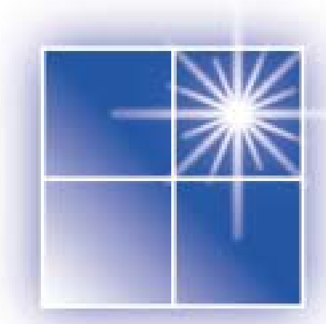
Accrediting Providers of Out-of-Hours Care

A system for improving patient care and assuring quality

A Handbook for PCT Accreditation Teams and Organised Providers of **Out-of-Hours Services**



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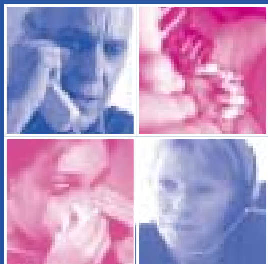


QUOTES from organised providers taking part in the pilot:

- *"Enjoyable"* • *"Enormously positive for our organisation"* •
- *"Good for our staff"* • *"Nothing was unachievable"* •
- *"Accelerates attention positively on priority areas"* •

Foreword

In March 2000, the Department of Health commissioned an independent review of GP out-of-hours services. The Review published its Report – *Raising Standards for Patients. New Partnerships in Out-of-Hours Care* – in October 2000 and, in accepting all of its twenty-two recommendations, the government endorsed its view that a new, integrated out-of-hours service could be developed by 2004. This new model will ensure that, for the first time, the same high quality out-of-hours service will be available to all NHS patients in England, regardless of where they live, or the GP Practice with which they are registered.

The Review identified a number of ways in which this consistency would be secured, of which the proposal to accredit all organised providers of out-of-hours services was one of the most important. While accreditation will, in the first instance, ensure that all organised providers meet a common set of minimum standards, the particular approach set out in this Handbook will go beyond this, putting in place a structure in each local health community that will ensure that all providers continue to develop and improve their services after their initial accreditation has been secured. In this way, accreditation will make an important contribution to the ongoing process of service development and improvement that is at the heart of the modernisation of the NHS.

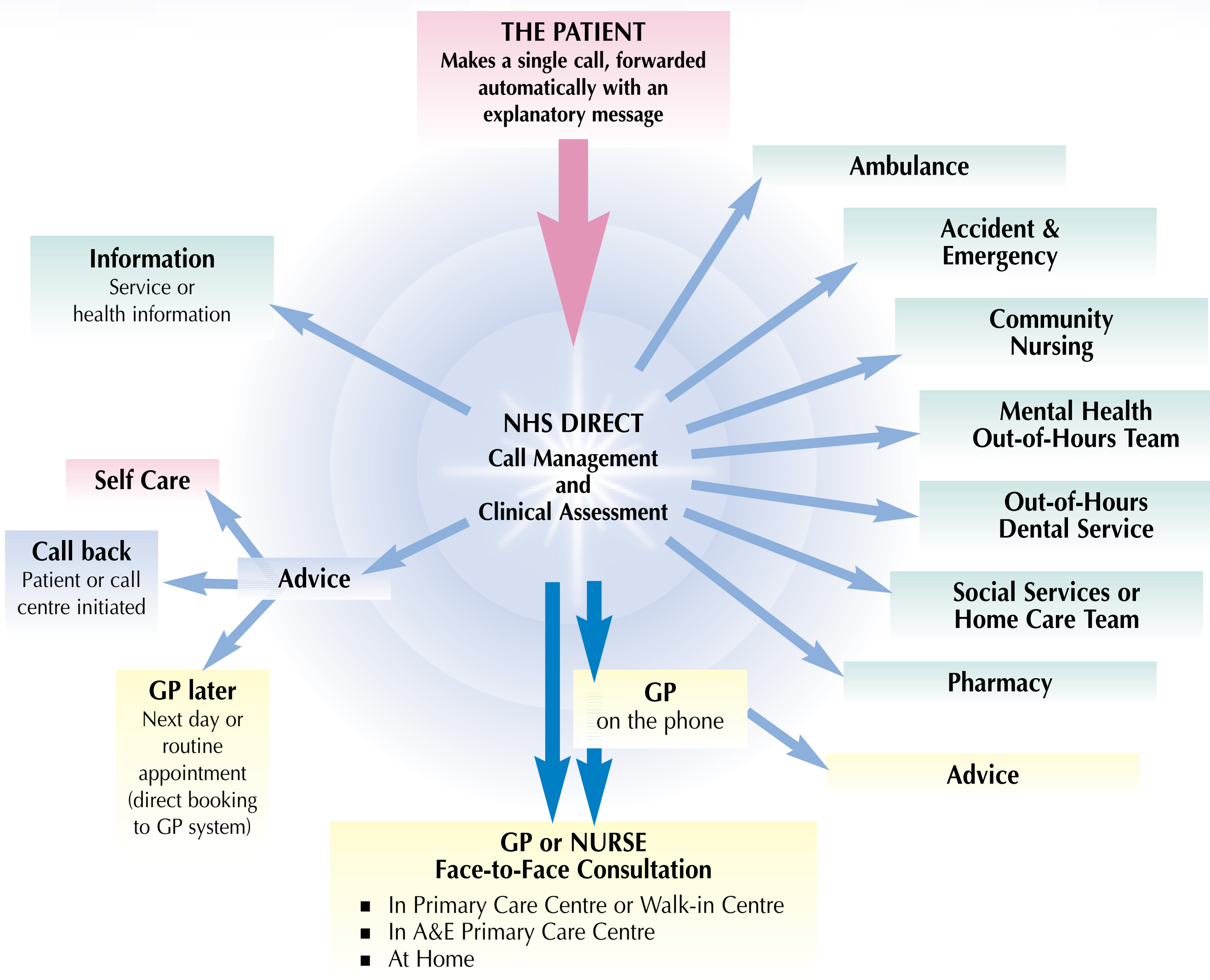
Not least because it was recognised at the outset that accreditation would only be useful if it was developed by those who have firsthand experience of GP out-of-hours services, the Department of Health commissioned the Royal College of General Practitioners to carry out the detailed development work. Thus, a model of accreditation was developed during 2001, and this was then tested in a number of pilot sites at the end of the year. That exercise confirmed that the approach was well-founded, although some important lessons were learned which have been incorporated into this final version of the Handbook.

May I take this opportunity to thank all of those who have worked so hard to complete this piece of work. First and foremost, Dr Tim Wilson and Ms Fiona Smith of the Quality Unit at the Royal College of General Practitioners. Secondly, the members of the Sub-Group who supported the project – Dr Helen Metcalf (Secretary of the NAGPC), Dr Andy Dun (Group Medical Director of Healthcall), Ms Gill Rogers (Deputy Director of Primary Care at the Ealing, Hammersmith and Hounslow Health Authority), Ms Helen Allanson (Medicines Management Pharmaceutical Adviser to the North West NHS Executive), Ms Julie Knott (Lead Nurse NHS Direct East Midlands), and Dr Nicholas Reeves and Ms Lyn English (both from the Out-of-Hours Implementation Team). Last, but by no means least, the organisations who so generously agreed to take part in the pilot at a particularly busy time of the year and within an extraordinarily tight timescale; so very special thanks to Blackburn with Darwen PCT, Gedling PCT, Leicester City West PCT, Cumbrian Out-of-hours Doctors Co-operative (CUEDOC), Coventry Healthcall and Nottingham Emergency Medical Services (NEMS).

Dr David Carson
Leader of the Out-of-Hours Implementation Team

Section 1
Introduction

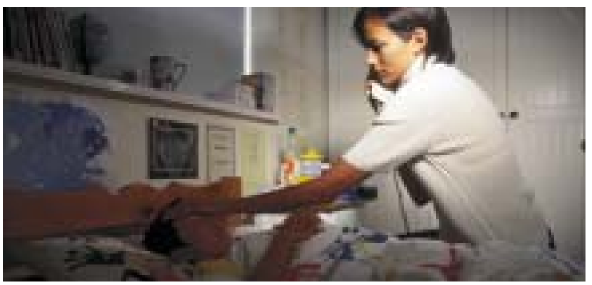
Accrediting Providers of Out-of-Hours Care



Background

The new, integrated model of out-of-hours provision can be summarised most easily in the diagram set out opposite. Patients access the out-of-hours service through a single telephone call and, after their needs have been carefully assessed, they are either advised to manage the problem themselves, or they are passed to the provider best placed to meet their particular needs. If those needs can be met on the telephone, then the patient is passed to that provider; if they need to be seen face-to-face, they end the telephone call with the clear understanding of where and when they will be seen. Thus, wherever patients live, they will have access to the same consistent, high quality service, and the characteristics of that service are defined in explicit Quality Standards.[1]

As part of the way in which those Quality Standards will be assured, Primary Care Trusts (PCTs) have been given the responsibility to accredit organised providers of out-of-hours services. This document is a guide to the way in which that accreditation will be delivered.

