Louth County Hospital

Quality Report

High Holme Rd
Louth
Lincolnshire
LN11 0EU
Tel: 01529 220300
www.lincolnshirecommunityhealthservices.nhs.uk

Date of inspection visit: 06/06/2014
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 this inspection

Page

Overall summary 3

The five questions we ask and what we found 4

What people who use the service say 7

Areas for improvement 7

Good practice 7

Detailed findings from this inspection

Our inspection team 9

Background to Louth County Hospital 9

Why we carried out this inspection 9

How we carried out this inspection 9

Action we have told the provider to take 23

Summary of findings

Overall summary

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

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.

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

There were systems in place to help ensure patient safety through learning from incidents 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 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 and we observed patients being treated with respect and kindness whilst their dignity and confidentiality was maintained.

The provider had in place business continuity and contingency plans that would enable the service to continue to operate in the event of a failure of, for example, the information technology or telecommunication systems.

We found that the service was well-led and managed by a knowledgeable senior management team and Board of Directors. They had taken action to help ensure their values and behaviours were shared by staff through regular engagement.

Members of the staff team we spoke with held positive views of management and their leadership and felt well supported in their roles. They told us the senior managers were approachable and listened to any concerns or suggestions they might have to improve the level of service provided to patients.

We found the provider did not have appropriate systems in place for safe storage, administration and recording of medicines. Following our visit the provider took steps to improve the medicines management systems to keep patients safe. The provider had suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment. Systems were not in place to ensure equipment was properly maintained and suitable for its purpose. Staff did not always implement these 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 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.

We found the provider did not have appropriate systems in place for safe storage, administration and recording of medicines.

Regular checks of availability and suitability of equipment were not always carried out. Procedures were in place to ensure checks were completed but these were not always carried out by staff.

The out- of -hours service shared facilities with the urgent care centre. The facilities used were clean well organised and maintained. We found that infection prevention and control measures were in place in all treatment areas and vehicles and that staff had received infection prevention and control training.

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 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 trust guidance, standards and best practice. They supported people to make informed decisions and gave informed consent.

Staff told us they had established joint working arrangements with staff on the urgent care unit. Staff told us they would seek support and guidance from other out-of-hours services run by Lincolnshire Community Health Services NHS Trust, to ensure positive outcomes for patients.

Are services caring?

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

The provider had made positive steps to meet the needs of patients from the gay, lesbian, trans-gender and bi-sexual community.

The provider 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?

We saw that leaflets that helped inform patients about the complaints procedure were only available in English with information about how to request these in other languages and formats printed on the back page. We saw documentary evidence

that indicated that the commissioners of the service had stated that they should not be printed in other languages due to financial implications. We were informed that information on how to make a complaint was available on the provider's website but upon looking at the site we were unable to find any information.

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.

Are services well-led?

We saw that the trust was well led by an experienced and diverse Board of Directors. The senior management team was knowledgeable and reflected high values and behaviours aimed at improving patient care.

The provider displayed open and transparent governance arrangements and minutes of the various Board and committee meetings were easily accessible on the provider's website.

We found that the interim Chief Executive was pro-active in seeking the views of staff 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

We received three Care Quality Commission (CQC) comment cards and a further comment was received via email. All four patients commented that the care they received was good. Patients stated they had been treated quickly and efficiently at Louth and spoken to in a personable manner.

We spoke with four patients using the service. All four told us they were happy with the care they received and had not had a long wait for an appointment. All four people told us they felt staff were friendly and professional and found the treatment and waiting areas to be clean and hygienic.

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.

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

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.

The provider must ensure that appropriate systems are in place for the safe storage, administration and recording of medicines.

The provider must ensure that appropriate systems are in place to carry out regular checks of the availability and suitability of equipment.

Action the service COULD take to improve

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

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

The provider 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.

Patients told us they were not provided with any information on how to make a complaint, or provide feedback about their care.

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.

Louth 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 6 June was undertaken by two CQC inspectors.

Background to Louth 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 provides care to patients who require urgent medical care from a GP outside of normal GP hours.102 GP practices are covered by the service. The provider employs the services of 100 GPs who are engaged on a sessional basis to deliver care to patients. The service operates county wide from 6.30pm-8am Monday – Thursday, 6.30pm Friday – 8am Monday, and all public holidays.

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

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

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

The County Hospital, Lincoln

John Coupland Community Hospital, Gainsborough

Grantham and District Hospital

Stamford and Rutland Hospital, Stamford

Johnson Community Hospital, Spalding

The Pilgrim Hospital, Boston

Skegness and District Hospital

County Hospital, Louth

In the year 2013/14 in excess of 100,000 patients accessed the out-of-hours service. The Out-of – Hours service at County Hospital Louth is located adjacent to the Urgent Care Centre.

