NHS
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Scotland

NHS Greater Glasgow

Local Report ~ April 2006

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

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

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 Greater Glasgow**. This review visit took place on **15 November 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.

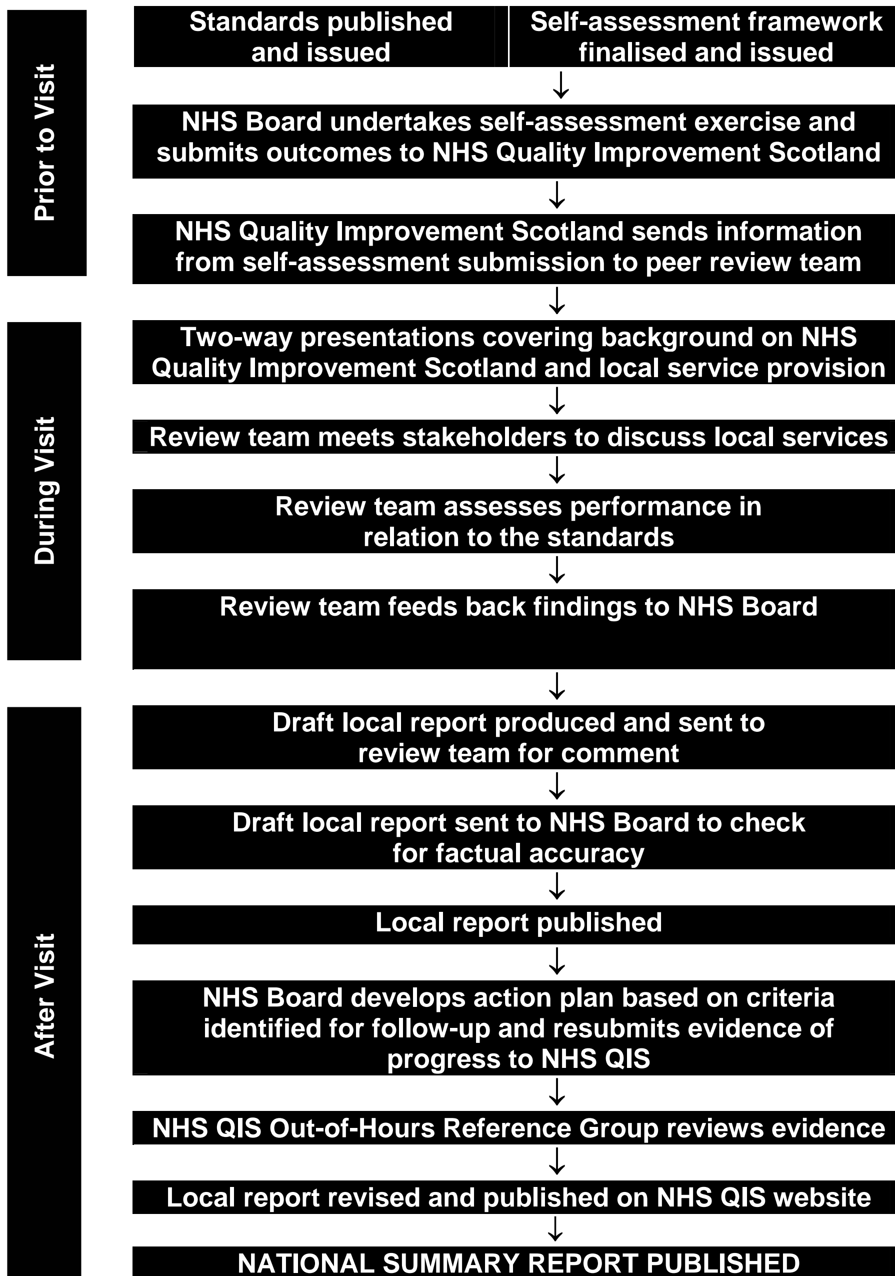
1.3 Reports

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

Greater Glasgow is a compact and densely populated urban region situated in west-central Scotland and has a population of around 867,100. The proportion of older people in the population is below the national average, whereas levels of illness and deprivation are relatively high.

Local NHS System and Services

Greater Glasgow 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 Greater Glasgow.

At the time of the review visit, NHS Greater Glasgow contained four NHS operating divisions: North Glasgow University Hospitals Division (acute care services); South Glasgow University Hospitals Division (acute care services); Greater Glasgow Primary Care Division (primary care services); and Yorkhill Division (women and child care services, including Scotland's largest children's hospital).

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 Greater Glasgow (www.nhsgg.org.uk).

NHS Glasgow Emergency Medical Services (GEMS) evolved from the independent GP out-of-hours co-operative, GEMS, which had been existence since February 1996 and was responsible for the provision of primary medical services out-of-hours. In June 2004, the transfer from GEMS to NHS GEMS took place. Links with NHS 24 were already established through GEMS.

There are six primary care emergency centres in NHS Greater Glasgow, four based within hospital sites in Glasgow: Western Infirmary; Stobhill Hospital; Victoria Infirmary and Drumchapel Hospital; and Easterhouse Health Centre and Cardonald Clinic. The primary care emergency centres at Stobhill Hospital and Victoria Infirmary remain open after midnight.