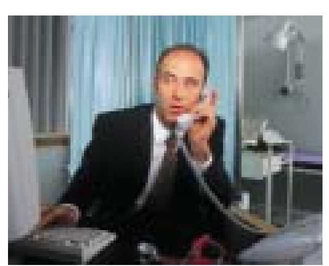


[1] The Quality Standards were first set out in the original report of the Review; they have now been published in a separate document, *Quality Standards in the Delivery of GP Out-of-Hours Services.*

Principles

Accreditation will play a supportive and developmental role in the delivery of out-of-hours services, and this approach has important implications for the manner in which it is undertaken. Some models of accreditation employ the services of a cadre of trained, 'expert' accreditors who visit an organisation, make their judgement and leave. The model set out here is fundamentally different. Accreditors will be expert in their role, but far from being 'parachuted' in from the outside, they will be drawn from within the local health community. With a proven local track record, they will be well-placed to give the process a local sensitivity and a credibility that it would otherwise lack. Moreover, as they grow in experience, so their value to that local community will grow, providing, in between accreditation visits, ongoing support grounded in a growing understanding of the characteristics of best practice provision. Whilst the standard of out-of-hours care is variable across the country, accreditation is not primarily about identifying poorly performing providers. It has been demonstrated many times that the bad apple theory of quality improvement (remove the worst and the remainder can be left alone) simply does not work. Instead, it is agreed by experts in quality improvement in health care and industry alike that, to assure a minimum standard of care whilst raising standards overall, a supportive approach is needed for all but a small minority of providers.

Accreditation will of course make new demands on all who deliver out-of-hours services, but far from this being an unhelpful additional burden, it can deliver real benefits to the organisation that is being accredited. Appropriate use of information technology will keep to a minimum the burden involved in the routine collection of data, and effective and appropriate use of that data opens up real opportunities for learning and service development. While the most obvious outcome will be the delivery of a better service to patients, more often than not those improvements in the character and quality of the service will be of real benefit to those who deliver the service as well.



Finally, it is important to emphasise that accreditation is only one of the new approaches being introduced to ensure the consistent delivery of high quality out-of-hours services. Service Level Agreements between the various individuals and organisations that, together, deliver the service in a given locality, provide the regular, day-to-day accountability in which all parties demonstrate their continuing ability to deliver a quality service, while performance against the Quality Standards is also reported to the PCT on a quarterly basis.[2]

[2] The manner in which all those engaged in the delivery of out-of-hours services will report on their performance is set out in is set out in Appendix A of *The Roles and Responsibilities of Those Engaged in the Delivery of GP Out-of-Hours Services. Notes for GPs, PCTs and Organised Providers in Respect of Reporting and Accreditation.*

Methodology

Primary Care Trusts' new responsibilities for the accreditation of organised providers of out-of-hours services take effect from October 2002 and, in the eighteen months that follows, all providers will have an accreditation visit.

The performance of all providers of out-of-hours services will be judged against the Quality Standards, and it is these Standards that provide the benchmark against which providers will be accredited. But, although many organisations come close, none is in a position to reach all these Standards today and, not least for this reason, it has been recognised that the Review will not be fully implemented until 2004. In this context, each provider seeking initial accreditation will therefore need not only to describe the character of its existing service, but to demonstrate ways in which the organisation plans to develop so that it can meet all the Standards by 2004.

Once accredited, organised providers report quarterly on their performance against the Quality Standards to all PCTs in whose areas they deliver their services, and it is this data that will quickly identify any problems with the existing provision, giving both the provider and the PCT sufficient early warning to enable them to take appropriate remedial action. Providers will be expected to demonstrate their continuing 'fitness for purpose' through a process of re-accreditation once every three years although, where any PCT has serious concerns about the quality of the provider's service, it may ask

the Accrediting PCT to initiate an earlier re-accreditation. In exceptional circumstances, where the provider's service poses a real threat to the safety of patients, the Accrediting PCT may suspend accreditation.

A PCT director will have overall responsibility for the accreditation process. The director will have discretion about how that process is managed at local level, although it is suggested that there should be a senior manager responsible for this important area of work. Looking at the current distribution of organised providers across the country, although some providers serve more than one PCT there is on average one organised provider for every PCT (although this may change as providers and PCTs merge), and this has two important implications:

- PCTs will have an apparent conflict of interest in accrediting providers in their own area and, objective scrutiny for the purposes of accountability could be compromised.
- Not every PCT will be able to develop a relationship with sufficient providers to acquire the experience needed for accreditation, and there are in any event real economies of scale to be gained from concentrating this work in a smaller number of PCTs.

For both these reasons, the following principles will apply:

- While responsibility for the accreditation of an organised provider will rest with the PCT to whom the provider submits its application to be accredited (the Accrediting PCT), it will always delegate the ***process*** of accreditation to another PCT (the Assessing PCT) which is responsible for an area in which the organised provider does not provide out-of-hours services.
- Every Accrediting PCT will therefore have to work with at least one other Assessing PCT to discharge this particular responsibility and, given the particular expertise and experience that will be required by those who carry out the process of accreditation, there is every reason for larger groups of PCTs to work collaboratively in this way. The real economies of scale are achieved when rather more than two PCTs share this work between them, although the precise size and composition of such groups must, of necessity, be determined locally.

The Process of Accreditation

PCTs will assume responsibility for the accreditation of organised providers on 1st October 2002 and their first task will be to accredit existing organised providers. At any time thereafter, however, groups or individuals may want to establish a new organised provider of out-of-hours services and it is therefore important to distinguish at the outset the different ways in which existing and new providers will be accredited. The account of the process that follows explores the inter-connecting roles of providers and PCTs, but their different roles and the timescales within which they will have to be delivered, are summarised on page 21.

Given the geographical complexity of existing provision and the changes in the pattern of service delivery that are beginning to take place, every application for accreditation will take the form of a letter of application, specifying both the precise geographical area in which the service is to be provided and the particular services that will be provided, and an Action Plan in which the provider sets out the character of its existing provision and the manner in which it will develop that provision to enable it to achieve all the Quality Standards by the end of March 2004. Assuming a successful outcome, the organised provider will only be accredited to deliver those particular services in that defined geographical area – any provider wishing to vary the geographical area or the range of services, would have to make a new application for accreditation.

All existing organised providers of out-of-hours services will have to apply for accreditation but, provided they are already providing out-of-hours services on 1st October 2002, that application will not be refused unless and until the process described below has been completed. Where they deliver that service in an area covered by more than one PCT, they should liaise with the PCTs involved to identify to which PCT they should present their application. Thereafter, the provider will be visited and, as a result of that visit, that accreditation will be confirmed, normally for a further three years but, where there are serious doubts about the quality of the service, for up to six months. All accredited providers will be visited by the end of March 2004. Providers will be re-accredited once every three years, although where any PCT has serious concerns about the quality of the provider's service, it may initiate an earlier re-accreditation. In exceptional circumstances, where the provider's service poses a real threat to the safety of patients, the PCT may suspend accreditation at any time.

In addition to the Action Plan submitted with the letter of application by 1st October 2002, organised providers will also have submitted their first quarterly report on the delivery of the Quality Standards.[3]

[3] For further advice on the manner in which reporting should take place see Appendix A of *The Roles and Responsibilities of Those Engaged in the Delivery of GP Out-of-Hours Services. Notes for GPs, PCTs and Organised Providers in Respect of Reporting and Accreditation.*

Taking account of both these documents, PCTs will identify the sequence in which providers will be visited and give providers due notice of those visits (further detail about this can be found on page 15 below). Once PCTs have had an opportunity to consider both the Action Plan and the first quarterly report, they will decide the order in which providers are visited, and will give providers due notice of that visit.

While the principles of accreditation for both existing and new providers are the same, the process is slightly different, and it is therefore important to distinguish the different ways in which existing and new providers will be accredited. Thus, where an existing organised provider is being accredited, Process A will be followed; where a new organised provider is being accredited, Process B will be followed.

Process A

Accreditation of existing organised providers delivering services at 1st October 2002.

■ Step One

The provider makes an application to a PCT in whose area it delivers services. As part of that application, it identifies both the precise geographical area in which it plans to provide services and the range of services it will provide. By accepting its application, the PCT becomes (for that provider) the Accrediting PCT. Provided the application is received by 1st October 2002 the provider is accredited.

■ Step Two

The Accrediting PCT then informs all the PCTs served by the provider that this application has been received, and delegates the process of accreditation to a PCT which is responsible for an area outside that in which the provider will provide services. When this second PCT accepts responsibility for the process of accreditation, it becomes (for that provider) the Assessing PCT.

