NHS
Quality Improvement Scotland

NHS Argyll & Clyde

Local Report ~ March 2006

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

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Out-of-hours services are intended to provide access to a healthcare professional in situations where the patient's clinical condition is such that it cannot wait until the next day. The NHS Quality Improvement Scotland (NHS QIS) Primary Medical Services Out-of-Hours Project Group concentrated on ensuring that out-of-hours services will be accessible, acceptable, available and responsive. The Project Group developed three standards covering: accessibility and availability at first point of contact; safe and effective care; and audit, monitoring and reporting. This report presents the findings from the peer review of performance against the standards.

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1 Setting the Scene

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. We do this by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

About this Report

The *Standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours* were published in August 2004. These standards are being used to assess the quality of services provided by NHSScotland nationwide.

This report presents the findings from the peer review of **NHS Argyll & Clyde**. This review visit took place on **22 September 2005**, and details of the visit, including membership of the review team, can be found in Appendix 3.

1.1 How the Standards were Developed

From 1 April 2004, the Primary Medical Services (Scotland) Act 2004 placed a duty on NHS Boards to provide 'primary medical services' for everyone living in the NHS Board area. GPs can continue to provide services during the out-of-hours period or can opt out of providing services during the out-of-hours period on condition that acceptable alternative services can be provided by the NHS Board. 'Out-of-hours' is defined in legislation as 6.30pm to 8.00am weekdays, weekends and public holidays. Local arrangements may vary.

In January 2004, a Primary Medical Services Out-of-Hours Project Group was established and chaired by The Very Reverend Graham Forbes CBE. Membership of the Project Group included both healthcare professionals and members of the public (see Appendix 4).

The Project Group oversaw the development of, and consultation on, the standards. In addition, it was responsible for recommending an external peer review process.

In July 2005, the Primary Medical Services Out-of-Hours Reference Group was established comprising healthcare professionals and members of the public (see Appendix 5). The Reference Group advises on the implementation and monitoring of the review process, and oversees:

- reviewing performance against the standards throughout Scotland, using self-assessment and external peer review, and

- reporting the findings from the review, and assigning registration status.

The draft primary medical services out-of-hours standards aimed to build on existing evidence and good practice. A Scotland-wide consultation process was then undertaken, during which the views of health service staff and the public were sought. The final standards were published in August 2004 and, subsequently, piloted at three NHS Boards: NHS Ayrshire & Arran, NHS Grampian and NHS Highland.

In September 2004, the Scottish Executive Health Department (SEHD) issued HDL(2004)41, NHS Quality Improvement Scotland: Standards for the Provision of Safe and Effective Primary Medical Services Out-of-Hours, outlining the action required by NHS Board chief executives on receipt of these standards and associated guidance from NHS Quality Improvement Scotland (NHS QIS). From 1 January 2005, all providers of primary medical services in the out-of-hours period must comply with standards developed by NHS QIS. This is a statutory requirement as set out in HDL(2004)41. All NHS Boards were asked to submit a completed registration application form to NHS QIS for each provider in their area. Each provider has received confirmation of their conditional registration with NHS QIS and their registration number.

1.2 How the Review Process Works

Types of Service Provision

There are two main types of out-of-hours service provision:

1 NHS Boards can provide out-of-hours services directly (sometimes referred to as direct provision). NHS QIS is responsible for reviewing performance against the standards for all NHS Boards directly providing primary medical services out-of-hours.

2 NHS Boards can also make arrangements (by contract or agreement) with a range of providers (sometimes referred to as level 1 provision) through:

- a General Medical Services (GMS) contract – nationally negotiated with some local flexibility for GPs to opt out of certain services or opt in to the provision of other services
- a Section 17C (formerly known as Personal Medical Services or PMS) agreement – locally negotiated agreements which are more flexible in accordance with local circumstances, and
- a Health Board Medical Services contract – the NHS Board can, in certain circumstances, make arrangements with, for example, a non-NHS organisation for the provision of NHS services.

Review Process for Direct Providers

The review process has two key parts: local self-assessment followed by external peer review. First, each NHS Board assesses its own performance against the standards. An external peer review team then further assesses performance, both by considering the self-assessment data and visiting the NHS Board to validate this information and discuss related issues. The review process is described in more detail below (see also the flow chart on page 11).

Review Process for Level 1 Providers

NHS Boards have a responsibility to review performance against the standards for any level 1 providers in their area, and report back to NHS QIS through the direct providers' review process. The review process mirrors that for direct providers. Each level 1 provider assesses its own performance against the standards using the self-assessment tool. The Board then further assesses performance, by considering the self-assessment data and visiting the provider to validate this information and discussing related issues. A summary of the Board's progress in reviewing any level 1 providers in its area can be found in Section 2.1.

Self-Assessment by NHS Boards

On receiving the standards, each NHS Board assesses its own performance using a framework produced by NHS QIS. This framework includes guidance about the type of evidence (eg guidelines, audit reports) required to allow a proper assessment of performance against the standards to be made.

The NHS Board submits the data it has collected for this self-assessment exercise to NHS QIS before the on-site visit, and it is this information that constitutes the main source of written evidence considered by the external peer review team.

External Peer Review

An external peer review team then visits and speaks with local stakeholders (eg staff, patients, carers) about the services provided. Review teams are multidisciplinary, and include both healthcare professionals and members of the public. All reviewers are trained. Each review team is led by an experienced reviewer, who is responsible for guiding the team in its work and ensuring that team members are in agreement about the assessment reached.

The composition of each team varies, and members have no connection with the NHS Board they are reviewing. Both of these factors facilitate the sharing of good practice across NHSScotland, and ensure that each review team assesses performance against the standards rather than make comparisons between one NHS Board and another.

At the start of the on-site visit, the review team meets key personnel responsible for the service under review. Reviewers then speak with local stakeholders about the services provided. After these meetings, the team assesses performance against the standards, based on the information gathered during both the self-assessment exercise and the on-site visit.

The visit concludes with the team providing feedback on its findings to the NHS Board, and informing the NHS Board of its registration status. The feedback includes specific examples of local initiatives drawn to the attention of the review team (recognising that other such examples may exist), together with an indication of any particular challenges.

Position Statements

Each review team assesses performance using a quality improvement tool comprising position statements for each criterion, standard statement and overall performance. This quality improvement tool enables the review team to assess how an NHS Board is 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 NHS Board will also use the position statements to assess the performance of its level 1 providers.

The most appropriate position statement is agreed by the review team to describe an NHS Board's current position against each criterion. This then allows 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.

The quality improvement tool used to assess out-of-hours providers is available via the NHS QIS website – www.nhshealthquality.org

Follow-up Process

Where improvement in performance against particular criteria is required (as identified in Appendix 1), the NHS Board is required to develop an action plan detailing action to be taken against each criterion and timescales for completion. This action plan, along with an initial progress report is to be submitted to NHS QIS 3 months from receipt of the final local report. All action has to be taken by July 2007.

