NHS Quality Improvement Scotland

NHS Lothian

Follow-up Report ~ December 2007

The Provision of Safe and Effective Primary Medical Services Out-of-Hours

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1 Setting the scene

Between September 2005–March 2006, peer review visits took place in every NHS board area that has responsibility for ensuring the provision of primary medical services out-of-hours. Local reports on the findings of these visits were published during 2006, and a subsequent national overview of service provision published in November 2006. These reports are available on request from NHS Quality Improvement Scotland (NHS QIS) or on the website: **www.nhshealthquality.org**

Each review team assessed performance against the provision of safe and effective primary medical services out-of-hours standards using a quality improvement tool, which comprised position statements for each criterion, standard statement and overall performance. This tool enabled NHS boards to be assessed on how they were achieving each standard through development, implementation and monitoring. These key stages represent the continuous improvement cycle through which each NHS board can ensure that all users of its out-of-hours services receive a high quality of care.

The review team used the most appropriate position statement to describe an NHS board's position against each criterion. This then allowed an overall position statement to be arrived at for each of the standards, and in turn, an overall registration status on completion of the review visit.

Follow-up process

At the time of the peer review visits, out-of-hours services were in a state of dynamic change due in part to the infancy of the arrangements. In order to maintain the momentum gained and promote continuous quality improvement in the out-of-hours service, NHS QIS initiated a process of follow-up. The primary objective of the follow-up was to ensure that all NHS boards achieved an overall registration status of 'Provider is largely compliant with the standards' by the end of the follow-up process. Where this level had already been achieved, the objective was to encourage improvement in the areas where the criteria assessments demonstrated non-compliance (detailed for this NHS board on page 6).

Each NHS board was required to develop an action plan for each appropriate criterion. This was submitted to NHS QIS, along with a progress report and supporting evidence of progress, 3 months from receipt of the final local report, and quarterly thereafter. After 12 months, each NHS board was allowed the opportunity to exception report against outstanding non-compliant criteria by September 2007. The NHS QIS primary medical services out-of-hours reference group (see Appendix 3 for membership details) reviewed the resubmitted evidence and agreed any changes to the position statements. The NHS board was informed of these amendments to allow action plans to be revised as necessary.

At the end of the follow-up process, all amendments to the position statements were collated for each NHS board, and corresponding detailed findings of the local report updated to reflect the progress made since the review visit. It is the responsibility of each NHS board to continue to monitor its own progress on performance against the standards.

1.1 Criteria identified for follow-up

The criteria detailed in the table below were identified during the initial review as areas for action by NHS Lothian, and this report outlines progress made between the review visit on 15 December 2005 and May 2007, as assessed by the NHS QIS primary medical services out-of-hours reference group.

Criteria identified for follow-up (2006)
1(a)4 Access to, and delivery of services, is not compromised by physical, language, cultural, social, economic and other barriers.
2(a)2 Patient Focus: Information is made available by the provider for the patient and their representatives regarding any care or treatment given.
2(a)3 Clinical Governance: There are clear, cohesive plans across the service that direct and support policy development and service delivery both internally and through delivery partners.
2(a)5 Clinical Governance: Providers of out-of-hours services have a system in place to report to NHS Board clinical governance committees regularly.
2(a)6 Clinical Governance: Arrangements are in place to communicate, inform and co-operate with key professionals, external parties and voluntary agencies.
2(a)8 Staff Governance: Staff are competent to perform their duties.
2(c)3 Systems are in place to ensure that patients are aware of, and agree to, the sharing of information about them and their care with other health professionals.
3(a)3 The service provider takes action to identify patient views and satisfaction levels.
3(a)4 A report on performance and services is published annually and is available to users of the service and those contracting services.

In some cases, amendments to criterion position statements have resulted in amendments to overall standard position statements, and the NHS board's registration status. These amendments are shown where appropriate in Section 3.

