

NHS Orkney

Follow-up Report ~ December 2007

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

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NHS Quality Improvement Scotland (NHS QIS) is committed to equality and diversity. We have assessed the performance assessment function for likely impact on the six equality groups defined by age, disability, gender, race, religion/belief and sexual orientation. For this equality and diversity impact assessment, please see our website (www.nhshealthquality.org). The full report in electronic or paper form is available on request from the NHS QIS Equality and Diversity Officer.

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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 Orkney, and this report outlines progress made between the review visit on 22 March 2006 and September 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)4 Clinical Governance: Service providers operate a system of risk management to ensure that risks are identified, assessed, controlled and minimised.
2(a)8 Staff Governance: Staff are competent to perform their duties.
2(a)9 Corporate Governance: All out-of-hours providers have systems in place that ensure financial probity.
2(b)1 Procedures are in place to ensure quick and easy access to evidence-based clinical guidelines to support clinical decision-making.
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.

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

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 Orkney has been amended to:

Registration status (2007)

Provider is largely compliant with the standards.

Registration status (2006)

Provider has achieved partial compliance 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 Orkney

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 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.**

At the time of the 3-month follow-up review, it was noted that an ethnic minority community-based working group had been established, and work was being undertaken to review and translate patient information leaflets for use locally. Interpreter cards are being sourced and clinical assessment frequently asked questions (FAQs) are being developed which will be translated into local foreign languages. Additionally, the reference group noted that Language Line, a telephone translation service, was now available in all GP practices and the outpatient departments.

At the time of the 12-month follow-up review, the reference group noted that induction loops are now available in healthcare premises. It was noted that an NHS board disability equality scheme and action plan, which includes sensory impairment, has been developed.

By the end of the follow-up process, plans to introduce a chaperone policy had been submitted to the NHS board's equality and diversity committee.

During the follow-up process, the reference group noted the ongoing scheme of improvements to buildings and access in relation to compliance with the Disability Discrimination Act 1995.

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 Orkney

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)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): **No change.**

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 was no computer or internet access readily available for use by the out-of-hours GP to enable access to national and condition-specific patient information websites and leaflets. During the follow-up process, the reference group noted the introduction of a wireless laptop in April 2007 for use by the out-of-hours GP. By the end of the follow-up process, a portable printer was reported to have been requested to enable the out-of-hours GP to print information from any location.

It was reported that a list of patient information leaflets available in the outpatient department of Balfour Hospital, Kirkwall, and in GP practices was being compiled. Consideration could be given to creating a register of most frequently accessed patient information leaflets and providing a readily accessible supply of leaflets of most common conditions for use by the out-of-hours GP during home visits.

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.

During the follow-up process, the reference group noted that the out-of-hours service is now managed by the primary care manager who reports to the community health partnership (CHP) general manager. The CHP general manager is a member of the NHS board's clinical governance team, which is chaired by the medical director. This team, in turn, reports to the NHS board's clinical governance, risk management and health & safety committee. The clinical governance team has approved the NHS board's clinical governance implementation and development plan. Additionally, a draft NHS board clinical governance reporting framework has been produced.

Monthly meetings are held between key staff from the out-of-hours service and partner organisations, including NHS 24 and the Scottish Ambulance Service. Clinical governance is a standing agenda item, as is feedback from each partner agency and consideration of any incident reports (IR1s) or equivalent logged by any of the organisations. The primary care manager is responsible for reporting monthly, through the CHP general manager, to the clinical governance team on activity and identified issues from these meetings.

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.

During the follow-up process, the reference group noted the formal appointments of the CHP general manager and primary care manager who will take the lead with the out-of-hours service. Risks identified relating to the out-of-hours service are investigated by the primary care manager and are processed through the appropriate channels. A clinical governance and risk management action plan has been produced.

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): Processes and procedures are not in place to demonstrate that staff are competent to perform their duties.

At the time of the initial review visit, there was a regular pool of locums, employed through a locum recruitment agency, who worked in the out-of-hours service in NHS Orkney. During the follow-up process, the reference group noted that there is now one permanent GP working in the out-of-hours service, and additional sessional local GPs. Locum agencies are only used in exceptional circumstances and in co-operation with NHS Highland's out-of-hours service for governance purposes. NHS Orkney reported that additional permanent staff are to be recruited over time. All GPs are subject to annual appraisal and review. There are no other staff directly employed in the out-of-hours service. All GPs working in the out-of-hours service are required to have attended, or are planning to attend, British Association of Immediate Care (BASICS) training.

