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NHS Lanarkshire

Follow-up Report ~ December 2007

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

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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 Lanarkshire, and this report outlines progress made between the review visit on 2 November 2005 and July 2007, as assessed by the NHS QIS primary medical services out-of-hours reference group.

Criteria identified for follow-up (2006)
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)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)4 Clinical Governance: Service providers operate a system of risk management to ensure that risks are identified, assessed, controlled and minimised.
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 organisations.
2(a)8 Staff Governance: Staff are competent to perform their duties.
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.

Future monitoring

The criteria detailed in the table below are the areas where the service remains non-compliant at the end of the follow-up process. The NHS board is responsible for ensuring compliance against these criteria, and continuing to monitor its own progress on performance against the standards.

Criteria identified for follow-up (2007)
2(a)6 Clinical Governance: Arrangements are in place to communicate, inform and co-operate with key professionals, external parties and voluntary organisations.
2(a)8 Staff Governance: Staff are competent to perform their duties.

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 Lanarkshire 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 Lanarkshire

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 9-month follow-up review, the reference group noted the work that was ongoing to integrate the clinical outcome codes used by the Adastra computer system (an electronic specialist call management, data distribution and clinical recording system) to facilitate the identification of the needs of those potentially using the service. As Adastra continues to be refined, it is anticipated that more detailed performance reports will be available to facilitate review. By early 2007, statistics reports were being tabled at the 2-monthly quality and standards group meetings. Evidence was provided of data analysis being undertaken and recommendations being made of approaches for future planning in response to this.

Following on from the public consultation on the NHS Lanarkshire-wide health strategy, Picture of Health, at the time of the 9-month follow-up review, further public consultation had begun with hospital-based services to consider patients' unscheduled care needs. The out-of-hours service will be jointly developing a recommendation on how unscheduled care will be delivered from new community casualties both in-hours and out-of-hours.

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.**

At the 9-month follow-up review, the reference group noted that an NHS 24 satellite centre was operating from Hairmyres District General Hospital, East Kilbride. Patients are triaged either by NHS 24 or, during peak periods, by Lanarkshire-based nursing staff at the satellite centre. A new dental triage service is also offered. Multidisciplinary care is now provided by trained nurses as well as doctors in the primary care emergency centres. All nurse practitioners working in these centres have been trained in minor illness, minor injury and extended nurse prescribing.

The reference group noted that a patient satisfaction survey had been conducted jointly with NHS 24 in November 2006.

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.**

At the 12-month follow-up review, the service reported that all local service-specific arrangements had been put in place to ensure compliance with the Disability Discrimination Act 1995.

A review of patient leaflets and information had been undertaken, which resulted in a direct link being established on all computers with the NHS Prodigy website. This website provides up-to-date evidence-based information for patients. In addition, electronic links are now available to a library of patient leaflets in other languages. The content includes comprehensive information on a number of elective procedures and common ailments and conditions, which have been translated into 12 languages, including Punjabi, Urdu, Bengali, Gujarati, Somali and Polish. The service now also uses leaflets in community languages issued by NHS 24 and NHS Direct.

A single chaperone policy has now been developed which, in June 2007, was awaiting ratification.

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 Lanarkshire

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

OVERALL POSITION STATEMENT (2006): **A comprehensive, patient-focused healthcare governance programme is being developed, but implementation has either not yet commenced, or has commenced but does not involve 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.**

At the end of the follow-up process, the reference group noted the work that had been undertaken to ensure the continuation of partnership working in the ongoing development and review of the out-of-hours service.

Since the review visit in 2005, there have been ongoing developments in the provision of healthcare services across NHS Lanarkshire. The out-of-hours service has been integrated into the wider unscheduled care service and systems have been put in place within this wider service to ensure that work is undertaken in partnership.

The out-of-hours service is hosted by the Clydesdale locality which forms part of the South Lanarkshire community health partnership (CHP). Operational issues are considered at the locality management meetings and, where appropriate, are brought to the South Lanarkshire CHP management team meetings. The out-of-hours executive group also meets monthly. Representation on this group includes relevant

partners, including the Scottish Ambulance Service, NHS 24, community nursing, community dentistry, and accident and emergency (A&E).

NHS Lanarkshire's plans for the future, as outlined in the document Picture of Health, focus on redesigning hospital services, moving care into the community and enhancing primary care. The plans are now being implemented and the out-of-hours service is actively contributing to the clinical and service modelling process, particularly in relation to emergency medicine, which also covers A&E, and primary care modernisation. There is consultation with the public on these plans. Stakeholder meetings have also been held as part of this process, and include health and social services, the Scottish Ambulance Service, NHS 24, and the general public.

Patient focus and public involvement (PFPI) groups have also been established in both North and South Lanarkshire CHPs, and it was reported that it will now be possible for the out-of-hours service to engage with these groups on a regular and planned basis.