2 Registration status

In 2006, a registration status was assigned to each NHS board following the review visit. As a result of the follow-up process, the registration status assigned to NHS Lothian has been amended to:

Registration status (2007)

Provider has achieved full compliance with the standards.

Registration status (2006)

Provider is largely compliant with the standards.

3 Detailed findings against the standards

Standard 1(a): Accessibility and Availability at First Point of Contact

Standard Statement
Out-of-hours services are available and accessible to patients and their representatives.*

** 'Out-of-hours' is defined in legislation as 6.30pm to 8.00am weekdays, weekends and public holidays. Local arrangements may vary.*

NHS Lothian

REVISED OVERALL POSITION STATEMENT (2007): **Processes for ensuring patient accessibility and availability at the first point of contact are being implemented and monitored fully.**

OVERALL POSITION STATEMENT (2006): **Processes for ensuring patient accessibility and availability at the first point of contact are being implemented, but monitoring has not yet commenced in all parts of the organisation.**

Essential Criterion

1(a)4: Access to, and delivery of services, is not compromised by physical, language, cultural, social, economic and other barriers.

REVISED STATUS (2007): **Arrangements are in place to ensure that access to, and delivery of, services is not compromised by physical, language, cultural, social, economic and other barriers.**

STATUS (2006): **Arrangements are in place to ensure that access to, and delivery of, services is not compromised by physical, language, cultural, social, economic and other barriers but are not fully implemented throughout the service.**

During the follow-up process, the reference group noted that the Lothian Unscheduled Care Service (LUCS) patient information leaflet had been revised and republished in May 2007. The leaflet is available at all bases, GP practices and other public areas, for example libraries. The leaflet contains textphone details for those patients with speech and hearing difficulties. The patient information leaflet is to be translated into Polish, Urdu, Chinese, Arabic and Bengali and will be distributed to relevant community groups and GP practices. Additionally, the service also has laminated pictorial expressive boards available at all bases and in all cars for patients with learning disabilities requiring assistance in expressing their symptoms or concerns.

Standard 2(a): Safe and Effective Care – Healthcare Governance

Standard Statement
Healthcare Governance: The service provider has a comprehensive, patient-focused healthcare governance programme in place.

NHS Lothian

REVISED OVERALL POSITION STATEMENT (2007): **No change.**

OVERALL POSITION STATEMENT (2006): **A comprehensive, patient-focused healthcare governance programme has been developed and is fully implemented, but monitoring has not yet commenced involving all parts of the organisation.**

Essential Criteria

2(a)2: Patient Focus: Information is made available by the provider for the patient and their representatives regarding any care or treatment given.

REVISED STATUS (2007): **Information regarding any care or treatment given is made available by the provider, and is easily accessible by patients and their representatives.**

STATUS (2006): **Information regarding any care or treatment given is made available by the provider, but it is not easily accessible by patients and their representatives.**

At the time of the initial review visit, there did not appear to be a positive directive to ensure that leaflets are provided to patients in all circumstances. During the follow-up process, the reference group noted a meeting of the quality improvement team where the importance of clinicians providing clear written information to patients and their representatives was discussed. Additionally, clinicians have been asked to identify which key leaflets should be printed in community languages.

2(a)3: Clinical Governance: There are clear, cohesive plans across the service that direct and support policy development and service delivery both internally and through delivery partners.

REVISED STATUS (2007): **There are clear, cohesive plans in place across the service that direct and support policy development and service delivery both internally and through delivery partners.**

STATUS (2006): **There are clear, cohesive plans in place, but they are not formalised and/or do not include internal and delivery partners**.

At the time of the initial review visit, NHS Lothian was undergoing a period of change and moving to single-system working. A new NHS Lothian clinical governance strategy was endorsed in December 2005, which has taken a performance management approach to clinical governance. LUCS quality improvement team has been identified (the clinical development group), in accordance with the new strategy arrangements, chaired by the clinical director. This group also includes representation from NHS 24 and the Scottish Ambulance Service. A formal LUCS quality improvement plan has been developed and submitted to NHS Lothian's clinical governance committee. The quality improvement team reports to the primary care organisation's clinical governance committee and NHS Lothian's clinical governance committee.

