Grantham Hospital

Quality Report

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Date of inspection visit: 5 and 7 June 2014
Date of publication: 10/07/2014

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

Summary of findings

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Summary of findings

Overall summary

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

Patients told us that they were happy with the care and treatment they received and felt safe. We spoke with representatives of three care homes, which provided care for older people some of whom lived with dementia. They told us the practice was helpful and responsive to their patients' needs. We received one comment card from a patient, which said they had found the service to be excellent.

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 had 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.

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.

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

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.

Some members of the staff team we spoke with felt well supported by management whilst others did not always hold positive views of the management team and their leadership. They told us there had been some recent improvements but they did not always feel well supported in their roles. They told us some managers did not listen and act on their concerns or suggestions 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. Following on our visit the provider took steps to improve the medicines management systems to keep patients safe.

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.

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. The staff were aware of reporting procedures using the incident reporting form.

There were inconsistent views among the staff team about their role in reporting and learning from incidents and dealing with risk

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

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

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, dispensing and management of medicines.

We found infection prevention and control measures were in place in treatment rooms and hand wash facilities and instructions were available although most patients said the GP did not wash their hands before carrying out examinations.

Are services effective?

The out-of-hours service at Grantham and District 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.

Summary of findings

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.

Are services caring?

We saw that patients were treated with dignity and respect. 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.

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.

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 and District Hospital . 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.

Summary of findings

Are services well-led?

We saw that the trust had a diverse board of directors. The senior management team was knowledgeable and actively demonstrated high values and behaviours aimed at improving patient care. At a service level, the staff did not always feel valued and although there had been improvements recently, they continued to feel isolated and lacking in support.

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 eight patients and reviewed one comments card. As part of our inspection, we send 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.

We also spoke with representatives of three care homes, which provided care for older people, some of whom were living with dementia. The representatives told us that the GPs and nurse practitioners who attended were helpful and responsive to their patients' needs. We reviewed one comment card completed by a patient who had used the service for the first time and found it to be excellent.

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.

The provider must ensure they have reliable and safe administration of medicines systems in place.

Action the service COULD take to improve

We received mixed feedback from staff about how they received information on the outcome of significant events and how the service was improved by the learning that had taken place from these adverse events. There were no formal arrangements in place to ensure that staff had read and understood the 'Lessons Learned' documents and had changed their practice where necessary. The provider could take better steps to communicate to staff learning from significant events.

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

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

The chaperone policy could not be implemented effectively because there were not enough staff to do so. The provider could take steps to ensure there are enough staff on duty to implement the chaperone policy effectively.

Hand sanitising liquids were available and posters were on display showing good hand hygiene procedures. Several patients told us that the GP did not wash their hands before examining them. The provider could improve arrangements for and attitudes about hand washing

The provider could ensure rooms that contained hazardous cleaning products are held securely. This presented a risk to people who used the service and others.

One of the sterile single use supplies for the ambu bag (used in resuscitation) was open. This meant that staff could not be confident that the equipment was sterile ready for use.

Summary of findings

The provider could make arrangements for patient records to be recorded electronically during home visits; and practitioners provided with access to current best practice guides once they were away from the main site.

Improvements could be made to staff recruitment and deployment. We were told that there were staff vacancies and that agency staff were used when regular staff could not provide the necessary cover. This had meant that on a small number of occasions, both of the nurse practitioners on duty were agency staff. This increased the risk that at these times, the staff on duty may not have the detailed knowledge of the service.

The provider could monitor staff attendance for the mandatory staff induction. Two staff members had received some training but had not been provided with an induction about the service and the location.

The provider could take steps to ensure staff are properly supervised and supported. Although there had been recent positive signs of improvement, some staff did not feel supported at work and were not positive about aspects of the management of the service.

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.

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Detailed findings

Our inspection team

Our inspection team was led by:

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

Two CQC inspectors undertook our inspection on 7 June 2014 accompanied by a practice nurse and an expert by experience.

Background to Grantham 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 out-of-hours service provided care to patients who required urgent medical care from a GP outside of normal GP hours.102 GP practices were covered by the service. The provider employed the services of 100 GPs who were engaged on a sessional basis to deliver care to patients.

