

Draft Standards ~ *March 2004*

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

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1. Introduction

This document introduces the NHS Quality Improvement Scotland (NHS QIS) *Draft Standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours*. These draft standards apply to specific elements of the service. They cover:

- Accessibility and Availability at First Point of Contact;
- Safe and Effective Care; and
- Audit, Monitoring and Reporting.

When finalised, the standards will be used to provide assurance that suitable arrangements are in place to provide Primary Medical Services out-of-hours for people in Scotland.

The initial sections of this document provide background information on NHS QIS and on the process used to develop the draft standards (Sections 2 and 3 respectively).

The development of the *Draft Standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours* is outlined in Section 4, and the membership of the Project Group undertaking this work is given in Section 5. The overarching principles guiding development of the draft standards are provided in Section 6, and Section 7 outlines some key terms relating to the draft standards.

Section 8 provides basic information about Primary Medical Services out-of-hours, and the evidence underpinning the draft standards is presented in Section 9.

Section 10 contains the *Draft Standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours*.

Section 11 provides a glossary of terms used in the standards.

Finally, Appendix 1 provides details of membership of the National Out-of-Hours Working Group.

2. Background on NHS Quality Improvement Scotland

NHS Quality Improvement Scotland (NHS QIS) was established by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. Our responsibilities cover all aspects of the services provided by the NHS and we provide an independent check on how these services are performing. We also support NHS staff by issuing clear, authoritative advice on effective clinical practice and service improvements.

Part of the NHS QIS remit is to develop and run a national system of quality assurance of clinical services. Working in partnership with healthcare professionals and members of the public, NHS QIS sets standards for clinical services, assesses performance throughout NHSScotland against these standards, and publishes the findings. The standards are based on the patient's journey as he or she moves through different parts of the health service. A wide range of diseases and services are at present being addressed, including infection control, maternity services and mental health services.

Project Groups

For each service in the work programme, NHS QIS appoints a project group comprising appropriate healthcare professionals and members of the public to:

- oversee the development of, and consultation on, the standards;
- recommend an external peer review process; and
- report on its findings to the NHS QIS Board.

As part of their rolling programme, individual project groups ensure that the standards are regularly evaluated and revised so that they remain relevant and up to date (reflecting new procedures and treatments). They also ensure that targets of achievement are raised as performance improves.

Development of Standards

The way in which standards are developed is a key element of the quality assurance process. Groups working on behalf of NHS QIS are expected to:

- adopt an open and inclusive process involving a wide range of both members of the public and professional people through a variety of mechanisms;
- work within NHS QIS policies and procedures; and
- test standards through undertaking pilot reviews to ensure that they meet the principles of NHS QIS.

In addition to standards for specific services or conditions, generic clinical governance standards have been set which apply to all clinical services. (Note: these are currently under revision.)

Review

The framework for the NHS QIS review process is as follows:

- once the standards have been finalised, each relevant NHS Board/service is asked to undertake a self-assessment of its service against the standards;
- a review team visits the NHS Board/service on behalf of NHS QIS to follow up this self-assessment exercise with an external peer review of performance in relation to the standards; and
- NHS QIS reports the findings for the NHS Board/service, based on the self-assessment exercise and panel's findings.

This model will be amended to assess the performance of primary medical services out-of-hours, against these standards.

All the processes being developed are subject to review and evaluation, which will help NHS QIS improve its quality assurance system.

Further Information

For further information about NHS QIS, or to obtain additional copies of these draft standards, please contact:

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Copies of all NHS QIS publications can also be downloaded from the website (www.nhshealthquality.org).

3. Background on Standards – Basic Principles

The standards set by NHS Quality Improvement Scotland (NHS QIS) are:

- focused on clinical issues and include non-clinical factors which impact on the quality of care;
- written in simple language;
- based on evidence (recognising that levels and types of evidence will vary);
- written to take into account other recognised standards and clinical guidelines;
- clear and measurable;
- achievable but stretching;
- developed by healthcare professionals and members of the public;
- consulted on widely;
- published on paper and electronically (on the Internet); and
- regularly reviewed and revised to make sure they remain relevant and up to date.

Some standards are common to all clinical services, others specific to particular conditions.

Format of Standards and Definition of Terminology

All standards set by NHS QIS follow the same format:

- each standard has a **title**, which summarises the area on which that standard focuses;
- this is followed by the **standard statement**, which explains the level of performance to be achieved;
- the **rationale** section provides the reasons why the standard is considered to be important; and
- the standard statement is expanded in the section headed **criteria**, which states exactly what must be achieved for the standard to be reached.

As already mentioned, NHS QIS aims to set standards that are **achievable but stretching**. This is reflected in the criteria. Most criteria are **essential**, in that it is expected that they will be met wherever a service is provided. Other criteria may be **desirable**, in that they are being met in some parts of the service and demonstrate levels of quality which other providers of a similar service should strive to achieve. Each project group is responsible for determining which criteria are essential and which are desirable.

The criteria are numbered for the sole reason of making the document easier to work with, particularly for the assessment process. The numbering of the criteria is not a reflection of priority. The distinction between 'essential' and 'desirable' is the only way in which criteria have been prioritised.

Generic Clinical Governance Standards

As mentioned earlier in this document, clinical governance standards have been developed which apply to clinical services generally. These are currently under revision and copies of the revised draft standards are available on request from NHS QIS or can be downloaded from the website (www.nhshealthquality.org).

