A G E N D A

Health Scrutiny Committee

Date:	**Tuesday, 5th September, 2006**
Time:	**2.30 p.m.**
Place:	**The Council Chamber, Brockington, 35 Hafod Road, Hereford**

Notes: Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

Tim Brown, Members' Services, Tel 01432 260239

E-Mail: tbrown@herefordshire.gov.uk

County of Herefordshire District Council

HEREFORDSHIRE COUNCIL

AGENDA

for the Meeting of the Health Scrutiny Committee

To: Councillor W.J.S. Thomas (Chairman)
Councillor T.M. James (Vice-Chairman)

Councillors Mrs. W.U. Attfield, Mrs. E.M. Bew, G.W. Davis, J.G. Jarvis, Brig. P. Jones CBE, G. Lucas, R. Mills, Ms. G.A. Powell and J.B. Williams

		Pages
1.	**APOLOGIES FOR ABSENCE** To receive apologies for absence.	
2.	**NAMED SUBSTITUTES (IF ANY)** To receive details of any Member nominated to attend the meeting in place of a Member of the Committee.	
3.	**DECLARATIONS OF INTEREST** To receive any declarations of interest by Members in respect of items on this agenda.	
4.	**MINUTES** To approve and sign the Minutes of the meeting held on 15th June, 2006.	1 - 8
5.	**SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY** To consider suggestions from members of the public on issues the Committee could scrutinise in the future.	
6.	**HEREFORD HOSPITALS NHS TRUST - FOUNDATION TRUST STATUS** To receive a presentation by the Chief Executive of the Trust.	
7.	**SPECIALIST CHILDREN'S SERVICES DEVELOPMENT** To consider consultation proposals by the Primary Care Trust.	9 - 32
8.	**"A STRONGER LOCAL VOICE"** To consider a response to the Department of Health (DoH) document, 'A Stronger Local Voice - A Framework for Creating a Stronger Local Voice in the Development of Health and Social Care Services'.	33 - 36
9.	**SCRUTINY REVIEW OF COMMMUNICATION IN THE LOCAL HEALTH SERVICE** To consider the findings of the Communication Review Group following its review of the Local Health Service's communications strategy and procedures.	37 - 48

10. SCRUTINY REVIEW OF GP OUT OF HOURS SERVICES 49 - 74

To consider the findings of the GP Out of Hours Services Review Group following its review of the GP out of hours service.

PUBLIC INFORMATION

HEREFORDSHIRE COUNCIL'S SCRUTINY COMMITTEES

The Council has established Scrutiny Committees for Adult Social Care and Strategic Housing, Childrens' Services, Community Services, Environment, and Health. A Strategic Monitoring Committee scrutinises corporate matters and co-ordinates the work of these Committees.

The purpose of the Committees is to ensure the accountability and transparency of the Council's decision making process.

The principal roles of Scrutiny Committees are to

- Help in developing Council policy
- Probe, investigate, test the options and ask the difficult questions before and after decisions are taken
- Look in more detail at areas of concern which may have been raised by the Cabinet itself, by other Councillors or by members of the public
- "call in" decisions - this is a statutory power which gives Scrutiny Committees the right to place a decision on hold pending further scrutiny.
- Review performance of the Council
- Conduct Best Value reviews
- Undertake external scrutiny work engaging partners and the public

Formal meetings of the Committees are held in public and information on your rights to attend meetings and access to information are set out overleaf

PUBLIC INFORMATION

Public Involvement at Scrutiny Committee Meetings

You can contact Councillors and Officers at any time about Scrutiny Committee matters and issues which you would like the Scrutiny Committees to investigate.

There are also two other ways in which you can directly contribute at Herefordshire Council's Scrutiny Committee meetings.

1. Identifying Areas for Scrutiny

At the meeting the Chairman will ask the members of the public present if they have any issues which they would like the Scrutiny Committee to investigate, however, there will be no discussion of the issue at the time when the matter is raised. Councillors will research the issue and consider whether it should form part of the Committee's work programme when compared with other competing priorities.

Please note that the Committees can only scrutinise items which fall within their specific remit (see below). If a matter is raised which falls within the remit of another Scrutiny Committee then it will be noted and passed on to the relevant Chairman for their consideration.

2. Questions from Members of the Public for Consideration at Scrutiny Committee Meetings and Participation at Meetings

You can submit a question for consideration at a Scrutiny Committee meeting so long as the question you are asking is directly related to an item listed on the agenda. If you have a question you would like to ask then please submit it **no later than two working days before the meeting** to the Committee Officer. This will help to ensure that an answer can be provided at the meeting. Contact details for the Committee Officer can be found on the front page of this agenda.

Generally, members of the public will also be able to contribute to the discussion at the meeting. This will be at the Chairman's discretion.

(Please note that the Scrutiny Committees are not able to discuss questions relating to personal or confidential issues.)

Remits of Herefordshire Council's Scrutiny Committees

Adult Social Care and Strategic Housing

Statutory functions for adult social services including:
Learning Disabilities
Strategic Housing
Supporting People
Public Health

Children's Services

Provision of services relating to the well-being of children including education, health and social care.