2(a)5: Clinical Governance: Providers of out-of-hours services have a system in place to report to NHS board clinical governance committees regularly.

REVISED STATUS (2007): **There is a system in place to report to the NHS board clinical governance committee regularly.**

STATUS (2006): **A system to report to the NHS board clinical governance committee regularly is under development.**

New clinical governance reporting arrangements have been established across NHS Lothian since the initial review visit, to which LUCS is adhering. LUCS quality improvement team has been identified, chaired by the clinical director. The quality improvement team reports to the primary care organisation's clinical governance committee and NHS Lothian's clinical governance committee.

2(a)6: Clinical Governance: Arrangements are in place to communicate, inform and co-operate with key professionals, external parties and voluntary agencies.

REVISED STATUS (2007): **Arrangements are in place to communicate, inform and co-operate with key professionals, external parties and voluntary agencies.**

STATUS (2006): **Arrangements are in place to communicate, inform and co-operate with some key professionals, external parties and voluntary agencies, but not all.**

At the time of the 3-month follow-up review, the reference group noted the progress being made to identify and establish better links with voluntary organisations. This includes the Edinburgh Crisis Centre, Carers of East Lothian, and East Lothian Community Care forum. LUCS continues to maintain regular contact with Minority Ethnic Health Inclusion Project (MEHIP) in order to link with ethnic minority community groups. This will include the use of summary extracts in community newsletters.

2(a)8: Staff Governance: Staff are competent to perform their duties.

REVISED STATUS (2007): **Processes and procedures are in place to demonstrate that staff are competent to perform their duties; staff are appraised annually and have personal development plans (PDPs) in place.**

STATUS (2006): **Some processes and procedures are in place to demonstrate that staff are competent, although there are no annual appraisal systems or PDPs in place.**

At the time of the initial review visit, job descriptions for non-medical staff had been agreed and appraisals for nursing staff, drivers, reception and hub staff were ongoing. There were PDPs for nursing staff and some GPs. PDPs were to be developed for other staff in line with the national NHS Knowledge and Skills Framework (KSF) outlines.

At the time of the 12-month follow-up review, the reference group noted that all non-clinical staff have had an appraisal and PDPs are in place. It was reported that all nurses in post as at January 2007 have had appraisals and PDPs are in place. Additionally, in terms of medical staff, as at January 2007, all salaried doctors have had an annual appraisal and a PDP agreed with the clinical director. Sessional doctors are in the process of one-to-one meetings with the clinical director. All sessional doctors are involved in NHS Education for Scotland (NES) annual appraisal and have been asked to submit a copy of their PDP to the clinical director to inform the planning of LUCS educational meetings.

Standard 2(c): Safe and Effective Care – Information and Communication

Standard Statement

Information and Communication: Information gathered during care out-of-hours is recorded (on paper or electronically) and communicated to those NHS professionals involved in the patient's ongoing care.

NHS Lothian

REVISED OVERALL POSITION STATEMENT (2007): **Processes and procedures for recording and communicating information gathered during care to relevant NHS professionals are fully implemented and monitored.**

OVERALL POSITION STATEMENT (2006): **Processes and procedures for recording and communicating information gathered during care to relevant NHS professionals are fully implemented, but monitoring involving all parts of the organisation has not yet commenced.**

Essential Criterion

2(c)3: Systems are in place to ensure that patients are aware of, and agree to, the sharing of information about them and their care with other health professionals.