■ Step Three

Wherever an Accrediting PCT receives more than one application for accreditation, it advises the Assessing PCT about the sequence in which accreditation visits are to be made, drawing particular attention to any anxieties it may have about the ability of a provider to deliver a safe service. The Assessing PCT will take proper account of these representations but, as it may well be fulfilling the same role for other Accrediting PCTs, it will have to determine the sequence in which it visits providers taking into account all their views.

■ Step Four

The Assessing PCT appoints a multi-professional Accreditation Team to carry out the visit and, advised by that Team, makes its recommendations to the Accrediting PCT. The Accrediting PCT then

accredits the provider for three years or, where there are serious doubts about the quality of the service, for up to six months, in which time it will be required to remedy any identified weaknesses.

Process B

Accreditation of New Organised Providers.

■ Step One

The provider makes an application to a PCT in whose area it plans to deliver services. As part of that application, it identifies the precise geographical area in which it plans to provide services and the range of services it will provide. By accepting that application, the PCT becomes (for that potential provider) the Accrediting PCT.

■ Step Two

The Accrediting PCT informs all the PCTs served by the provider that this application has been received and delegates the process of accreditation to a PCT which is responsible for an area outside that in which the provider will provide services. When this second PCT accepts responsibility for the process of accreditation, it becomes (for that provider) the Assessing PCT.

■ Step Three

The Assessing PCT appoints a multi-professional Accreditation Team who hold a preliminary meeting with the provider to establish that the provider's application is well-founded.

■ Step Four

As a result of that meeting the Assessing PCT makes a recommendation to the Accrediting PCT about next steps. It may recommend that the provider be accredited for up to six months, or it may advise that further work needs to be done before the application is resubmitted.

■ Step Five

Once accreditation for up to six months has been agreed, the provider reports monthly to the Accrediting PCT on its performance against the Quality Standards. Assuming that this monthly reporting reveals nothing particularly untoward, the Accrediting PCT will then ask the Assessing PCT to carry out a full accreditation visit at the end of those six months or sooner.

■ Step Six

The Assessing PCT appoints a multi-professional team to carry out the visit and, advised by that team, makes its recommendations to the Accrediting PCT. The Accrediting PCT then accredits the provider for three years or, where there are serious doubts about the quality of the service, for up to six months, in which time it will be required to remedy any identified weaknesses.

The Outcome of an Accreditation Visit

An accreditation visit will always result in one of the following outcomes:

- **One: The application is approved and the provider is accredited for three years.**

  The provider will demonstrate that it is already meeting many of the Quality Standards, and that it has rigorous and credible plans to meet all the others standards within a clearly defined timescale. The provider is accredited for three years.

- **Two: The application is approved and the provider is accredited for up to six months.**

  The provider will demonstrate that it is meeting some of the Quality Standards, and that it has developed a plan to meet the outstanding Standards. While a good start has been made, the Accreditation Team is not satisfied that the provider is entirely 'fit for purpose', and thus it will be accredited for an initial period of six months. During those months, the provider will work with the Accreditation Team to develop an Action Plan to address the concerns raised by the visit and, at the end of that period, it will submit further evidence to the Team of the work that has been achieved. The Team will then be able to decide whether a second visit is necessary, depending on the nature of the changes that have been achieved and the evidence provided.

- **Three: The application is not approved, the provider is not accredited and urgent action is required.**

  The provider will fail to demonstrate an ability to meet the Quality Standards, and will not yet have developed realistic plans to meet them in the months ahead. The provider will not be accredited, and the Accreditation Team will initiate an intensive period of planning for the urgent development of the organisation, in which both the provider and the Accrediting PCT will be involved. An explicit, rigorous, time-limited development plan will be developed within a month, setting out clearly the objectives that the provider will need to achieve so that it can reach a position where it can properly bid for accreditation once more. This process of development will be rigorously monitored by the Accrediting PCT and if at any time (during or at the end of this process) it is convinced that the service offered by the provider endangers the safety of patients, it will deny the provider any further opportunity to bid for accreditation and will make alternative arrangements for the provision of out-of-hours services in that locality. The responsibility for making those alternative arrangements rests solely with the PCT – it would be entirely unacceptable for the PCT simply to hand responsibility for out-of-hours services back to individual GPs.

The Action Plan

At the heart of accreditation is an assessment of whether the organised provider is taking proper account of the Quality Standards. It is these Standards that provide the benchmark against which providers will be accredited and, although many organisations come close, none is in a position to reach all these Standards today. Thus, it is within this context that each provider seeking accreditation will need to make the case for that accreditation in an Action Plan that sets out, not simply the character of its existing service, but the ways in which the organisation plans to develop so that it can indeed meet all the Standards by 2004.

Section Two of this Handbook sets out the major elements that each provider will need to address:

1 Clinical Governance.

- **1.1** People.
- **1.2** Record Keeping and Auditing.
- **1.3** Communications within the NHS.
- **1.4** Complaints, Significant Events and Patients' Satisfaction Data.

2 Service and Organisational Models.

3 Access and Clinical Assessment.

- **3.1** Telephone Access.
- **3.2** Face to Face Consultation.
- **3.3** Patients with special needs.

4 Equipment, Premises and Transport.

In each area, the appropriate Standard is defined, and this definition is then supported by two further elements. The first, 'Possible evidence might include', indicates the kind of evidence that an accreditation team might expect to see to support the claim that the Standard is being met; the second, 'Comments', provides additional explanation of the Standard itself and, where appropriate, the reasons why the particular Standard is included.

While it is hoped that providers will find this guidance useful, it is important to recognise that one of the well-known dangers of a formal process of accreditation is that all involved develop an unduly 'tick-box' approach to their task. Thus, providers might focus all their energy on presenting statistical data, where this initial submission ought to set out a clear vision of the particular character of the organisation, the services it provides and the manner in which it proposes to grow and develop in the years ahead.

The purpose of the Action Plan is to demonstrate how the provider is currently performing against the standards set out in Section Two of this Handbook, and how it plans to reach the required standards where there are shortfalls. We have not provided a proforma for providers to complete, as it is important that providers develop a plan to meet their own purposes – a suggested outline is shown below.

An Action Plan for Out-of-Hours Providers

- Using the headings below, judge how well you are performing against the standards within them.

  1 Clinical Governance.

  1.1 People.

  1.2 Record Keeping and Auditing.

  1.3 Communications within the NHS.

  1.4 Complaints, Significant Events and Patients' Satisfaction Data.

  2 Service and Organisational Models.

  3 Access and Clinical Assessment.

  3.1 Telephone Access.

  3.2 Face to Face Consultation.

  3.3 Patients with special needs.

  4 Equipment, Premises, and Transport.

- Make an assessment of whether, based on the standards above, you are providing a service fit for purpose.
- Give an outline of the evidence used to come to this judgement.
- Clearly identify the priority areas (be realistic).
- Identify what action needs to be taken, when it will be taken, the resources that will be needed, who will action them & when that action will be reviewed (SMART objectives).
- For the areas not deemed a priority for the immediate period suggest when they will be reviewed and how appropriate action will be taken.

The Accreditation Team

It is the responsibility of the Assessing PCT to identify appropriate Accreditation Teams to carry out the detailed work of accreditation. They will be led by a person (lay, clinical or manager) experienced in visiting and accreditation and who has attended the national training programme on accreditation of out-of-hours providers. The multi-professional team will normally be made up of the following members but, where appropriate, additional professionals (a pharmacist, for example) might be included as well:

- A lay member.
- A manager from an out-of-hours provider.
- A general practitioner.
- A registered nurse.
- A practice manager.
- A PCT senior manager.

Two characteristics of the team are especially important. The members of the team are drawn from the local health community and, not least because of work that they have already done (perhaps in delivering the local clinical governance agenda), they will bring a considerable understanding of the health services in their area to the work of accreditation. The multi-professional character of the team is just as important, however, for it is only by being able to draw on this wide range of clinical and managerial experience that the team will be able to make appropriate and rigorous judgements about the quality of the service that is being provided.

The position of the lay member of the team is slightly different. In addition to bringing the patient's perspective, a lay person stands outside all the organisations and professional groups involved in the delivery of the service and is thus ideally placed to ensure that the process is both objective and works rigorously within its own terms of reference. Lay people serving in whatever role within local PCTs provide an obvious pool of people from which to recruit the lay member of the accreditation team, and this would have the additional advantage of providing an easy route for communication between the Team and the PCT. Accreditation teams may like to understand the theories of accreditation further and a good introduction can be found in *Accreditation in Primary Care.*[4]

Given the number of organisations that will need to be accredited, each PCT will probably need to recruit more than one accreditation team, but it will be important to ensure real continuity in the membership of those teams. For it is only through such continuity that members will develop that level of understanding

[4] Kieran Walshe, Nicola Walshe, Theo Schofield, Clare Blakeway-Philips, Liam Donaldson (editors), *Accreditation in Primary Care,* Radcliffe Medical Press, 1999.

of the character and quality of local provision that will enable them to play the supportive and developmental role identified in the Principles above. On the other hand, an individual team member may have a potential conflict of interest in relation to a particular accreditation visit, and it is therefore important that this be declared at the outset so that, where necessary, an alternative team member may be used.