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 place with a team that consisted of CQC inspectors, a GP,

Detailed findings

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 6 June we carried out an announced inspection at Louth Hospital and spoke with patients who used the service. We observed how people were being cared for and talked with carers. We reviewed four 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 members of staff employed by the out-of-hours service and with GP's.

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

We spoke to five members of staff employed by the out of hours service as well as one staff member from the urgent care centre.

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.

We found the provider did not have appropriate systems in place for safe storage, administration and recording of medicines.

Regular checks of availability and suitability of equipment were not always carried out. Procedures were in place to ensure checks were completed but these were not always carried out by staff.

The out- of -hours service shared facilities with the urgent care centre. The facilities used were clean well organised and maintained. We found that infection prevention and control measures were in place in all treatment areas and vehicles and that staff had received infection prevention and control training.

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.

The out-of-hours service was located in a shared facility with the urgent care centre. We found that the reception and treatment areas were clean. We found that walls and surfaces of the accessible toilet were grimy and the toilet dirty. The weekly cleaning schedule displayed on the toilet wall, recorded the times the toilet was cleaned on two occasions but no dates were recorded. There was a fold down baby changing equipment but this looked dirty with no protective covers or wipes provided

The unit had a specialist childrens' waiting room and treatment room. These areas were equipped and designed for younger children with toys and play materials

Staff were able to demonstrate how blank prescription pads, medicines and controlled drugs were stored securely.

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 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 ongoing.

We viewed copies of the 'Lessons Learned' document that was published quarterly and disseminated to all staff. The

documents were subtitled 'Listen, learn, share' and quantified the number and types of complaints and serious incidents and the learning and lessons that had been taken from them.

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

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

Monitoring Safety & 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.

We examined the records for the fridge used to store medicines for the period February to May 2014. We found that information had not been recorded on a number of dates each month and the safe operating range of temperature was not recorded.This could put patients at risk of receiving unsafe or ineffective care as certain medicines need to be stored at low temperatures to maintain there effectiveness. The process and operating systems for medicine that required cold storage where not reliable or safe.

We found that appropriate and safe systems were in place to store controlled drugs at the out- of- hours unit. We saw how all medicines were stored securely in the outofhours unit then transferred to the vehicle by staff. A designated palliative care (end of life care) medicines bag containing controlled drugs was prepared and checked by the pharmacist before being taken to the vehicle.

A checklist of available medicines for the vehicle was kept on the unit. We found that the list did not correlate with the available medicines. We found one example were a medicine was not recorded at all on the checklist but present in the vehicle. Four doses of a second medicine were available in the vehicle but only two recorded on the

Are services safe?

checklist. The provider had appropriate systems in place to record available medicines but these were not always used. Thorough checks of available medicines would ensure staff would have access to required medicines at all times and the provider would have a clear record of use and adminaitration of medicines.

We found three 100ml bottles of the drug Oramorph, a class two controlled drug containing morphine, available in the vehicle drug bags. We saw that one of these bottles had been opened and an amount of the drug had been dispensed. We could not find a record of when the drug was dispensed and the date of opening was not recorded on the bottle. The manufacturers guidelines stated the date must be recorded and the bottle discarded after three months. The provider could not be assured that the medicine was dispensed appropriately or that the medicine had not exceeded its use by date as accurate records were not kept.

We found that a number of medicines and some equipment was kept stored in the vehicle throughout the day. During our inspection we noted that the interior of the vehicle was very warm and some of the medicines and equipment were uncomfortably hot to pick up. This could mean that medicines are not effective as they were stored inappropriately.

Cleanliness & Infection Control

The rooms and vehicles used by the out-of-hours service were clean and hygienic. We found linen sheets were used to cover the treatment couch and replaced following each use. We saw fresh stocks of sheets were available. Hand washing facilities were available in all areas. 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. Sharps disposal boxes were present throughout the unit and in vehicles.

Staff told us that the hospital estates team were responsible for all cleaning and waste removal from the out-of- hours service and urgent care centre. The urgent care centre had a dedicated infection prevention and control lead who was also the lead for the out-of-hours-service and worked across both departments. Staff we spoke with told us they had received infection control training recently and found it useful.

Staffing & Recruitment

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

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

We saw that there was no system in place for the provider to ensure that GP's working in the out-of-hours service had the appropriate professional indemnity and the provider had relied upon an annual self-declaration that such cover was in place. We also saw that in some cases, Disclosure and Barring Service checks (formally Criminal Records Bureau checks), which are carried out to disclose any previous criminal convictions, had not been renewed by the GP's every three years. This requirement formed part of the trust's conditions for continued work in the out-of-hours service.

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.

Staff at Louth Hospital told us that copies of the out- of-hours policies and the emergency continuity plan were available on file and on the intranet and they would go on line to view current versions.

Are services safe?

