

NHS Grampian

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](http://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 Grampian, and this report outlines progress made between the review visit on 22 February 2006 and September 2007, as assessed by the NHS QIS primary medical services out-of-hours reference group.

<b>Criteria identified for follow-up (2006)</b>
1(a)1 Arrangements are in place to identify the needs of those potentially using these services.
1(a)2: Arrangements are in place to meet the needs of those potentially using these services.
1(a)4 Access to, and delivery of services, is not compromised by physical, language, cultural, social, economic and other barriers.
2(a)1 Patient Focus: Throughout the service, work is undertaken in partnership with individuals, communities and community planning partners in the design, development and review of services. The results of this work are acted upon and feedback is provided to all those involved.
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)4 Clinical Governance: Service providers operate a system of risk management to ensure that risks are identified, assessed, controlled and minimised.
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(b)3 The service has drugs which are in date and equipment which is regularly maintained.
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)1 A set of provider-specific key performance indicators (patient-focused public involvement, clinical and organisational) are in place.
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 Grampian remains as:

### Registration status (2007)

**Provider is largely compliant 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 Grampian

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

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 Criteria

*1(a)1: Arrangements are in place to identify the needs of those potentially using these services.*

REVISED STATUS (2007): **Arrangements are in place to identify the needs of those potentially using the service, using a comprehensive system with a variety of information sources.**

STATUS (2006): **There are some arrangements in place to identify the needs of those potentially using the service.**

At the time of the 9-month follow-up review, the reference group noted that the out-of-hours service, Grampian Medical Emergency Department (G-MED), is utilising the NHS Grampian 'traffic lights' system to pinpoint areas and ongoing topics for action in relation to potential users' medical requirements in the out-of-hours period. Information from this system is used in conjunction with call management data to identify the top 10 presenting conditions, age group of users and clinical coding to appropriately develop the service provided. This information helps ensure that the appropriate resource is available for presenting conditions in the most appropriate areas. Additionally, it was noted that G-MED has moved from using its own local call management system to Adastra (an electronic specialist call management, data distribution and clinical recording system). Monthly reports can be produced through Adastra to aid service planning by identifying the needs of those using the out-of-hours service and most likely causes for use of G-MED.

At the time of the initial review visit, it was reported that a review of G-MED was planned for spring 2006 to determine whether the configuration of G-MED remained fit for purpose and examine whether further improvements could be made.

During the follow-up process, the reference group noted the G-MED report following this review. Report recommendations include the need for the development of a workforce plan and to further investigate the reasons underlying the increasing activity trend in the out-of-hours period. The report includes a service communication and involvement plan for 2006–2007.

*1(a)2: Arrangements are in place to meet the needs of those potentially using these services.*

**REVISED STATUS (2007): Arrangements are in place to meet the needs of those potentially using the service.**

**STATUS (2006): Arrangements are in place to meet the needs of some, but not all, of those potentially using the service.**

During the follow-up process, the reference group noted that G-MED is utilising the NHS Grampian traffic lights system to pinpoint areas and ongoing topics for action in relation to potential users' medical requirements in the out-of-hours period. Review of data from this system, as well as the first 6 months' data from Adastra, has identified areas of particular interest and demand on the service, which includes asthma, particularly asthma in children, and palliative care measures. As a result, G-MED is able to identify and act on common issues and meet the needs of those patients presenting with prevalent conditions to the service.

Subsequent educational events are being held covering these particular topics, providing learning for all levels of practitioner within the G-MED service as well as providing updates on acute management.

*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, Typetalk, a communication link for use by deaf or speech impaired callers, was introduced for use in G-MED. At the time of the 9-month follow-up review, the reference group noted that induction loop systems were now available in reception areas and portable loops are available for consultation rooms. A number of additional issues continue to be addressed, such as upgrading of signage.

Language Line, a telephone translation service, is to be introduced within G-MED, with training cards and instruction leaflets to ensure clinicians and operational staff make full use of the service.

Work is in progress in relation to the development of an NHS board-wide chaperone policy.