REVISED STATUS (2007): **A system is in place to ensure that patients are aware of, and agree to, the sharing of information about them and their care with other health professionals, which is fully implemented across the service and monitored.**

STATUS (2006): **A system is in place to ensure that patients are aware of, and agree to, the sharing of information about them and their care with other health professionals, but this is not fully implemented across the service.**

During the follow-up process, the reference group noted that the Adastra system in operation across LUCS has been modified since the initial review. Clinicians must complete a field confirming that consent is asked of all patients, including 'walk-in' patients (patients who present without having contacted NHS 24). The reference group commended the monthly audit undertaken to demonstrate that consent is asked of walk-in patients.

Standard 3(a): Audit, Monitoring and Reporting

Standard Statement
A provider-specific quality assurance framework is in place to support routine audit, monitoring and reporting of performance.

NHS Lothian

REVISED OVERALL POSITION STATEMENT (2007): **Processes for auditing, monitoring and reporting on the out-of-hours service are fully implemented and monitored.**

OVERALL POSITION STATEMENT (2006): **Processes for auditing, monitoring and reporting on the out-of-hours service are fully implemented, but monitoring has not commenced involving all parts of the organisation.**

Essential Criteria

3(a)3: The service provider takes action to identify patient views and satisfaction levels.

REVISED STATUS (2007): **The provider takes action to identify patient views and satisfaction levels through a formalised process.**

STATUS (2006): **The provider takes action to identify patient views and satisfaction levels on an informal basis.**

During the follow-up process, the reference group noted a repeat patient satisfaction audit which was undertaken by LUCS with colleagues from NHS 24 in December 2006. It was reported that a series of local audits were also to be carried out by LUCS during the second half of 2007. This will be undertaken as an ongoing process, with learning points fed into the LUCS quality improvement team objectives.

3(a)4: A report on performance and services is published annually and is available to users of the service and those contracting services.

REVISED STATUS (2007): **A formal report on performance and services is published annually and is available widely to users and those contracting the service.**

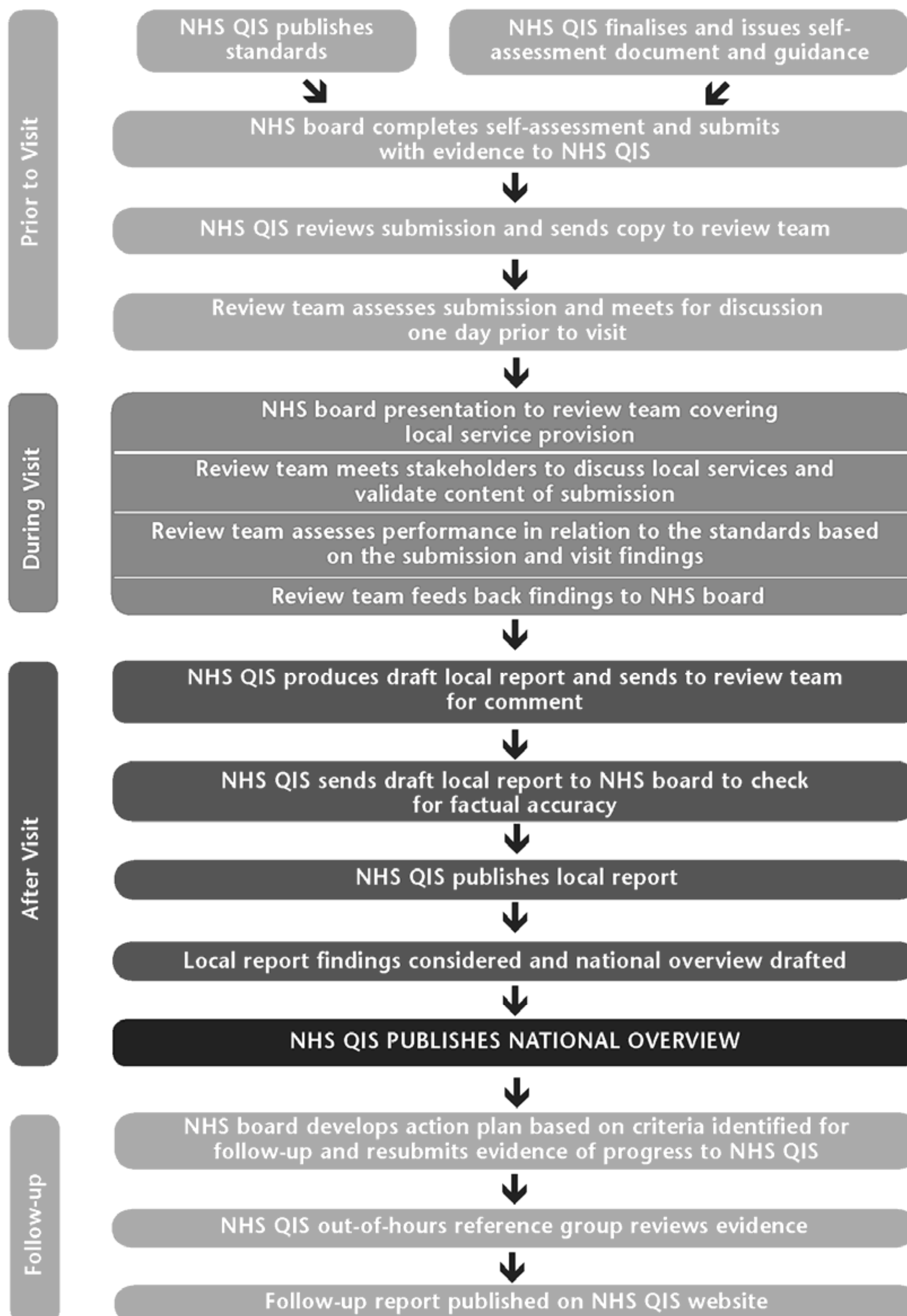
STATUS (2006): **An annual report on performance and services is produced, but not formally published.**