NHS Greater Glasgow is undergoing a period of organisational change including a reduction in the number of accident and emergency (A&E) units from five to two, with the development of two ambulatory care and diagnostic (ACAD) units, 'one-stop' diagnosis and treatment units for patients who do not require admission to hospital, by 2007–2008. These units will be based at Stobhill Hospital and Victoria Infirmary. This will bring together and integrate key primary care out-of-hours emergency services, including district nursing, GP, dental, pharmacy, community psychiatric nursing, social care and a nurse-led minor injuries service.

NHS GEMS has cross-border arrangements in place with the NHS Boards in Forth Valley, Lanarkshire and Argyll & Clyde. Patients registered with doctors in these areas can request to attend an NHS GEMS primary care emergency centre.

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

Glasgow Emergency Medical Services (GEMS), the previous independent GP out-of-hours co-operative in NHS Greater Glasgow, had been in existence since February 1996. Using available GEMS historical data, for example, workload figures, numbers of people attending and numbers of home visits, it was decided that very little required to change in terms of service delivery when the out-of-hours service evolved into NHS GEMS in 2004.

There is continuous monitoring of the level of usage of the service; however, a more proactive, predictive approach requires to be developed to identify the needs of the population, based on wider public health information, and patient profiles and needs.

Examples of the arrangements that are in place to meet the needs of those potentially using the out-of-hours services were presented to the review team, for example, focus groups resulting in the development of a patient group directive (PGD).

NHS 24 is now the initial point of contact for patients contacting the out-of-hours services in NHS Greater Glasgow and is primarily responsible for identifying the needs of the patient over the telephone at the point of access. Consideration does require to be given to formalising local contingency plans if telephone access to NHS 24 fails.

There is awareness by NHS GEMS of gaps in relation to ensuring information on access to and delivery of services is available for all patient groups, for example, the Chinese population and patients with visual impairments. Discussion is under way with the primary care division's communication department to produce the NHS GEMS information leaflet in other languages.

Example of a local initiative…

A language questionnaire has been developed for which a series of closed questions is available in a number of languages. This was developed by a member of staff as part of their diploma course and has been tailored for use by NHS GEMS.

Healthcare governance

Work is undertaken in partnership with individuals, communities and community planning partners in the design, development and review of services. Many relationships with stakeholders and external parties had previously developed through GEMS, and these relationships have evolved as GEMS transferred into the NHS Board.

Verbal information is provided to the patient and their representatives regarding any care or treatment given and there is a small number of patient information leaflets available. Consideration does require to be given, however, to the further development of information at the point of contact for patients and their representatives.

A quality assurance committee had been established which has an internal quality assurance function and will ensure robust internal performance management. The first meeting of the quality assurance committee took place in October 2005. The committee will report directly to the GP subcommittee and the primary care division's clinical governance committee in relation to clinical governance arrangements and key performance indicators.

There is much work in progress in relation to clinical governance activities and an established clinical governance planning cycle is in place across the primary care division. However, as a result of the impending reorganisation across NHS Greater Glasgow, service areas were not expected to produce clinical governance reports for 2004–2005.

Recognition was given to the impending reorganisation across NHS Greater Glasgow and the imminent move by NHS GEMS from the primary care to the acute division of NHS Greater Glasgow and discussions have since commenced in relation to future clinical governance arrangements, reporting structures, and roles and responsibilities.

There is a primary care division-wide incident reporting system (IR1 system) in operation. However, consideration does require to be given to widening the scope of risk management from the exception monitoring scheme in operation.

There are procedures and processes to demonstrate that staff involved in out-of-hours care meet employment requirements, including qualifications. With the exception of administrative staff, new non-clinical employees are subject to enhanced level Disclosure Scotland checks. General Medical Council (GMC) registration is checked when a doctor initially applies to become a NHS GEMS doctor. Nursing registration is checked annually through the Nursing and Midwifery Council (NMC) in accordance with internal processes.

At the time of the review, NHS GEMS was in the process of implementing a new standardised induction process for control centre, administrative and nursing staff. This includes the use of a checklist to identify tasks which should be completed within the first month of employment.

A cohort of minor illness nurses has completed a 6-month training course at Caledonian University, Glasgow. At the time of the review, the nurses were undergoing a period of consolidation of their knowledge and clinical skills while attached to the NHS GEMS sites. It is proposed that a second 6-month period will be mentored and supervised by GPs before the nurses function as autonomous practitioners, at which time they will undertake the assessment and management of some patients with certain conditions who currently require to be seen by doctors.

NHS GEMS adheres to the NHS Board's corporate governance regime and is subject to the same policies and procedures. This includes standing financial instructions, a fraud and corruption policy, fraud and irregularity response plan and freedom of expression policy.

Clinical care

Although clinical nursing procedure reference books and clinical information folders are retained in each of the primary care emergency centres, local and national guidelines, for example, Scottish Intercollegiate Guidelines Network (SIGN) Guidelines, PGDs and equipment instructions, are not retained on-site; access to these is through the senior nurse advisor. Consideration requires to be given to establishing immediate access to guidelines for staff in each of the centres. At the time of the review, there was no internet or intranet access at the primary care emergency centres. The proposed development of the IT infrastructures will assist in the accessing of guidelines through the provision of internet access.

