Skegness County Hospital

Quality Report

Dorothy Avenue
Skegness
Lincolnshire
PE25 2BS
Tel: 01529 220300
www.lincolnshirecommunityhealthservices.nhs.uk

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

Contents

Summary of findings

Overall summary

Lincolnshire Community Health Services NHS Trust provided out-of-hours General Practitioner (GP) services for patients living across 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 country. 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 Skegness 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 provided was registered to provide the regulated activities of diagnostic and screening procedures and the treatment of disease, disorder or injury. In addition Skegness and District Hospital was registered to provide the regulated activities of family planning.

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

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.

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

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

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

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.

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 appropriate systems in place for the safe and reliable administration and storage of medicines. 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.

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 and the provider had taken steps to investigate such incidents and inform staff of the findings to help prevent any re-occurrence.

We saw the provider had put into place actions plans in response to concerns and 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 appropriate systems in place for the reliable and safe, storage and administration of medicines.

We found the out-of-hours service at Skegness and District Hospital was located in a single room and the layout was clean, well organised and maintained.

We found infection prevention and control measures were in place in treatment rooms, and hand washing facilities were available. Staff had received recent infection control training.

We saw that staff at the out-of-hours unit at Skegness and District Hospital did not have any means of summoning assistance in an emergency or if staff felt threated, other than a panic button on the computer system.

Are services effective?

GPs' who were engaged to deliver 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.

Staff told us they delivered care and treatment in line with trust guidance, standards and best practice. They supported patients to make informed decisions and gave informed consent.

Staff told us they worked well with the minor injuries unit staff and shared information. Staff would seek support and guidance from staff at other out-of-hours services run by the Trust to ensure positive outcomes for patients.

Are services caring?

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 they were treated with kindness and respect and had positive relationships with staff delivering their treatment and care.

Are services responsive to people's needs?

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.

Summary of findings

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 which had resulted in a measurable decrease in admissions into Accident and Emergency departments.

Patients told us they were able to make appointments easily, and were seen in a timely and effective way.

Patients did not know how to raise complaints if they had concerns. We did not see any information on the out-of-hours unit around complaints procedures and ways to give feedback to the provider.

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 actively demonstrated 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 and there was a program of staff engagement events being held across the county of Lincolnshire aimed at reaching as many staff as possible.

Staff were given the option to undertake various training opportunities pertinent to their role and were supported to improve and reflect upon their performance through annual appraisal and regular supervision.

There was a clear desire to develop and improve the level of service and the trust was working with other health care providers to improve healthcare outcomes for patients.

Summary of findings

What people who use the service say

The Care Quality Commission (CQC) provided comment cards to enable patients to tell us about the service provided by the out-of-hours service. Three comment cards were returned. Two patients commented care received was of a high standard and they found the service was clean and well maintained. Another patient described staff had a friendly approach. We spoke with five patients they told us the service was prompt, and staff explained their care and treatment and responded compassionately to their health needs. Patients told us that they were happy with the care and treatment they received and felt safe. Patients told us they did not know how to raise concerns or make a complaint.

Patient surveys that had been undertaken by the provider showed that patients were happy with the care and treatment they received. Some patients had commented upon lengthy waiting times at some primary care centres whilst others had responded in positive terms about how quickly they had been seen.

Areas for improvement

Action the service MUST take to improve

The provider must ensure that 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 should 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 of medicines received and held. 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.

At Skegness and District Hospital the out-of-hours service did not provide information on how to raise a complaint in languages other than English and we found that accessing any information about the complaints procedure on the provider's website very difficult to understand.

Patients at the out-of-hours service at Skegness and District Hospital were not provided with any information on how to make a complaint, or encouraged to provide feedback about their care.

The provider could provide emergency call buttons or pull cords in areas where staff are working at Skegness and District Hospital. This would improve safety for staff and patients. Staff would be able to summon assistance in an emergency or if they felt threated, other than the computer system.

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.

Summary of findings

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.

Skegness County 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.

Our inspection on 7 June was undertaken by two CQC inspectors.

Background to Skegness County Hospital

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

The 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 report focussed on the out-of-hours service at Skegness 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.