Once again, members of the accreditation team might be tempted to develop an unduly 'tick-box' approach to their task, working their way through a check list of items, making simple, black-and-white judgements about whether or not a particular standard has been met. But if accreditation is to meet the Principles set out above, then it is vital that everyone approaches the task in a more thoughtful and sophisticated way. The accreditation team must focus proper attention on the Standards, but they must also use their experience and knowledge to make a more complex and subtle judgement about whether the provider is indeed 'fit for purpose'. In short, at its best, accreditation takes the form of an informed and vigorous dialogue between the accreditation team and the provider organisation. The effectiveness of the process is in direct relationship to the quality of the relationship that the two partners are able to develop.

The Timing of a Visit

The timing of a visit raises a number of critical issues for both the accreditation team and the provider. Thus, providers should be given two months notice for their visit. They should then provide an updated and extended version of their Action Plan to the accreditation team within two months of that notice being given. The visit should then occur within one month of the updated Action Plan being provided, allowing for proper for dissemination and discussion amongst the accreditation team and for any further information to be obtained. Once the visit has taken place the final report should be with the PCT within one month.

Preparatory Work

Preparing for the accreditation visit is a crucial part of the process as a whole. It allows for an effective working relationship to be developed between the provider and the accreditor, the only basis on which effective accreditation take place. It was the unanimous view of those who participated in the piloting of this guidance, that fair and rigorous accreditation would only be achieved where there had been effective preparation for the accreditation visit.

Once the Action Plan has been sent to the accrediting PCT, it is then distributed to the accreditation team. At this stage the team needs to take time to study the information provided, develop areas they wish to explore further and ask for further information, either immediately or to be provided on the day. The accreditation team should discuss the visit and agree their objectives for the day. Members of the team who have not previously been involved in an accreditation visit (for out-of-hours providers) should be briefed by the team leader. It is during this preparatory period that the accreditation team leader develops an effective relationship with the provider and, together, they develop a provisional understanding of how the accreditation visit will be conducted.

In particular, they should agree the timetable for the visit. It will need to include time to:

- Conduct the interviews
  (who will be interviewed and by whom).
- See around the premises.
- See further information as needed.
- Enable the accreditation team to discuss their findings.
- Feedback initial impressions.

In all of this, there needs to be a proper balance between, on the one hand, giving the accreditors sufficient time with the provider to develop a real understanding of the way in which they work and, on the other hand not disrupting the quality of the service which is provided to patients at the time of the visit.

Process of the visit

The importance of keeping to time was highlighted during the pilots, not least so that people who are being interviewed will not be kept waiting, and time needed for discussion and reflection will not be lost. Designating one member of the team to act as a facilitator to keep time was also found to be very valuable. This person could also co-ordinate the flow of information and observe the provider in action (not always possible whilst conducting an interview).

Interviews with most personnel can be conducted 1:1 and take 20–30 minutes. However, those with the general manager or medical director of the provider generally take 45 minutes and are better conducted with two interviewers. Although it is obviously not possible to interview a representative sample of patients, a small number of interviews with patients using the service at the time of the visit was found to be very helpful.

In the pilots, most accreditation visits lasted between seven and eight hours. For providers the total time taken in preparing for accreditation and working with the accreditation team during the visit itself was around 100–200 person hours. However, while this certainly represents a considerable investment on the part of the provider, it was the unanimous view of those providers who participated in the pilots that all of this work made a real contribution to the quality of the service they provided – in short, **no time was taken that would not otherwise have been taken in quality improvement work**. Accreditors found that they took a total of 100–150 person hours to prepare for the visit and write the report, but this was of course for teams undertaking this work for the very first time. There is every reason to suppose that as accreditation teams become more experienced, this workload will decline significantly.

Feedback and report

Both the feedback and the report should be based on evidence. In some cases it will be quite clear whether or not a provider has achieved a particular standard (e.g. with access times). In other areas, the judgement will be less black-and-white, and it may well be helpful to think about the quality of the provision in terms of the degree to which it complies with the standard in question – thus, the provider does not comply with standard at all, or it complies partially, or it complies fully. Whatever form of judgement is being made, however, it must be based on appropriate evidence, and it is critically important that this evidence is properly documented at the time of the visit.

It is almost always easier to focus on the negative aspects of a provider, and it is therefore important that the accrediting team pays proper attention to the positive characteristics of the provision. The team should therefore congratulate the provider on their positive attributes as well as drawing their attention to those areas in which their service could be improved. Thus, both in the oral feedback given at the end of the visit, and in the final report, the approach should be always be constructive. In the pilots, feedback sessions were made to as many staff as wished to come – this was felt to be very positive.

Structuring the report around the standards can be helpful to providers, both in determining how best to respond to the report, and in developing future Action Plans. Some accreditors in the pilot based their report around a grid in which, for each standard, they identified commendations (aspects of the provision about which they were particularly impressed), suggestions (helpful ideas that the provider might like to consider) and recommendations (which they would require the provider to implement) In the pilot, one accrediting team shared responsibility for writing the report between the different members of the team, and managed to write the outline during the visit (which they then used as a basis for the feedback session). Whether or not this is done, it is important that members of the team make their own notes during the visit and that all these notes are then made available to the person who is writing the report.

An example of a possible section in the Report

Standard 14

You conducted one patient survey last year but there is no evidence that you used it to change the way you provide care. You have not repeated the survey or used other means to sample the patient experience.

Action

You need to be systematic in regularly sampling patient experience, consider using other methods other than a survey and most importantly incorporate the findings into your development plans. You should indicate in your next quarterly report to the PCT what plans you have made for this and within the next six months have conducted another sample of patient experience and made it clear how this information is being used in your plans.

A draft report should be sent to the provider before the Report is sent to the PCT. This would give the provider an opportunity to identify any factual inaccuracies in the original draft, although the judgement as to whether these should affect the conclusions in the Report would of course rest with the accrediting team.

Although we have recommended that the report and feedback be structured around the standards, an assessment of the overall organisational characteristics and culture based on the findings would also be helpful. This is an analysis of the provider from a different perspective, but using the same information. Once again, where criticisms are made about aspects of the service, they should be backed up with clear evidence and include constructive suggestions about how to improve them. The following areas should be covered and might usefully be used in a report.

- **Patient focus**

  Any health care provider should be thinking how they will serve their patient population to their best ability. This means balancing individuals needs ('every patient is the only patient', making sure patients in a vulnerable situation are helped to their best ability) with those of the population as a whole.

- **Equity**

  All providers should be aware of continuing equity issues in the health service. This particularly includes hard-to-reach groups, the disabled, ethnic minorities and disadvantaged populations.

- **Quality improvement**

  The provider should have a system for quality improvement including a group identified with delivering the clinical governance agenda. This should be multi-disciplinary with a mix of management and clinical staff. All aspects of clinical governance should be covered (many are within the standards above) including risk management.

■ Team-working

Strong multi-disciplinary team-working is essential in any successful out-of-hours service. Regular time together and clear, open communication channels should have been demonstrated. A strong hierarchical structure, particularly with doctors at the pinnacle should be viewed with suspicion – do the doctors listen to criticism or to suggestions, for instance? However, strong leadership is also to be encouraged – do the doctors lead by example? Leadership is different to hierarchical behaviour.

■ Environment

The environment in which care is delivered has a strong influence on those being cared for as well as those working there. For instance: what does it feel like to be a patient in the centre? What state is the car in? Would you like to be a patient here or work here?

■ Use of evidence

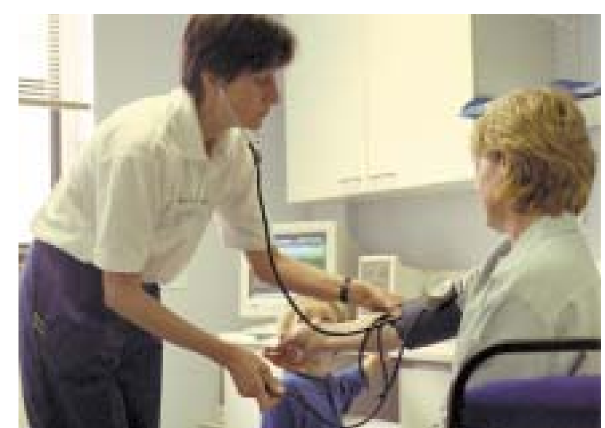
Good providers will give their staff access to important information. This might be access to evidence databases (e.g. Clinical Evidence), up-to-date copies of the BNF or poisons databases. Further, access to expert advice for special patients (e.g. palliative care will reduce the need for admission in some cases and improve care generally).