All community hospitals with an emergency centre have been assessed to ensure compliance with the Disability Discrimination Act 1995. Work is progressing to address non-compliance issues, notably the installation of induction loops and automated front door access.

## 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 Grampian

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)1: Patient Focus: Throughout the service, work is undertaken in partnership with individuals, communities and community planning partners in the design, development and review of services. The results of this work are acted upon and feedback is provided to all those involved.*

REVISED STATUS (2007): **Work is undertaken in partnership with individuals, communities and community planning partners in the design, development and review of services. The results of this work are not fully acted upon and/or feedback is not provided.**

STATUS (2006): **There is limited partnership working in the design, development and review of services.**

During the follow-up process, the reference group noted patient representation on the G-MED clinical governance group and management groups. Additionally, there was patient representation on the G-MED evolution group, which took responsibility for the review of G-MED.

G-MED is actively linking with the community health partnerships (CHPs) to discuss Adastra performance and demand reports. There is representation from the out-of-hours service on the integrated care group which meets monthly to consider delayed discharge.

The reference group noted work ongoing in relation to the planned G-MED website.

*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 across the service that direct and support policy development and service delivery both internally and through delivery partners, and the plans are monitored and regularly reviewed.**

**STATUS (2006): There are no clear, cohesive plans across the service that direct and support policy development and service delivery both internally and through delivery partners.**

At the time of the 9-month follow-up review, the reference group commended G-MED for the progress made in relation to the development of robust clinical governance arrangements. The G-MED clinical governance group has been established to discuss all aspects of clinical governance. Standing agenda items include complaints, clinical audit, key performance indicators and the risk control plan. The group meets monthly and has formally agreed its role, remit, membership and clinical governance framework, which was agreed in partnership with NHS Grampian's clinical governance team.

A G-MED clinical governance team workplan has been developed which identifies issues, actions, lead responsible and target dates. There is regular, formal reporting to NHS Grampian's clinical governance team through the sector reporting framework. This formally identifies areas of concern, progress against these, areas of achievement and recommendations.

*2(a)4: Clinical Governance: Service providers operate a system of risk management to ensure that risks are identified, assessed, controlled and minimised.*

**REVISED STATUS (2007): There is a system of risk management in place to ensure that risks are identified, assessed, controlled and minimised, which is fully implemented across the service.**

**STATUS (2006): A system of risk management is in place, but it is not formalised and/or is not formally implemented across the service.**

There is an NHS board-wide risk management policy, and it was reported at the time of the initial review visit that all associated policies and guidance were being introduced to the out-of-hours service on a planned basis.

At the time of the 9-month follow-up review, it was noted that the G-MED risk control plan has been in operation since December 2005 and is reviewed at senior management meetings. Progress is also monitored as a standing agenda item through the G-MED clinical governance group and this, in turn, is one of the sources that informs the G-MED clinical governance workplan.

During the follow-up process, it was reported that Datix, a new risk management system, was being rolled out across NHS Grampian. Staff training is under way to ensure staff report adverse events or near misses on the system.

The reference group noted the business continuity pre-planning document which will assist in identifying risks to the service and will facilitate the development of a strategy and action plans to deal with those risks.

*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.**

The G-MED clinical governance group has been established with invited representation including patient representatives, CHP representatives, NHS 24 and the Scottish Ambulance Service.

G-MED representatives attend local community and voluntary group meetings as and when necessary.

*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.**

Non-clinical staff attend the corporate NHS Grampian induction and orientation programme for new staff. At the time of the initial review visit, it was reported that there had been no recent new starts to G-MED and there was no formal induction process to G-MED for non-clinical staff. At the time of the 3-month follow-up review, the reference group noted that an induction programme for G-MED drivers had been developed.

During the follow-up process, it was reported to the reference group that all G-MED salaried medical staff are up to date with appraisals. This also covers non-GP principals working in G-MED.