Community Services Scrutiny Committee

Libraries
Cultural Services including heritage and tourism
Leisure Services
Parks and Countryside
Community Safety
Economic Development
Youth Services

Health

Planning, provision and operation of health services affecting the area
Health Improvement
Services provided by the NHS

Environment

Environmental Issues
Highways and Transportation

Strategic Monitoring Committee
Corporate Strategy and Finance
Resources
Corporate and Customer Services
Human Resources

The Public's Rights to Information and Attendance at Meetings

YOU HAVE A RIGHT TO: -

- Attend all Council, Cabinet, Committee and Sub-Committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.

- Inspect agenda and public reports at least five clear days before the date of the meeting.

- Inspect minutes of the Council and all Committees and Sub-Committees and written statements of decisions taken by the Cabinet or individual Cabinet Members for up to six years following a meeting.

- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.

- Access to a public Register stating the names, addresses and wards of all Councillors with details of the membership of Cabinet and of all Committees and Sub-Committees.

- Have a reasonable number of copies of agenda and reports (relating to items to be considered in public) made available to the public attending meetings of the Council, Cabinet, Committees and Sub-Committees.

- Have access to a list specifying those powers on which the Council have delegated decision making to their officers identifying the officers concerned by title.

- Copy any of the documents mentioned above to which you have a right of access, subject to a reasonable charge (20p per sheet subject to a maximum of £5.00 per agenda plus a nominal fee of £1.50 for postage).

- Access to this summary of your rights as members of the public to attend meetings of the Council, Cabinet, Committees and Sub-Committees and to inspect and copy documents.

Please Note:

Agenda and individual reports can be made available in large print. Please contact the officer named on the front cover of this agenda **in advance** of the meeting who will be pleased to deal with your request.

The Council Chamber where the meeting will be held is accessible for visitors in wheelchairs, for whom toilets are also available.

A public telephone is available in the reception area.

Public Transport Links

- Public transport access can be gained to Brockington via the service runs approximately every half hour from the 'Hopper' bus station at the Tesco store in Bewell Street (next to the roundabout junction of Blueschool Street / Victoria Street / Edgar Street).

- The nearest bus stop to Brockington is located in Old Eign Hill near to its junction with Hafod Road. The return journey can be made from the same bus stop.

If you have any questions about this agenda, how the Council works or would like more information or wish to exercise your rights to access the information described above, you may do so either by telephoning the officer named on the front cover of this agenda or by visiting in person during office hours (8.45 a.m. - 5.00 p.m. Monday - Thursday and 8.45 a.m. - 4.45 p.m. Friday) at the Council Offices, Brockington, 35 Hafod Road, Hereford.

COUNTY OF HEREFORDSHIRE DISTRICT COUNCIL

BROCKINGTON, 35 HAFOD ROAD, HEREFORD.

FIRE AND EMERGENCY EVACUATION PROCEDURE

In the event of a fire or emergency the alarm bell will ring continuously.

You should vacate the building in an orderly manner through the nearest available fire exit.

You should then proceed to Assembly Point J which is located at the southern entrance to the car park. A check will be undertaken to ensure that those recorded as present have vacated the building following which further instructions will be given.

Please do not allow any items of clothing, etc. to obstruct any of the exits.

Do not delay your vacation of the building by stopping or returning to collect coats or other personal belongings.

COUNTY OF HEREFORDSHIRE DISTRICT COUNCIL

MINUTES of the meeting of Health Scrutiny Committee held at The Council Chamber, Brockington, 35 Hafod Road, Hereford on Thursday, 15th June, 2006 at 10.00 a.m.

Present: **Councillor W.J.S. Thomas (Chairman)**

Councillors: Mrs. W.U. Attfield, G.W. Davis, P.E. Harling, Brig. P. Jones CBE, G. Lucas, R. Mills and Ms. G.A. Powell

In attendance: Councillors Mrs. L.O. Barnett and Mrs. M.D. Lloyd-Hayes

50. APOLOGIES FOR ABSENCE

Apologies were received from Councillors T.M. James and J.B. Williams. Mrs A. Stoakes of the Primary Care Trust Patient and Public Involvement Forum also submitted her apologies.

51. NAMED SUBSTITUTES

There were no named substitutes.

52. DECLARATIONS OF INTEREST

There were no declarations of interest.

53. MINUTES

RESOLVED: That the Minutes of the meeting held on 23rd March, 2006 be confirmed as a correct record and signed by the Chairman

54. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

There were no suggestions.

55. PRESENTATIONS ON BEHALF OF THE HEREFORDSHIRE PRIMARY CARE TRUST AND THE HEREFORD HOSPITALS NHS TRUST

The Committee received presentations from Mr David Rose, Chief Executive of the Hereford Hospitals NHS Trust, and Mr Simon Hairsnape, Deputy Chief Executive of the Herefordshire Primary Care Trust (PCT) on the work of the Trusts in the preceding year and future plans and thoughts and a statement by the Cabinet Member (Social Care Adults and Health.)