The service operated county wide from 6.30pm-8am Monday – Thursday, 6.30pm Friday – 8am Monday, and all public holidays. Skegness and District Hospital is located north east of Lincolnshire and provides out-of-hours services to people in the surrounding area Saturday and Sunday and bank holidays 08.00 to 20.00.

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

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

The provider delivers an-out-of hours service 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 across the county.

This inspection focused on the out-of-hours service at Grantham and District 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?

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 (CCG's), with the lead for out-of-hours services being Lincolnshire East CCG.

The out-of-hours service provided 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. Advanced nurse practitioners and GPs dealt with all patients who contacted the service out of hours (1830-0800 Monday – Thursday, 1830 Friday – 0800 Monday, and all Bank Holidays) with primary care needs. Initial telephone contact with the out-of-hours service is through NHS 111, a service provided by another healthcare provider.

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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 Grantham and District Hospital.

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. The staff were aware of reporting procedures using the incident reporting form.

There were inconsistent views among the staff team about their role in reporting and learning from incidents and dealing with risk

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

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

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, dispensing and management of medicines.

We found infection prevention and control measures were in place in treatment rooms and hand wash facilities and instructions were available although most patients said the GP did not wash their hands before carrying out examinations.

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 had been 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.

We received mixed feedback from staff about how they received this information and how the service was improved by learning from these adverse events. We were

told that there were no formal arrangements in place to ensure that staff had read and understood the 'Lessons Learned' documents and had changed their practice where necessary.

Safeguarding

We saw that most staff received training in safeguarding children and vulnerable adults. One GP had not undertaken safeguarding adults training however, they, as well as other members of staff, understood the signs of abuse and knew how to report concerns with the right person. We looked at some of the training material available. The training also encompassed training in the Mental Capacity Act and the Deprivation of Liberty Safeguards, which are aimed at protecting vulnerable people. We spoke with staff who were able to describe their understanding of the Mental Capacity Act and when it might be necessary for the service to consider how and when to act in a patient's best interests. We spoke with the safeguarding lead for the provider who informed us that they were currently providing all staff with training regarding domestic abuse and that this was seen as a priority-training requirement.

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

Members of staff we spoke with could demonstrate 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.

One staff member we spoke with described how they had come to recognise an abusive situation involving the family of a patient with a cognitive impairment. The actions they took ensured that the family received the support they required as unpaid carers. We saw evidence of safeguarding concerns that had been shared with the local authority and notified to the CQC.

We saw the chaperone policy, which said that all patients should be routinely offered a chaperone during any consultation or procedure. The staff we spoke with said chaperones would be made available if intimate examinations were required but they did not have the resources to offer chaperones at every consultation. This brought into question how the chaperone policy could be implemented effectively.

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 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 not stored near patient areas which meant there may be a delay in accessing the equipment in an emergency situation.

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.

Are services safe?

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.

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

Clear procedures were followed in practice for the management of controlled drugs and we saw that plans to implement recent changes in the storage requirements of one drug were underway. We checked medicine cupboards and all of the medicines we looked at were in date. 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 had been checked on arrival at the hospital or any record that staff had recorded the arrival of the medicine. Staff were unable to demonstrate the available stock level of any medicine on the unit, with the exception of controlled drugs. We also found that medicines were not stored in a systematic and organised way.

We saw that there was a plentiful supply of medical equipment and supplies available. 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.

Recent practice was that advanced nurse practitioners were not to take any opened controlled drugs to a patient's home. However, there were no unopened drug boxes in stock to use in these circumstances. We found that a GP on duty did not know the process for prescribing starter packs of drugs and was reliant on other out-of-hours staff for this information. The possibility of having smaller pack sizes of drugs was discussed as individual doses were being taken out of larger packs for prescriptions from stock, and were being dispensed to patients in foil wrappers. This meant the drugs were not appropriately labelled and did not have the expiry date on them, which was a safety concern.

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 that 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.

We spoke with staff about the procedures they followed to ensure the safe storage and supply of prescription forms. We found there was no audit or recording of one type of prescription. Staff were not following the NHS Protect Security of Prescription Forms Guidance, August 2013, in relation to prescription form stock control. This could lead to controlled stationery (prescriptions) being diverted meaning people who used the service and others may be at risk.

An action plan for Grantham and District Hospital dated May 2014, which included medication management, incident and complaint management, and quality monitoring, were available to staff on the notice board.