4. Development of the Draft Standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours

Background

The term 'new GP contract' is used widely to describe changes in the provision of primary care services provided by GPs, their practice teams and related NHS services. As part of these new arrangements, responsibility for providing care out-of-hours shifts from individual GPs to NHS Boards. NHS Boards may arrange for this care to be provided by GPs or make other arrangements. Section 8 gives a detailed description of the provision of primary medical services out-of-hours. These draft standards are applicable to providers of care and do not extend to NHS Boards in relation to their responsibility to ensure these services are in place. This is covered in the National Health Service (Scotland) Act 1978.

The public must have confidence in the services which are provided during the out-of-hours period. There has to be an assurance that people can access care when they need to, and that the services which are in place respond in a way which is appropriate to the clinical need of the patient. Out-of-hours services are not just a continuation or an extension of services provided by GP practices during the day. 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.

In addition to a range of legal requirements, any provider of services in the out-of-hours period will be placed under a specific requirement, from 1 January 2005, to comply with a set of standards issued by NHS Quality Improvement Scotland.

This document is a working draft and the standards will be validated through an accreditation process which is still under development.

The development of the draft standards has been led by a project group established by NHS Quality Improvement Scotland (NHS QIS). The membership of the Group reflects the perspectives and interests of the professionals, organisations and agencies responsible for the planning, provision and monitoring of out-of-hours services under these new arrangements. Membership is given in Section 5. Crucially, the Project Group includes lay representatives and the Scottish Consumer Council, to ensure that patient focus is core to the development of the draft standards.

In developing the draft standards the Project Group reviewed existing work in the provision of out-of-hours services and included elements of this where appropriate. As a result, these new draft standards build on existing evidence and good practice. A full list of associated documents is provided in the list of evidence in Section 9. However, it is important to highlight four key documents which underpin the development of the draft standards:

- Royal College of General Practitioners (RCGP) Out-of-Hours Working Party. 2002. Report on Quality Assurance System for Out-of-Hours Co-operatives Edinburgh: RCGP.

- Department of Health. 2000. Raising Standards for Patients: New Partnerships in Out-of-Hours Care. An Independent Review of GP Out-of-Hours Services in England. London: Department of Health. (Carson Standards)
- Department of Health. 2002. Quality Standards in the Delivery of GP Out-of-Hours Services. London: Department of Health.
- Turner J, Elliot F, Robson B, et al. 2003. New GMS Contract Out-of-Hours (OOHs) Working Group: Interim Report. Edinburgh: National Out-of-Hours Working Group, NHSScotland.

In addition, the Project Group has sought to ensure that the draft standards reflect and incorporate the NHS QIS draft standards for healthcare governance and relevant legislation and guidance issued to NHS Scotland by the Scottish Executive Health Department (SEHD). As a result, evidence prepared for these purposes can also be used in relation to the review of out-of-hours services. While these key elements may be duplicated, this is to emphasise their importance rather than to duplicate work. Information prepared for other purposes will not need to be duplicated. It also means that the assessment arrangements can be tailored to different types of provider, ranging from single-handed practitioners to large complex organisations. At this stage, these are referred to as:

- those providing care for their own patients only; and
- those providing care for their own and/or other patients.

The NHS QIS Project Group has also worked with the National Working Group, established by the SEHD to support the implementation of new out-of-hours arrangements in Scotland. The National Working Group has identified the ways in which services are likely to be provided in the future. In describing the new arrangements, the National Working Group has underlined that, because of the structural and geographical diversity of Scotland, from densely populated urban centres to sparsely populated remote and rural areas (including a large number of island communities), there is no single solution for the design of a model of out-of-hours service provision. Each NHS Board in Scotland will put arrangements in place in accordance with local circumstances, but to a set of common standards, the draft of which are provided in this document.

Following a period of consultation on the *Draft Standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours*, the standards will be published by NHS QIS, after which the performance of all primary medical services out-of-hours providers in Scotland will be assessed.

Submitting Your Comments

Comments on the *Draft Standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours* should be submitted by **Monday 31 May 2004**.
Please send these to:

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5. Membership of the Primary Medical Services Out-of-Hours Project Group

The membership of the Primary Medical Services Out-of-Hours Project Group, chaired by The Very Reverend Graham Forbes CBE, is presented below:

Name	Title	NHS Board Area/Organisation
Mr Colin Brown	Branch Head, Primary Care Development and Performance Management Branch	Primary Care Division, Scottish Executive Health Department
Dr Andrew Buist	General Practitioner	Scottish General Practitioners' Committee
Ms Fiona Dalziel	Independent Consultant in General Practice Management	DL Practice Management Consultancy
Dr Liz Duncan	Associate Medical Director	NHS24
Dr Norrie Gaw	Divisional Medical Director, Primary Care	Greater Glasgow
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	General Practitioner	Ayrshire & Arran
Mr David Paul	Lay Representative	Greater Glasgow
Dr Ken Proctor	Medical Director, Highland Primary Care NHS Trust	Highland
Mr Ian Reid	Chief Executive, Greater Glasgow Primary Care NHS Trust	Greater Glasgow
Dr Brian Robson	Medical Director	NHS24
Dr Mairi Scott	Chair	Royal College of General Practitioners Scotland
Ms Karen Spence	Business Manager	Ayrshire Doctors On Call
Dr Marion Storrie	Out-of-Hours Redesign Lead, East of Scotland	Lothian
Dr Bill Taylor	General Practitioner	Grampian
Ms Susan Watt	Education and Clinical Advisor	Royal College of Nursing
Ms Helen Whyte	Out-of-Hours Lead, Pay Modernisation	Scottish Executive

The NHS Quality Improvement Scotland (NHS QIS) Board member specifically working with The Provision of Primary Medical Services Out-of-Hours Project Group is The Very Reverend Graham Forbes CBE.