Presentation by Mr Rose

The presentation covered performance for 2005/06, key developments and issues for 2006/07 and the intention to seek to become a Foundation Trust.

Key points of the presentation were:

- Key Operational Successes 2005/06: Mr Rose informed the Committee that Hereford Hospital was the strongest performing hospital in the West Midlands (South) area. He highlighted success in achieving the standard that over 98% of patients waited under four hours for treatment in the Accident and Emergency Unit; that no patient waited for more than 11 weeks for an outpatient appointment and the hospital was close to achieving a maximum wait of 8 weeks, ahead of the Government target; there was a maximum 6 month wait for elective surgery: all patients booked appointments were fulfilled; cancer wait targets had been achieved; and a stroke unit with dedicated staff had been created.

- That financial balance had been achieved and all financial responsibilities met. It was particularly important, as a small hospital, that debt was not accumulated.

- That the hospital had met all except one of the national standards for better health. The one not met was standard C7c relating to undertaking systematic risk assessment and risk management. An action plan had been agreed with the internal auditors which would ensure compliance by the end of July 2006.

- Key developments and issues for 2006/07 included a move towards 18 week waits, with maximum waiting targets of 11 weeks for outpatients and 20 weeks for in-patients; maintaining performance on A&E and cancer waiting times; achieving a 90% target on choose and book appointments, a focus on improving theatre efficiency and utilisation; development of orthopaedic, gastroenterology, paediatric and diabetes services, noting the ongoing efforts to recruit 2 orthopaedic Consultants, and the recruitment of 2 paediatric consultants which it was hoped would secure the future of the service in Hereford; a focus on reducing the length of stay for emergency patients noting that this was both good for patients and would also allow the hospital to consider whether it could reduce the number of beds, so helping it meet its financial obligations; improving access to diagnostic services noting that if waiting times for diagnostic services were low this might encourage patients to choose to be diagnosed at Hereford making it likely that they would also then opt for treatment at the hospital, development of the Macmillan Renton Cancer Unit which would offer the best standards for patients, and the intention to bid to provide radiotherapy services.

- The financial outlook for 2006/07 was difficult. There was a financial deficit of £4.6 million to resolve, representing 5% of the budget. Mr Rose commented on the pressure caused by pay awards under the national contracts and other cost pressures. He expressed regret that the hospital had enjoyed its most successful year but yet had to consider how to address a deficit. The hospital had to avoid debt to ensure that its future was secure. The Trust Board would need to consider the options open to it at its next meeting.

- Action taken to tackle an increase in MRSA cases returning the hospital to the best performing group of hospitals in this respect was described.

- Action taken to address a strain of Clostridium Difficile detected in February 2006 and resulting in a reduction of cases in April and May 2006 was also described.

- The rationale for seeking foundation trust status was discussed. Mr Rose said that he believed that becoming a Foundation Trust (FT) was a way of ensuring that there was a locally governed hospital for Herefordshire and part of Wales.

He explained that an FT was a not for profit hospital business that provided care mostly to the NHS and was unable to dramatically grow private business. It was accountable to staff and local people who could become members or governors of the Trust. An FT hospital would be free from the control of the Government and the Strategic Health Authority, although required to meet national standards. Whilst not required to break even each year it had to be financially viable and achieve balance over a 5 year period. This provided greater flexibility than the current arrangements.

- Becoming an FT would provide the hospital with control over its own destiny, with freedom to make local choices, more control over its strategy and able to respond more effectively to local needs making required improvements to services. Legal contracts would ensure it got paid appropriately for the work that it did, noting that at the moment the hospital was underpaid by the Welsh Assembly by £1.4 million. It would be able to form joint ventures. Through Governors and Members of the Trust it would reflect local priorities.

In response to questions Mr Rose commented as follows:

- The hospital had been working with the Ambulance Trust and the Strategic Health Authority on schemes which reduced emergency admissions to hospital but more work needed to be done.

- New parking arrangements at the hospital were to be implemented in July which it was expected would improve the situation.

- He confirmed that the waiting time for hearing aids was 18 months because the hospital remained unable to recruit a specialist.

- He clarified the improvements necessary to ensure that the hospital's risk management processes met the national standard.

- He noted support for the provision of radiotherapy services at Hereford and commented further on some of the issues which would need to be addressed if the hospital's bid to the Three Counties Cancer Network was to succeed.

- He confirmed that as a financial control measure recruitment was being managed and vacancies, mainly in nursing staff, were not being filled.

- He acknowledged the role of the Community Hospitals in providing healthcare in Herefordshire and advised that the Hospital Trust was working closely with the Primary Care Trust, who managed the community hospitals on this aspect of provision.

- In response to a question about suspended appointments Mr Rose said this matter was audited independently and there was no indication that this happened routinely. He requested that if anyone was aware of examples of this happening that they bring them to his attention.

- He confirmed that as a Foundation Trust hospital the hospital would need to continue to work closely with partners.