The review team was satisfied that there are processes in place for clinical and NHS 24 assessments to take place, which appear to be safe and effective. If required, there is a retriage and reprioritisation system in operation if competing priorities arise, whereby patients are retriaged into ascending clinical need. Responsibility lies with the GP to contact and reassess the patient, if necessary.

There is no appointment system in the primary care emergency centres; a key performance indicator states that patients should be seen within 30 minutes of arrival at a primary care emergency centre. The number of 'walk-in' patients (patients who present without having contacted the out-of-hours service) was reported to be rising which may lead to potential conflict and may be a particularly pertinent issue to consider as part of winter care planning.

Systems are in place to follow up patients who, although having contacted NHS GEMS, subsequently do not attend a primary care emergency centre as instructed.

There are established drug management and equipment maintenance systems in operation.

Example of a local initiative…

A colour-coded tagging system is in use which indicates when drug bags have been used and when they require restocking. Bags are re-tagged when they have been restocked.

Information and communication

The Knightowl computer system is in operation across NHS GEMS. Patient call sheets are created on the Knightowl computer system for any patient contact. These are then printed off at the primary care emergency centre and the time of the patient arrival logged. A handwritten summary of the consultation is manually recorded by the GP onto the call sheet. This information is subsequently entered onto the Knightowl system by the receptionist, with any queries addressed by the GP. All hard

copy patient contact call sheets are stored centrally for 3 months before being scanned onto a CD-rom; original records are subsequently destroyed.

Information on patient contact and outcomes is faxed to the appropriate GP practices by the next working day. A summary report system is also in operation to reconcile the receipt of faxes, including nil returns. Work is in progress to develop the IT infrastructures to allow information to be emailed to the GP practices rather than faxed. It is anticipated that this electronic system will be in place by early 2006.

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.

The GP emergency care summary system will be implemented across NHS GEMS by mid-November 2005. This system will hold information on patients with any known allergies and prescribing details, for example, latex allergies and patients who misuse opiates.

At the first point of contact with NHS 24, patients are asked for their consent to the sharing of 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, appropriate systems are in place to ensure that information is transferred only between NHS 24, the hub (dispatch centre) and the primary care emergency centre. A confidential pseudo GP practice has been established for the storing of summary consultation information on patients who have refused consent.

Audit, monitoring and reporting

Reports on performance against an initial set of nursing, operational and medical key performance indicators are presented to the quality assurance committee. Six-monthly reports will be presented to the primary care division's clinical governance committee and annual reports presented to Greater Glasgow NHS Board.

There is an awareness of the need to be responsive to service developments and to work with other partners to develop joint key performance indicators. This will be particularly pertinent when NHS GEMS moves in an organisational capacity to the acute division of NHS Greater Glasgow.

Complaints are dealt with in accordance with the primary care division's complaints procedure, and there is a reported low volume of complaints across the primary care division.

Complaints are received by the clinical director, logged and passed to the relevant senior staff member for investigation and review. Outcomes from complaints are reported back to the clinical director and NHS GEMS management team, if necessary, and shared with staff. Complaints are also discussed in detail at the quality assurance committee.

A recent patient satisfaction survey was undertaken across all primary care emergency centres during a one-week period in October. A summary analysis paper

of the patient satisfaction survey results is to be discussed at a future NHS GEMS management team meeting. This information will then be presented to the primary care division's clinical governance committee, and information on the survey results widely disseminated across NHS GEMS.

Due to the impending organisational changes across NHS Greater Glasgow, and the impact this will have on the out-of-hours service, it was agreed with the primary care division that no annual report would be produced for 2004–2005.

The NHS GEMS management team will share responsibility for developing an annual report for 2005–2006.

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 Greater Glasgow can be found below:

Registration status assigned to NHS Greater Glasgow:

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 Greater Glasgow

OVERALL POSITION STATEMENT: **Processes for ensuring patient accessibility and availability at the first point of contact are being developed but implementation has either not yet commenced, or has commenced but does not involve 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.**

Glasgow Emergency Medical Services (GEMS), the previous independent GP out-of-hours co-operative in NHS Greater Glasgow, had been in existence since February 1996. Using available GEMS historical data, for example, workload figures, numbers of people attending and numbers of home visits, it was decided that very little required to change in terms of service delivery when the out-of-hours service evolved into NHS GEMS in 2004. The transition from GEMS to NHS GEMS was reported to be relatively seamless. It was reported that there was a clear message from representatives from the local health care co-operatives (LHCCs) prior to the move to NHS GEMS that they did not feel the service should change.

Through regular monitoring of the level of usage of the service over the years, awareness has been gathered on the flow of patients, peak times, etc, and further refining in terms of service provision is undertaken as and when required. Using the GEMS IT system, Knightowl, a daily summary report is produced on the number of home visits, priority timescales, number of patients admitted to hospital. This summary is reviewed by the clinical director and operations manager.

Consideration does require to be given, however, to developing a more proactive, predictive approach to identifying the needs of the population, based on wider public health information and patient profiles and needs.