Support from NHS QIS is being provided by Ms Jan Warner (Director of Performance Assessment and Practice Development), Ms Hilary Davison (Standards Development Team Manager), Mr Steven Wilson (Review Team Manager), Mrs Selina Clinch (Senior Project Officer), Mrs Fiona Russell (Senior Project Officer), Miss Michelle Cargill (Project Officer), and Mrs Lorraine Inglis (Project Administrator).

6. Overarching Principles

The introduction of the new General Medical Services (GMS) contract brings with it many changes to the way in which these services will be provided. During the transition period from existing working practices to the new contract, it is important that the public and the service are well informed about what is to happen, how, and when, and that any associated risks are well managed.

In order to support this process, a number of overarching principles have guided the development of the *Draft Standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours*. Firstly, these draft standards are intended to ensure that out-of-hours services will be accessible, acceptable and available to patients and their representatives. These are cornerstone principles for all health services.

Secondly, the service has to be responsive to those using it, and to make sure they know what to expect and when. Out-of-hours medical services will be based on clinical need and will be provided in a variety of ways. The standards have to reflect the different circumstances in which care will be provided.

Thirdly, the draft standards must build on work already carried out in Scotland and elsewhere in the UK. It is important to learn from experience and to share what works well.

Finally, it is important to make sure that the draft standards focus on the **key** aspects of the following:

- patient experience;
- safe and effective care; and
- monitoring and reporting.

By targeting these aspects of care, the draft standards will support the new providers in putting the new arrangements for out-of-hours services in place. Over time, the standards will be further developed as the service matures. Statutory and legislative requirements, such as the Disability Discrimination Act 1995, for the provision of primary medical care are not included in these draft standards, as arrangements are already in place to ensure that service providers comply with these requirements.

7. Key Terms within the Draft Standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours

Certain terms are used throughout these draft standards. These have specific meaning in relation to the provision of out-of-hours services and are defined in this section for ease of reference when using the draft standards.

accessibility	Accessibility includes an obligation to let people know about out-of-hours services, how to contact them, and to ensure that services are physically accessible.
clinical governance committee	NHS Boards are required to work within a framework through which NHS organisations are accountable for both continuously improving the quality of their services, and safeguarding high standards of care. The NHS Board clinical governance committee has a duty to oversee delivery of these.
clinical information	The information needed to support clinical decision making, and to facilitate delivery of quality, timely services to patients. This includes patient records, agreed clinical protocols and guidelines, and access to the best clinical evidence available.
clinical need	Healthcare decisions can be said to be made necessary, or justified, by the specific physical or mental problems of a patient, or what is described as their clinical need.
direct provision	Primary medical services provided directly by a NHS Board for their residents under Section 2C(2) of the National Health Services (Scotland) Act 1978. See primary care.
General Medical Services (GMS)	Primary medical services provided by an NHS Board under Section 17J of the National Health Service (Scotland) Act 1978, between the NHS Board and a provider. Nationally negotiated with some local flexibility for GPs to 'opt out' of certain services or 'opt in' to the provision of other services.
health board medical services	Primary medical services included in a contract under Section 2C(2) of the National Health Service (Scotland) Act 1978, between the NHS Board and a provider.
healthcare governance	This is the collective term used to describe the overarching accountability of NHS Boards to ensure patient focus, clinical governance (safe and effective care) staff governance (competent and supported staff) and corporate governance (financial probity).
indirect provision	In the context of out-of-hours arrangements, where the NHS Board contracts a third party to provide out-of-hours services.
multi-agency	Involving a range of organisations which deliver various aspects of services in, for example, the patient pathway.
multi-professional	Consisting of members of more than one profession.

NHS Board	NHS Boards are responsible for the strategic planning, service delivery, performance management and governance of each of Scotland's 15 local health systems. Since 1 April 2004, most NHS Board areas (excluding Island NHS Boards) have contained NHS operating divisions which are the successors to the NHS Acute and Primary Care Trusts. Divisions are not equivalent to NHS Trusts, since the latter had a separately-identifiable legal status and were overseen by an appointed Board with a Chair, remunerated members, etc.
NHS Trust	NHS Trusts were organisations responsible for providing a group of healthcare services for the local population. An Acute Trust provided hospital services. A Primary Care Trust provided primary care/community health services. Mental health services (both hospital and community based) were usually provided by Primary Care Trusts. Since 2001 Trusts operated within an overall framework drawn up by their NHS Board. Trusts were dissolved on 31 March 2004, becoming operating divisions of the NHS Board.
opting-out	The term used when a practice no longer provides services out-of-hours. If a practice wants to opt out, it can do this without the approval of the NHS Board. The only exception to this is those practices in very remote or isolated areas.
out-of-hours	Under legislation, the out-of-hours period is defined as: (1) the period beginning at 6.30pm on any day from Monday to Thursday and ending at 8.00am the following day; (2) the period between 6.30pm on Friday and 8.00am on the following Monday; and (3) Christmas Day, New Year's Day and other public or local holidays. This may vary locally.
patient	A person who is receiving care or medical treatment. A person who is registered with a doctor, dentist, or other healthcare professional, and is treated by him/her when necessary. Sometimes referred to as a user.
patient's representative	A person acting on behalf of the patient.
performers	From 1 April 2004, anyone who performs primary medical services will need to be included in the NHS Board's Primary Medical Services Performers' List. This will be a legal requirement. Performers are the health professionals who treat patients.
Patient Focus and Public Involvement	Patient focus and public involvement is a framework for change which aims to support NHS staff and NHS organisations to develop services which in partnership with those who use them.