The Chairman congratulated Mr Rose on the Trust's performance and acknowledged the rationale behind the Trust seeking to become a Foundation Trust. He expressed regret at the pressure the Trust faced in addressing its financial deficit given that in the national context it was a relatively modest sum.

He added that the Trust would need to discuss the Committee's role in relation to the Foundation Trust proposal with the Committee.

Presentation by Mr Hairsnape

Mr Hairsnape's presentation covered the Trust's objectives for 2005/06, its achievements for 2005/06 and its 2006/07 objectives.

Key points of his presentation were:

- The key issues identified in the 2005/06 Local Delivery Plan had been: improving access targets; improving NHS dentistry; developing public health; improving choice; developing cancer services; developing stroke services; supporting people with long term conditions through ever closer partnership working; developing practice based commissioning; being recognised as a high performing PCT and achieving financial breakeven. Three things in particular upon which the PCT had wished to make progress had been waiting times, where the Trust had now been successful in achieving the lowest waiting times ever; dental services, where whilst there was still a shortfall provision had now been made for the vast majority of patients; and supporting people with long term conditions through ever closer partnership working.

- The achievements listed in 2005/06 were summarised as follows:

    - Improving access: delivered 6 months and 13 weeks, waiting list targets achieved, target for patients waiting at the Accident and Emergency Unit Met and 31 and 62 day cancer target achieved. Mr Hairsnape commented on the very good performance of the Hospital Trust in this regard and expressed the view that it was well positioned to seek Foundation Trust status.

    - Dental Services: over 10,000 new NHS dental places created, a new dental contract in place, new out of hours GP arrangements in place, agreement on a site for a new dental surgery in Leominster.

    - Long Term Conditions: development of seven clinical networks and related projects, development of community matron role and case management, with District Nurses focusing on patients who had had a number of readmissions to hospital and the roll out of the expert patient programme.

    - Partnership Working: early work on the development of a Herefordshire Public Service Trust and the retention of a Herefordshire PCT the 21st smallest of the 150 PCTs.

    - Patient and Public Involvement: an adult mental health carers group established and a good working relationship with the Patient and Public Involvement Forum with the Patient Advice and Liaison Service winning the national NHS Alliance award for the second year running).

    - Improving Cancer Services: development of the Integrated Cancer Care programme, a national pilot, achievement of the 31 day and 62 day target, active debate on radiotherapy services with a strong local campaign for services to be delivered in Herefordshire and continued development of local chemotherapy services to meet a doubling in demand in recent years.

- Choice: 100% coverage of practice based commissioning providing an incentive to innovate with all practices in the County signed up (one of the few PCTs in the Country to have achieved this), and choice of at least four providers being offered for all new hospital treatment (although it was hoped that most would choose the high quality local provider: Hereford Hospital Trust.)

- Developing Stroke Services: this had been a area of concern in recent years and was being addressed by the provision of a new stroke unit at Hereford Hospital and agreed plans for a new community facility at Hillside.

- Performance: whilst the Trust had been disappointed to be awarded a two star rating in 2004/05, having previously held a three star rating, there was optimism about the outcome of the new Healthcare Commission ratings which would be available in October 2006.

- Finance: the PCT had been one of only 10 PCTs in the Country to break even.

- Objectives for 2006/07 included: developing Herefordshire PCT as part of a Public Service Trust, something which the Trust considered would have a lasting impact on local people; fitness for purpose of services provided by the PCT and the need to have a strategic view on their provision; reduced waiting times (meeting the new targets); Improved cancer services - Meeting the demanding 31 day and 62 day targets; reduced MRSA rates; improved sexual health and GUM services; a reduction in the number of adults who smoke; meeting the A&E waiting time target; managing unscheduled emergency care (a critical issue because between one quarter and one-third of cases did not need to be admitted); improved dental services; and achieving financial balance.

In conclusion he said that 2005/06 had been a good year for the PCT. It had achieved most targets including all of the critical ones and made progress towards other more aspirational targets. Whilst 2006/07 was likely to be a challenging year financially, a reduction of £6 million would have some impact, however much the PCT sought to minimise the effect. Nevertheless there was a determination to move forward and the creation of a Public Service Trust and Foundation Trust status for Hereford Hospital Trust were significant steps with long-term implications for Herefordshire.

It was asked why it had been decided to provide 12,000 additional dental places in Leominster, rather than elsewhere in the County. In reply Mr Hairsnape said that registration was low in the Leominster area, that need appeared greater in the North of the County than in Hereford and the South and an opportunity had arisen to make the provision.

The Chairman endorsed the conclusion that the PCT had had a good year.

Statement by Cabinet Member (Adult Social Care and Health)

A report by Councillor Mrs L.O. Barnett, Cabinet Member (Adult Social Care and Health) on progress in both Adult Social Care and Strategic Housing in 2005/06 and future challenges had been circulated separately to Members of the Committee recognising how the Council's work in these areas and more generally contributed to the health of people in Herefordshire.