How we carried out this inspection

We carried out the inspection as part of our new inspection programme to test our approach going forward. It took

Detailed findings

place with a team that consisted of CQC inspectors, a GP, GP practice managers, nurses and experts-by-experience. An expert-by-experience is somebody who had personal knowledge of using services either as a patient or as a carer of a patient who has used similar services. We spoke with patients and members of the public who used the service to help us capture their experience.

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.

On 7 June we carried out an announced inspection at Skegness and District Hospital and spoke with patients who used the service. We observed how people were being cared for and talked with carers. We reviewed three 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 to one member of staff employed by the out-of-hours service and one nurse from the minor injuries unit.

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

We looked at the arrangements for the safe storage and management of medicines and emergency medical equipment.

Are services safe?

Summary of findings

There was a clear process for recording patient safety incidents and concerns and the provider had taken steps to investigate such incidents and inform staff of the findings to help prevent any re-occurrence.

We saw the provider had put into place actions plans in response to concerns and 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 systems in place. This impacted on patients' safe care and treatment. We have told the provider that they must take action to improve.

We found the out-of-hours service at Skegness and District Hospital was located in a single room and the layout was clean, well organised and maintained.

We found infection prevention and control measures were in place to treatment rooms, and hand washing facilities were available. Staff had received recent infection control training.

We saw that staff at the out-of-hours unit at Skegness and District Hospital did not have any means of summoning assistance in an emergency or if staff felt threated, other than a panic button on the computer system.

Our findings

Safe patient care

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. A full root cause analysis had been completed and 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 such as additional telephone triage training for staff was on going.

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

Staff told us that where accidents, near misses and significant events had occurred in the service these had been documented and learning and action points had been identified. The learning from incidents would be discussed at team meetings. Where staff had been involved in an incident, the issues would be discussed in a one to one meeting with their manager.

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 Depravation of Liberty Safeguards, both pieces of legislation aimed at protecting vulnerable people. We spoke with the safeguarding lead for the provider who informed us that they were currently providing all staff with training regarding domestic abuse and it 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 on the procedures for raising their concerns about suspected wrongdoing at work.

Members of staff that we spoke could demonstrate a 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 appraised of the outcomes of any referral they may have made where that was appropriate.

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

Staff told us safeguarding packs were available for guidance and included relevant safeguarding contact details. Staff showed us safeguarding written policies and procedures to protect vulnerable children and adults. Staff were aware of signs and types of abuse and what their responsibilities were in raising their concerns..

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.

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 and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription)

We saw that 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 upon.

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

The out-of-hours service was located in a single room in the urgent care department at Skegness Hospital. The treatment room was clean and well organised. We found medical gasses were stored safely and serviced by the hospitals maintenance team. Medicine fridge temperatures were recorded daily and had not exceeded the stated safe range. Emergency resuscitation equipment was available and shared by the out-of-hours service and the minor injuries unit. All equipment was maintained and emergency drugs were in date.

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 audit of the number of medicines available. Staff told us that any medicines dispensed were immediately reorded. We saw examples of completed medicine ordering forms. These showed that the medicines were checked by the dispensing pharmacist. We did not see evidence that the medicines are checked upon arrival at the hospital or any record that out-of-hours 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.

Staff told us bi monthly audits were carried out by hospital staff (medicines lead nurse and senior sister) to review expiry dates. Any medicines found to have exceeded or be

close to their expiry date were recorded on a hand written list. This list was then pinned up in the main medicines store room for night staff to use to remove the medicines. We did not see a written procedure for this or any record of the number of medicines available. Staff we spoke with confirmed they did not have a formal procedure or use any 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. We found safe systems were not in place and may impact on the patients care and treatment. The provider took steps after the inspection to make improvements to the medicine management systems.

Cleanliness and infection control

We found the out-of-hours room was clean and hygienic. We saw disposable towels were used to cover the treatment couch and hand washing facilities were available. Disposable paper curtains were used to reduce infection risk. The date the curtains were first used was recorded and was within the time stated for renewal in the infection control policy. A sharps disposal box was present and had been correctly assembled. Staff told us that the hospital estates team were responsible for all cleaning and waste removal from the out-of- hours service The hospital has a dedicated infection prevention and control lead who was also the lead for the out-of-hours service and worked across both departments. The nurse we spoke with told us she had received infection control training.

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 in other cases 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.

We saw one staff member was working in the out-of-hours service. Staff told us arrangements were in place for staff to assist as a chaperone from the minor injuries unit when required. We saw two patients received consultations with a chaperone. This confirmed patients received appropriate care and their privacy and dignity were respected.