primary medical services (PMS)	NHS Boards are required to provide or secure certain services for their own population and may provide those services for patients who live outside of the NHS Board's area. These are the services that would be provided by GP practices to patients registered with them. If the practice with which the patient is registered does not provide some of these services, the NHS Board must ensure that alternative services are in place.
professional judgement	Where a healthcare professional makes careful decisions in the patient's interests, drawing on the training, and expertise they have acquired and where necessary, on advice from others.
provider	The 'provider' enters into a contract or agreement with the NHS Board. This might be a GP practice for example. Different provider models are possible as set out in legislation.
quality assurance framework	A model used to define and monitor the standard of care that is required and provided.
scheme of delegation/escalation	An agreed document setting out the way in which issues should either be given to more junior staff or passed to a higher level.
Section 17C Agreement	Primary medical services included in an agreement made under Section 17C of the National Health Service (Scotland) Act 1978 between the NHS Board and a provider. These are locally negotiated agreements which are more flexible in accordance with local circumstances.

8. An Introduction to The Provision of Primary Medical Services Out-of-Hours

Until April 2004, GPs had 24-hour responsibility for the care of their own patients. During the out-of-hours period, GPs provided services themselves or delegated responsibility to another doctor through, for example, an out-of-hours co-operative.

From 1 April 2004, the Primary Medical Services (Scotland) Act 2004 places a duty on NHS Boards to provide 'primary medical services' for everyone living in the NHS Board area. NHS Boards can do so by providing services directly (this is known as 'direct provision') or by making arrangements (by 'contract' or 'agreement') with a range of 'providers' (known as indirect provision) through:

- a 'GMS' (General Medical Services) 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.

Under the new arrangements 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. If they have 'opted out' of out-of-hours provision, the GPs concerned no longer have personal 24-hour responsibility for their own patients. It is the whole practice which 'opts out' not an individual GP within the practice. Overall, NHS Boards have responsibility for providing out-of-hours services. Where GPs opt out of out-of-hours provision, an NHS Board can provide the services itself through 'direct provision', or by entering into a 'contract' or an 'agreement' for services with another provider. **Whatever the arrangements, the out-of-hours 'provider' (including the NHS Board if it is providing services directly) will be required, as a duty to meet the standards established by NHS Quality Improvement Scotland.**

Traditionally, out-of-hours services have been doctor-led, but increasingly, patients will be dealt with by a range of healthcare professionals. In many cases, NHS24 will have a key role in simplifying access arrangements for the public to a healthcare professional. Using their professional skills, they will determine the best course of action. This could be, for example:

- a home visit (for patients whose clinical condition, in the professional judgement of a healthcare professional, is such that it would not be appropriate for the patient to travel);
- a visit to a local out-of-hours centre; or
- an assurance that any concerns can be managed at home.

Other courses of action could also be taken, depending on the individual circumstances.

The public need to be confident that any healthcare professionals (and those providing support to them) working in the out-of-hours period, will have the right training, skills and competencies to provide a service appropriate to the clinical needs of the patient in the most appropriate setting.

During the out-of-hours period, a number of agencies and healthcare professionals have to work together to ensure that the services provided are integrated so that the patient receives the care they need. This is equally important when that care extends into the daytime period for the purposes of continuity of care. This means that arrangements must be in place to support multi-agency and multi-professional working. All those involved in the care of a patient must have access to the information they need to provide that care; and in turn, they must communicate with other healthcare professionals and agencies to manage each point of the patient's journey. There are safeguards in place for both professionals and patients to ensure that such information is only accessed and communicated when it is necessary for the purposes of a particular episode of care. However, as care is being provided for patients who are registered with a GP practice, the patient's own GP will need to be aware of care provided during the out-of-hours period.

9. Evidence Base for the Draft Standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours

Anderson R and Thomas D. 2000. Out-of-Hours Dental Services: A Survey of Current Provision in the United Kingdom. *British Dental Journal*, **188** (5): 269-274.

Barach P and Small S. 2000. Reporting and Preventing Medical Mishaps: Lessons from Non-Medical Near Miss Reporting Systems. *British Medical Journal*, **320**: 759-763.

Currell R, Urquhart C, Wainwright P, et al. 2004. Telemedicine Versus Face to Face Patient Care: Effects on Professional Practice and Health Care Outcomes (Cochrane Review). in *The Cochrane Library*. Issue 1. Chichester: John Wiley & Sons, Ltd. <http://www.update-software.com/abstracts/AB002098.htm> [full document] URL accessed 23/03/04.