As the deadlines for action are reached, the NHS Board will resubmit the evidence to support its progress to NHS QIS, detailing what work has been undertaken to meet the identified criteria. This resubmitted evidence will then be analysed and reviewed by the NHS QIS Out-of-Hours Reference Group. Once all reviews of a Board's resubmitted evidence have been carried out, any necessary amendments to the status of the position statements will be made; the accompanying detailed findings in Section 4 of the local report will be updated and published on the NHS QIS website. In most instances, these reviews will not require a visit to the NHS Board to further assess performance; however, a review visit may be carried out if deemed necessary by the Reference Group.

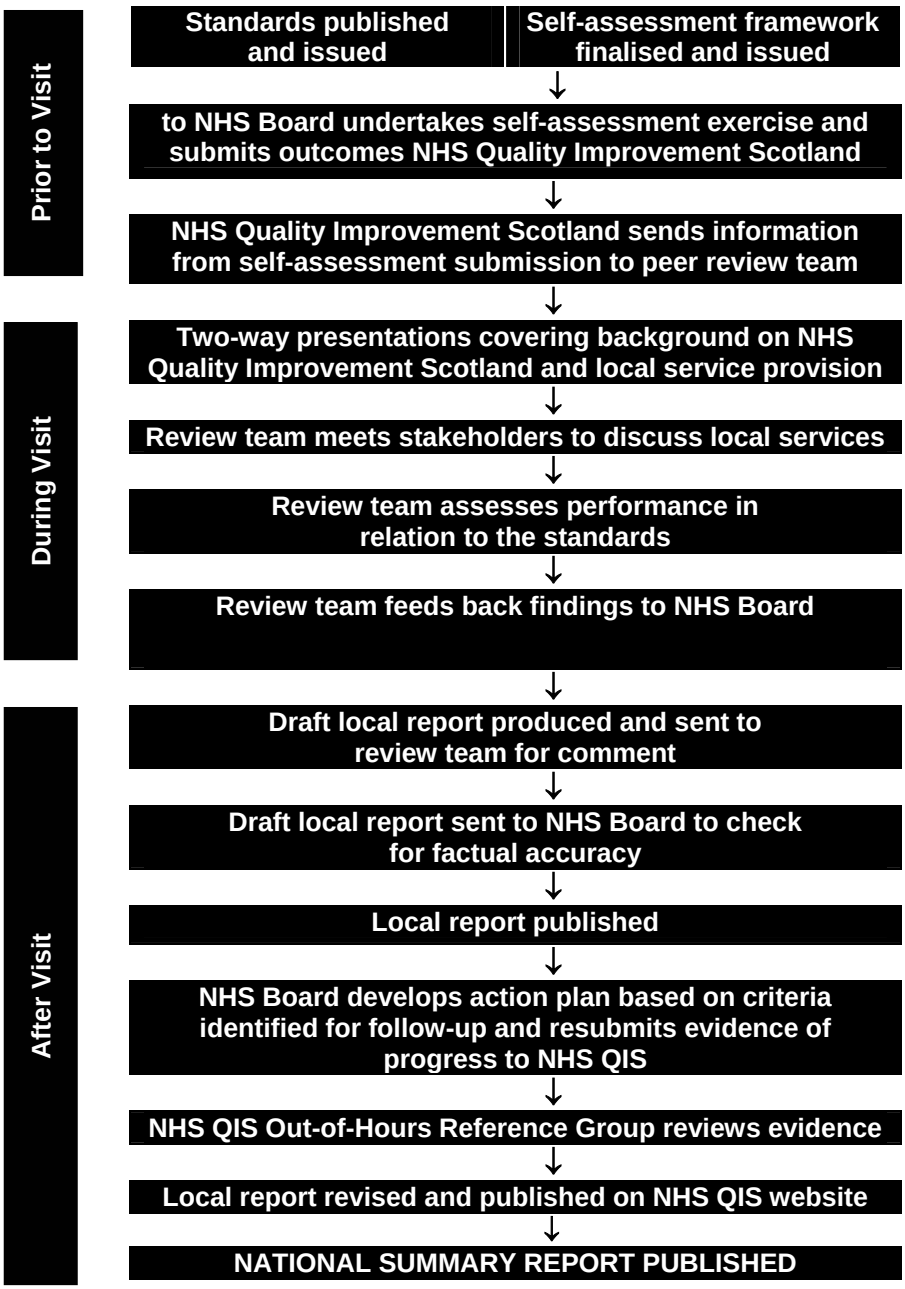
1.3 Reports

After each review visit, NHS QIS staff, with clinical input as appropriate, draft a local report detailing the findings of the review team. The draft report will also include a detailed resubmission schedule for those criteria or standards that require action and follow-up. This draft report is sent to the review team for comment, and then to the NHS Board to check for factual accuracy. The local report will then be published and made available on the NHS QIS website. Any necessary addendums to the local report, as a result of any follow-up action, will also be published on the NHS QIS website.

Once the initial national review cycle is completed, a report summarising national performance will be prepared. This document includes both a summary of the findings (highlighting examples of local initiatives and challenges for the service) and recommendations for improvement.

Part of the remit of NHS QIS is to report whether the services provided by NHSScotland, both nationally and locally, meet the agreed standards. This does not include reviewing the work of individual healthcare professionals. In achieving this aim, variations in practice (and potential quality) within a service will be encountered and subsequently reported.

The Review Process



2 Summary of Findings

2.1 Overview of Local Service Provision

Local NHS System and Services

Argyll & Clyde is situated in west-central Scotland and has a population of around 415,658. It is a region of contrasts, where the majority of the population live in densely populated urban areas, some of which have high levels of illness and deprivation. However, a significant proportion of the population live in remote and rural areas and on island locations.

Argyll & Clyde NHS Board is responsible for improving the health of the local population and for the delivery of the healthcare required. It provides strategic leadership and has responsibility for the efficient, effective and accountable performance of the NHS in Argyll & Clyde.

At the time of the review visit, NHS Argyll & Clyde contained three NHS operating divisions, each of which provide acute and primary care services: Inverclyde Division; Greater Renfrewshire Division; and Lomond & Argyll Division.

The NHS Board is accountable for both continuously improving the quality of health services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish (framework of clinical governance).

Further information about the local NHS system can be accessed via the website of NHS Argyll & Clyde (www.show.scot.nhs.uk/achb).

NHS Argyll & Clyde progressively took over responsibility for the provision of out-of-hours primary medical services from 28 September 2004. The primary care emergency service evolved from three GP out-of-hours co-operatives and individual GP practices which had operated the out-of-hours service previously.

NHS Argyll & Clyde's primary care emergency service operates from 6pm to 8am weekdays, all weekend, bank holidays and public holidays. The primary care emergency service operates from three main centres based at Greenock Health Centre, Inverclyde; Royal Alexandra Hospital, Paisley; and Vale of Level Hospital, Alexandria. Additionally, due to the geographical nature of Argyll, there are an additional six primary care emergency centres based across the region.

At the time of the review there were a total of 20 out-of-hours providers in NHS Argyll & Clyde, 18 of which were level 1 providers, plus two direct providers, which included one practice which was administered by the NHS Board because of a vacancy. The vacancy is now filled; therefore, at the time of publication there are now 19 level 1 providers and one direct provider which is NHS Argyll & Clyde.