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.

Staff showed us the Skegness hospital emergency continuity plan and confirmed their understanding of responding to major incidents.

Equipment

The layout of the building provided one treatment room for the-out-of-hours service at Skegness Hospital. Staff confirmed systems and processes were in place to report on maintenance of equipment to managers and staff at the minor injuries unit. Staff protected and promoted patient safety

Are services effective?

(for example, treatment is effective)

Summary of findings

GPs' who were engaged to deliver 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 audit 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.

Staff told us they delivered care and treatment in line with recognised guidance, standards and best practice. They supported people to make informed decisions and give informed consent.

Staff told us they worked well with the minor injuries unit staff and shared information. Staff would seek support and guidance from staff at other out-of-hours services run by the Trust to ensure positive outcomes for patients.

Our findings

Promoting best practice

We saw that the provider had undertaken a range of clinical audits, which aimed to improve patients' care and treatment. We looked at an audit that had been carried out on urinary tract infections 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-amoxicil and cephalexin in two areas of the county. Action had been taken to reduce the incidence of prescribed antibiotics and a repeat audit to monitor the effectiveness had been due in March 2014 but had not yet been completed. We saw that a conference had been arranged for September 2014 to include a Microbiologist and GPs in order to change behaviour around the prescribing of anti-biotic for patients with urinary tract infections. This showed that the provider had responded to the clinical audit it had undertaken to help improve and care and treatment for patients.

Management, monitoring and improving outcomes for people

We saw evidence that the provider reviewed clinicians' face to face consultations and telephone advice to patients. This was undertaken using random selection of cases and was scored using the Royal College of General Practitioners toolkit. Any areas of poor practice that had been highlighted 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 at the induction process that all new staff underwent. It included local induction at the staff member's primary care centre. The induction included details of the staffing structure and management contact details. The induction process encompassed mandatory training in fire safety, medicine management, immediate life support, moving and handling, safeguarding children and vulnerable adults, domestic abuse, hand hygiene, equality and diversity and more.

Are services effective?

(for example, treatment is effective)

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 new staff training tool titled 'Your Performance Matters'. We saw that this booklet was being introduced and was individual to each member of staff. It was used to record staff training, professional learning, work achievements and development plans. The book was used to record supervisions and appraisal meetings.

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.

Staff told us they had informal joint working arrangements with the minor injuries unit staff and shared information and decision making about a patients care, particularly when a person had complex health needs. We saw evidence of reception staff based at the minor injuries unit making appointments for patients for the out-of-hours service. Staff told us they would seek advice and support from clinicians at the minor injuries unit to ensure patients received positive outcomes.

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 they were treated with kindness and respect and had positive relationships with staff delivering their treatment and care.

Staff told us they delivered care and treatment in line with recognised guidance, standards and best practice. They supported people to make informed decisions and gave informed consent.

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. Patients told us they were treated with kindness and respect and had found staff had positive attitudes when delivering their treatment and care. One patient told us they had felt embarrassed about their health condition but staff had responded compassionately to their concerns and distress.

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 spoke with five patients who alltold us they had been involved in planning and making decisions about their care and treatment and had given informed consent. One patient told us the nurse took time to explain their treatment in detail. Another patient told us they had opportunities to discuss their health concerns with the nurse, and according to their wishes, their family members were involved in these discussions.

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

Are services caring?

Staff at out-of-hours service at Skegness and District Hospital told us there were interpretation services were available for patients who did not speak English as their first language, for example a telephone translation service was available.

Are services responsive to people's needs?

(for example, to feedback?)

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 which had resulted in a measurable decrease in admissions into Accident and Emergency departments.

Patients told us they were able to make appointments easily, and were seen in a timely and effective way.

Patients did not know how to raise complaints if they had concerns. We did not see any information around complaints procedures and ways to give feedback to the provider.

Our findings

Responding to and meeting people's needs

The provider used the 'OK to Ask' Make Every Contact Count (MECC) campaign which helped to improve the health and wellbeing of patients, the public and staff. The scheme aimed to encourage staff and patients to engage in conversations about any area of health, 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 need 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 service 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 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-8am Monday – Thursday, 6.30pm Friday – 8am Monday, and all public and bank holidays. The out-of-hours service at Skegness and District Hospital was open from 8.00am -8pm on Saturdays and Sundays and bank holidays All the patients we spoke with told us they had been able to make appointments to access care at the right time. They told us the appointment system was easy to use and they were given the choice to attend different primary care centres.