She commented briefly on each section of her report highlighting the extent of joint

working between the Health Service and the Council. She noted in particular the development of the integrated stroke service at Hillside and her view that whilst this was to be welcomed it was important that there was careful monitoring of the changes. She also emphasised how important it was that the Public Service Trust was successful and the need for all parties to ensure that they worked together effectively to realise its potential.

The Committee noted that it would need to give careful consideration to the development of the Public Service Trust.

56. COST SAVING PROPOSALS - PROVIDER ARM OF HEREFORDSHIRE PRIMARY CARE TRUST

The Committee considered cost saving proposals by the provider arm of the Primary Care Trust.

Mr Mike Thomas, Director of Operations at the Primary Care Trust had submitted a briefing paper setting out proposals to achieve cost savings in 2006/07.

Mr Simon Hairsnape, Deputy Chief Executive of the Primary Care Trust introduced the briefing paper, explaining that as a consequence of the financial pressure on the NHS nationally the PCT was required to save £6.6 million of its 2006/07 budget (3.3%). The savings made were to be contributed to a national NHS bank to fund NHS bodies in most difficulty. This was a challenge. However, the PCT was determined to act quickly in the belief that this would enable it to minimise the impact. It was proposed that one-third of the money would be saved in Commissioning by focusing on value for money and managing emergency admissions (not to the detriment of services), one-third in Primary Care (a contractual matter with the GPs and consequently not a matter for the Committee), and one-third on Services provided directly by the PCT as described in the briefing paper. Whilst the PCT maintained that the proposed savings on directly provided services did not have a significant impact on services it had been thought appropriate for the Committee to consider the matter. However, he cautioned that if the Committee was minded to require a consultation exercise on the proposals the consequent delay in implementing reductions could mean tougher decisions would be needed later in the year.

Mr Thomas then presented the briefing paper he had submitted, commenting on each of the proposed reductions. The paper noted that the proposals listed left a £350,000 shortfall in the savings target and that a range of other areas where savings could be made were being explored, again with the intention of not impacting on service provision. It was also noted that an additional saving requirement, failure to achieve the savings as proposed or deterioration in the financial position could lead to a harsher saving proposal.

Mr Thomas emphasised in conclusion that the aim had been to avoid reductions in services or redundancies and that it was intended that the reductions would be temporary and that the services would be developed further in the future.

Mr Hairsnape added that the financial pressure on the NHS should only affect the current financial year. He reiterated that the proposals were considered to be the best package that could be put forward to allow the PCT to break even and minimise the effect on services.

A question was asked about the decision to postpone the introduction of two new consultant posts in the Mental Health Service. In reply it was stated that this did not impact on the current service but represented a future development opportunity.

It was noted that the proposals had been discussed with the Patient and Public Involvement Forum and were supported by them.

The Committee's view was that the proposals could not be considered to represent a substantial variation, noting the assurances that the effect on services had been minimised and the importance of the Trust implementing measures as soon as possible.

RESOLVED: That the cost saving proposals by the provider arm of the Primary Care Trust as set out in the briefing paper be endorsed to enable the Trust to proceed with their implementation at the earliest opportunity.

The meeting ended at 12.04 p.m. **CHAIRMAN**

SPECIALIST CHILDREN'S SERVICES DEVELOPMENT

Report By: Director of Adult and Community Services

Wards Affected

County-wide

Purpose

1. To consider consultation proposals by the Primary Care Trust.

Financial implications

2. As set out in the consultation document.

Background

3. A consultation document on the development of Specialist Children's Services in the County is attached.

RECOMMENDATION

THAT the consultation proposals be considered.

BACKGROUND PAPERS

- None

Health Overview & Scrutiny Committee

Consultation Document About a New Centre for Children and Young Peoples' Specialist Community Services

1. Background

The attached draft consultation document has been drawn up by members of the working group from social care, health and education which has been looking at the possibility of developing a central building for specialist community services for children with developmental problems/disabilities.

The PCT Board is keen to develop a Business Case to test the affordability of such a centre, recognizing that its current buildings for these services do not support the key ways of effective working identified in the Herefordshire Childrens' and Young Peoples' Plan. Good practice in service user involvement, and indeed, legislative requirements, mean that it is important we involve families, parents (and staff) in the initial debate over the content and nature of a possible centre. Having done that during a consultation period from September to December, we can then develop a Business Case if appropriate early in 2007.

2. Consultation Process

Please note that there is a much shorter summary version of this consultation document, which we aim to also have available for the Childrens' Partnership Board to see at its meeting. Section 8 of the consultation document describes how the consultation will take place, involving offering meetings at schools or other venues preferred by families, and displays at sites. We very much recognize the need to go to where people are to talk to them, and to do more than simply distribute the document. The PCT's Involving People Team will be supporting the process.

Conclusion

The Health Overview & Scrutiny Committee is asked to support the consultation and for any comments on the draft consultation document. Views on who the document should be sent to would also be helpful.