■ Safety

Does the provider consider patient safety? What do they do about it? Is there evidence that safety is important? Has it been brought up at meetings on a regular basis? Is there evidence of this from minutes taken?

■ How much they value and develop their staff

Staff constitute the NHS's most important asset – how much does the provider value its staff? This means not just pay, but other important matters such as educational support, good practice in times of sickness, proper rest area etc.



A Timetable for the first two years of accreditation visits

All existing providers will be visited by the end of March 2004 and the timetable that follows sets out the roles and responsibilities of PCTs and organised providers in that period.

DATE	PCT	ORGANISED PROVIDER
December 2001	PCTs complete a stock take of all existing out-of-hours services.	
End of February 2002	PCTs complete their 3 year plan for the implementation of the Out-of-hours Review in their locality.	
By 1st October 2002		All providers submit a letter of application for accreditation to a PCT in the area in which they deliver services (in which they identify both the geographical area in which the service will be delivered, and the range of services that will be offered), together with an Action Plan setting out the manner in which they will be able to deliver a service that meets all the Quality Standards by March 2004.
April to October 2002	All PCTs will have access to a national programme of training. During this period resources from the national Out-of-hours Implementation Fund will be made available to PCTs to support the process of accreditation.	All providers will have access to a national programme of training. During this period resources from the national Out-of-hours Implementation Fund will be made available to providers to support the process of accreditation.
October and November 2002	All PCTs consider the applications that they have received and, where a provider offers services in more than one PCT area, informs all those PCTs that it has received an application. Accrediting PCTs reach a view about the order in which providers should be visited and, having identified a potential Assessing PCT, pass the application to the Assessing PCT with advice on the sequence in which providers should be visited.	
December 2002	Assessing PCTs consider the applications and the advice that they have received from Accrediting PCTs and prioritise the sequence of visits over the 2 year period up to March 2004 in which all providers will be visited. They inform providers of the date on which they will be visited.	
January 2003 to March 2004	Assessing PCTs visit all providers.	All providers are visited.

After March 2004, all providers will be re-accredited at least once every three years and the sequence of those re-accreditations will take proper account of the date on which the provider was originally accredited.

Section 2
Standards

Standards

In each area, the appropriate *Standard* is defined, and this definition is then supported by two further elements.

1. Possible evidence might include – indicates the kind of evidence that an accreditation team might expect to see to support the claim that the Standard is being met; it is not, however, a checklist of all the evidence that must be presented and not the only evidence that might be used.

2. Comments – provides additional explanation of the Standard itself and, where appropriate, the reasons why the particular Standard is included.

The standards are carried over from the OOH Review in the three broad areas:

- *Clinical Governance.*
- *Service and Organisational Models.*
- *Access and Clinical Assessment.*

Standard One

All professionals involved in out-of-hours care must be eligible to be employed within the relevant parts of the NHS.

1 Possible evidence might include

- For doctors, inclusion on a Health Authority Medical List; or on a Health Authority Supplementary List; or be named as a performer of PMS in an agreement under section 2 of the Primary Care Act 1997.
- For nurses this should include UKCC registration.
- For pharmacists this should include RPSGB registration.
- For drivers this should include checking their driving licence and that they have no medical contraindications to driving and regular rechecks on the licence.
- For staff coming into direct contact with children and vulnerable adults etc. this should include evidence of a suitable police check.
- There should be use of other checks such as NHS Alert procedure, GMC investigations.
- For all staff references should be obtained from a reputable and preferably known source.
- Recruitment procedures should comply with all equal opportunities legislation.

2 Comments

It is important that staff should be checked for eligibility to provide a service, often in isolated conditions when patients are at their most vulnerable and distressed. Out-of-hours providers sometimes attract peripatetic staff and locums who whilst in the majority provide an excellent service are often unknown in their locality.

There should be mechanisms for staff to highlight if there are concerns about performance. This system should be supportive both to those whose performance is in doubt and the person who expresses concern.

Standard Two

The annual appraisal of individual professionals involved in out-of-hours care will include the assessment of out-of-hours skills. (For GPs, this will take place within NHS appraisal; for other staff, it will be part of the routine systems developed by all out-of-hours providers.)

Standard Three

Personal Development Plans should include the development of skills related to out-of-hours activity. These may include telephone clinical assessment skills development. Appropriate staff and doctors will be encouraged to have training in telephone communication skills.

1 Possible evidence might include

- For doctors there should be evidence of liaison between their appraiser and the OOH provider.
- Evidence of annual appraisal for employed staff.
- Statement of appraisal process and outline of how it works (including a structure and timetable of appraisals).
- Staff should be asked whether their appraisals occurred in a timely and appropriate fashion.
- Evidence of training (internal and external) sessions attended by OOH provider staff (doctors or employees).
- Evidence of training sessions provided / funded.
- Anonymised example of PDPs of employed staff.
- Interviews with employed staff about their PDP.
- Interviews with non-employed staff about their PDP, which should include a statement about the need for training to provide OOH care.
- Evidence that these plans include appropriate training for out-of-hours care.
- Evidence that such training sessions have been provided or that staff or doctors have attended such sessions.
- Interviews with staff.
- Satisfaction of patients with telephone communication (e.g. as part of a survey).

2 Comments

It is reasonable that there should be some communication between the doctor's appraiser(s) and the OOH provider to state that their our of hours skills have been considered and any agreed learning needs put into their learning plan. Access to PDPs for non-employed staff, like doctors, will be difficult but interviews should give a good idea of what is happening. However, it is accepted that everyone in the NHS should have a confidential appraisal and development plan.

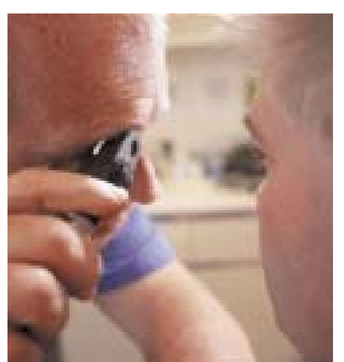
A combination of structure and timing of the appraisals combined with interviews with staff should give a clear indication of whether the provider is developing its staff. Provision of anonymised examples might be more difficult in smaller providers.

These issues will be more complicated in the use of agency, bank or locum staff. However, good locums will be keeping records of their personal development along the lines suggested by the National Association of Non-Principals and revalidation. Good agencies will ensure that their staff will have appraisals and development plans – the provider should ensure that this is the case when contracting or hiring from an agency.

Good providers will be considering ways in which to ensure that all staff are developed to their full potential – this includes nurses, receptionists and drivers.

Apart from telephone clinical assessment other particular areas for training might include, for instance, mental health (including sectioning), tackling violence, palliative care, resuscitation, vulnerable children, learning and physical disabilities. This will depend on local needs.

Telephone skills are particularly important for out-of-hours care. Many doctors, although trained in consultation skills have never been formally trained in telephone skills. Other staff should also receive training in these skills. Interviews with staff and doctors might establish how effective the training has been.



Clinical Governance

Standard Four

Out-of-hours records will be maintained with reference to the standards that are set out in *Good Medical Practice*.[5] Nursing records will be maintained with reference to UKCC guidelines on record keeping.

Standard Five

A procedure for assessing a random sample of calls (for example 1% per month/ quarter) will be developed for use by all providers and will be based on current examples of good practice, including methods for multidisciplinary peer review.

[5] *Good Medical Practice* is published by the General Medical Committee and can be found at: **http://www.gmc-uk.org/standards/good.htm#Decisions%20about%20access%20to%20medical%20care**. Good Medical Practice describes in general terms what is required of a doctor. The GMC asked Royal Colleges and specialist societies to describe in greater detail what 'good medical practice' means for their particular discipline and the Royal College of General Practitioners (RCGP), working with members of the General Practitioners' Committee of the British Medical Association (GPC) and other organisations, developed *Good Medical Practice for General Practitioners* – this can be found at: **http://www.rcgp.org.uk/rcgp/corporate/position/good_med_prac/index.asp**

Standard Six

The sampling process will enable providers to review aspects of individual professional performance (such as referral patterns and prescribing practices). The process will be lead by a clinician with suitable experience in providing out-of-hours care. These data will facilitate feedback to individuals, and will inform the preparation of summary reports to PCTs.

Standard Seven

The reporting of performance will be open within the organisation, and the collated information of subscribing contractors will be reported to the local PCT.