Equipment

The out- of- hours service had two vehicles on site although one was not operational at the time of our visit. We found that both vehicles were in good working order and had received recent maintenance. Equipment was available to allow staff to carry out their duties. We saw a check list that staff had to complete prior to using the vehicle. The checklist covered the road worthiness of the vehicle along with confirming the availability and suitability of equipment. We found that the checklist was not always completed by staff and had been completed incorrectly prior to our visit. This meant that staff could not be assured that all equipment was available and in good working order prior to use and could expose patients to the risk of unsafe or ineffective care.

The available equipment included a nebuliser,a machine used to deliver high doses of medicines in the form of a mist that is breathed in by a patient. We saw checks which showed the nebuliser had been classed as fit for use however our examination showed it had not been serviced since July 2012. This was confirmed by staff we spoke with. This could put people at risk of receiving unsafe or ineffective care as the machine may not be in good working order.

Staff we spoke with acknowledged that equipment and medicines checklists had not been regularly completed. The provider may wish to note that we found different staff groups believed responsibility for completing the checklists lay with other staff. This meant that checks were not completed as clear directives had not been given.

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 trust guidance, standards and best practice. They supported people to make informed decisions and gave informed consent.

Staff told us they had established joint working arrangements with staff on the urgent care unit. Staff told us they would seek support and guidance from other out-of-hours services run by Lincolnshire Community Health Services NHS 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-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 a conference had been arranged for September 2014 to include a Microbiologist and GPs in order to change behaviour around the prescribing of anti-biotics for patients with urinary tract infections. This showed that the provider had responded to the clinical audit it had undertaken to help improve and care and treatment for patients.

Management, monitoring and improving outcomes for people

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

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

Staffing

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

Are services effective?

(for example, treatment is effective)

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

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.

We saw arrangements were in place for joint working with staff on the urgent care centre. For example the infection control lead workedacross both units and reception staff organised appointments and requests for tests such as X-rays for all patients. Staff told us they would seek advice and support from clinicians on the urgent care centre to ensure patients received positive outcomes. All staff we spoke with confirmed there was joint working with other health and social care providers and with patients GP's and relevant parties. Staff spoke about liaising with Health Visitors and Mental health services in Lincoln, Grimsby and Boston.

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 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.

Our findings

Respect, Dignity, Compassion & 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. Staff told us home visit teams consisted of one male and one female staff member to ensure patients have a chaperone. The trust had a policy called "protective measure" which stated that patients must have access to a chaperone. Staff told us that privacy and dignity was always respected particularly during physical and intimate care.

A clinical staff member told us they took steps to respect patients dignity by requesting a chaperone and asking for a staff member to assist. They told us they call patents by their preferred name, ensure privacy is maintained by closing doors and confirming consent was given.

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 four patients about their care. They told us they had been involved in planning and decisions regarding their care and felt they were able to give informed consent. All four patients told us clinical staff had taken time to discuss their care and listen to their concerns. Patients felt that staff explained everything and they knew what to expect from any treatment given.

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

Are services caring?

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. At Louth Hospital we did not see any information around access to interpreters or information available in other languages.. Staff told us there was interpretation services 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

We saw that leaflets that helped inform patients about the complaints procedure were only available in English with information about how to request these in other languages and formats printed on the back page. We saw documentary evidence that indicated that the commissioners of the service had stated that they should not be printed in other languages due to financial implications. We were informed that information on how to make a complaint was available on the provider's website but upon looking at the site we were unable to find any information.

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.

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.

Concerns & 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.

We saw that leaflets which helped inform patients about the complaints procedure were only available in English with information about how to request these in other languages and formats printed on the back page. We saw documentary evidence that indicated that the commissioners of the service had stated that they should not be printed in other languages on financial grounds. We

Are services responsive to people's needs?

(for example, to feedback?)

were informed that information on how to make a complaint was available on the provider's website but upon looking at the site we were unable to find any information to that effect.

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 & 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.

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 hours provision being managed at a local level by the Urgent Care Matron within each of the geographical areas.

We saw evidence that telephone conferencing took place twice a week, and more often if required, to provide a position statement in relation to staffing of the service. The conferences, to included 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 Care Matron, Clinical Team Lead and administration for all of the geographical business units were expected to attend. This confirm and challenge process provided assurance that the service was being risk managed.

Are services well-led?

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

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 & 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 & 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 & 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 & Improvement

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

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008. Management of Medicines. We found the provider did not have reliable and safe administration of medicines systems in place. There were no formal procedures or audits for medicines received and held

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008. Safety and Suitability of equipment. The provider had suitable arrangements to protect service users and others who may be at risk from the use of unsafe equipment. Systems were not in place to ensure equipment was properly maintained and suitable for its purpose. Staff did not always implement these systems Regulation 16 (1) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008. Requirements relating to workers. The provider did not have effective recruitment procedures to ensure that people employed were of good character and had the qualifications, skills and experience necessary for the work to be performed. 21 (a) (i)(ii)