An example given to the review team of how the needs of patients was identified was a recent stakeholder event in which issues were identified with patients with

addiction problems presenting in the out-of-hours period, as there is no direct service available to which to refer them. Community addiction teams had been established, but they are not accessible in the out-of-hours period or through the weekend. It was reported that this issue will be taken forward by the out-of-hours city-wide steering group in consultation with the head of addictions.

The review team noted the development of five community health and social care partnerships across NHS Greater Glasgow, which will be run jointly by NHS Greater Glasgow and Glasgow City Council. Links are being established between these partnerships and the out-of-hours service which will further assist in identifying the needs of patients.

The review team noted that a cohort of minor illness nurses has completed a 6-month training course at Caledonian University, Glasgow. At the time of the review, the nurses had completed their initial training course and were undergoing a period of consolidation of their knowledge and clinical skills while attached to the NHS GEMS sites. It is proposed that a second 6-month period will be mentored and supervised by GPs before the nurses function as autonomous practitioners at which time they will undertake the assessment and management of some patients with certain conditions who currently require to be seen by doctors.

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.**

The review team was satisfied that arrangements and infrastructures are in place to meet the service needs of those patient groups that have been identified. Examples given include direct access to the community psychiatric nurse (CPN) service, whereby patients requiring mental health input can by seen by the CPN service either in the primary care emergency centre or through a home visit. This move was initiated by the mental health service and has been an established service since 2001.

There is a strong commitment to communicating with the large asylum seeker population across NHS Greater Glasgow to ensure that ethnic minority groups are able to access the service, for example, through the use of interpreters. However, a recent public health survey has identified that the Chinese population in some areas of Glasgow are low users of the out-of-hours service. Consideration does require to be given to following through on these issues to ensure awareness of the out-of-hours service and how the service should be accessed by this potential group of patients.

As a result of focus groups held with the public health department to identify patient needs in relation to sexual and reproductive health services, a nurse prescribing patient group directive (PGD) was developed on the administration of emergency contraception.

An initial audit was undertaken across NHS Greater Glasgow's district nursing service to look at their patients who also regularly present to the out-of-hours service at weekends. These patients are now referred directly from NHS GEMS to the district nursing service and are seen at home. A clinical record sheet is being developed which the patient can bring with them when they access NHS GEMS.

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).**

Prior to the establishment of NHS GEMS, patients in NHS Greater Glasgow could choose to contact their GP practice or telephone NHS 24 out-of-hours. A patient information leaflet was distributed and GP practice leaflets were subsequently amended to ensure patients were aware of how to access NHS GEMS by contacting NHS 24 in the first instance. A substantial media campaign was also undertaken. NHS 24 is now the initial point of contact for patients contacting the out-of-hours services in NHS Greater Glasgow and is primarily responsible for identifying the needs of the patient over the telephone at the point of access.

Contingency plans are in place in NHS 24 whereby calls can be rerouted to one of the other two contact centres should the telephone system fail or there is an increased demand to the service. Should difficulties occur in patients being able to access NHS 24, NHS 24 would inform the primary care emergency service hub (dispatch centre) and a British Telecom message would be relayed when patients contacted NHS 24. NHS GEMS would utilise local radio networks to ensure patients know how to contact their nearest primary care emergency centre. However, consideration does require to be given to formalising local contingency plans if telephone access to NHS 24 fails.

Similarly, if NHS GEMS telephone systems became inaccessible, local radio networks would be utilised to inform the public and the service would instantly become a walk-in service, with all patients triaged face-to-face.

It was reported that a joint NHS Greater Glasgow and NHS 24 winter festive campaign is to commence with advertisements in the local press to ensure patients contact NHS 24 in the first instance.

All communications are logged and a professional-to-professional direct line for advice is available.

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.**

NHS GEMS is aware of gaps in relation to ensuring information on access to and delivery of services is available for all patient groups, for example, the Chinese population and patients with visual impairments. It was noted that discussion is under way with the primary care division's communication department to produce the NHS GEMS information leaflet in other languages.

NHS 24 has access to Language Line, a translation service, if required. NHS 24 also provides patient leaflets in various languages and leaflets have also been produced for patients with learning disabilities, in Braille and on cassette tape. All primary care emergency centres have language identification cards and posters advertising the availability of the interpreter service. The review team commended the development of a collated language questionnaire, whereby a series of closed questions is available in a number of languages. This was developed by a member of staff as part of their diploma course.

Induction loop systems are clearly signed and available in all locations. NHS 24 utilises a Typetalk service which is a communication link for use by deaf or speech impaired callers.

The primary care division's chaperoning policy is in use in NHS GEMS.

A corporate implementation plan relating to the Disability Discrimination Act 1995 was produced, which was updated in April 2005. It was reported that all NHS GEMS premises are in the process of undergoing a full analysis of compliance, although no evidence was provided to this effect.

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 Greater Glasgow

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

Essential Criteria

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

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

The review team was satisfied that much work has been undertaken in partnership with individuals, communities and community planning partners in the design, development and review of services.