1 Possible evidence might include

- Evidence of a culture of reflective and learning practice.
- Evidence of a survey or training session of a sample of records to check for.
- Satisfactory legibility.
- Appropriate operational prioritisation (e.g. Immediately life threatening).
- Appropriate clinical prioritisation.
- Evidence of an appropriate consultation (e.g. adequate history, examination).
- Satisfactory management plan established including prescribing and referral.
- Evidence of multi-disciplinary meetings to perform (random and problem) case analysis and study clinical data.
- Anonymised reports to the PCT with timely and supportive response from the PCT to the data (i.e. benchmarking with other providers and sharing good practice).
- Interviews with clinicians on the quality of this review process.

2 Comments

Basically two areas are being explored here. The first is to help clinicians develop and adopt a reflective habit, the second is to look for outliers who may have particular performance issues.

Ideally the provider will have performed a peer review of cases with the clinicians as the most appropriate learning vehicle. This should be led by a senior clinician experienced in this field. Learning from cases is a very potent form of education. In this case staff should be asked whether it was valuable learning experience. We would encourage reflective practice by providers using a combination of random and problem case analysis in addition to monitoring performance indicators

As a minimum, a survey should look for clinicians whose behaviour is unusual and then use this as a means of discussing their performance with the provider. External use of data to judge performance has many dangers – indeed most experts in quality would warn against it;[6] it often leads to defensive behaviour if simple numbers are analysed without proper consideration of their meaning, so it should be done in a sensitive and discursive manner.

The sharing of data within the OOH provider is a good marker of an open and honest culture.

[6] See for example, Donald M Berwick, 'The NHS: feeling well and thriving at 75', *BMJ*, 1998 Vol. 317, pp. 57-61

For some this information might need to be anonymised at first but as time goes by should be identifiable.

If monitoring of performance indicators is used, then around 1% per clinician is the suggested sample level. The numbers to be audited will depend on the activity levels of the clinician and the process used, (for instance, is this an in depth analysis or fast survey?). If variation between clinicians is being analysed then there should be evidence that proper statistical methods are being used (i.e. knowing the mean and standard deviation for any data being analysed including description of what is considered exceptional or special cause variation). Again, analysis of the figures should be done in a supportive and meaningful way, or it will promote defensive behaviour. If a clinician is thought to be an outlier (quality experts would suggest two or three standards deviations), then a decision needs to be taken whether this is because of problems with care or excellent care (for instance, doctors with paediatric training will refer more).

Reports to the PCT must be meaningful, with useful and timely responses including district wide benchmarking figures and suggestions and observations.

The recommended minimum periods of retention of GP patients' records are:[7]

- *Maternity records: 25 years.*
- *Records relating to children and young people (including paediatric, vaccination and community child health service records): until the patient's 25th birthday or 26th if an entry was made when the young person was 17; or 10 years after death of a patient if sooner.*
- *Records relating to persons receiving treatment for a mental disorder within the meaning of the Mental Health Act 1983; 20 years after no further treatment considered necessary; or 10 years after patient's death if sooner.*
- *Records relating to those serving in HM Armed Forces: not to be destroyed.*
- *Records relating to those serving a prison sentence: not to be destroyed.*
- *All other personal health records 10 years after conclusion of treatment, the patient's death or after the patient has permanently left the country.*

All information should be handled with respect to the Data Protection Act and Caldicott guidelines.

[7] For detailed guidance on the retention of GP patients' records, see Health Service Circular HSC 1998/217, *Preservation, Retention and Destruction of GP General Medical Services Records Relating to Patients.*

Standard Eight

Out-of-hours service providers must be able to supply full clinical details of consultations to the host GP by the start of the next working day and providers will monitor the flow of information within and between provider organisations.

Standard Nine

There must be rapid and effective transmission of out-of-hours patient data between NHSD, other service providers and the GP practice.

Standard Ten

There should be a system for transmission of information about patients with special needs (including terminal care, violent, vulnerable patients) from the practice to the provider.

1 Possible evidence might include

- Information handling procedures.
- A sample of call records audited to monitor the speed with which records are transferred to GP surgeries, from NHS Direct and to any other relevant organisations.
- Interviews with staff about how information is transmitted and what they do when the system breaks down.
- System for transmitting the information from practice to provider.
- Use of an information system for special patients.

2 Comments

The frequency of the surveys will vary but it suggested that they should, as a minimum, be conducted annually and cover different time periods when the provider is working. However, the provider should be aware of a fallback if problems occur, and a way staff can report problems if they occur.

The system for transmitting information between practice and provider about special patients should probably use a 'handover form' and have a system for updating and review.[8]

There should be clear and understandable lines of communication with other out-of-hours providers including social services, dentists, community pharmacists, ambulance services and community nurses.

[8] For examples of possible handover forms for palliative care patients see Keri Thomas, *Out-of-hours palliative care in the community,* Macmillian Cancer Relief, March 2001, pp. 20–22.

Standard Eleven

All out-of-hours providers will comply with the NHS complaints procedure.

Standard Twelve

All providers will monitor and audit complaints in relation to individual staff.

1 Possible evidence might include

- Evidence of the complaints procedure and survey of how cases have been handled including adherence to timescale. Use of NHS complaints procedure.
- Interview with staff to see if they understand how to deal with complaints.
- Name of responsible person who has an overview of all complaints and their understanding of what to do if patterns emerge.
- Interview with the responsible person.
- Action Plans and learning from complaints.
- Use of compliments for service development and staff morale.

2 Comments

Ideally one single person will be responsible for complaints in order to act as a mechanism for spotting patterns. If possible they should be interviewed about this role and about what they do with complaints.

Standard Thirteen

All providers must investigate and review all major significant events and all reports on such events must include clear recommendations; all reports will be submitted to the PCT responsible for the area in which the event took place.

1 Possible evidence might include

- Significant event audit (SEA) process used.
- Summary data on SEA meetings and case breakdown with actions.
- Prompt and useful response from a senior member of the monitoring authority with evidence of spread of good practice or common problems.
- Interviews with staff regarding SEA meetings.

2 Comments

Significant event auditing should include both good and bad events. A systems approach is essential, as finding blame with individuals will not remedy any problems and will soon discredit the process. The accreditation team should be familiar with the current literature on this subject as should the provider. In particular, the accrediting team should understand what significant events are and how an SEA is properly conducted; the RCGP Occasional Paper or the University of Exeter web site on this topic both provide useful starting points.[9]

[9] Pringle M, Bradley CP, Carmichael CM, Wallis H, Moore A, *Significant Event Auditing*, Occasional Paper 70, Royal College of General Practitioners, Exeter, 1995; and **http://latis.ex.ac.uk/sigevent/**

Standard Fourteen

All providers must demonstrate that they are regularly monitoring patient experience and taking appropriate action on the results of that monitoring.

1 Possible evidence might include:

- Patient experience survey.
- Use of a patient liaison group.
- involvement of patients in planning decisions.
- Patient member on the provider board.
- Use of focus groups.
- Monitoring of compliments and complaints for trends and outcomes.
- Use of a mystery shopper (someone asked to experience the service).
- Use of a "walk of shame" (senior managers in retail industry frequently walk through their premises to assess what it is like for their customers).

2 Comments

It is possible to explore patient experiences from a number of sources. Generally different techniques are useful for asking different questions. The important aspect is that the public and patients are in some way involved in the planning process – the provider seeks their opinions and it makes a difference. Details are not given here but the accreditation team should make themselves aware of the different methodologies available so they are able to discuss them with the provider.[10] PCTs often have a member of staff with specialist knowledge of public involvement and it might be worth discussing this with them. A basic provider will have sought public opinion in some meaningful manner on at least one occasion whilst a good provider will use a variety of methods regularly.

[10] See Rowson D. Chapter on Patient involvement in, T. Wilson (editor), *The PCG Development Guide*. Edited by Wilson T. Radcliffe Medical Press 1998

Standard Sixteen

All accredited organisations must have clear mechanisms for accepting delegated responsibility (including indemnity cover) for the patients for whom they make provision out-of-hours.

The provider must demonstrate their ability to match their capacity to meet the (changing) demand for those services and not return responsibility to subscribing GPs.

1 Possible evidence might include

Delegated responsibility

- Evidence of policy and checks made of indemnity cover.
- Interview with doctors whom use and/or work for the provider.

Capacity

- Evidence of planning for service provision against predictable changes in demand.
- Policy for monitoring demand and planning according to results – i.e. rota planning to reflect peak loads.
- Policy for calling extra doctors or other staff in times of unpredicted surges in demand.
- Contingency plans (in the case of emergencies, illness etc.).

2 Comments

This Standard encapsulates two separate, but inter-connected aspects of the service provision and it is important that due attention is paid to both.

Delegated responsibility – Responsibility is a legal issue addressed within the GP contract, however it is important that everyone involved is aware of these responsibilities, Interviews are likely to be the best method for identifying awareness of these issues and any problems that have occurred. There should be clarity about hand over times, what to do with patients who contact near hand over times and how the responsible person can be contacted.