Julie Thornby, Director of Corporate Development, Herefordshire Primary Care Trust, on behalf of the multi-agency Childrens' Building Steering Group.
August 2006

Version 2
31/08/2006

Herefordshire NHS
Primary Care Trust

DRAFT

Public Consultation Document
Period of Consultation
25 September
to
22 December 2006

This document:

1. Describes how Herefordshire Primary Care Trust (HPCT) would like to develop Specialist Children's Services within the county in partnership with education and social care service – especially the idea of a new centre.

2. Asks for your ideas and suggestions on a number of points to help us make sure we get it right. These points are indicated Q and the questions relating to them are included on the feedback sheet.

The specialist services referred to in this document refer to services that are currently provided in the community, not those at the County Hospital or outside Herefordshire.

SECTION 1

Specialist Services for Children in Herefordshire – as they are now

What do we mean by specialist services?

Herefordshire PCT provides health services to all children and young people living in the county. Some services are available to all children, such as immunisations. Other services are provided only when the child or young person is identified as having additional needs. The services that are provided when a child or young person has additional needs are referred to as specialist services.

Specialist services can be provided in the community or in a hospital environment. There are times when children and young people need to be admitted to hospital, in Hereford and outside the county, or attend out patient appointments at a hospital.

This document is about specialist services provided in the community.

Where are specialist services provided now?

Specialist services are currently provided in a number of different settings throughout the county. These include Community Hospitals, the Child Development Centre in Ross Road in Hereford, community clinics including Gaol Street Clinic in Hereford, schools, childrens' centres and in the home environment. The site may change according to the facilities required for the purpose and therefore a child or young person may often have to attend more than one of these settings.

The staff

The staff involved in providing specialist services include consultants, paediatricians, physiotherapists, occupational therapists, speech and language therapists, community childrens' nurses, psychologists, portage workers, teachers, special educational needs co-ordinators, the social care team, support staff and administrative staff. The staff are currently based at different sites including the Child Development Centre (Ross Road, Hereford), the Kite Centre (Ledbury Road, Hereford), Hereford County Hospital, PCT HQ at Belmont, community clinics and the Education Directorate at Blackfriars.

There are multidisciplinary teams at some of these sites and multi-agency teams at the Kite Centre and Child Development Centre.

(Sue Doheny to check) Over 60 staff are involved in providing these services, including health staff and social care staff.

How many children use the services? (Sue Doheny to complete)

Because the services are so varied and are provided in so many places, it is difficult to sum up how many children use them.

To give an indication, each year:

- x children attend the Child Development Centre

- x children attend the Child and Adolescent Mental Health Service
- x children attend the Audiology Centre

plus, plus

- ideally add how much contact children have per year with each service on average.
- add how many children typically have to attend more than one site.

SECTION 2

Why do we need to change

There are a number of reasons why we think that developing new facilities would help us improve specialist childrens' services in the community.

National Guidelines

There have been some important recent publications from the Department of Health and Department for Education and Skills to guide the future development of services for children. These papers include "Valuing People", The Special Educational Needs Code of Practice, "Together from the Start" and the Early Support Programme.

The publication of Every Child Matters, the Children and Young People's National Service Framework, and the Common Assessment Framework provide clear guidelines on the provision of services to improve the outcomes for children and young people. These publications were published in a direct response to Lord Laming's report in 2003. The tragic death of Victoria Climbie in 2000, led to a lengthy investigation led by Lord Laming. The report from the investigation was published in 2003. There were very clear recommendations in the report that showed the inadequacies of services for children. As a consequence, there has been clear direction from central Government on how childrens' services should be provided.

All the documents referred to can be found at the following websites www.dfes.gov.uk/publications, www.dh.gov.uk/policyandguidance .

There are three common themes throughout these publications, on what makes an effective service. We need to consider if the facilities we have now help or hinder us in being effective:

- Effective co-ordination of services

  At any time there may be several agencies involved with a child and their family. These may include Education, Social Services, Health and voluntary organisations. Without effective co-ordination of how these services best meet the needs of the child, there is potential for misunderstandings and duplication and unfortunately a situation where the child's needs may not be met as a consequence. There needs to be effective care planning by the agencies together to ensure co-ordination.

- Effective Communication

  This is key to ensure the needs of a child are met in the most effective way - communication between professionals as well as communication with parents/carers and the child. Parents are often surprised that professionals do not 'talk' more to each other and often feel that as parents they are expected to pass on information from one professional to another.

  Evidence suggests that basing professionals in the same facility (co-location) is the most effective way of improving communication between them. There are obvious advantages to co-location :

  - professionals working from the same base can gain a greater understanding of roles and responsibilities.
  - Formal meetings are easier to organise
  - Informal contacts will enable clarity to be gained on a case or spark an idea of a more appropriate way to manage a complex situation.

  Co-location enables more effective communication on a formal and informal basis and helps innovative ideas for service provision to develop.

- Service provision should be as close to the child's home/school as possible.

  In particular, the NSF describes the 'diagnosis and assessment facility' for children with a disability, being as close to the child's home as possible with multi-professional co-location.