Work is being undertaken with the Scottish Ambulance Service to consider an enhanced role for paramedic staff.

2(a)9: Corporate Governance: All out-of-hours providers have systems in place that ensure financial probity.

REVISED STATUS (2007): A system to ensure financial probity is fully implemented throughout the service.

STATUS (2006): A system to ensure financial probity is in place, but it is not formalised and/or not fully implemented across the service.

At the time of the 12-month follow-up review, the reference group noted that the process for locum payment arrangements had been formalised and a tariff of fees formally issued to all employed doctors providing out-of-hours services. The primary care manager is responsible for authorisation of timesheets and submission to payroll.

Due to the length of time the out-of-hours service has been operational, there have been, as yet, no internal audits of the out-of-hours service. During the follow-up process, the reference group noted plans for an annual internal audit of the service which will be undertaken by the primary care manager commencing in autumn 2007.

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 Orkney

REVISED OVERALL POSITION STATEMENT (2007): **Processes and procedures to support clinical decision-making are fully implemented, but monitoring has not yet commenced involving all parts of the organisation.**

OVERALL POSITION STATEMENT (2006): **Processes and procedures to support clinical decision-making are being developed, but implementation has either not yet commenced, or has commenced but does not involve all parts of the organisation.**

Essential Criteria

2(b)1: Procedures are in place to ensure quick and easy access to evidence-based clinical guidelines to support clinical decision-making.

REVISED STATUS (2007): **Procedures are in place for quick and easy access to evidence-based guidelines.**

STATUS (2006): **Procedures are being developed to enable quick and easy access to evidence-based guidelines.**

At the time of the initial review visit, there was no computer or internet access readily available for the out-of-hours GP to quickly and easily access evidence-based clinical guidelines. The out-of-hours GP carried a selection of hard copy clinical guidelines and guidance in the out-of-hours GP bag.

During the follow-up process, the reference group noted the introduction of a wireless laptop in April 2007 for use by the out-of-hours GP, thus allowing immediate electronic accessibility of national guidance and guidelines.

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.

During the follow-up process, the reference group noted that the drug box is maintained by the hospital chief pharmacist. Drugs are now securely stored in the outpatients department and stock control operates through the hospital pharmacy. Pharmacy services are responsible for agreeing the content, storage, monitoring and replacement procedures for drugs used in the out-of-hours period. Prior to April 2007, Scapa GP practice had been responsible for restocking and maintaining the drug box.

Equipment lists for immediate and emergency care were agreed in April 2007. A 'sandpiper' bag containing lifesaving emergency medical equipment is in use by the out-of-hours GP. At the time of the 12-month follow-up review, it was reported that a dedicated out-of-hours vehicle has been supplied by the Scottish Ambulance Service on a 6-month trial basis, with full satellite navigation and communications equipment on board. Work is under way to identify a dedicated driver who would have responsibility for the day-to-day maintenance and use of this vehicle.

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 Orkney

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, the reference group noted that processes had changed since the initial review visit in that patients who telephone Balfour Hospital directly to access the out-of-hours service are now transferred to NHS 24. Additionally, at the time of the 12-month follow-up review, the reference group noted a draft consent policy for 'walk-in' patients (patients who present without having contacted NHS 24) advising patients that they must contact NHS 24 in the first instance.

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 Orkney

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 but not implemented within the organisation.**

STATUS (2006): **No provider-specific key performance indicators have yet been developed.**

By the end of the follow-up process, the reference group was presented with a key performance indicators monitoring report which had been completed for the out-of-hours service. The reference group considered this to relate more to the overall performance management of the service, but noted that this should provide a starting point and focus for the continued development of measurable key performance indicators relating to patient-focused public involvement, clinical and organisational aspects specific to the out-of-hours service.

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

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

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 that a patient satisfaction survey is planned following the expansion of the out-of-hours service to include the mainland and linked south isles as this will provide more statistically meaningful data,

covering approximately 12,000 patients. It is anticipated that this will be undertaken as part of the annual internal audit which is to be undertaken in autumn 2007.

