoming, compassionate, and efficient.

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 help prevent re-occurrence.

Involvement in decisions and consent

We saw that the provider's website was informative and described the out-of-hours service and the location at

Are services caring?

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

The practice also used telephone interpretation and the staff were aware how to access this. A parent whose first language was not English told us how gentle and unfrightening the GP had been with their child and that they had taken time to explain what was happening to them in simple English.

Patients told us and wrote on comments cards that they thought that staff were well trained and knowledgeable. They said that the GPs listened to them and asked relevant questions before considering any treatment. They told us the GP discussed any possible side effects and risks associated with a drug before prescribing it. This was particularly important to a patient who attended having previously suffered a bad reaction to prescribed drugs.

Our interview with the GP revealed they were aware of the need to obtain consent and check a person's capacity to make decisions where necessary.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

There were copies of the complaints procedure in the waiting area. This included information in six community languages about how to obtain the leaflet in those languages. We spoke with patients who said they knew about the complaints leaflet but had not had cause to make a complaint.

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

The provider responded to 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 measurable decrease in admissions into Accident and Emergency departments.

Patients were able to make appointments easily, and were seen in a timely and effective way. The 111 service misdirected some patients to the Stamford and Rutland Hospital out-of hours service. They were seen nonetheless and the staff ensured they did not receive a delay in their care.

Our findings

Responding to and meeting people's needs

We saw that the practice staff and GPs worked in a calm and unhurried way. They were aware of the guidelines in place to ensure people who contacted the service received a timely response, which was appropriate to their clinical needs. The health care assistant was knowledgeable and provided competent and efficient support to the out-of-hours GP.

Patients told us they were seen promptly even when they had not made an appointment through NHS 111. NHS 111 is used when patients need medical help fast but not in an emergency. Patients told us that staff took into account the potential seriousness of their situation especially when it related to the health of a child. They told us they were offered assistance with interpreting and their wish to have the support of a friend was accepted without a problem.

Patients with a life limiting condition with palliative care needs were provided with the telephone number of the out-of-hours service so that they could receive direct access to medical advice with minimal delay.

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

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

Access to the service

The provider worked with other healthcare providers to ensure patients' needs were met. The provider had implemented a system of direct referrals from East Midlands Ambulance Service to the out-of-hours service, which had resulted in a measurable decrease in admissions into Accident and Emergency departments. The ambulance service was provided with a direct dial telephone number to enable them to contact the out-of-hours service without the need to go through the 111 system. Evidence we saw

Are services responsive to people's needs?

(for example, to feedback?)

showed that in the year 2013/14 1661 patients had been referred directly into the out-of-hours service by the ambulance service, who might otherwise have used accident and emergency services.

The out-of-hours service operated county wide from 6.30pm to 8am Monday to Thursday, 6.30pm on Friday to 8am on Monday, and all public and bank holidays. This location was accessible to patients from 7pm to 11pm Monday to Friday and 8 am to 11 pm at weekends. Outside of those hours, patients were offered face-to-face consultations at other locations.

The provider had arranged for people with diverse needs to access the service. Hearing loops were available to assist people who were hearing impaired. There was a specialist language translation service for people who did not speak English as their first language although there were no posters about the availability of this service within the waiting area. Parking, baby changing facilities, and wheelchair access was available at the practice.

Concerns and complaints

There were copies of the complaints procedure in the waiting area. This included information in six community languages about how to obtain the leaflet in those languages. We spoke with patients who said they knew about the complaints leaflet but had not had cause to make a complaint.

We saw that the provider had a system for dealing with complaints about the service and we saw evidence that the majority of complaints that had been received had been investigated. Where necessary, action had been taken in response to the findings of the compliant investigations. We saw a file containing concerns and complaints was held at the service and these had not been added to the electronic complaint record system in line with the policy. The manager took immediate action on this to ensure the information was properly recorded.

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 easily accessible on the provider's website.

We found that the interim Chief Executive was pro-active in seeking the views of staff. There was a programme of staff engagement events taking place 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. The directors 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.

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

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

Governance arrangements

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

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

Are services well-led?

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

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 day's 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 to 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 to 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 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 at various locations to enable as many staff as possible the opportunity to attend. Regular team meetings at a local level were held to enable staff to engage with managers. These meetings gave staff the opportunity to raise issues that affected patient care. One senior member of staff told us how they made sure that individuals were apprised 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.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of Medicines. We found the provider did not have reliable and safe administration of medicines systems in place. There were no formal procedures or audits for medicines received and held. Reliable checks would ensure safe administration of medicines and minimise the potential for error.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of Medicines. We found the provider did not have reliable and safe administration of medicines systems in place. There were no formal procedures or audits for medicines received and held. Reliable checks would ensure safe administration of medicines and minimise the potential for error.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21(a)(i)(ii)(iii)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. The provider must ensure that there is in place a robust and effective recruitment system to ensure that patients are cared for or supported by GPs who are qualified, skilled and experienced. Appropriate checks must be documented and the provider must ensure that the GPs are suitable to work in the out-of-hours service.

This section is primarily information for the provider

Compliance actions

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