At the time of the visit, NHS Argyll and Clyde had not started to review their level 1 providers; however, the NHS Board reported that it plans to undertake a programme of visits to the individual practice providers as outlined below. The primary care emergency service manager has expressed a desire to be trained as an assessor for this work.

Timetable for review of level 1 providers:

October 2005	Workshop for practice managers
November–December 2005	Practices prepare for assessment
January–September 2006	Programme of assessment visits to all GMS contracted providers.

2.2 Summary of Findings Against the Standards

A summary of the findings from the review, including examples of local initiatives drawn to the attention of the review team, is presented in this section. A detailed description of performance against the standards/criteria is included in Section 4.

Accessibility and availability at first point of contact

Although the review team noted that the primary care emergency service is linking in to a variety of local information to help with the planning and delivery of the service, the service was unable to demonstrate that there are formal arrangements in place to identify the needs of those potentially using the service. The service reported at the time of the visit that arrangements are in place to meet the needs of some, but not all, of those potentially using the primary care emergency service.

Across the primary care emergency service in NHS Argyll & Clyde, arrangements are in place for patients or their representatives to access care by telephone (in the first instance). Patients first access the service through NHS 24; if, after triage by NHS 24, the patient requires further care, either NHS 24 will liaise with the hub (dispatch centre) to arrange attendance at a primary care emergency centre or the patient will be contacted directly by the hub to arrange a home visit or attendance at a primary care emergency centre. The review team noted that contingency procedures are in place should the usual method of telephone access be unavailable to patients or their representatives. The service reported that the contingency plan will be tested in October 2005 when a mock electrical failure scenario will be undertaken.

There is an NHS Argyll & Clyde Board-wide equality and diversity policy in place which is adhered to by the primary care emergency service. Braille and audio tapes relating to services provided by NHS 24 are available to patients, and these services are advertised through posters in GP practices. The review team identified that a challenge to the service is the production of locally specific information on the primary care emergency service for minority ethnic and special needs groups.

Healthcare governance

The primary care emergency service recognises that although patient needs may be similar in urban and rural areas, this is complicated in NHS Argyll & Clyde by local geography and accessibility to the service. Development and redesign of the primary care emergency service was undertaken in consultation with various stakeholders, and several public meetings were held across NHS Argyll & Clyde. A stakeholders' day was held in April 2004, and pre- and post-service launch meetings were also held in each locality to review the service and address any emerging issues. An information leaflet detailing service changes was produced as well as an 'advertorial' article, which was published in the local media.

A major challenge for the primary care emergency service is to ensure it becomes an integrated part of the NHS Board. There is awareness that the service is very medical/doctor dependent and that it is regarded by patients and staff as an extension of NHS 24 with no links to other local NHS services.

The primary care emergency service does not appear to be fully integrated into the NHS Argyll & Clyde clinical governance infrastructure, particularly in terms of

accountability and responsibilities. There is no proactive approach taken, with a lack of clarity around the clinical governance programme in relation to infrastructure, strategy and planning. Although the service appears disengaged from the formal NHS Board-wide clinical governance programme, the review team recognised the reactive approach that has been taken due to the evolving nature of the service. Consideration also requires to be given to the establishment of regular, formal reporting mechanisms. A GP audit facilitator is to take up employment in September 2005. This post will have a clinical governance remit, giving consideration to clinical audit for the service.

There are NHS Board-wide incident reporting and risk management systems in operation, however, these systems are not aligned to or systematically applied to the out-of-hours services. There is awareness that there is much work still to be undertaken in this area, and that formal documentation underpinning the risk management systems is lacking. At the time of the review, the NHS Board-wide risk register had recently been updated, and the service risk register was under development.

It was acknowledged that there has been a reactive approach taken with efforts focused on raising awareness and areas of responsibility in relation to risk management.

A mock emergency planning event is planned for October 2005, which will identify learning points and highlight gaps in the service, as well as ensuring business continuity should any part of the system fail.

Example of a local initiative…

A medicines management group has been formalised to establish a cohesive approach to medicines management and equipment. This group comprises a principal pharmacist, three urban GPs and one rural GP. Consideration will be given to the equipment available in the primary care emergency centres and cars, and prescribing issues, for example, identifying a drug stock formulary. This should then assist in identifying training needs and requirements for GPs.

At the time of the review, there were some procedures and processes in place to demonstrate that staff involved in out-of-hours care meet employment requirements, including suitable qualifications, and once employed, are competent to perform their duties.

There is an established recruitment and selection process undertaken in conjunction with the NHS Board's human resources department, with policies and procedures to underpin this. Although job descriptions have been prepared for all staff working in the primary care emergency service, there are no competency frameworks underpinning the job descriptions other than the minimum legal training requirements for GPs. Staff confirmed that consideration is now being given to these issues, in particular for those GPs employed to work in more remote and rural areas.

There are no personal development plans (PDPs) or annual appraisal systems in place for staff. At the time of the review, core corporate activities, such as health and safety needs, were being prioritised over personal development needs. There are plans to commence with PDPs and annual appraisal systems for staff in early 2006. The service recognises the need to formalise induction programmes and orientation processes for both clinical and non-clinical staff. At the time of the review, formal induction programmes were being established for drivers and dispatchers. These programmes will cover aspects such as training on the Adastra computer system, local geography and NHS 24 processes.

NHS Argyll & Clyde's primary care emergency service operates within the NHS Board's standing financial instructions, and is covered by the NHS Board's primary care organisation scheme of delegation.

Clinical care

Cascade systems are in operation to facilitate circulation of key documents and guidance across the primary care emergency centres to support clinical decision-making. There is a need, however, to ensure equity of access to national guidelines across all providers.

There are robust systems in place for clinical and NHS 24 assessments to take place and, if required, there is a retriage system in operation. However, there are no established local policies with regard to the out-of-hours service's liaison with other professional groups, for example, in relation to child protection and vulnerable adults. The service is aware that these are gaps that require to be addressed.

There are established drug management and equipment maintenance systems in operation. There is a controlled drugs cupboard and drug stock register in each primary care emergency centre and there are plans under way to standardise drug stocks across the primary care emergency centres.

Information and communication

Despite the complexities of NHS Argyll & Clyde, there are well understood, robust local processes in place for the completion, use, storage and retrieval of patient records. Staff are allocated specific levels of authorisation for access to the computer system appropriate to their role. Clinicians have responsibility to enter all medical information in the computer system in the primary care emergency centre, or have full responsibility for any information that has been entered on their behalf. There is a daily back-up of the computer system undertaken by the IT department.

Information on patient contact and outcomes is emailed or faxed to the appropriate GP practices by the next working day. Systems are also in place to ensure the transfer of information to other healthcare professionals. Similarly, information from the patient's own GP can be transferred to the out-of-hours service for patients that require special care or the adoption of different processes, through the use of special patient notes.