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): **No change.**

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

During the follow-up process, the reference group noted that an annual report on the out-of-hours service was to have been prepared in July 2007 covering the period June 2006–June 2007. This was to incorporate development of the service plus 3 months of the expanded service and future plans. This has since been delayed until November 2007 and will be produced following the annual internal audit which is to be undertaken in autumn 2007.

Appendix 1 – Glossary of abbreviations

Abbreviation

BASICS British Association of Immediate Care

CHP community health partnership

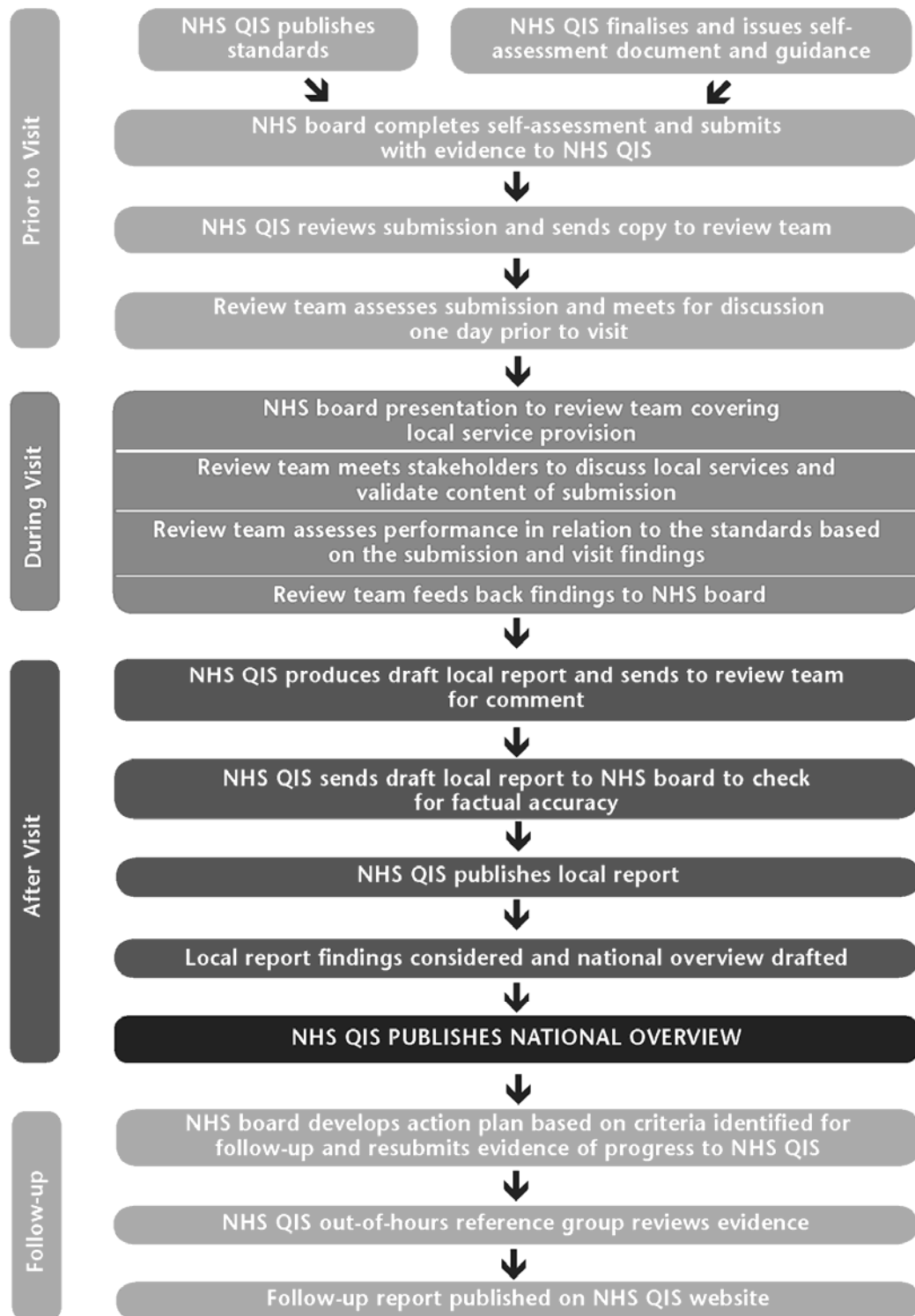
FAQ frequently asked question

GP general practitioner

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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