An example of this was the wide public engagement model developed during the proposal in late 2004 to move the primary care emergency centre from Lightburn Hospital to Easterhouse Community Health Centre. A number of public meetings were held, press releases were issued and copies of a consultation leaflet were distributed to health centres, clinics and GP surgeries across east Glasgow. A database was developed of over 400 local organisations, community and voluntary bodies who were also issued with the consultation leaflet. The leaflet included a return questionnaire asking respondents to identify issues or concerns relating to the relocation; resulting issues included patient and staff safety and public transport. A second patient information leaflet was then produced following relocation of the primary care emergency centre, and leaflets and posters were placed in local shops in a bid to educate the public on accessing the out-of-hours service.

Two stakeholder events have been held to improve understanding of the impending reorganisation across NHS Greater Glasgow and the imminent move by NHS GEMS from primary care to the acute division of NHS Greater Glasgow. These events were held in a bid to review and influence joint planning and collaborative working opportunities and agree the next steps for the redesign of the service. Attendees included representation from clinicians and managers from both acute and

primary care, social work services, NHS 24, voluntary agencies, service users and community partners.

It was reported that all GPs in Glasgow are issued with 3-monthly updates to keep them informed of developments in NHS GEMS. Annual meetings are held which provide a platform to raise any issues or concerns. In addition, there is an active GP subcommittee which can have a significant input to any proposed developments or service changes.

A quality assurance forum is held, which includes representation from GPs, clinical governance and lay representation. This forum gives consideration to statistics and complaints which can help further shape the service.

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 but it is not easily accessible by patients and their representatives.**

Verbal information is provided to the patient and their representatives regarding any care or treatment, with either patient information leaflets or handwritten advice and care instructions to reinforce verbal information.

Consideration does require to be given, however, to the further development of information at the point of contact for patients and their representatives. A small number of evidence-based leaflets have been developed, for example, head injury leaflets, based on leaflets validated for use in the Royal Hospital for Sick Children, Yorkhill, Glasgow. It was reported that specific information leaflets on medication, for example, emergency contraception and the use of antibiotics when taking oral contraception, had been printed in the previous month, with several more leaflets in draft format.

There are no internet or intranet facilities at the primary care emergency centres. The proposed development of the IT infrastructures will assist in the availability of patient information and guidance.

It was reported that a reminder newsletter was issued to all GPs to ensure that medication summaries are provided to all patients when prescribed medication, ie note of medication, instructions and dosage information.

If a patient’s condition deteriorates after contact with NHS GEMS, they are required to re-contact NHS 24. It was accepted that this is problematic as NHS 24 does not then have any information on any previous clinical intervention.

> *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.**

At the time of the review, a quality assurance committee had been established which has an internal quality assurance function and will ensure robust internal performance management. It was reported that this committee replaces the joint deputing service committee. The first meeting of the quality assurance committee took place in October 2005. The committee will report directly to the GP subcommittee and the primary care division's clinical governance committee in relation to clinical governance arrangements and key performance indicators. This will include issues such as complaints and risk handling, time periods for attending house calls, appropriateness of hospital admissions and prescribing issues. The clinical director and clinical governance lead sit on this committee. It was reported that a lay representative is to be invited onto the committee.

The review team noted work in progress in relation to clinical governance activities, for example, systematic reviews by the clinical director of hospital admissions referred from the out-of-hours service, strategic discussions and planning on consequences to the out-of-hours service of the reduction in the number of accident and emergency (A&E) departments across NHS Greater Glasgow.

An established clinical governance planning cycle is in place across the primary care division. Clinical governance plans are developed within service development plans rather than as discrete documents. However, as a result of the impending reorganisation across NHS Greater Glasgow, service areas were not expected to produce clinical governance reports for 2004–2005. With the imminent move by NHS GEMS to the acute division of NHS Greater Glasgow, discussions have since commenced in relation to future clinical governance arrangements, reporting structures and roles and responsibilities.

> *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 a primary care division-wide incident reporting system (IR1 system) in operation, and IR1 books are retained in each primary care emergency centre. Risks are recorded on the IR1 form and sent to the operations manager who will identify which senior staff member should investigate a particular risk. There is no service-specific risk register. Risks associated with NHS GEMS will be escalated into

the primary care division's strategic risk register for review if NHS GEMS does not have the capacity to resolve the issue, for example, relating to IT hardware issues.

Consideration does require to be given to widening the scope of risk management from the exception monitoring scheme in operation.

It was reported that the transition from GEMS to NHS GEMS was highlighted on the corporate risk register, and it is anticipated that the service's move from the primary care to acute division will also be included on the corporate risk register.

Examples given to the review team of potential risks identified which resulted in operational changes included capping the number of hours worked by GEMS GPs and, more recently, winter care planning arrangements.

It was reported that a health and safety assessment had recently been undertaken across all NHS GEMS sites taking into consideration aspects such as lighting and cable management.

The review team commended the practice of circulating significant event analyses in the quarterly GP newsletters. This has proved useful for GPs when identifying training needs.

NHS GEMS has no formal involvement during a major incident, but would provide appropriate clinical back-up support, as required. The service is governed by the primary care division's emergency contingency continuity plans.