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 for the patients and their representatives in a variety of formats and languages.**

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 3-month follow-up review, the service reported that an NHS board-wide review of patient information leaflets had been undertaken and had resulted in a direct link being set up to the NHS Prodigy website on all computers. This website provides up-to-date evidence-based information. By June 2007, electronic links had been made available to a library of leaflets in other languages which staff can print off and give directly to patients. Leaflets in community languages issued by NHS 24 and NHS Direct are also used when required.

A patient leaflet containing out-of-hours service-specific information is under development. In addition, the feasibility of an internet web page or link for patients to access information regarding their care or treatment is being investigated.

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 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 initial review, the service reported that it was waiting for clarification on the arrangements for CHPs prior to establishing a clinical governance structure for the service. At the end of the follow-up process, the reference group was reassured that clinical governance structures had been put in place. A local clinical governance group, the quality and standards group, had been established. Membership of this group includes relevant internal and delivery partners. The quality and standards group submits monthly reports to the NHS board, regularly reviews complaints and feeds back outcomes to staff, develops protocols and key performance indicators, and conducts audits relating to dentistry and pharmacy. The out-of-hours executive group continues to meet monthly and clinical governance issues are also discussed. In July 2007, work was under way on the work plan for 2007–2008.

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.**

The out-of-hours service continues to follow the corporate risk management strategy to identify and assess risks. The risk management IT system, Datix, is used to support the out-of-hours risk register and enable monitoring of risks, clinical incidents and complaints.

At the 3-month follow-up review, the service confirmed that the risk register is reviewed and updated on a 6-monthly basis. Reviews are carried out by the quality and standards group before being passed to the out-of-hours executive group to action.

The risk management system was in the early stages of being monitored. Regular audits of nursing and doctor records were planned, and audit criteria were being

developed to be presented to the quality and standards group. It was reported that a pilot audit of out-of-hours e-records was under way.

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): **A system is in place to report to the NHS board clinical governance committee, but it is on an ad hoc basis.**

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

The reference group noted that, by September 2006, systems had been developed to report to the NHS board clinical governance committee. The quality and standards group had been set up and minutes from this group are submitted to the joint CHP clinical effectiveness and risk committee, which meets on a 2-monthly basis. The minutes are also submitted to the NHS Lanarkshire health and clinical governance steering committee.

However, at the time of submission of the action plan, the reference group considered that there was insufficient evidence of regular reporting to the NHS board clinical governance committee due to the early stage of establishment of the relevant committees.

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): **No change.**

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

During the follow-up review process, the service cited a variety of ways in which clinical governance activity in the out-of-hours service is communicated to key professionals, external parties and voluntary agencies. However, the evidence provided, particularly in relation to voluntary agencies, was largely anecdotal.

The reference group noted the facilitated stakeholder away day that had been held in February 2006. The service anticipates that this will be an annual event involving members of the out-of-hours staff, social service carers, NHS 24, and members of the public. The service reported that an outcome of this day is the production of a 6-monthly newsletter to inform staff and the public of continual development within the out-of-hours service.

There are regular meetings with salaried GPs and nurses working in the out-of-hours service, with minutes sent to relevant staff. It was reported that it was the intention to inform other agencies through the CHP management reports.

It was noted that the quality and standards group includes membership from relevant internal and delivery partners. In addition, it was reported that other relevant stakeholders are involved in meetings, for example acute services and specialist services such as child protection and the procurator fiscal. Minutes of these meetings are reported at the primary care clinical effectiveness committee.

It was reported that closer links with patient participation groups will be able to be developed through the establishment of the CHPs. However, by the end of the follow-up process, the reference group did not consider that sufficient evidence had been submitted to demonstrate that arrangements are yet in place to communicate, inform and co-operate with voluntary organisations.

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

REVISED STATUS (2007): **No change.**

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

The service reported that all salaried doctors working in the out-of-hours service received an appraisal during 2006 from an approved appraiser as part of NHS Lanarkshire's GP appraisal scheme.

The reference group noted that the national NHS Knowledge and Skills Framework (KSF) for non-clinical staff was agreed by May 2007. It was reported that the lead nurse had introduced regular performance management and supervision sessions for all nursing staff employed in the out-of-hours service. This is seen as a supplement to PDPs. Between May–July 2007, 65% of senior nursing staff had participated in an individual performance management interview to review education, training and skills in relation to their current roles, and to explore and agree future development needs. These nurses are responsible for undertaking PDPs for their staff. The reference group considered there to be good evidence of clinical training in place for nursing staff.

However, while the reference group acknowledged the progress being made against this criterion, it did not consider there to have been sufficient evidence submitted to demonstrate that PDPs had either been carried out or were scheduled for all staff working in the out-of-hours service.

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 Lanarkshire

REVISED OVERALL POSITION STATEMENT (2007): **Processes for auditing, monitoring and reporting on the out-of-hours service are fully implemented, but monitoring has not yet 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): **No provider-specific key performance indicators have yet been developed.**

At the time of the 9-month follow-up review, a part set of provider-specific key performance indicators had been developed. The reference group agreed that these indicators are primarily clinical and organisational. The out-of-hours service is monitored monthly with a subsequent report on activity sent to the NHS Lanarkshire board.