Concerns and complaints

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

Are services responsive to people's needs?

(for example, to feedback?)

At the out-of-hours service at Skegness and District hospital we did not see any information around complaints procedures or ways to give feedback to the provider. We saw a suggestion box but staff told us this was always empty. Patients told us they did not know how to raise complaints if they had concerns.

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 and there was a program of staff engagement events being held across the county of Lincolnshire aimed at reaching as many staff as possible.

Staff were given the option to undertake various training opportunities pertinent to their role and were supported to improve and reflect upon their performance through annual appraisal and regular supervision.

There was a clear desire to develop and improve the level of service and the trust was working with other health care providers to improve healthcare outcomes for patients.

Our findings

Leadership and culture

We found that the service was well led by a dedicated team of experienced senior managers who reported to a board of directors who were drawn from a range of backgrounds, including healthcare and public service. The board displayed high values and held senior managers to account. There was an emphasis on quality outcomes for patients which was evidenced by the records of meetings that were available to view on the provider's website.

During our inspection we found staff at all levels to be honest and open. Staff told us about areas of the service that were less strong and governance arrangements ensured problems were identified, understood and addressed. For example plans had been drawn up to review and improve the service with the engagement and involvement with patients, commissioners, and staff.

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 conferences, to include any perceived risks and incidents which could impact on providing a quality and equitable service across the county. The meeting was chaired by the Senior Matron or deputy and representatives of the Urgent

Are services well-led?

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

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 days training. There was a positive reliance on face to face training as staff had expressed their preference for this type of input, but some training was also available on-line. Managers continually reviewed attendance and non- attendance at mandatory training was followed up to ensure it was completed.

Systems to monitor and improve quality and improvement

The National Quality Requirements (NQR) were designed to ensure that GP out-of-hours services were safe, clinically effective and delivered in a way that gave the patient a positive experience. The provider was consistently meeting full compliance with all of the requirements with the exception of NQR 12, which stated that face to face consultations must be started within one hour for emergencies, two hours for urgent and six hours for less urgent.

The trust had undertaken an audit to try and resolve these issues. It had been identified that the 111 service provider had incorrectly assessed the clinical needs of some patients resulting in there being a higher number of cases than would be expected being assessed as requiring urgent face to face consultation. The provider was working with the 111 provider to try and ensure that patients received the appropriate assessment of their needs.

Patient experience and involvement

We saw evidence that that the provider used a variety of methods to capture the experiences of patients using the out-of-hours service. These included patient satisfaction questionnaires that had been given to every patient when they attended a primary care centre and also the providers own random selection of patients.

We viewed the results of these questionnaires and found that the results were overwhelming positive for the service. Patients had commented upon the short waiting times from arriving at the primary care centre to seeing a doctor and 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 as waiting times.

Staff engagement and involvement

We found that the service was open and transparent and encouraged staff engagement. We saw evidence that there were regular meetings held for staff which had been held at various locations to enable as many staff as possible the opportunity to attend. Regular team meetings at a local level were held to enable staff to engage with managers. These meetings gave staff the opportunity to raise issues that affected patient care. One senior member of staff told how they made sure that individuals were appraised of any developments or issues raised at meetings by speaking to them on a one- to- one basis in the event they not been at the meeting.

Learning and improvement

We reviewed the minutes of the Quality and Risk Committee for the previous 12 months and saw that there was a clear emphasis on quality and improvement. Matters having an effect on quality, safety and the patient experience had been discussed in depth and action taken where necessary. Standing items on the meeting agenda included compliance with the National Quality Requirements for out-of-hours GP services.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of Medicines. We found the provider did not have appropriate systems in place for the safe and reliable administration and storage of medicines. 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
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 appropriate systems in place for the safe and reliable administration and storage of medicines. 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 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 by GP's who are qualified, skilled and experienced. Appropriate checks should be documented and the provider must ensure that the GP's are suitable to work in the out-of-hours service.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 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 by GP's who are qualified, skilled and experienced. Appropriate checks should be documented and the provider must ensure that the GPs are suitable to work in the out-of-hours service.