By the end of the follow-up process, the reference group noted that non-clinical staff groups had appraisal systems and PDPs in place, based on the national NHS Knowledge and Skills Framework (KSF). This includes the traffic control team (traffic controller, operations managers and drivers) and reception staff.

## Standard 2(b): Safe and Effective Care – Clinical Care

### Standard Statement

*Clinical Care: Clinical guidelines are readily available to support clinical decision-making and facilitate delivery of quality services to patients.*

### NHS Grampian

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

OVERALL POSITION STATEMENT (2006): **Processes and procedures to support clinical decision-making are fully implemented, but monitoring has not yet commenced involving all parts of the organisation.**

### Essential Criterion

*2(b)3: The service has drugs which are in date and equipment which is regularly maintained.*

REVISED STATUS (2007): **The service has drug and equipment maintenance procedures in place which are formal and are fully implemented across the service.**

STATUS (2006): **The service has drug and equipment maintenance procedures in place, but these are not formalised and/or not fully implemented across the service.**

At the time of the 9-month follow-up review, the reference group noted pharmacy standard operating procedures which have been implemented for the management of ordering, receipt, storage and return of all medicines including controlled drugs for the G-MED service. A dedicated pharmacy technician for the out-of-hours service was appointed in February 2007.

At the time of the 3-month follow-up review, a draft proposal, which has been produced in relation to the purchasing of new defibrillators, was noted.

## 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 Grampian

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

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.**

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, it was confirmed that 'walk-in' patients (patients who present without having contacted NHS 24) are asked for consent and this is recorded within the newly implemented Adastra system.

## 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 Grampian

REVISED OVERALL POSITION STATEMENT (2007): **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.**

OVERALL POSITION STATEMENT (2006): **Processes for auditing, monitoring and reporting on the out-of-hours service are being developed, but implementation has either not yet commenced, or has commenced but does not involve all parts of the organisation.**

### Essential Criteria

*3(a)1: A set of provider-specific key performance indicators (patient-focused public involvement, clinical and organisational) are in place.*

REVISED STATUS (2007): **A full or part set of provider-specific key performance indicators has been developed and implemented within the organisation.**

STATUS (2006): **A full or part set of provider-specific key performance indicators has been developed, but not implemented within the organisation.**

During the follow-up process, the reference group noted that clinical performance was now measurable in relation to time stratification on call types as set by the triaging nurse at NHS 24. Reports are used monthly to assess performance, measure improvement and to alert G-MED to areas of adverse performance in order to initiate appropriate action plans.

Additionally, work is ongoing with corporate communications in relation to patient focus public involvement work (PFPI) and engaging with the wider public.

*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 the pilot patient experience survey based on two questionnaires conducted in September 2006. One questionnaire gathered information from patients who were seen for assessment and

treatment at the G-MED centres within the Grampian area; the second questionnaire was given to patients who were visited at home by a health professional from one of the G-MED centres. The patient experience survey was subsequently rolled out in November 2006. The reference group was presented with the draft survey report which includes an action plan based on findings. It was noted that the report is to be distributed by the NHS board's clinical effectiveness department and cascaded throughout NHS Grampian. Service users will be informed of survey results through a poster campaign in waiting areas across the service. The patient experience survey is to be undertaken on an annual basis.

*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): No annual report on performance and services is produced.**

During the follow-up process, the reference group was presented with the NHS board's annual report in which there was a section relating to unscheduled care and the out-of-hours service. In addition, a separate, distinct report for the G-MED out-of-hours service has been produced for 2006–2007, containing more detailed information relating to performance, services and activity levels. By the end of the follow-up process, this report had been circulated to all CHP leads, operational directorates within NHS Grampian and all partner agencies including NHS 24 and the Scottish Ambulance Service. The report is also available on the internet.