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.**

At the 9-month follow-up review, the reference group noted that a programme of patient satisfaction surveys had been instigated, the first having been undertaken in February 2006. A further patient satisfaction survey was undertaken in collaboration with NHS 24 in November 2006.

In addition, it is intended to hold an annual facilitated service stakeholder away day involving members of the out-of-hours service staff, social service carers, NHS 24 and members of the public. The first event was held in February 2006. It is planned to develop closer links with patient participation groups following the establishment of CHPs.

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.**

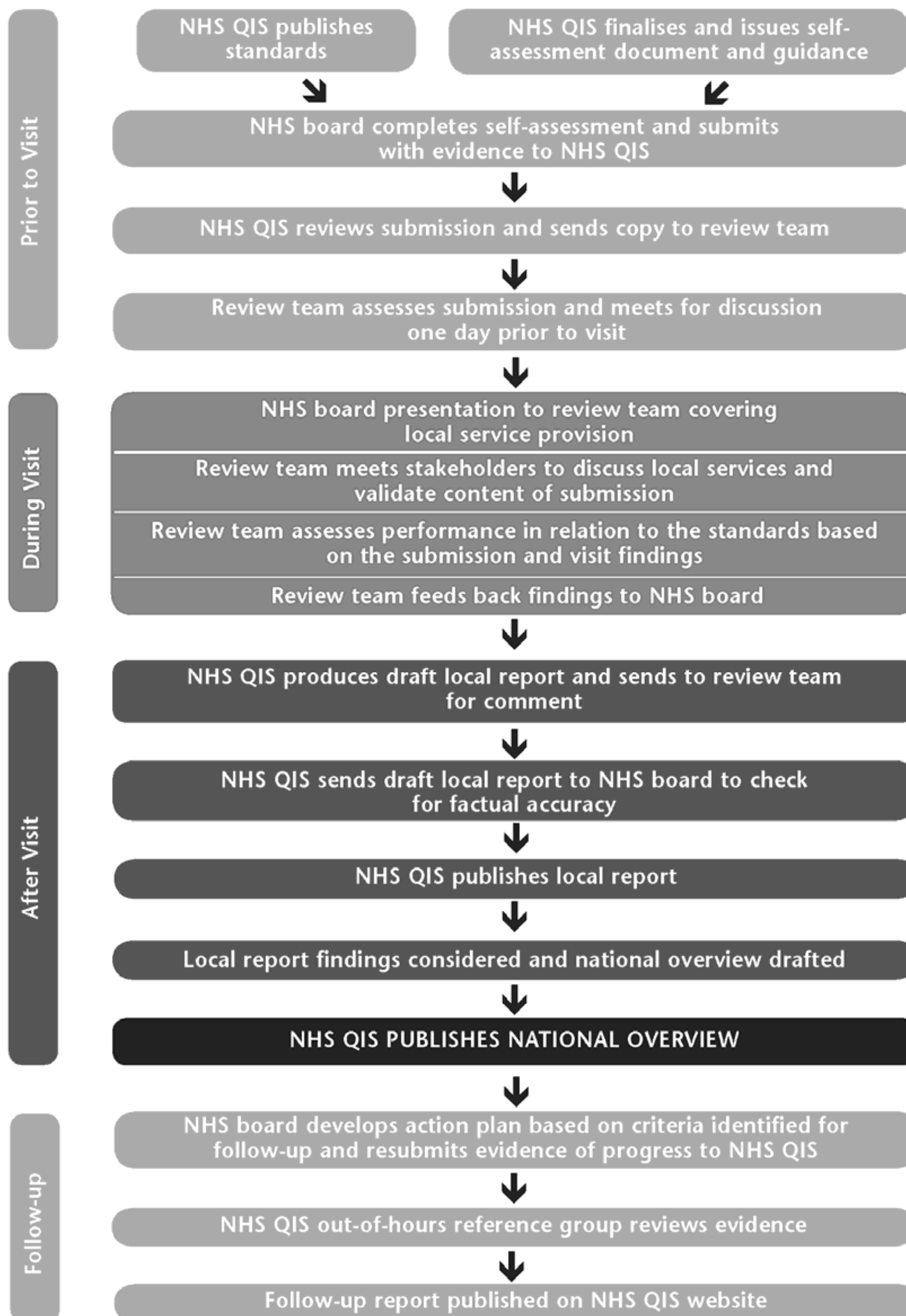
STATUS (2006): **No annual report on performance and services is produced.**

At the 12-month follow-up review, the reference group noted that a formal annual report on performance and services had been published on the NHS Lanarkshire website. This report was also distributed to a number of committees including the North and South CHP operating committees.

Appendix 1 – Glossary of abbreviations

Abbreviation	
A&E	accident and emergency
CHP	community health partnership
GP	general practitioner
KSF	Knowledge and Skills Framework
NHS QIS	NHS Quality Improvement Scotland
PDP	personal development plan
PFPI	patient focus and 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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