Department of Health. 2002. Quality Standards in the Delivery of GP Out-of-Hours Services. London: Department of Health. <http://www.dh.gov.uk/assetRoot/04/06/68/30/04066830.pdf> [full document] URL accessed 19/03/04.

Department of Health. 2000. Raising Standards for Patients: New Partnerships in Out-of-Hours Care. An Independent Review of GP Out-of-Hours Services in England. London: Department of Health. <http://www.dh.gov.uk/assetRoot/04/06/68/27/04066827.pdf> [full document] URL accessed 19/03/04.

Fitzpatrick R. 1991. Surveys of Patient Satisfaction: 1-Important General Information. *British Medical Journal*, **302**: 887-889.

Hallam L, Wilkin D and Roland M, eds. 1996. *24 Hour Responsive Health Care*. Primary Care Briefing Paper. National Primary Care Research and Development Centre, University of Manchester. Edinburgh: Churchill Livingstone.

Munro J, Nicholl J, O'Cathain A, et al. 2000. Impact of NHS Direct on Demand for Immediate Care: Observational Study. *British Medical Journal*, **321**: 150-153.

NHS Quality Improvement Scotland (NHS QIS). 2004. *Draft Clinical Standards: Healthcare Governance: Working Towards Safe and Effective Patient Focused Care*. Edinburgh: NHS QIS. <http://www.nhshealthquality.org> [access to full document]

O'Dowd T and Sinclair H. 1994. Open All Hours: Night Visits in General Practice. *British Medical Journal*, **308**: 1386.

Rourke M. 1999. "Open All Hours?": *Inspection of Local Authority Social Services Emergency Out of Hours Arrangements*. London: Department of Health.

Royal College of General Practitioners (RCGP). 1999. *GP Out of Hours Services Working Group Report*. RCGP Summary Paper, 99/01. Edinburgh: RCGP Scottish Office.

Royal College of General Practitioners (RCGP) Out-of-Hours Working Party. 2002. Report on Quality Assurance System for Out-of-Hours Co-Operatives. Edinburgh: RCGP.

Salisbury C. 2000. Out-of-Hours Care: Ensuring Accessible High Quality Care for All Groups of Patients. *British Journal of General Practice*, **50** (455): 443-444.

Shipman C, Payne F, Hooper R, et al. 2000. Patient Satisfaction with Out-of-Hours Services: How Do GP Co-Operatives Compare with Deputizing and Practice-Based Arrangements? *Journal of Public Health Medicine*, **22** (2): 149-154.

Stroud J. 1999. *Access to GPs and Clinics Outside Office Hours, England 1999*. London: NHS Executive, Department of Health.

Telephone Helplines Group. 1993. *Telephone Helplines: Guidelines for Good Practice*. 2nd ed. London: Telephone Helplines Group.

Turner J, Elliot F, Robson B, et al. 2003. New GMS Contract out-of-Hours (OOHs) Working Group: Interim Report. Edinburgh: National Out-of-Hours Working Group, NHS Scotland.

<http://www.show.scot.nhs.uk/sehd/paymodernisation/Documents/OOHFINALMinistersVersion241003.pdf> [full document] URL accessed 19/03/04.

10. Draft Standards for The Provision of Safe and Effective Primary Medical Services Out-of-Hours

STANDARD 1 - Accessibility and Availability at First Point of Contact

STANDARD 2 - Safe and Effective Care

STANDARD 3 - Audit, Monitoring and Reporting

STANDARD 1 - Accessibility and Availability at First Point of Contact

Standard Statement	Rationale	Criteria
<p>Out-of-hours services* are available and accessible to patients and their representatives.</p> <p><i>* 'Out-of-hours' is defined in legislation as 6.30pm to 8.00am weekdays, weekends and public holidays. Local arrangements may vary.</i></p>	<p>Illness or health-related problems happen after GP practices have closed:</p> <ul style="list-style-type: none"> • Patients and their representatives need access to care at all times; • NHS Boards have a legal responsibility to provide or make sure primary medical services are provided at all times, including out-of-hours; • NHS Boards also have a responsibility to inform everyone living in their area about the out-of-hours medical services in place, and how to access them. 	<p>1.1 Arrangements are in place to identify the needs of those potentially using these services.</p> <p>1.2 Arrangements are in place to meet the needs of those potentially using these services.</p> <p>1.3 Arrangements are in place for patients or their representatives to access the service by telephone (in the first instance).</p> <p>1.4 Access to, and delivery of services, is not compromised by physical, language, cultural, social, economic and other barriers.</p>