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. Hand sanitising liquids were available and posters were on display showing good hand hygiene procedures. Several patients told us that the GP did not wash their hands before examining them.

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 one room contained hazardous cleaning products, which were not stored securely. This presented a risk to people who used the service and others.

One of the sterile single use supplies for the ambu bag (used in resuscitation) was open. This meant that staff could not be confident that the equipment was sterile ready for use.

Are services safe?

The vehicle used to take clinicians to consultations and those used to transport patients to the treatment centre were seen to be well maintained and clean. We noted that patient details could not be recorded electronically in the vehicle and practitioners did not have access to current best practice guides once they were away from the main site. We spoke with the health care assistant who was also the driver of the vehicle and found they were knowledgeable and proficient about the use of the safety equipment.

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 were included.

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.

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

Dealing with Emergencies

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

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

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 checked and maintained. The equipment, which was carried in the vehicles for use by a clinician to manage medical emergencies was also maintained and checked regularly.

Are services effective?

(for example, treatment is effective)

Summary of findings

The out-of-hours service at Grantham and District 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.

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 and a repeat audit to monitor the effectiveness had been due in March 2014 but had not yet been completed.

We saw that the staff had access to evidence based practice materials at the service apart from when in the out-of-hour's vehicle or on home visits. This increased the risk that those patients who were seen at home may not be treated in accordance with current best practice. Staff did however have access to a set of approved instructions (algorithms) to identify and treat a number of health conditions and these could be taken on home visits.

Staff learning and development was supported and we saw that the provider had arranged a conference 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.

We saw how one advanced nurse practitioner used a holistic approach to their telephone triage. Triage is the process of determining the priority of patients' treatments based on the severity of their condition. By careful questioning, they ensured that they understood fully the current physical condition and presenting needs of the patient. They also asked after the patient's carers and reviewed their home situation to complete a rounded assessment. They gave the person confidence that they could manage the situation and that help was on the way. They identified risk and gave clear advice to the person on the telephone as to how to manage the risk. On one call this included adjusting the risk assessment and advising care home staff that they should call the emergency services.

Are services effective?

(for example, treatment is effective)

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.

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.

We saw that patients were contacted if the advanced nurse practitioner was going to be delayed in reaching the patient during which time their needs were triaged again to check the patient's condition had not worsened.

The feedback from patients we spoke with was very complimentary about the service they received. They thought that the staff were well trained and knowledgeable and they had been kept informed about how their health care needs would be managed and met.

Staffing

We looked at staffing across the out-of-hours service and saw that there was usually a mix of skills and experience to meet patient needs. There were two advanced nurse practitioners on duty together at the service. We were told that there were staff vacancies and that agency staff were used when regular staff could not provide the necessary cover. This had meant that on a small number of occasions, both of the nurse practitioners on duty were agency staff. This increased the risk that at these times, the staff on duty may not have the detailed knowledge of the service. The provider assured us of their plans to fill vacant posts which would further minimise the risk of this happening in the future.

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 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.

We asked staff about their induction to the service and found that the process described to us was not always followed in practice. Two staff members had received some training but had not been provided with an induction about the service and the location. The staff described they had regular training and refresher courses. This included infection control and hand washing, basic life support, risk management and safeguarding children and vulnerable adults.

The provider had mechanisms in place for 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 they had received a yearly appraisal of their performance and work by a manager. The staff themselves said they did not always receive copies of their appraisals. We were told that GP appraisals were undertaken 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. The staff said they had regular supervision meetings.

Staff reported that they had been asked to volunteer to become supervisors of their peers for which they would receive training. We were told that none of the staff had volunteered for this but clinical staff did provide each other with informal clinical supervision on a regular basis.

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. The staff were well informed about the need to share this information and

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 NHS 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. Recent arrangements where the out-of-hours service worked alongside the rapid response

Are services effective?

(for example, treatment is effective)

team, which employed complex case managers, was working well and all staff could see the benefits of this. We saw the process whereby patients' needs were being referred to the most appropriate service from this arrangement.

Are services caring?

Summary of findings

We saw that patients were treated with dignity and respect. 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.