Capacity – Demand is variable. However, in the last few years data has been collected about fluctuations showing that much of this variation is predictable and so providers should be able to demonstrate use of this data for supply/demand matching. For smaller providers, the level of prediction becomes less reliable (variability is greater in proportion to its size).

The provider needs to demonstrate that they have clear mechanisms for calling in extra staff, especially doctors. In what conditions would an extra doctor be called? Clear parameters (time to visiting or number of visits outstanding) will help reduce the reluctance of many doctors to admit that they are having trouble coping with a high demand situation thereby putting patients at risk.

Service and Organisational Models

Standard Seventeen

All accredited organisations must report quarterly to the PCT with evidence that they are continuing to meet the Quality Standards.

1 Possible evidence might include

Evidence of reports and prompt and supportive commentaries on these reports from a senior member of the PCT.

2 Comments

The PCT has a statutory duty to ensure that good quality care is provided in their area. However, from the point of view of quality improvement, reporting to the PCT should primarily be for two reasons firstly and most importantly for the PCT to give helpful feedback and support. Secondly, the PCT will want to be aware that some monitoring is going on in the PCT and intervene if they think additional support is required.

Standard Eighteen

Service Level Agreements will include standards for both parties to the agreement – e.g. NHS Direct and the out-of-hours provider or OOH provider and GP, or the OOH provider/PCT and the local pharmacy contractor or individual pharmacist.

1 Possible evidence might include

Evidence of such agreements.

2 Comments

While the OOH Implementation Team will identify the elements that will be common to all such SLAs, if such agreements are to be effective they will need to be tailored to meet the particular needs of the local health community.

Service and Organisational Models

Standard Nineteen

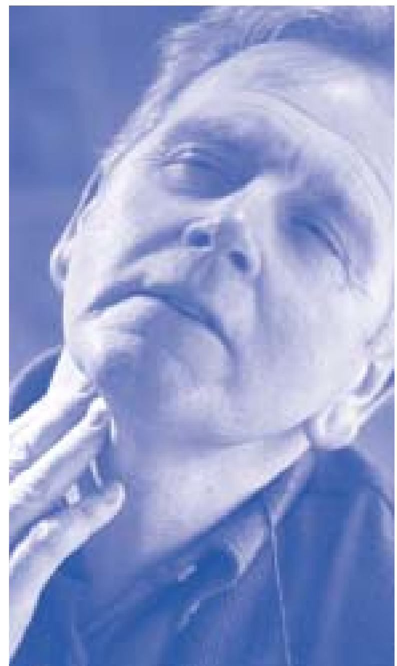
All out-of-hours providers must be represented in, and play an active role within, the local capacity planning system, including local Capacity Planning Groups. Providers should have good working relationships with other out-of-hours services (including community nurses, dentists, ambulance trust, emergency departments, pharmacies, social services and mental health services).

1 Possible evidence might include

- Evidence that the provider has been invited to meetings held at appropriate times and that the OOH provider has attended a reasonable number of these meetings.
- Evidence of liaison between the OOH provider and other OOH services.
- Evidence that the OOH provider is a member of the NHSD clinical steering group.
- Interview evidence of collaborative working.

2 Comments

It is important that the provider is involved in planning in their locality so they can integrate fully with other services. They should play an active part in these meetings and attend on a reasonable number of occasions. However, many providers are run by clinicians, so the timings and frequencies of the meetings should be sensitive to this, giving due notice and not being planned at times of high demand (e.g. Mondays).



Standard Twenty

All out-of-hours organisations that employ staff and are stewards of public funds must comply with appropriate NHS corporate governance standards.

1 Possible evidence might include

- Constitution or Standing Orders should be available and should cover:
  - Composition of Organisation including appointment of officers or directors (as appropriate).
  - Meetings (Notice of Meetings, Voting, Quorum etc).
  - Appointment of Committees.
  - Declarations of Interest.
  - Pecuniary Interests.
  - Standards of Business Conduct.
  - Tendering procedures (where appropriate).
- Standing Financial Instructions should be available and should cover:
  - Management of bank accounts.
  - Audit requirements (audit report).
  - Annual accounts and reports.
  - Retention of documents.
  - Risk Management and Insurance.
  - Asset Register.

2 Comments

NHS Corporate Governance standards provide a robust framework for ensuring appropriate controls assurance within the NHS. Whilst it would be unreasonable to expect OOH organisations to comply with the full set of standards, by complying with the above, OOH organisations will fulfil the dual role of protecting their organisation's interests and protecting staff from accusations that they have acted less than properly.

Service and Organisational Models

Standard Twenty-One

All organisations providing or employing clinical staff must be able to support continuing registration requirements.

Standard Twenty-Two

All organisations must meet NHS human resources standards for continuing personal development and the accreditation of staff.

Standard Twenty-Three

All employment practices must conform to NHS human resources standards.

1 Possible evidence might include

- Staff contracts, including evidence of adherence to statutory regulations in relation to staff employment (e.g. equal opportunities, proper recruitment procedures, staff contracts, National Insurance, PAYE, statutory maternity and sick pay). Inspection to ascertain there are appropriate personnel files kept on staff. Evidence of disciplinary procedures. Compliance with working time directives where appropriate. Evidence that staff are allowed to comply with revalidation and continuing professional development regulations.
- Adherence to health and safety procedures and COSHH guidelines.
- Evidence of a policy to protect staff from violence or abuse including persona safety procedures.
- Confidentiality clause in contract.
- Proper recruitment processes including approved application forms with a declaration that all information provided is correct.

2 Comments

All clinical staff have to undertake some form of re-accreditation, re-certification or re-validation. Standard 1 highlighted the importance of only employing staff who have met these requirements. However, it is also important that the OOH provider supports the process towards these requirements and in interviews with managers and staff it would be prudent to find out whether this is the case.

Staff records are confidential but evidence that they are kept is sufficient. Interviews with staff will give additional information about the way they are treated and developed. Generally, although strict adherence to human resources policies are important, the main issue is how staff are treated and the prevailing culture within which they work. Good employers will additionally provide a flexible, family friendly approach that includes measures such as self-rostering.

Standard Twenty-Four

Medicines should be purchased, stored, supplied, administered and disposed of in a safe and secure manner in accordance with current legislation, licensing requirements and best practice.

1 Suggested evidence might include

- Standard operating procedures for the purchase, administration, supply and disposal of medicines with evidence of regular reconciliation of stock medicines.
- Records of all transactions in respect of medicines should be available for audit purposes whilst ensuring appropriate safe-guards are in place to maintain the confidentiality of patient identifiable data.
- Evidence of clear policies to prevent the opportunity to commit financial fraud or theft of medicines from the designated centre.
- Evidence that medicines management procedures are followed. This includes evidence of regular feedback to the Board of the OOH provider on prescribing and medicines related issues.

2 Comments

The issues of safe and secure handling of medicines highlights the need for effective clinical and corporate governance mechanisms to safeguard the best interests of the patient and healthcare staff operating from the OOH premises. Appropriate policies, procedures and quality assurance systems should be in place which minimise risk to patients, staff handling medicines and the OOH provider.

Standard Twenty-Five

Call engaged and abandonment standards (an abandoned call is defined as one where the caller discontinues the call after 30 seconds, allowing time to listen to a message which may be played before the call is answered):

- **No more than 0.1% of calls engaged.**
- **No more than 5% calls abandoned.**

Standard Twenty-Six

Time taken for the initial call to be answered by a person:

- **90% answered within 30 seconds.**
- **All answered within 90 seconds.**

Standard Twenty-Seven

Identification of immediate life threatening conditions:

- **90% of immediate life threatening conditions identified within 1 minute.**
- **All life threatening conditions identified within 15 minutes.**
- **90% of immediate life threatening conditions passed to the Ambulance Service within 1 minute.**
- **All life threatening conditions passed to the Ambulance Service within 15 minutes.**

Standard Twenty-Eight

Definitive telephone clinical assessment and disposal (excluding those patients who access a Primary Care Centre, Accident and Emergency Department or Walk-in Centre direct, without preliminary telephone assessment – see *Standard 31* below):

- **90% complete within 20 minutes.**
- **All complete within 30 minutes.**

1 Possible evidence might include

- Survey or complete records (especially if summary available from computerised system) of call handling times with breakdown by clinical need.
- Example of the service level agreement with NHS Direct.
- Survey or full record of these standards as provided by NHS Direct.

2 Comments

It is important that patients have good access to the right provider to meet their urgent, clinical needs and these standards have been defined to ensure this.

There should be information about how telephone calls are being handled. If there are problems there should be evidence of a dialogue between NHS Direct, the PCT, any other provider and any out-of-hours planning groups with an appropriate plan of action by the call handling service (in all cases this will be NHSD by 2004).

The provider or PCT should both be monitoring these standards, to act as an early warning system for Strategic Health Authorities and so they know that the telephone response service their patients are receiving is of a required standard.