STANDARD 2 – Safe and Effective Care		
2a – Healthcare Governance		
Standard Statement	Rationale	Criteria
<p>The service provider has a comprehensive patient-focused healthcare governance programme in place.</p>	<p>Involving patients in their care supports their decision-making and there is good evidence that outcomes are improved.</p> <p>Safe and effective care can only be provided if:</p> <ul style="list-style-type: none"> • patient safety is at the core of all care and treatment and risks are identified, managed and minimised (clinical governance); • staff are competent, supported and have ongoing training (staff governance); and • NHS Boards have robust arrangements in place to make best use of all resources (corporate governance). <p>Healthcare governance aims to put in place the necessary clinical staffing and corporate infrastructure that informs the identification of risks and supports the provision of safe and effective care.</p>	<p>PATIENT FOCUS</p> <p>2.a.1 All levels of the service work in partnership with individuals, communities and community planning partners in the design, development and review of services; have acted upon the results of this work; and have provided feedback to all those involved.</p> <p>CLINICAL GOVERNANCE</p> <p>2.a.2 There are clear, cohesive plans across the service that direct and support policy development and service delivery both internally and through delivery partners.</p> <p>2.a.3 Service providers operate a system of risk management to ensure that risks are identified, assessed, controlled and minimised.</p> <p>2.a.4 Providers of out-of-hours services have arrangements in place to report regularly to NHS Board clinical governance committees.</p> <p>2.a.5 Arrangements are in place to communicate, inform and co-operate with key professionals, external parties and voluntary agencies.</p> <p>STAFF GOVERNANCE</p> <p>2.a.6 Staff involved in out-of-hours care meet employment requirements, including qualifications.</p> <p>2.a.7 Staff are competent to perform their duties.</p>

		CORPORATE GOVERNANCE 2.a.8 All out-of-hours providers that employ staff and are stewards of public funds have systems in place that ensure financial probity.
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STANDARD 2 – Safe and Effective Care		
2b – Clinical Care		
Standard Statement	Rationale	Criteria
Guidelines are readily available to support clinical decision-making and facilitate delivery of quality, timely services to patients.	Effective patient care cannot be provided without knowledge and understanding of, and access to, information based on the best available evidence.	<p>2.b.1 Systems are in place to ensure quick and easy access to evidence-based guidelines to support clinical decision-making and facilitate delivery of quality, timely services to patients.</p> <p>2.b.2 Patients are assessed and responded to, based on clinical need and professional judgement.</p> <p>2.b.3 The service has up-to-date emergency equipment and drugs which are readily accessible to appropriately qualified healthcare professionals within the service.</p>

STANDARD 2 – Safe and Effective Care		
2c – Information and Communication		
Standard Statement	Rationale	Criteria
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.	A patient's treatment or follow-up is effective when clear and appropriate information is communicated to those providing ongoing care.	<p>2.c.1 Comprehensive systems are in place for the completion, use, storage and retrieval of records including compliance with the Data Protection Act 1998.</p> <p>2.c.2 Arrangements are in place to ensure that patients and their representatives have access to information about any care or treatment they are given.</p> <p>2.c.3 Systems are in place for receiving and communicating information to inform patients' ongoing care.</p> <p>2.c.4 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.</p>

STANDARD 3 – Audit, Monitoring and Reporting		
Standard Statement	Rationale	Criteria
A provider-specific quality assurance framework is in place to support routine audit, monitoring and reporting of performance.	Monitoring of performance helps to identify and manage risks and supports the continual improvement of care.	<p>3.1 A set of provider-specific key performance indicators (PFPI, clinical and organisational) are in place.</p> <p>3.2 Comments, complaints and compliments are recorded and regularly reviewed and action taken.</p> <p>3.3 The service provider takes action to identify patient views and satisfaction levels.</p> <p>3.4 A report on performance and services is published annually and is available to users of the service and those contracting services.</p>

11. Glossary of Terms

accreditation	A process, based on a system of external peer review using written standards, designed to assess the quality of an activity, service or organisation.
advocacy	Where an individual acts independently on behalf of, and in the interests of, patients/users who may feel unable to represent themselves in their contacts with a healthcare or other facility.
AHP	See allied health professions.
allied health professions (AHPs)	Healthcare professionals directly involved in the provision of primary and secondary healthcare. Includes several groups such as physiotherapists, occupational therapists, dietitians, etc. Formerly known as professions allied to medicine (PAMs).
assessment	The process of measuring patients' needs and/or the quality of an activity, service or organisation.
audit	Systematic review of the procedures used for: diagnosis, care, treatment and rehabilitation, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient.
clinical care	Care provided by healthcare professionals, and related to physical or mental health problems.
clinical governance	<p>A framework through which NHS organisations are accountable for both continuously improving the quality of their services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.</p> <p>Management of clinical risk at an organisational level is an important aspect of clinical governance. Clinical risk management recognises that risk can arise at many points in a patient's journey, and that aspects of how organisations are managed can systematically influence the degree of risk.</p>
clinical infrastructure	The environment which supports clinical care and research. This includes support staffing, which may be specialised, and the systematic provision of resources such as information networks or laboratory facilities.
contracting	A person who is contracting is someone who is responsible for securing a contractor to deliver a service.
criterion(sing.)/criteria(pl)	Provide the more detailed and practical information on how to achieve the standard, and relate to structure, process or outcome factors.
data source	The source of evidence to demonstrate whether a standard or criterion is being met.