At the first point of contact with NHS 24, patients are asked for consent to share their information with other healthcare professionals, for example, the patient's own

GP. If consent is not given, appropriate systems are in place to ensure that information is transferred only between NHS 24, the hub and the primary care emergency centre.

Audit, monitoring and reporting

At the time of the review, a set of provider-specific key performance indicators were not in place for the primary care emergency service. The service reported that an annual report on the service is to be produced in February 2006, which will help to inform and formulate the key performance indicators for 2006.

Comments, complaints and compliments received by the primary care service are recorded, regularly reviewed and acted upon. Clinical complaints are investigated by the clinical director of the service and non-clinical complaints are investigated by the service manager. In both instances, once the complaint has been investigated, a response to the complainant is then drafted and forwarded to the NHS Argyll & Clyde complaints manager, in accordance with the NHS Board's complaints management policy.

If, after investigation, complaints are escalated to a critical incident or significant event, the incident or event is discussed at the primary care quality assurance committee to ensure that lessons are learnt and action to avoid a recurrence is agreed and taken.

At the time of the review, the service did not have a formal system in place to identify patient views and satisfaction levels. Patient views of the service are gathered through complaint and compliment letters, as well as through meetings with local community groups. The review team noted that the primary care emergency service is planning to introduce patient satisfaction surveys, the findings of which will be discussed at the primary care quality assurance committee.

The primary care emergency service had only been operational for 9 months at the time of the review. Therefore, a report on annual performance and service had not been published.

3 Registration Status

The NHS QIS primary medical services out-of-hours standards were published in August 2004. In September 2004, the Scottish Executive Health Department issued a health department letter, HDL(2004)41, which outlined the action required by NHS Board chief executives on receipt of these standards and associated guidance. From 1 January 2005, there is a statutory requirement for all providers of primary medical services in the out-of-hours period to comply with these standards. All NHS Boards were required to submit a completed registration application form, by November 2004, for all providers of primary medical services out-of-hours in their area. Each provider was then given conditional registration with NHS QIS along with their registration number. Following each NHS Board's review visit to assess performance against the standards, a registration status will be assigned. The registration status for NHS Argyll & Clyde can be found below:

Registration status assigned to NHS Argyll & Clyde:

Provider is largely compliant with the standards.

Please refer to the NHS QIS website for details of any follow-up outcomes and subsequent amendments to registration status, position statements and detailed findings.

4 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 Argyll & Clyde

OVERALL POSITION STATEMENT: **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.

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

The primary care emergency service reported that information on patient demographics and usage of primary medical services out-of-hours had been gathered from the previous GP out-of-hours co-operatives in the suburban areas of NHS Argyll & Clyde. This information was used to identify patterns of patient activity and to plan the required staffing levels for the new primary care emergency service.

Clinical information on patients is recorded on the Adastra computer system (an electronic specialist call management, data distribution and clinical recording system). This information is coded; however, staff reported that the clinical coding information is limited and therefore has minimal value. The review team noted that plans are under way to expand the use of clinical codes.

The service reported that a GP audit facilitator post for the primary care emergency service has been filled. The facilitator's role will be to assist with the planning and development of the service based on audit findings.

Representatives of the service meet with NHS 24 on a 2-monthly basis; discussion at the meeting includes the prediction of call levels over specific periods which helps to inform the planning of appropriate staffing levels.

The NHS Argyll & Clyde public health plan also contains information which helps to support service development and planning of the service.

The review team noted a number of examples where the service has been adapted following feedback from key professionals; this includes the identification by the colorectal surgeon of patients who have undergone colorectal procedures and may require readmission during the out-of-hours period. This information is flagged up in the special patient notes to ensure that patients are dealt with in an appropriate and timeous manner by the service. Additionally, the primary care emergency service is working with the laboratory service to develop an approach to ensure that abnormal results received in the out-of-hours period are dealt with appropriately and the information is passed to the patient's GP in-hours.

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

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

At the time of the visit, the NHS Argyll & Clyde primary care emergency service reported that, because of the infancy of the service, the service was not proactively considering the needs of those potentially using the service. The review team noted that, following the redesign of mental health services within the area, the service had identified a requirement to look at the availability of community psychiatric nurses out-of-hours. In addition, the review team noted a number of issues that have been raised by groups potentially using the service and how these issues have been addressed by the service. The review team commended the introduction of the Palliative Care Gold Standard, which involves sharing patient information out-of-hours between the patient's GP, district nurses, NHS 24 and the out-of-hours GP.

1(a)3: Arrangements are in place for patients or their representatives to access care by telephone (in the first instance).

STATUS: **Arrangements are in place for patients or their representatives to access care by telephone (in the first instance), and contingency plans are in place if the usual method of access is unavailable.**

There are arrangements in place for patients or their representatives to access care by telephone in the first instance. Patients within NHS Argyll & Clyde first access the primary care emergency service through a telephone call to NHS 24. Then, after triage by NHS 24, either NHS 24 will liaise with the hub (dispatch centre) to arrange attendance at a primary care emergency centre or the patient will be contacted directly by the hub to arrange a home visit or attendance at a primary care emergency centre.

The out-of-hours service is advertised to patients and their representatives through a variety of formats. Information is provided to patients at GP practices and the primary care emergency service centres through leaflets and advice cards.

The review team noted that the primary care emergency service is producing guidance which is to be distributed to pharmacies and GP practices in preparation for winter and the expected surge in demand for the out-of-hours service over this period.

When patients or their representatives contact NHS 24, all calls are recorded. Communication between NHS 24 and the service regarding patient information is recorded on the Adastra system. In addition, the review team noted that there are formal logging procedures for defined call categories; all these calls are logged.

Contingency plans are in place should the usual method of telephone access be unavailable to patients and their representatives; if there was a switchboard failure at the primary care emergency service, NHS 24 would be advised of the situation and communication from NHS 24 would be faxed to the primary care emergency service hub. All other communication would then be via the direct telephone line or by mobile telephone. If switchboard failure was to continue for over an hour, the telephone and fax facilities in the emergency control centre at the hub would be utilised. The primary care emergency service reported that the service plans to test the contingency plan in October 2005 by holding a full mock electrical failure scenario.

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

STATUS: **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.**

The NHS Board-wide equality and diversity policy has been implemented across the primary care emergency service.

The NHS Argyll & Clyde public health needs assessment identifies population trends which can highlight the requirement for specialist services for the local population. At the time of the visit, local information materials for minority groups had not been produced; however, it was reported that the service hopes to implement specific information shortly.

Braille and audio cassettes with information relating to services provided by NHS 24 are available to patients with sensory impairment. When a caller with sensory impairment is passed from NHS 24 to the local service, the NHS 24 staff member will make the local staff aware of the patient's sensory impairment. A needs assessment to establish the level of compliance with the Disability Discrimination Act 1995 was co-ordinated by the estates department of NHS Argyll & Clyde. The assessment identified that there is disabled access to, and disabled access toilet facilities at, all the primary care emergency service centres. Additionally, over 50% of the primary care emergency service centres are fitted with loop hearing systems, and

the remaining 50% have funding in place to install loop hearing systems in the centres.