Government policies and guidelines are almost always based on a much more urban situation than applies in Herefordshire. Herefordshire has challenges in implementing such models. Because of the relatively small population and large geographic area, we would not be able to afford more than one assessment centre – unlike one of the major cities with a far bigger population and therefore a larger budget, and with a smaller area to cover.

Local Service Provision

The three key themes above form the basis for the Herefordshire's Children and Young People's Plan. This is a multi-agency plan that sets out how the needs of young people are going to be met over the next 5-10 years. The plan is based on the five outcomes from "Every Child Matters". This plan will enable the development of services to be co-ordinated across all agencies.

One of the main challenges in Herefordshire of providing services is the rurality of the county. A significant amount of time can be spent by professionals travelling between sites. This time can then not be spent with children and their families. An example of the impact of this recently may help explain. It is welcomed that many children with additional needs are now attending mainstream schools but this has meant that professionals have potentially to travel to all the schools in the county and not just the special schools. This has an impact on reducing the time and resources available to spend with children.

The provision of specialist services in Herefordshire currently is from a wide variety of sites. Professionals, in the main, are not located together, but are scattered across many sites. The development of Childrens' Centres will enable some

aspects of specialist services to be provided closer to home for many pre-school children, as has been shown with the centres that are already in use.

However, even with the welcome development of Childrens' Centres, there will still need to be appropriate facilities available to provide specialist diagnosis and assessments when needed and provide accommodation for co-location of staff. The current facilities were generally not designed for this purpose and do not lend themselves to further development. The PCT's two main sites for children are of particular concern.

The Child Development Centre, Ross Road

Of all the PCT's properties, The Child Development Centre (CDC), at the Ross Road clinic, is the highest priority for replacement within the PCT's Estates strategy, given its substantial problems of lack of space and limited facilities. Adjoining land from the Council has been acquired in the past to extend the building, but it is now at the limit of what the site will allow. The site itself is not well placed for children's services, being a few metres away from the edge of the main A49 into Hereford, with very limited parking or drop off facilities. In view of these problems, the decision has been made not to substantially refurbish the current building but to look, as a priority, for a replacement – which could potentially be as part of a larger children's building.

The CDC currently has assessment and therapeutic groups running there, mainly for the pre-school age group. The expansion of services is not possible due to the lack of space and poor suitability of the property. For the same reasons, it is not possible to base more staff there so that all the relevant professionals join together in one place.

The facility currently does not provide adequate space to allow for assessment and treatment of children of any age. Although it is currently being used for pre-school children assessment, it is inadequate for this purpose.

There are no suitable rooms for holding care planning meetings where upwards of 15 people may be involved.

The Ross Road site also has the Child Hearing Centre which has been specifically adapted to enable specialised hearing tests to be undertaken. The facility is not ideally suited for this service and access for families is not ideal given the parking and drop off problems already described.

The Kite Centre, Ledbury Road

The Kite Centre provides limited office space for the community therapy teams, community nurses, learning disability nurses, psychologists, administration and social services disability team. The offices are on the upper floor of an old building where the lower floor is used for respite care for children with behavioural problems. There are no lifts so the only access is by stairs. There are no meeting room facilities and no therapeutic space for treatment.

The teams work hard to provide a multidisciplinary approach to the service they provide but the cramped building, and space which was originally designed for entirely different purposes, does not support them.

The buildings we have currently are not suitable, and hinder us in providing the type of modern, effective service we wish to provide, and which good practice guidance points us towards. In putting this right, we have to face the challenge of being a rural area. This means we have a relatively small population and therefore budget, but need to provide services across a large geographical area. We need to think how to develop the service and what facilities we need to support that.

SECTION 3

What could a new service look like?

The specialist childrens' community service is for children from birth to 19 years old, with additional needs. The service needs to be well co-ordinated, facilitate effective communication and be as close to home/school as possible. It needs to meet national guidelines and local needs. Most of the current childrens' community health facilities within Herefordshire were not designed specifically for childrens' services and there is little room for expansion. There needs therefore to be a change in the way we currently provide services to children with additional needs.

The national guidelines recommend that facilities are as close to childrens' home/school as possible. In our plans, specialist childrens' community services would continue to be provided out to the market towns and wider Herefordshire. Services would still be provided by team members to schools, in homes and at the childrens' centres now being developed. However, we could improve services by developing a specialist assessment centre, providing specialist equipment and a base for a full multi-disciplinary team. **A major benefit would be that this would help the different agencies, and different professionals, to co-ordinate effectively their assessments and care for individual children.**

The costs of such a centre, in relation to the relatively small population of Herefordshire, mean it would not be affordable to provide and run specialist assessment centres in each of the market towns. We would either have to duplicate equipment and facilities – which is very unlikely to be affordable – or transport equipment, which is not practical. It would be very difficult to provide a multi-disciplinary team for each such centre.

We are therefore proposing a service which still visits children at home and in settings nearer home, but also has a central facility.

Any new service would need to ensure that it provides:

- An easy-to-understand "one stop shop" for families and professionals needing developmental and disability services for children.
  This would be for professionals and parents/carers - access to information, assessment and provision of treatment/intervention. All appointments during assessment would be in one place. Any on-going intervention/therapy/treatment would be co-ordinated from the facility.