delegation	Where someone with responsibility for another person(s) sets out specific tasks this individual is to perform. Delegation requires a clear remit and limited transfer of authority, adequate briefing and resources, and scope for feedback. The authority of the person who has made the delegation ultimately underpins the process.
diagnosis	Identification of an illness or health problem by means of its signs and symptoms. This involves ruling out other illnesses and causal factors for the symptoms.
discharge	A discharge marks the end of an episode of care. Types of discharge include in-patient discharge, day-case discharge, day-patient discharge, out-patient discharge and allied health professions (see AHPs) discharge.
episode of care	An episode of care can be of various types: in-patient; day case; day patient; haemodialysis patient; outpatient or AHP. Each episode is initiated by a referral (including re-referral) or admission and is ended by a discharge. Each patient type, with a few minor exceptions, is associated with a type of episode of care. These episodes comprise a series of service contacts. It is important to note that a person may be in more than one episode at a time.
escalation	Advancing an issue to a higher level for resolution. If this level is unable to provide a resolution, the issue is moved up to the next appropriate level, and so on. Efficient escalation requires agreement on what types of decision need to be made at certain levels, how to identify such issues and who and how to contact at senior levels.
essential (criterion/criteria)	A criterion that should be met wherever a service is provided.
evaluation	The study of the performance of a service (or element of treatment and care) with the aim of identifying successful and problem areas of activity.
evidence-based medicine	Evidence-based clinical practice is an approach to decision making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits that patient best.
follow-up	Where a patient receives continuing care after the initial episode of care and/or where the outcome of initial care is checked up.
General Practice Administration System for Scotland (GPASS)	GPASS is the national primary care system for Scotland and is one of Britain's leading general practice computer systems.
GP	General Practitioner.
guidelines	Systematically developed statements which help in deciding how to treat particular conditions.
HDL	See Health Department Letter.

Health Council	Each NHS Board area has a Health Council, an organisation whose aim is to promote public consultation and participation in health-related matters. Sometimes referred to as a Local Health Council.
Health Department Letter (HDL)	Formal communications from the Scottish Executive Health Department to NHSScotland (formerly known as Management Executive Letter - MEL).
healthcare governance standards (under consultation)	The NHS QIS healthcare governance standards provide a framework for the continuous improvement of the quality, safety and effectiveness of clinical services. These standards are 'generic' in that they apply to all NHSScotland services.
healthcare professional induction programme	A person qualified in a health discipline. Learning activities designed to enable newly appointed staff to function effectively in their new job.
Island NHS Board	There are three Island NHS Boards (Orkney, Shetland and the Western Isles). They have always had a combined strategic and operational role. See NHS Board and NHS operating division.
Joint Future agenda	An initiative by the Scottish Executive to look at issues in care services and to: agree a list of joint measures which agencies need to have in place to deliver effective services, and to set deadlines for that; advise on the balance between residential and home-based care; advise on options for charging for care at home; and advise on how to identify and share good practice. The Joint Future Group report was published in November 2001.
managed clinical network (MCN)	A formally organised network of clinicians. The main function is to audit performance on the basis of standards and guidelines, with the aim of improving healthcare across a wide geographic area, or for specific conditions. Each MCN is required to have a Quality Assurance Framework describing the standards the service will meet. The Framework has to be accredited by NHS QIS and an annual report on progress is also required.
MCN	See managed clinical network.
monitoring	The systematic process of collecting information on the performance of clinical or non-clinical activities, actions or systems. Monitoring may be intermittent or continuous. It may also be undertaken in relation to specific incidents of concern or to check key performance areas. Monitoring is used to appraise strengths, weaknesses, opportunities and threats.

multidisciplinary team	A multidisciplinary team is a group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors. These include: the specific condition, the scale of the service being provided, and geographical/socio-economic factors in the local area.
NHS	National Health Service.
NHS operating division	On 1 April 2004, NHS Trusts in Scotland were replaced by NHS operating divisions. NHS operating divisions are committees of an NHS Board, with schemes of delegated authority setting out operational freedom for the delivery of services. While they are successors to the NHS Acute and Primary Care Trusts, they have no separate legal identity from the NHS Board. In two areas - Borders and Dumfries & Galloway - there are no operating divisions, with the NHS Board fulfilling a role like that of the three Island Boards.
NHS QIS	See NHS Quality Improvement Scotland.
NHS Quality Improvement Scotland (NHS QIS)	NHS Quality Improvement Scotland is a statutory body, established as a Special Health Board in January 2003. Its role is to focus on improving the quality of patient care and the health of patients. It will have a particular emphasis on the quality of care and the patient journey for vulnerable groups. NHS Quality Improvement Scotland has been created by the merger of five organisations: Clinical Standards Board for Scotland (CSBS); Health Technology Board for Scotland (HTBS); the Scottish Health Advisory Service (SHAS); Nursing and Midwifery Practice Development Unit (NMPDU), and the Clinical Resources and Audit Group (CRAG). Website: www.nhshealthquality.org
NHSScotland outcome	The National Health Service in Scotland. The end result of care and treatment and/or rehabilitation. In other words, the change in health, functional ability, symptoms or situation of a person, which can be used to measure the effectiveness of care and treatment, and/or rehabilitation.
palliative care	Palliative care is the active total care of patients and their families by a multi-professional team when the patient's disease is no longer responsive to curative treatment.
patient journey	The pathway through the health services taken by the patient (the person who is receiving treatment), and as viewed by the patient.
PCT	Primary Care Trust. See primary care.