The review team noted the difficulty the service has had with acquiring translator services. Translator services for the out-of-hours period have to be booked in advance through NHS Greater Glasgow.

The review team encouraged the provision of locally produced information leaflets for patients with special needs and those patients from disadvantaged or ethnic minority groups.

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 Argyll & Clyde

OVERALL POSITION STATEMENT: **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.

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

Development and redesign of the primary care emergency service was overseen by the management committee, which had representation from various stakeholders, including patients, GPs, nursing, the local health council, ambulance service and NHS 24. Several public meetings were also held across NHS Argyll & Clyde.

A stakeholders' day was held in April 2004 to present the proposed redesigned service model prior to presentation to the NHS Board for approval, and to provide the opportunity to explore the emerging issues and challenges faced. Pre- and post-service launch meetings were also held in each locality to review the service and address any emerging issues.

A communications group, chaired by a patient representative, was established to give consideration as to how best to communicate service changes to the public. This resulted in the production of an information leaflet and an 'advertorial' article, which was published in the local media.

The service recognises that, although patient needs may be similar in urban and rural areas, this is complicated in NHS Argyll & Clyde by local geography and accessibility to the service. There is also awareness that patients can feel isolated in some areas. As much as possible, a pragmatic approach to standardisation of the quality of the service has been taken across the rural areas. This also helps minimise risks, although there are local variations in terms of service delivery where necessary.

A major challenge for the primary care emergency service is to become an integrated part of the NHS Board. There is awareness that the service is very medical/doctor dependent and that it is regarded by patients and staff as an extension of NHS 24

with no links to other local NHS services. The service manager has had discussions with various nursing groups, which were reported to have proved beneficial.

Links have now been established through the community health partnerships' (CHPs) patient representative groups rather than establishing a specific out-of-hours patient group.

A patient satisfaction survey was undertaken in September 2005, across a Friday–Sunday weekend period, which had a high response rate. The survey results will be used to further assist the development of the primary care emergency service. At the time of the review, the survey results were in the process of being collated. However, key findings from the Inverclyde division appeared to indicate that approximately 50% of patients would be happy to see another healthcare professional other than a doctor. Staff reported that patients had requested to receive a copy of the final report detailing the survey's responses. It is planned to explore further when the next patient survey is undertaken which healthcare staff groups, other than a doctor, patients would be happy to see.

Complaints are dealt with in accordance with the NHS Board's complaints policy. However, the review team was not satisfied that there is a systematic approach to feedback and complaints/comments received by the primary care emergency service. The service accepted that this could be better formalised, as responses are tailored to each particular situation. For example, there has been an open-house approach adopted and members of the public have been shown around the service in a bid to alleviate concerns.

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

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

GPs give verbal information to the patient regarding their condition, treatment and follow-up action. Where available, this is entered onto the Adastra computer system. In addition, there is a full range of patient clinical information leaflets available on, for example, minor injuries, asthma, soft tissue injuries and childhood illnesses.

There are plans to provide GPs with access to IT-based information, for example the British National Formulary and SIGN Guidelines, on a standardised desk-top accessible via the Adastra computer system. This would help ensure consistent approaches to treatment and care. There is recognition, however, of the IT software licensing issues with this approach, as well as the challenges faced in relation to capturing those GP practices not linked into the Adastra computer system.

At the time of the review, disks with local guidelines were available in primary care emergency centres with A4-sized information sheets printed off for staff and patients.

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.

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

The primary care emergency service has established a healthcare governance committee, which is represented through the Inverclyde healthcare clinical governance committee and is accountable to the NHS Board in terms of clinical governance. The Inverclyde healthcare governance committee reports to the operational management clinical governance group, which, in turn, reports to the NHS Board. The review team identified that clarity around accountability and responsibility was required, as the current model is unclear and difficult to easily interpret.

A quality assurance group has also been established to provide a more operational element across the service with a responsibility to develop clinical, corporate and staff governance mechanisms in order to ensure the delivery of a high quality, safe and sustainable service. The group has representation from urban and rural GPs, nurses, healthcare governance management, the ambulance service and NHS 24. The group reports to the primary care emergency service healthcare governance committee, and disseminates and feeds back information on clinical governance issues to the wider out-of-hours service.

The review team, however, was not satisfied that the primary care emergency service is fully integrated into the NHS Argyll & Clyde clinical governance infrastructure, particularly in terms of accountability and responsibilities. There is no proactive approach taken and a lack of clarity around the clinical governance programme in relation to strategy, infrastructure and planning. The service appears disengaged from the formal Board-wide clinical governance programme. Staff recognised the reactive approach that has been taken because of the evolving nature of the service and reported that they now wish to commence a systematic, planned approach to the review of key, defined issues.

There is awareness that the clinical governance agenda could be driven by the service, for example prescribing audits and response times. This information could then be used, for example, to inform GP appraisals. It was reported that, because of the infancy of the service, such audits have not been viable, as useful and useable information is not yet available. There is recognition that these audits will subsequently result in learning points for both NHS Argyll & Clyde and NHS 24, and inform service delivery.

It was reported that a medicines management group has been formalised to establish a cohesive approach to medicines management and equipment. This group comprises a principal pharmacist, three urban GPs and one rural GP. This group will give consideration to the equipment available in the primary care emergency centres

and cars, and prescribing issues, for example, identifying a drug stock formulary. This should then assist in identifying training needs and requirements for GPs. It was noted that the NHS Board formulary was updated in August 2005, and this group will streamline this formulary for use in out-of-hours services.

It was reported that a GP audit facilitator is to take up employment in September 2005. This post will have a clinical governance remit, giving consideration to clinical audit for the service. It was reported that a pharmacy audit facilitator is also to be appointed.

There are plans to hold a stakeholder day in the forthcoming months with various workshops to provide information and raise awareness on, for example, cardiopulmonary resuscitation (CPR) training and the new Mental Health Act. The service reported that this could be targeted as a clinical governance development event. An initial stakeholder day was held in March 2004, which had a good attendance. It is hoped that this would become a regular feature, on a possible 6-monthly basis.

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

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

There is awareness that there is much work still to be undertaken with regard to risk management and that formal documentation underpinning the risk management systems is currently unavailable. It was recognised that there has been a reactive approach taken to risk management as there has not been the management capacity to undertake this fully. Efforts have primarily been focused on raising awareness and areas of responsibility. The service manager has responsibility to manage the risk management programme for out-of-hours services.

There is an NHS Board-wide incident reporting system (IR1 system) in operation. In addition, the electronic Datix risk management and patient safety software system produces monthly reports. Although well developed, these two systems are not fully formalised and not aligned to or systematically applied to the out-of-hours services.

Staff are trained in the policies for risk management, for example, health and safety. It was reported that a new set of NHS Board policies had been ratified in September 2005, including the NHS Board-wide adverse incident management policy. The NHS Board-wide risk register has recently been updated, and the service risk register is under development.

It was noted that a primary care emergency service health and safety committee is to be established in September 2005, which will review and discuss health and safety issues within the service. A new health and safety control book is to be launched across NHS Argyll & Clyde in the forthcoming months.