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: **There is a system in place to report to the NHS Board clinical governance committee regularly.**

The quality assurance committee has an internal quality assurance function and will report directly to the primary care division's clinical governance committee in relation to clinical governance arrangements and key performance indicators. This includes issues such as complaints and risk handling, time periods for attending house calls, appropriateness of hospital admissions and prescribing issues. The clinical director and clinical governance lead sit on this committee. NHS GEMS also routinely reports to the primary care division's management team and out-of-hours city-wide steering group.

It was noted that an A&E representative is also a member of the quality assurance committee, which has proved beneficial with the impending move by NHS GEMS from the primary care to the acute division of NHS Greater Glasgow.

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 key professionals, external parties and voluntary agencies.**

The review team was satisfied that NHS GEMS has arrangements to communicate, inform and co-operate with key professionals, external parties and voluntary agencies. Many relationships with stakeholders and external parties had previously developed through GEMS, and these relationships have evolved as GEMS transferred into the NHS Board.

The clinical director chairs the out-of-hours city-wide steering group. This group meets bimonthly and has representation from acute and primary care, community psychiatric nursing, dental services, local medical committee, social work services, NHS 24 and lay representation. The public involvement officer also sits on this group.

Representatives from NHS GEMS sit on the sector management team within the primary care division which all LHCC managers are involved with. Relevant issues relating to the out-of-hours service can be disseminated across the GP practices from this team, as well as utilising their links with voluntary agencies. Direct links are also being developed with the community health social care partnerships. This can assist in linking with voluntary organisations.

An acute stroke protocol has been developed through partnership working with the Scottish Ambulance Service and the acute service. A verification of an unexpected death protocol has also been developed through partnership working with the Scottish Ambulance Service and procurator fiscal. The review team noted work undertaken with the homeless sector, resulting in the development of formal policies.

It was reported that NHS GEMS has been approached to link in with projects relating to both palliative care services and women fleeing violence.

A GP newsletter is published quarterly, and internal bulletins, memos and email are used to communicate and share information about the service to staff.

Recognition was given to the impending reorganisation across NHS Greater Glasgow and the imminent move by NHS GEMS from the primary care to acute division of NHS Greater Glasgow. The clinical director is a member of the unscheduled care collaborative steering group. Stakeholder events have been held to improve understanding of the service changes and agree the next steps for the redesign of the service. These events included representation from clinicians and managers from both acute and primary care, social work services, NHS 24, voluntary agencies, service users and community partners.

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

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

Procedures and processes are in place to demonstrate that staff involved in out-of-hours care meet employment requirements, including qualifications.

Standard NHS Board-wide employment and recruitment procedures apply for all staff employed by NHS GEMS.

With the exception of some administrative staff, new non-clinical employees are subject to enhanced level Disclosure Scotland checks. Discussions are under way with the primary care division's medical director in relation to the undertaking of Disclosure Scotland checks for GPs already on the Primary Medical Services (PMS) Performers' List.

General Medical Council (GMC) registration is checked when a doctor initially applies to become a NHS GEMS doctor. However, regular monitoring of doctors' registration status is not then subsequently undertaken.

Nursing registration is checked annually through the Nursing and Midwifery Council (NMC) in accordance with internal processes.

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.**

At the time of the review, NHS GEMS was in the process of implementing a new standardised induction process for control centre, administrative and nursing staff. This includes the use of a checklist to identify tasks which should be completed within the first month of employment.

There are no salaried doctors in NHS GEMS. As a result, individual doctors are responsible for undertaking appraisals through their own GP practices, identifying individual learning needs and undertaking appropriate training. All GPs working in NHS GEMS who will carry out telephone consultations have specific training on clinical and IT issues.

There is a requirement for cardiopulmonary resuscitation (CPR) training for clinical staff, and training has been extended to drivers and security staff. Consideration is being given to accrediting GPs who attend future training events.

Training for nursing staff is self-directed through need or by service changes, for example, the recently developed PGD for the administration of emergency contraception required training and awareness sessions to be held.

Specific training sessions are also arranged for staff as a result of, for example, outcomes from complaints, adverse or significant events. Awareness training sessions have been organised in relation to the new Mental Health Act and the introduction of the GP emergency care summary system. Educational events and training were organised for clinical staff following the introduction of a guideline relating to the referral of stroke patients to secondary care.

It was noted that a cohort of minor illness nurses has completed a 6-month training course at Caledonian University, Glasgow. At the time of the review, the nurses were undergoing a period of consolidation of their knowledge and clinical skills while attached to the NHS GEMS sites. It is proposed that during a second 6-month period the nurses will be mentored and supervised by GPs before they function as autonomous practitioners. In addition, the nurses will also complete an extended nurse prescribing course.

It was noted that the NHS Knowledge and Skills Framework (KSF) work programme has impacted on the process for appraising and developing personal development plans (PDPs) for staff. At the time of the review, job descriptions and draft KSF outlines had been developed for nursing staff.

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 GEMS adheres to the NHS Board’s corporate governance regime and is subject to the same policies and procedures. This includes standing financial instructions, a fraud and corruption policy, fraud and irregularity response plan and freedom of expression policy.

The Board’s financial systems are covered by internal audit reviews which are reported to both management and the audit committee.

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 Greater Glasgow

OVERALL POSITION STATEMENT: **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.