There should be a policy for managing calls from pay phones or phone boxes; facilitating calls from NHS staff in a patients home (so as not to unnecessarily delay them); use of answer machines and whether it is audible, clear and uses a suitable (locally agreed) message.

Standard Twenty-Nine

Time until the episode is complete

Visiting standard:

- **Emergency:** Within 1 hour.
- **Urgent:** Within 2 hours.
- **Less urgent:** Within 6 hours.

Standard Thirty

Patients to be informed of timescale during initial consultation, including time to visit at home or appointment time at Primary Care Centre or Walk-in Centre, and always contacted if an agreed home visit is delayed or if an appointment time at a Primary Care Centre is delayed.

Standard Thirty-One

For those patients who have not been clinically assessed on the telephone and who access a Primary Care Centre, Accident and Emergency Department or Walk-in Centre direct:

Time from arrival to initial contact:

- 90% of initial assessment completed within 5 minutes.
- All initial assessment completed within 10 minutes.

Time from initial contact to consultation (see Comments section below):

- 90% of patients offered consultation within 45 minutes of arrival. Where clinically appropriate.
- All patients offered consultation within 60 minutes of arrival where clinically appropriate.

1 Possible evidence might include

- Computer generated report of the above standards.
- Retrospective audit of a sample of cases (or full record if available) to assess access times.
- Evidence of the policy of how patients are informed of time to consultation or that there may be a delay. Interview of drivers and reception staff.
- Results of a patient experience survey that specifically asks whether they were told a time scale or of why any delay occurred.
- Policy for patients that walk in without first using NHS Direct and how these patients are prioritised.
- Interviews with staff about how patients are handled, times set and cases prioritised for walk in patients.

2 Comments

Definitions of emergency, urgent or non-urgent should be made by the clinician dealing with the case. The record system will need a means of capturing and auditing this information. Clinical appropriateness for patients who have not been assessed by phone will be based on a local clinical assessment process.

Patients who are in a situation where they are distressed and vulnerable, should be informed of how long it will be until they are seen, and similarly, if it is likely that there will be an unavoidable delay, how long that is to be. Interviewing staff about how this is done, might be the most sensitive way of finding out what happens. Whenever home visits are delayed it should be possible for explanatory phone calls to be logged and audited.

Patients who walk into the primary care centre, or walk in centre, deserve equal care to those that access the service by phone. There may not always be a clinician in a primary care centre, or walk in centre, therefore it would be reasonable for some patients, if there is no clinical urgency, to be given an appointment at a later time. The intention of this standard is not to give patients the ability to jump the queue, or to divert doctors who are visiting housebound patients, but rather to ensure that patients accessing a centre are treated in a clinically appropriate time. Patients

should always in these circumstances be informed how to make best use of the service and encouraged to access out-of-hours care via NHS Direct. For A&E departments there will always be a doctor present, so it is reasonable to expect that all patients be seen within the above time-scales. Anecdotal evidence suggests that some patients will always seek the fastest route to care, obtaining care faster than patients who have waited longer. In assessing these standards we suggest that sensitivity to clinical need, distress and social circumstances are considered by the provider. This might best be found from interviews with staff.

Some providers will choose not to use a primary care centre, although we suspect this will be unusual as they offer benefits to both patients and staff. Where a primary care centre is provided some estimation as to whether sufficient centres are provided to meet the above standards and allow reasonable access for patients should be made.

Consultation standards for face to face visits should be broadly the same as for the visit standards shown above.

Patients with Special Needs

Standard Thirty-Two

Non English speaking users:

- **90% provided with translation service within 10 minutes of initial contact.**
- **All provided with translation service within 15 minutes of initial contact.**

Standard Thirty-Three

Patients with impaired hearing:

- **A dedicated telephone number will be provided for text phone users to enable them to access the service.**
- **Appropriate technology will be installed in NHS Direct call centres to enable callers with less severe hearing impairment to access the service.**

1 Possible evidence might include

- Service provision by NHS Direct.
- Description of SLA with NHS Direct (or other appropriate service) and survey of their performance.
- Interviews with staff about what to do with this group of patients or what to do if something goes wrong.
- Cultural awareness training.
- Deaf awareness training.
- Use of text phones.
- Links with special needs groups.
- Ability for patients to appropriately access aids and devices to help them take the right medicines at the right time.

2 Comments

This is a vulnerable group of patients and it is important that problems are flagged up as soon as possible. It is most important that staff know what to do if a problem is encountered on a shift.

If there are problems then there should be evidence of a dialogue between NHS Direct, any other provider (or out-of-hours planning group) and the PCT(s).

Medical and Pharmaceutical Equipment

These final three standards do not have their origin in the Review. Rather, they derive from the broader statutory and regulatory framework (including Health and Safety regulations) within which equipment, premises and transport is provided.

Standard

Any medical (e.g. ECG machines), or pharmaceutical equipment (e.g. refrigerators, alarm systems, nebulisers) provided should be properly used, serviced and maintained. Staff should be trained in the use of this equipment.

1 Possible evidence might include

- Maintenance programme/ contract. Evidence of repairs/ servicing.
- Cupboards conforming to BS:2881 and the Misuse of Drugs (Safe Custody) Regulations should be available as appropriate.
- Evidence of training or competence to use equipment by appropriate staff.
- Health and safety policy.
- Public liability insurance.
- Temperature monitoring of medicinal products and their storage environment where appropriate.

2 Comments

Clearly it is unacceptable for a provider to have outdated or unsafe equipment. Further, staff should be competent in using it. Some means of assessing this competence is suggested (such as regular training and assessment sessions).

Standard

- **The primary care centre premises should be fit for purpose.**
- **Premises management ensures safety for the public and staff working there.**
- **A comprehensive policy exists which ensures security in the premises is maintained.**
- **All statutory requirements must be adhered to and high standards of hygiene ensured.**
- **Where appropriate, there should be a designated area for the provision of pharmaceutical services which should be easily identified.**
- **The area in which medicines are stored must not be accessible to the public.**

1 Possible evidence might include

Inspection of the premises.

2 Comments

The Statement for Fees and Allowances might be used as a starting point although there are no clear standards for out-of-hours premises - as far as meeting the particular requirements for the provision of medicines are concerned, the Royal Pharmaceutical Society of Great Britain (RPSGB) Standards for Premises may be a helpful starting point. However, the premises should be safe for staff and patients, be appropriate, have good access (including for disabled- or alternative provision if not applicable) and allow for patient confidentiality and dignity (e.g. in undressing).

Standard

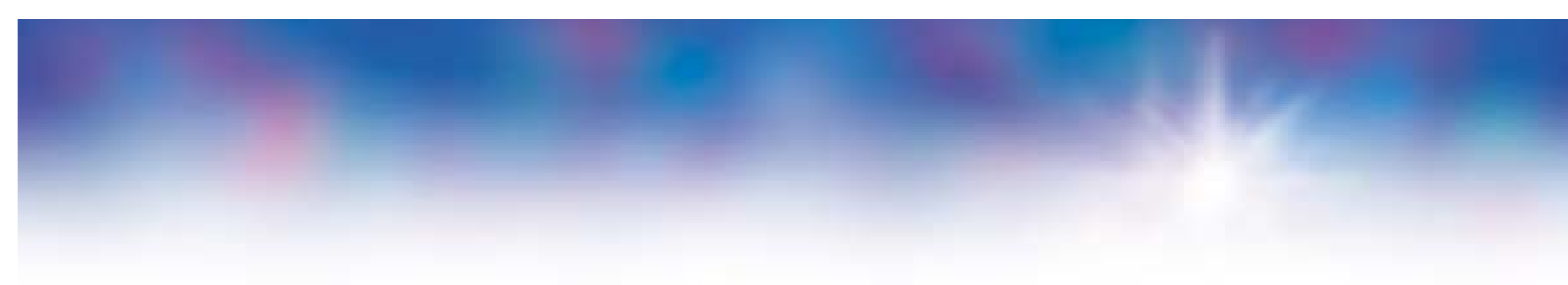
Transport for clinicians and patients (where provided) should be reliable, safe and legal.

1 Possible evidence might include

- Inspection of vehicles to ensure that they are suitable for purpose including provision of suitable (child) seating and safety belts.
- Reliable communication method with the vehicle.
- System for inspecting drivers' licenses and have within their contract a clause to report changes.
- Contingency plans for breakdown.
- Inspection of service schedule, insurance certificates and MOT (if applicable).
- Policy for the safety of the lone driver.
- Safe storage and disposal of all medicines and equipment in the vehicle.

2 Comments

Not all providers supply patient transport but, where they do, it should be safe. Most will provide clinician transport.



This Handbook is also available on the Department of Health website:
http://www.doh.gov.uk/pricare/accredhandbook.htm

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