The review team commended the procedures for managing violent and aggressive patients, which is an extension of the in-hours service. Three GP practices with a certain degree of experience and expertise have been designated to receive and manage this category of patients. Patients are reviewed by a multidisciplinary panel, placed on the violent patients' register and allocated to one of the GP practices with specific restrictions in terms of access, etc. These restrictions are highlighted in the Adastra computer system to ensure that they are also complied with out-of-hours. For example, a patient may only be seen with police present at an appropriate primary care emergency centre.

It was reported that a mock emergency planning event is planned for October 2005. It is anticipated that this event will identify learning points and highlight gaps in the service, as well as testing business continuity should any part of the system fail. The service manager is a member of the NHS Board-wide emergency planning executive group and is working with general managers from the hospital sites to ensure that an integrated approach to major incident emergency planning is taken. It was noted that the out-of-hours service is not regarded as the primary contact in major emergencies; rather, it has an emergency control room function and has a key role in supporting the accident and emergency (A&E) department.

With regard to service continuity, the service is trying to build in flexibility to ensure that all doctor rotas are filled. It was reported that this had been the main risk management issue and adequate time had been required to rectify this. It was reported that a small number of salaried doctors have been employed in recent months. This has highlighted the need to formalise induction programmes and orientation processes.

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.

STATUS: **A system to report to the NHS Board clinical governance committee regularly is under development.**

The primary care emergency service has established a healthcare governance committee, which is represented through the Inverclyde healthcare clinical governance committee and is accountable to the NHS Board in terms of clinical governance. The Inverclyde healthcare governance committee reports to the operational management clinical governance group, which, in turn, reports to the NHS Board. The review team, however, was not satisfied that the primary care emergency service is fully integrated into the NHS Argyll & Clyde clinical governance infrastructure, particularly in terms of accountability and responsibilities.

It was noted that committee minutes will be widely shared and placed on the NHS Board's intranet. Consideration does require to be given, however, to the establishment of regular, formal reporting mechanisms.

It was reported that the clinical director will be reporting to the Inverclyde healthcare governance committee in September 2005. A presentation on winter pressures on the out-of-hours service had been given earlier in the year. It is anticipated that the service's annual report will be presented in March 2006.

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

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

Although there are unstructured programmes in place to communicate, inform and co-operate with key professionals, external parties and voluntary agencies, including email, letter and telephone communication, the review team was provided with good, practical examples of communication systems, for example, the links between the out-of-hours service and nursing homes.

General communication to GP practices is usually undertaken via email, and there is a failsafe mechanism in place which generates a message when the computer system fails to send an email or fax, or if the recipient fails to receive a message.

There is a professional-to-professional telephone line with direct access to the hub. This is frequently used by, for example, pharmacists, police, ambulance service, nursing homes and hospices.

Minutes of the quality assurance group are available on the NHS Board's intranet.

It was recognised that the external organisational structure, ie the numerous local authorities in the area, does create difficulties in interacting with other agencies.

2(a)7: Staff Governance: Staff involved in out-of-hours care meet employment requirements, including qualifications.

STATUS: **There are some defined processes and procedures in place to demonstrate that some staff groups involved in out-of-hours care meet employment requirements.**

The review team was not satisfied that sufficient focus was being given to ensuring that procedures and processes are in place to demonstrate that staff involved in out-of-hours care meet employment requirements, including qualifications.

There is an established recruitment and selection process handled in conjunction with the NHS Board's human resources department, with policies and procedures to underpin this. Although job descriptions have been prepared for all staff working in the primary care emergency service, there are no competency frameworks underpinning the job descriptions other than the minimum legal training requirements for GPs. There are also no additional training requirements specified

when employing locum doctors, for example, CPR training certificates and defibrillator training. Staff confirmed that consideration is now being given to these issues, in particular for those GPs employed to work in more remote and rural areas. It was noted that the establishment of the medicines management group will assist in identifying training needs and requirements for GPs.

Staff are aware that review of existing medical practitioners already placed on the Primary Medical Services Performers' List should be undertaken. Currently, this is only undertaken for new starts for inclusion on the Performers' List.

Disclosure Scotland pre-employment checks are undertaken for new starts as part of the NHS Board's established recruitment and selection procedures.

As above, established GP principals and medical practitioners already on the Performers' List will have had Disclosure Scotland checks previously undertaken. At the time of the review, there were no review processes in place to maintain an updated status.

The NHS Argyll & Clyde indemnity scheme covers all salaried staff, including GPs.

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

STATUS: **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 review team was not satisfied that sufficient focus was being given to ensuring that procedures and processes are in place to demonstrate that staff are competent to perform their duties.

There are no personal development plans (PDPs) or annual appraisal systems in place for staff. The service manager confirmed that there are plans to commence this in early 2006. The review team recognised that, because of the infancy of the service, sufficient time was needed to ensure that staff are able to demonstrate competence in the job and tasks being undertaken. At the time of the review, core corporate activities, such as health and safety needs, were being addressed more than personal development needs.

Doctors who work in the primary care emergency service are provided with a doctor's handbook, and informal arrangements are in place to ensure that another staff member working on the same shift will show the new start around the primary care emergency centre. It was reported that a small number of salaried doctors have been employed in recent months. This has highlighted the need to formalise induction programmes and orientation processes.

It was reported that GP appraisals and continuing professional development (CPD) requirements are the responsibility of the individual and their specific locality; this includes doctors working in the primary care emergency service. It was reported that protected learning days are well established in the Lomond area. The primary care

emergency service wishes to ensure input into the organisation of GP training days in order that a broad range of CPD needs are met.

Consideration is being given to the development of induction programmes for non-clinical staff and, at the time of the review, formal induction programmes were being established for drivers and dispatchers. These programmes will cover aspects such as training on the Adastra computer system, local geography and NHS 24 processes.

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

STATUS: **A system to ensure financial probity is fully implemented and is monitored across the service.**

NHS Argyll & Clyde's primary care emergency service operates within the NHS Board's standing financial instructions and is covered by the NHS Board's primary care organisation scheme of delegation.

There is a system of authorised signatories in place.

Regular meetings are held with the service manager, practitioner services and management accountants to review budgets.

The NHS Board's internal audit service reviewed the primary care emergency service procedures for recording staff attendance, and for compiling and authorising payroll duty sheets. As a result of the internal audit, consideration is being given to streamlining these processes.

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 Argyll & Clyde

OVERALL POSTION STATEMENT: **Processes and procedures to support clinical decision-making are fully implemented, but monitoring has not yet commenced involving 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.

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

Cascade systems are in operation to facilitate circulation of key documents and guidance across the primary care emergency centres to support clinical decision-making. Documents are also placed on noticeboards and guidance manuals are available in the primary care emergency centres and cars. Receptionists also bring key documents to the attention of the GPs. It was noted, however, that there is no apparent sign-off system to indicate that key documents have been received or read. It is anticipated that the GP audit facilitator will support this further.

There are plans to provide GPs with access to IT-based information, for example, the British National Formulary and SIGN Guidelines, on a standardised desk-top accessible via the Adastra computer system. This would help ensure consistent approaches to treatment and care. There is recognition, however, of the challenges faced in relation to capturing those GP practices not linked into the Adastra computer system.