Our findings

Respect, dignity, compassion and empathy

The staff members and the GPs we talked with spoke about their commitment to serving patients. We observed staff taking calls from patients in a calm, respectful and reassuring manner. We also saw staff welcoming patients at the out-of-hours service in a polite and professional way. Patients we spoke with were happy with the way they had been dealt with by staff. They consistently said they felt well-cared for and well informed about what was happening. They also said they had a say in their treatment and felt involved.

One patient who had visited the service before said they could sometimes feel rushed during busy periods but they always left feeling that they knew about the course of treatment they had been prescribed and overall they were impressed by the service.

We heard one advanced nurse practitioner providing support to the relative of a patient who was waiting for a home visit. They gave them confidence that the actions they were taking to keep their relative comfortable was effective and agreed a time scale about when the clinician would arrive. We noted though that patient confidentiality could not always be guaranteed due to the position of the reception desk in a corridor, which people used to access other services.

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.

We observed that patients were treated with kindness, dignity, and respect. This included people who had self-referred without using the NHS 111 telephone service. We saw the receptionist ensure that a patient with physical disabilities received their prescribed medicines by contacting the pharmacist and a carer.

Our interview with the GP revealed they were well informed about the need to obtain the consent of patients and to check a person's capacity to make decisions where necessary. Patients confirmed they were asked for their views about the treatment options available to them.

The practice also used telephone interpretation, which the staff were all well informed about.

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.

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.

Our findings

Responding to and meeting people's needs

We saw that the staff were busy but worked in a calm and organised way. They responded fully to people's needs and ensured they contacted patients by telephone to inform them of any delays to their home visit or treatment.

Guidelines were in place to ensure people who contacted the service received a timely response appropriate to their clinical need. Call operators were competent in the use of NHS Pathways, which is clinical assessment software developed by GPs and nurses. We saw that the practice staff and GPs were well organised and 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.

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.

We were told the service had a system to alert staff members about people who were particularly vulnerable with end of life care needs, mental health needs or where there were safeguarding concerns. This enabled staff to respond more effectively to the person's needs. The system also alerted staff when people used the service regularly. The patient's own GP was informed about the contact they had with the out-of-hours service. This was provided by 8am the following day and meant GPs were aware of any issues which might need following up to help promote continuity of care.

The provider used the Making Every Contact Count (MECC) campaign, which helped to improve the health and

Are services responsive to people's needs?

(for example, to feedback?)

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 that patient's needs were met. The provider had implemented a system of direct referrals from East Midlands Ambulance Service to the out-of-hours, which had resulted in a measurable decrease in admissions into Accident and Emergency departments. The ambulance services were provided with a direct dial telephone number to enable them to contact the out-of-hours service without the need to go through the NHS 111 system. Evidence we saw showed that in the year 2013/14 1661 patients had been referred directly into the out-of-hours service by the ambulance service, 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 during these times.

All of the patients we spoke with were pleased with the timeliness of the service form calling the NHS 111 number to being seen. Two patients suggested better signage form the entrance to the hospital to the out-of -hour's service.

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 had a diverse board of directors. The senior management team was knowledgeable and actively demonstrated high values and behaviours aimed at improving patient care. At a service level, the staff did not always feel valued and although there had been improvements recently, they continued to feel isolated and lacking in support.

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.

Our findings

Leadership and culture

The board of 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.

Staff from Grantham and District Hospital told us that they have not felt listened to including when they have reported issues that may present a reputational risk to the trust and their service. They have also been concerned that risk reporting had not been taken seriously. Many of the staff spoken said they felt isolated and unsupported however. They did not think the service was well led or and did not feel fully valued. This showed that staff did not always feel well supported. A recent team meeting with managers was much more positive and staff were hopeful, but sceptical that lasting change would take place. Our observations of the conduct of staff in their role and feedback from patients and staff suggested this lack of morale had not had a negative influence on the patient experience.

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 out-of-hours could be delivered more effectively and responsively in an urgent care setting and 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 hour's 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

Are services well-led?

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

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 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 NHS 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 NHS 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	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Regulation 13, Management of medicines:** **How the regulation was not being met:** 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	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Regulation 13, Management of medicines:** **How the regulation was not being met:** 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	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Regulation 21 (a)(i)(ii)(iii)(b), Requirements relating to workers:**

This section is primarily information for the provider

Compliance actions

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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Regulation 21 (a)(i)(ii)(iii)(b), 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.