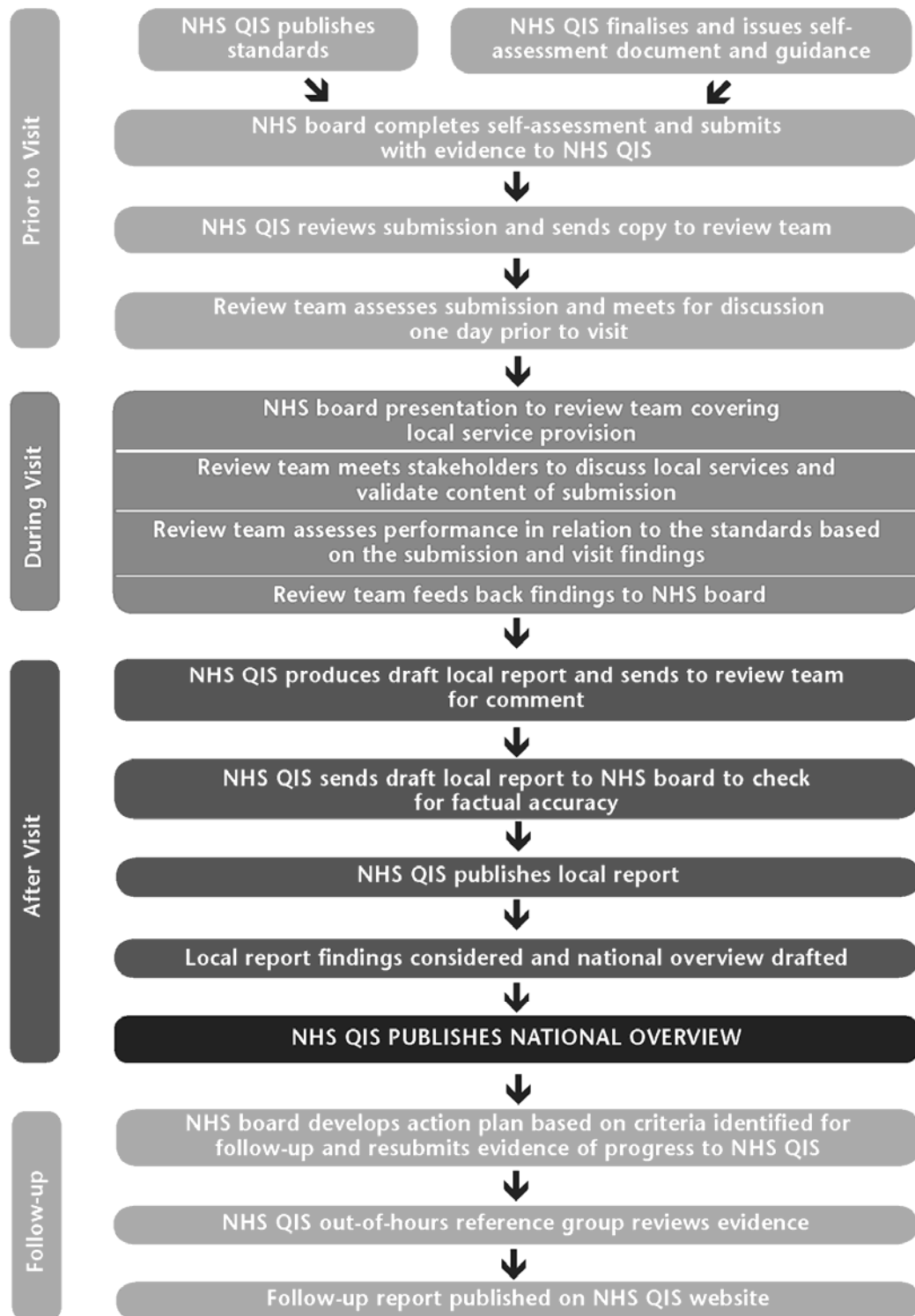
## Appendix 1 – Glossary of abbreviations

### Abbreviation

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<b>CHP</b>	community health partnership
<b>G-MED</b>	Grampian Medical Emergency Department
<b>GP</b>	general practitioner
<b>KSF</b>	Knowledge and Skills Framework
<b>NHS QIS</b>	NHS Quality Improvement Scotland
<b>PDP</b>	personal development plan
<b>PFPI</b>	patient focus public involvement

## 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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