2(b)2: Patients are assessed and responded to, based on clinical need and professional judgement.

STATUS: **There is a system in place to ensure that patients are assessed and responded to on the basis of clinical need and professional judgement, but it has not been fully implemented.**

The review team was satisfied that, within a complex organisation, there are robust systems in place for clinical assessments to take place, which appear safe and effective.

If required, there is a retriage system in operation and a clinician can reassess the NHS 24 recommendation. In the case of home visits in rural areas, decisions around triage may be undertaken by an individual clinician, ie the most accessible location for the patient contact to take place.

There are no established local policies with regard to the out-of-hours service's liaison with other professional groups, for example, in relation to child protection and vulnerable adults. The service is aware that these are gaps that require to be addressed.

At the time of the review, it was reported that an NHS Board-wide vulnerable adults policy was due to be ratified in the coming months.

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

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

There are established drug management and equipment maintenance systems in operation. There is a controlled drugs cupboard and drug stock register in each primary care emergency centre for which the hospital pharmacies have a responsibility to check and re-stock as required. Individual practitioners keep their own controlled drugs register and reorder as appropriate through the clinical director. There are plans under way to standardise drug stocks across the primary care emergency centres, and a draft drug list has been produced.

It was reported that there is work ongoing to consider controlled drugs for palliative care.

All clinical equipment is registered with the medical physics department. Asset registers have been established by both medical physics and the primary care emergency service.

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 Argyll & Clyde

OVERALL POSITION STATEMENT: **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 Criteria

2(c)1: Systems are in place for the completion, use, storage and retrieval of records including compliance with the Data Protection Act 1998.

STATUS: **A system is in place for the completion, use, storage and retrieval of records including compliance with the Data Protection Act 1998 and is fully implemented across the service.**

The Adastra computer system is in operation across the primary care emergency service, and is available in the hub, primary care emergency centres and in the cars. Staff are allocated specific levels of authorisation for access to the Adastra computer system appropriate to their role.

The review team was satisfied that, within a complex organisation, there are well understood, robust local processes in place.

The clinicians have responsibility for entering all medical information into the Adastra computer system in the primary care emergency centre. In rural areas, the clinicians can telephone the hub and dictate to staff the information to be recorded on the patient record. The clinician will then check this information when in the primary care emergency centre and has full responsibility for any information that has been entered on their behalf.

The receptionists enter information onto the system for patients who present directly to the primary care emergency centre without an appointment. The call-handler enters professional-to-professional contact information.

Unique Adastra reference numbers are assigned to each entry. Community Health Index (CHI) numbers are also used by NHS 24 and these are included when information is passed to the hub. It was noted, however, that there are no systems in place to capture this information retrospectively for patients who present directly to the primary care emergency centre without an appointment.

Daily back-up of the computer system is undertaken by the IT department.

A log terminal is in use for cross-referencing information sent from NHS 24 to ensure that no patients have been lost on the system.

2(c)2: Systems are in place for receiving and communicating information to inform patients' ongoing care, by the next working day.

STATUS: **A system is in place for receiving and communicating information to inform patients' ongoing care, by the next working day, which is fully implemented.**

Information on patient contact and outcomes is emailed or faxed to the appropriate GP practices by the next working day.

Systems are in place to ensure the transfer of information to other healthcare professionals. This can be done electronically, by telephone or written communication, or through a verbal handover. If patients are admitted to hospital, information can be faxed to the receiving ward.

Information from the patient's own GP can be transferred to the out-of-hours service for patients requiring special care or the adoption of different processes, through the use of special patient notes, for example, palliative care patients, mental health patients, violent patients. This information is entered onto the Adastra computer system and shared by NHS 24. This information is then displayed when the patient makes contact with NHS 24.

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.

STATUS: **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.**

At the first point of contact with NHS 24, patients are asked for consent to share their information with other healthcare professionals, for example, the patient's own GP. Consent to share information is recorded as given or refused. If consent is not given, NHS 24 faxes the call information to the hub, which is then faxed to the primary care emergency centre. Following the patient consultation, the GP manually records any information/outcome onto the hard copy faxed record which is then faxed back to the hub, where the hard copy record is filed.

Staff reported that, out of 80,000 contact episodes, only two patients had requested that their details were not shared with other healthcare professionals.

It was noted that there are plans to establish a local information-sharing protocol with external agencies where no formal agreement currently exists, for example, the police 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 Argyll & Clyde

OVERALL POSITION STATEMENT**: 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.

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

At the time of the visit, the NHS Argyll & Clyde primary care emergency service did not have any formal key performance indicators in place. The service reported that it is still in the process of developing from GP co-operatives to the new primary care emergency service. An annual report on the primary care emergency service is due to be produced in February 2006, which the service hopes will help inform the formulation of key performance indicators for 2006; in addition, the new post of GP audit facilitator will support the development of key performance indicators.

The review team identified that a challenge to the service is to develop a system of agreeing key performance indicators within the NHS Board structure, which will help develop a more structured approach to demonstrating a safe and effective service.

3(a)2: Comments, complaints and compliments are recorded, regularly reviewed and action taken.

STATUS: **There is a system in place for recording and reviewing comments, complaints and compliments, which is fully implemented across the service, and action is taken where appropriate.**

The NHS Argyll & Clyde primary care emergency service reported that since the implementation of the service there have been 10 service-specific complaints. Clinical complaints regarding the service are investigated by the service clinical director; a response is drafted and then forwarded to NHS Argyll & Clyde's complaints manager in accordance with the NHS Board's complaints management policy. Non-clinical complaints are investigated and responded to by the service manager. Feedback on the service is also received from GP practices; this feedback is also dealt with by the service manager. The clinical director and service manager of the primary

care emergency service are responsible for ensuring that any action required to be taken following a complaint is acted upon.

The service reported that a number of complaints are received from patients regarding the service provided by NHS 24. These complaints are forwarded to NHS 24, and the complainant is informed. The service also advises patients of the difference between NHS 24 and the primary care emergency service.

Where complaints or feedback lead to an investigation of a critical incident or significant event, these incidents or events are discussed at the primary care quality assurance committee to ensure that any action required to avoid a recurrence is agreed and taken.

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

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

At the time of the visit, the primary care emergency service did not have a formal system in place to identify patient views and satisfaction levels. The service did, however, identify that patient views of the service are gathered through complaint and compliment letters and also through meetings that are held with local community groups. The service reported that many of the meetings are held with rural community groups, in areas where the arrangements for the delivery of out-of-hours care have changed the most. The service also has plans to use the patient partnership forums of CHPs, once these have been formally developed, to discuss arrangements for delivery of the out-of-hours service in their localities.

The primary care emergency service informed the review team that the service plans to introduce patient satisfaction surveys. Feedback from surveys will be discussed at the primary care quality assurance committee and it is anticipated that this feedback will inform future service delivery plans and the service's annual assurance report to NHS Argyll & Clyde's operational management governance committee.