STATUS: **No procedures are in place for quick and easy access to evidence-based guidelines.**

Clinical nursing procedure reference books and clinical information folders are retained in each of the primary care emergency centres. The NHS GEMS drug formulary is also available in the primary care emergency centres.

However, local and national guidelines, for example, Scottish Intercollegiate Guidelines Network (SIGN) Guidelines, PGDs and equipment instructions, are not retained on-site; access to these is through the senior nurse advisor. General update information, for example, relating to new guidelines, is issued by the senior nurse advisor to each of the primary care emergency centres. Consideration requires to be given to establishing immediate access to guidelines for staff in each of the centres.

At the time of the review, there was no internet or intranet access at the primary care emergency centres. The proposed development of the IT infrastructures will assist in the accessing of guidelines through the provision of internet access.

A PGD has been developed for the administration of emergency contraception, with a corresponding clinical record sheet developed. At the time of the review, work was under way by the minor illness nurse practitioners to develop a PGD for the administration of antibiotics.

A NHS GEMS information handbook is under development which will contain procedures and algorithms to assist with clinical decision-making.

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, and this system is fully implemented across the service.**

The review team was satisfied that there are processes in place for clinical and NHS 24 assessments to take place, which appear to be safe and effective.

If required, there is a retriage and reprioritisation system in operation if competing priorities arise, whereby patients are retriaged into ascending clinical need. The hub controller is responsible for initially identifying a specified time period based on prioritisation for patients requiring follow-up. Depending on patient need, the hub controller will arrange, with advice from the GP if required, for a home visit, patient transport, CPN or district nursing input. A professional-to-professional direct line for advice is also available.

There is no appointment system in the primary care emergency centres; a key performance indicator states that patients should be seen within 30 minutes of arrival at a primary care emergency centre. The review team noted potential conflicts with patients accessing NHS GEMS and 'walk-in' patients (patients who present without having contacted the out-of-hours service). The number of walk-in patients was reported to be rising, and may be a particularly pertinent issue to consider as part of winter care planning. Discussions are being held in relation to the minor illness nurse practitioners undertaking face-to-face triage, should the need arise.

Systems are in place to follow up patients who, although having contacted NHS GEMS, subsequently do not attend a primary care emergency centre as instructed.

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. The review team commended the colour-coded tagging system in use which indicates when drug bags have been used and when they require restocking. Bags are re-tagged when they have been restocked.

Nursing staff are responsible for checking and restocking drug bags and drug store cupboards. This was the role of the pharmacist; however, at the time of the review, this post was vacant. Ampule trays are restocked by the local community pharmacists. The senior nurse advisor is responsible for cross-referencing drug stock and equipment orders.

The NHS GEMS drug formulary is available in the primary care emergency centres, and details minimum and maximum drug stock levels for each site.

No controlled drugs are stored in the primary care emergency centres. Individual doctors are responsible for the use of controlled drugs and retain individual drug books. Arrangements are in place, through the clinical director, if requests are made for controlled drugs.

Consideration does require to be given to monitoring the use of drugs, including controlled drugs.

Site nurse co-ordinators are responsible for the safe storage and ordering of equipment. Equipment is either maintained by way of a service contract or is regularly serviced by the community pharmacy service. Equipment faults are reported to the senior nurse advisor who authorises repair or replacement of equipment.

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 Greater Glasgow

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 Knightowl computer system is in operation across NHS GEMS. Patient call sheets are created on the Knightowl computer system for any patient contact. These are then printed off at the primary care emergency centre and the time of the patient arrival logged. A handwritten summary of the consultation is manually recorded by the GP onto the call sheet. This information is subsequently entered onto the Knightowl system by the receptionist, with any queries addressed by the GP. It was reported that the hub will contact the relevant GP practice to ensure follow-up if a revisit is required for the patient.

All hard copy patient contact call sheets are returned from the primary care emergency centres to the hub and stored centrally for 3 months before being scanned onto a CD-rom. The review team noted that original records are subsequently destroyed.

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 faxed to the appropriate GP practices by the next working day. A summary report system is also in operation to reconcile the receipt of faxes, including nil returns.

Work is in progress to develop the IT infrastructures to allow information to be emailed to the GP practices rather than faxed. It is anticipated that this electronic system will be in place by early 2006.

The transfer of patient information to other healthcare professionals takes place through the internal computer system or using a recorded telephone line.

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, for example, patients receiving palliative care, patients with mental health issues, and those with a history of violence. This information is entered onto the Knightowl computer system and shared by NHS 24. This information is then displayed when the patient makes contact with NHS 24.

It was noted that the GP emergency care summary system will be implemented across NHS GEMS by mid-November 2005. This system will hold information on any known allergies and prescribing details, for example, latex allergies and patients who misuse opiates. This system has also been trialled in NHS Ayrshire & Arran and NHS Grampian.

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 their consent to share 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, and this is then faxed to the primary care emergency centre. Following the patient consultation, the GP manually records any relevant information including the outcome onto the hard copy faxed record. This is then faxed back to hub, where the hard copy record is filed. This information is not shared with other healthcare professionals. The review team noted the use of a confidential pseudo GP practice for the storing of summary consultation information on patients who have refused consent.

For patients who have refused consent, reviews are undertaken by the clinical director to ensure that it is safe for information not to be transferred to another healthcare professional, for example, child safety concerns.