peer review	Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review. In the NHS Quality Improvement Scotland approach, all members of a review team are equal.
Performance Assessment Framework (PAF)	The method used within NHSScotland to measure the performance of Trusts (see NHS Trust) and NHS Boards against agreed indicators.
performance indicators	Key measures of performance.
pharmacist	A qualified professional who understands the nature and effect of medicines and how they are produced and used to prevent and treat illness, relieve symptoms or assist in the diagnosis of disease. Pharmacists use their expertise for the wellbeing and safety of users and the public.
physician	A specialist in medicine.
point of contact	The staff member who is first to be contacted by a member of the public, using a recognised channel such as a dedicated telephone number, or face to face.
policy	An operational statement of intent in a given situation.
prescription	Usually a written recipe of treatment.
primary care	The conventional first point of contact between a patient and the NHS. This is the component of care delivered to patients outside hospitals and is typically, though by no means exclusively, delivered through general practices. Primary care services are the most frequently used of all services provided by the NHS. Primary care encompasses a range of family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.
protocol	A policy or strategy which defines appropriate action in specific circumstances. Protocols may be national, or agreed locally to take into account local requirements.
provider-specific	Tailored to the way in which a particular provider has agreed to provide a service.
QA	See quality assurance.
quality assurance (QA)	Improving performance and preventing problems through planned and systematic activities including documentation, training and review.
Quality Assurance Manual	Document outlining the methods and procedures to be used in setting standards and reviewing services.
rationale	Scientific/objective reason for taking specific action.
referral	The process whereby a patient is transferred from one professional to another, usually for specialist advice and/or treatment.

reporting	The effective presentation and dissemination of information collected through monitoring processes.
review	See peer review.
Scottish Executive Health Department (SEHD)	The Scottish Executive Health Department is responsible for health policy and the administration of NHS Scotland. Website: www.show.scot.nhs.uk/sehd
SEHD	See Scottish Executive Health Department.
self-assessment	Assessment of performance against standards by individual/clinical team/NHS operating division/NHS Board providing the service to which the standards are related.
Special Health Board	The name given to Health Boards with a national remit. These boards are focused on specific areas, eg NHS Education for Scotland, or NHS Quality Improvement Scotland. Special Health Boards match regional NHS Boards in terms of administrative grading.
standard	Agreed level of performance.
standard statement	An overall statement of agreed performance.
statutory	Enacted by statute; depending on statute for its authority as a statutory provision. Required by law.

Appendix 1 - Membership of the National Out-of-Hours Working Group

The membership of the National Out-of-Hours Working Group, chaired by Dr Frances Elliot, Fife Primary Care NHS Trust, is presented below (members of the NHS QIS Provision of Safe and Effective Primary Medical Services Out-of-Hours Project Group are in italics):

Name	NHS Board Area/Organisation
Derek Bell	Lothian
David Bolton	Lothian
<i>Andrew Buist</i>	<i>Scottish General Practitioners' Committee</i>
Linda Bunney	Dumfries & Galloway
Ross Cameron	Borders
Jim Crombie	North Glasgow
Roelf Dijkhuizen	Grampian
Carol Gillie	Borders
John Glennie	Borders
Laura Gray	Grampian
David Heaney	University of Aberdeen
Helen Kelly	Forth Valley
Annie Ingram	North Scotland Regional Planning Group
Michael Johnson	Shetland
Colville Laird	Highland
Paul Leak	Highland
Stewart MacDonald	Lanarkshire
Fiona McKay	Grampian
Shiona Mackie	Lanarkshire
Richie Malloch	Scottish Executive Health Department
<i>Andrew Marsden</i>	<i>Scottish Ambulance Service</i>
Kingsley Matthews	Argyll & Clyde
David Meikle	Renfrew & Inverclyde
Gordon Melrose (until March 2004)	Forth Valley
Catriona Ness	Tayside
Lynn Perkins	Lanarkshire
Gordon Peterkin	Grampian
<i>Ken Proctor</i>	<i>Highland</i>

Martin Pucci	Grampian
Keith Redpath	Greater Glasgow
<i>Brian Robson</i>	<i>NHS 24</i>
Shirley Rogers	Scottish Ambulance Service
Douglas Rolland	National Association of GP Co-operatives
Ian Ross	Lanarkshire
<i>Karen Spence</i>	<i>National Association of GP Co-operatives</i>
<i>Marion Storrie</i>	<i>Lothian</i>
John Turner	General Medical Services
Graham Waller	Scottish Executive Health Department
Iain Wallace	Greater Glasgow
Hugh Whyte (until January 2004)	Scottish Executive Health Department

Our Commitment

Our work will be undertaken in line with the following values:

- **patient and public focus**
 - ~ promoting a patient-focused NHS that is responsive to the views of the public
- **independence**
 - ~ reaching our own conclusions and communicating what we find
- **partnership**
 - ~ involving patients, carers and the public in all parts of our work
 - ~ working with and supporting NHS staff in improving quality
 - ~ collaborating with other organisations such as public bodies, voluntary organisations and manufacturers to avoid duplication of effort
- **evidence-based**
 - ~ basing conclusions and recommendations on the best evidence available
- **openness and transparency**
 - ~ promoting understanding of our work
 - ~ explaining the rationale for our recommendations and conclusions
 - ~ communicating in language and formats that are easily accessible
- **quality assurance**
 - ~ aiming to focus our work on areas where significant improvements can be made
 - ~ ensuring that our work is subject to internal and external quality assurance and evaluation
- **professionalism**
 - ~ promoting excellence individually and as teams and ensuring value for money in the use of public resources (human and financial)
- **sensitivity**
 - ~ recognising the needs, opinions and beliefs of individuals and organisations and respecting and encouraging diversity

This document can be viewed on the NHS Quality Improvement Scotland website. It is also available, on request, from NHS Quality Improvement Scotland in the following formats:

- Electronic
- Audio cassette
- Large print

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