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

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

At the time of the visit the primary care emergency service in NHS Argyll & Clyde had been under the full operational control of the Board for 9 months. The service confirmed that a report on progress since its implementation was provided to the Inverclyde divisional management committee, 3 months after the start of the service.

The review team noted that the primary care emergency service will provide an annual assurance report on the provision and performance of the primary care emergency service in February 2006. The service reported that the annual assurance

report will be made available on the NHS Argyll & Clyde website and will also be disseminated to CHPs for further dissemination to their patient partnership forums.

Appendix 1 – Criteria Identified for Follow-up

The criteria detailed in the table below have been identified by the review team as areas for action by Argyll & Clyde NHS Board. The NHS Board will develop an action plan which will be submitted to NHS QIS, along with an initial progress report, 3 months from receipt of the final local report. All action will require to be taken by July 2007. Resubmission of the self-assessment will be required for these criteria, along with any updated supporting evidence of progress, as deadlines detailed in the action plan are reached. The NHS QIS Out-of-Hours Reference Group will review this resubmitted evidence. Following review of the resubmitted evidence for all action points, any necessary amendments to the status of the position statements will be made, and the accompanying report narrative updated and published on the NHS QIS website. In most instances, these reviews will not require a visit to the NHS Board to further assess performance; however, a review visit may be carried out if deemed necessary by the Reference Group.

NHS Argyll & Clyde
Criteria Identified for Follow-up
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 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 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 Service providers operate a system of risk management to ensure that risks are identified, assessed, controlled and minimised.
2(a)5 Providers of out-of-hours services have a system in place to report regularly to NHS Board clinical governance committees.
2(a)6 Arrangements are in place to communicate, inform and co-operate with key professionals, external parties and voluntary agencies.
2(a)7 Staff involved in out-of-hours care meet employment requirements, including qualifications.
2(a)8 Staff are competent to perform their duties.
2(b)2 Patients are assessed and responded to, based on clinical need and professional judgement.
3(a)1 A set of provider-specific key performance indicators (PFPI, 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.

Appendix 2 – Glossary of Abbreviations

Abbreviation	
A&E	accident and emergency
CHI	community health index
CHP	community health partnership
CPD	continuing professional development
CPR	cardiopulmonary resuscitation
GMS	General Medical Services
GP	general practitioner
HDL	health department letter
LHCC	local health care co-operative
NHS QIS	NHS Quality Improvement Scotland
PDP	personal development plan
PMS	Personal Medical Services
SIGN	Scottish Intercollegiate Guidelines Network

Appendix 3 – Details of Review Visit

The review visit to NHS Argyll & Clyde was conducted on 22 September 2005.

Review Team Members

Dr Ross Cameron (Team Leader)
Medical Director, NHS Borders

Ms Jillian Croll-Sinclair
Head of Clinical Governance, NHS 24

Mrs Muriel Holroyd
Lay Representative, Forth Valley

Mrs Margaret Smith
Operations Manager, Lothian Unscheduled Care Service

NHS Quality Improvement Scotland Personnel

Miss Jan Nicolson
Project Officer

Miss Josephine O'Sullivan
Project Officer

Mr Steven Wilson
Team Manager

During the visit, members of the review team met with executive staff, service managers, GPs, nursing representatives, NHS 24 representatives, clinical governance staff and human resources representatives.

Appendix 4 – Primary Medical Services Out-of-Hours Project Group Members

Chair

The Very Reverend Graham Forbes CBE
NHS Quality Improvement Scotland Board Member

Project Group Members

Mr Colin Brown
Branch Head, Primary Care Development and Performance Management Branch, Scottish Executive Health Department

Dr Andrew Buist
Scottish General Practitioners' Committee (SGPC) Representative

Ms Fiona Dalziel
Practice Manager, NHS Grampian

Dr Liz Duncan
Assistant Medical Director, NHS 24

Dr Norrie Gaw
Divisional Medical Director, NHS Greater Glasgow – Primary Care Division

Mrs Muriel Holroyd
Lay Representative, Forth Valley

Ms Liz Macdonald
Policy Manager, Scottish Consumer Council

Mr Andrew Marsden
Medical Director, Scottish Ambulance Service

Ms Theresa McLean
Nurse Advisor, Royal College of Nursing

Dr Bruce McMaster
Scottish Association of Community Hospitals (SACH) Representative

Mr David Paul
Lay Representative, Greater Glasgow

Dr Ken Proctor
Medical Director, Highland Direct Health Services (Operations)

Mr Ian Reid
Chief Executive, NHS Greater Glasgow – Primary Care Division

Dr Brian Robson
Medical Director, NHS 24

Dr Mairi Scott
Chair, Royal College of General Practitioners Scotland (RGCP)

Ms Karen Spence
Business Manager, NHS Ayrshire Doctors on Call (ADOC)

Dr Marion Storrie
Clinical Director, Lothian Unscheduled Care Service

Dr Bill Taylor
General Practitioner, NHS Grampian

Ms Susan Watt
Education and Clinical Advisor, Royal College of Nursing

Ms Helen Whyte
Out-of-Hours Lead, Pay Modernisation, Scottish Executive Health Department (until March 2005)

Support from NHS QIS was provided by **Ms Jan Warner** (Director of Performance Assessment and Practice Development), **Mr Steven Wilson** (Team Manager), **Mrs Fiona Russell** (Senior Project Officer), **Miss Jan Nicolson** (Project Officer), **Miss Josephine O'Sullivan** (Project Officer) and **Mr Alan Ketchen** (Project Administrator).

Appendix 5 – Primary Medical Services Out-of-Hours Reference Group Members

Chair

Ms Jane Bryce
Lay Representative, Highland

Dr Ross Cameron
Medical Director, NHS Borders

Dr Liz Duncan
Assistant Medical Director, NHS 24

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

Mr Martin Moffat
Branch Head, Scottish Executive Health Department

Dr Marion Storrie
Clinical Director, Lothian Unscheduled Care Service

Dr Susan Taylor
General Practitioner, NHS Highland

Support from NHS QIS was provided by **Ms Jan Warner** (Director of Performance Assessment and Practice Development), **Mr Steven Wilson** (Team Manager), **Mrs Fiona Russell** (Senior Project Officer), **Miss Jan Nicolson** (Project Officer), **Miss Josephine O'Sullivan** (Project Officer) and **Mr Alan Ketchen** (Project Administrator).

Appendix 6 – Timetable of Review Visits

Organisation Reviewed	Visit Date(s)
NHS Argyll & Clyde	22 September 2005
NHS Ayrshire & Arran	1 December 2005
NHS Borders	9 February 2006
NHS Dumfries & Galloway	26 January 2006
NHS Fife	5 October 2005
NHS Forth Valley	20 October 2005
NHS Grampian	22 February 2006
NHS Greater Glasgow	15 November 2005
NHS Highland	12 January 2006
NHS Lanarkshire	2 November 2005
NHS Lothian	15 December 2005
NHS Orkney	22 March 2006
NHS Shetland	5 April 2006
NHS Tayside	27 October 2005
NHS Western Isles	8 March 2006

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