It is standard practice for walk-in patients to a primary care emergency centre to be asked for their consent during the patient consultation.

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 Greater Glasgow

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

Essential Criteria

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

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

The NHS GEMS management team, which includes the clinical director, operations manager, rota manager and senior nurse advisor, identified an initial set of nursing, operational and medical key performance indicators. These were agreed with the clinical governance manager and chair of the primary care division's clinical governance committee and signed off by the primary care division medical director. However, it was noted that no patient-focused public involvement key performance indicators have been developed.

Reports on performance against the key performance indicators are presented to the quality assurance committee. Six-monthly reports will be presented to the primary care division's clinical governance committee and annual reports presented to Greater Glasgow NHS Board.

There is an awareness of the need to be responsive to service developments and to work with other partners to develop future joint key performance indicators. This will be particularly pertinent when NHS GEMS moves in an organisational capacity to the acute division of NHS Greater Glasgow, particularly in relation to future clinical governance arrangements, reporting structures, and roles and responsibilities.

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.**

Complaints are dealt with in accordance with the primary care division's complaints procedure.

Complaints are received by the clinical director, logged and passed to the relevant senior staff member for investigation and review. Outcomes from complaints are reported back to the clinical director and NHS GEMS management team, if necessary. They are also shared with staff through internal staff bulletins, memos and email, if appropriate. Complaints are also discussed in detail at the quality assurance committee.

All complaints are passed to the primary care division's complaints manager to ensure any learning points and necessary action plans are in place. The complaints department produces 6-monthly and annual reports to identify trends across the primary care division. These reports are presented to the primary care division's clinical governance committee. Root cause analysis is undertaken if necessary, which can also result in learning points for the system. It was reported that there is a very low volume of complaints across the primary care division.

Feedback from complaints which result in a significant event or critical incident are circulated through the critical incident bulletin which is issued to all sites.

Compliments are sent to the appropriate site for sharing with staff. Highlighted good practice is widely disseminated, for example, through memos, nurse meetings and quarterly GP newsletters.

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 through a formalised process.**

A recent patient satisfaction survey was undertaken across all primary care emergency centres during a one-week period in October. The survey resulted in 369 responses. The review team noted that the questionnaire had been based on the validated General Practice Assessment Questionnaire (GPAQ) which specifically focuses on reflective questions about access, interpersonal aspects of care and continuity of care.

On the day of the visit, the clinical director presented the review team with a summary analysis paper of the NHS GEMS patient satisfaction survey results. This paper is to be discussed at a future NHS GEMS management team meeting. This will then be presented to the primary care division's clinical governance committee, and information on the survey results widely disseminated across NHS GEMS. It was reported that this patient satisfaction survey will be undertaken on an annual basis.

It was noted that the minor illness nurse practitioners have developed a patient feedback evaluation tool, which will be implemented following consolidation of their role early next year. Consideration is also being given to implementing patient opinion/satisfaction meters in the primary care emergency centres.

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.**

Due to the impending organisational changes across NHS Greater Glasgow, and the impact this will have on the out-of-hours service, no annual report has been produced for 2004–2005.

The NHS GEMS management team will share responsibility for developing an annual report for 2005–2006. It is anticipated that this report will include information on the organisational move from the primary care to acute division (emergency care and medical specialties directorate) and the proposed IT infrastructures. It was noted that the out-of-hours service will be based within the acute division when this report is produced.

The annual report will become a public document once produced and will be publicised through traditional methods, for example, the intranet and internet and newsletters.

On a daily basis, the NHS GEMS rota manager produces a summary report on the level of priority calls which have run over predefined targets. Activity reports are regularly provided for the clinical director and NHS GEMS management team.

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 Greater Glasgow 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 GREATER GLASGOW
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)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(b)1 Procedures are in place to ensure quick and easy access to evidence-based clinical guidelines to support clinical decision-making.
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
ACAD	ambulatory care and diagnostic
CPN	community psychiatric nurse
GEMS	Glasgow Emergency Medical Services
GMC	General Medical Council
GMS	General Medical Services
GP	general practitioner
GPAQ	General Practice Assessment Questionnaire
HDL	health department letter
KSF	Knowledge and Skills Framework
LHCC	local health care co-operative
NHS QIS	NHS Quality Improvement Scotland
NMC	Nursing and Midwifery Council
PGD	patient group directive
PMS	Personal Medical Services
SIGN	Scottish Intercollegiate Guidelines Network

Appendix 3 – Details of Review Visit

The review visit to NHS Greater Glasgow was conducted on 15 November 2005.

Review Team Members

Dr Marion Storrie (Team Leader)
Clinical Director, Lothian Unscheduled Care Service

Ms Chris Flannery
Service Manager, Lothian Unscheduled Care Service

Dr John Lwanda
General Practitioner, NHS Lanarkshire

Mr David Robb
Lay Representative, Grampian

Mrs Janice Rollo
Sector Clinical Governance Co-ordinator, NHS Grampian

NHS Quality Improvement Scotland Personnel

Miss Jan Nicolson
Project Officer

Mrs Fiona Russell
Senior Project Officer

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
Associate 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
Associate 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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