During the follow-up process, the reference group noted that the LUCS annual report, submitted as evidence at the time of the initial review, has since been circulated to senior staff in NHS Lothian, the community health partnerships (CHPs), patient involvement workers and partner organisations. The annual report is also available on the NHS Lothian website and the various internal intranet systems across NHS Lothian.

Appendix 1 – Glossary of abbreviations

Abbreviation	
CHP	community health partnership
GP	general practitioner
KSF	Knowledge and Skills Framework
LUCS	Lothian Unscheduled Care Service
MEHIP	Minority Ethnic Health Inclusion Project
NES	NHS Education for Scotland
NHS QIS	NHS Quality Improvement Scotland
PDP	personal development plan

Appendix 2 – Review process



Appendix 3 – Primary medical services out-of-hours reference group members

Chair

Ms Jane Bryce
Public Partner, Highland

Reference group members

Dr Ross Cameron
Medical Director, NHS Borders

Dr Liz Duncan
Associate Medical Director, NHS 24 (until August 2006)
Clinical Director Out-of-Hours Services, NHS Lanarkshire (from August 2006)

Ms Jennifer Hogg
Nurse Practitioner – NHS Ayrshire Doctors on Call (ADOC)

Dr Shiona Mackie
Divisional Medical Director, Lanarkshire Primary Care Division

Mrs Linda McGregor
Service Manager, Argyll & Clyde Primary Care Emergency Service (until October 2007)
Out-of-Hours Service Manager, NHS Lanarkshire (from October 2007)

Mr Martin Moffat
Branch Head, Scottish Government Health Directorate

Dr Marion Storrie
Clinical Director, Lothian Unscheduled Care Service

Dr Susan Taylor
General Practitioner, NHS Highland

Support from NHS QIS was provided by **Mr Steven Wilson** (Performance Assessment Team Manager), **Mrs Fiona Russell** (Senior Project Officer) and **Miss Jan Nicolson** (Project Officer).

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