- Cost effective specialist service
  Having all specialists in one place makes them more available as a resource. A team approach to providing input to children and families is more readily available.

- Centre of excellence
  A new modern purpose built facility will attract professionals to work in Herefordshire. The facility could include enabling professionals to hold seminars and training. This would all facilitate 'best practice' provision of services.

- Co-ordinated high quality family centred services
  The co-location of staff would enable them to share professional notes that facilitate better co-ordination and communication.

- Co-location of multi-agency multi-professional workforce
  Many of the benefits of co-location have been discussed in this paper:
  - Easy access to other professionals
  - More effective informal and formal communication
  - Innovative and creative solutions to care planning
  - Understanding of roles and responsibilities

What are the core services?

The core specialist community services required for children and young people with developmental problems/disabilities are:

- Consultation
- Single and multi professional assessment for the child or young person
- Multi agency assessments
- Interventions (individual and group therapeutic work)
- Co-ordination of care both planning and provision
- Family support
- Teams / services for specific conditions eg
  - Multi-agency child development team
  - Multi-agency assessment and management service for children with autistic spectrum disorders
  - Multi-disciplinary feeding service
  - Team for children with emotional and behavioural disorders
  - Visual impairment team

Aspects of these services could be based in a new central facility – including a base for the staff, and facilities for specialist assessment and treatments/care.

Q: Do you think there would be benefits from including some or all of these services in a new central facility? Please explain.

Q: What other core services do you think should or could be provided, based at a central facility?

Additional Services

There are additional childrens' services that may be included in specialist services and could also be based at a new central facility such as

- CAMHS (Children & Adolescent Mental Health Services) – currently at Gaol Street Clinic in Hereford
- Audiology – currently at the Child Development Centre, Ross Road in Hereford
- Nursery provision

Q: Do you think there would be benefit from including some or all of these additional services in a new central childrens' facility? Please explain.

Q: What other additional services do you think should or could be provided at a central facility.

There are other childrens' services that may be appropriate to be included dependant upon location:

- Acute Outpatient Clinics
- Diagnostics eg X-ray

These services could be provided if the site was close enough to Hereford County Hospital, so that staff from there could provide the services, and if necessary supporting facilities could be provided.

Q: Do you think there would be benefits from including acute hospital (eg County Hospital) outpatient services and diagnostics, like x-ray with the other services described above?

Q: What other additional services do you think should or could be provided if the new facility was very close to Hereford County Hospital – for example, any other childrens' services at the County Hospital now?

How could these services be provided?

It is not economically feasible to provide a facility in each of the Herefordshire market towns, or for each part of the county, that could provide the base for all the professionals, and adequate space to provide a high quality service in line with national guidelines.

The most appropriate option may be to provide a central site where all staff are based and some aspects of services are provided.

Where appropriate teams or individuals would provide a service nearer to the home in schools, community hospitals, children centres etc. This is obviously dependent on the intervention required and on the practicalities involved eg equipment needed. The economies of scale suggest that for some services, it will be possible for more children to be seen, and to have access to better resources, if they travel to a centre.

Q: Which services do you think it would be reasonable to travel to a central site for?

Q: Which services would be reasonable to provide in childrens' homes or nearby?

SECTION 4

Options for providing the service

The previous sections have explained why we believe that a new specialist facility would improve services, and that we could not afford to provide and run more than one such specialist facility in the county. Duplicating such facilities across market towns, for example, would not be economically viable.

At this early stage we estimate that we would need very approximately 1400 sq m of building for the core services. This increases to 1700 sq m if the additional services are included. The total cost of building the facility we estimate at very approximately in the range of £4 to £5 million.

Based on this, we think there are four options.

Option 1

Do nothing.

This leaves us with a service which is not able to meet national guidance fully, and with buildings which are outdated and not ideal for modern services. In this option we would simply refurbish buildings as far as possible with their current layouts.

Option 2

Continue with current buildings with refurbishment. Either adapt one of them to provide a limited assessment/diagnosis centre, or develop a new site for a limited assessment/diagnosis centre. Services continue to be provided nearer to homes and schools; some more specialist assessment/diagnosis provided in the new limited centre.

- This would improve facilities for some assessment/diagnosis.
- However, it would not achieve any of the benefits of having services and the professionals who provide them on one site. The current fragmentation of service would continue.
- Refurbishment of our current buildings in Hereford would improve them, but could not tackle problems such as closeness to main roads or fundamentally unsuitable buildings.
- Our current buildings in Hereford are full and sites are constrained, making it difficult to add a new assessment/diagnosis centre, even if its contents were limited.

Option 3

Develop a new central specialist childrens' services building. This would be a single combined facility. It could be at a new, different site, or could reuse one of our existing sites, with a completely remodelled building. Services would continue to be provided nearer homes and schools; some services would be provided in the new facility.

This is our preferred option.

At this stage we do not have a preferred location. That will be resolved later. But further on in this document we ask you what you think would make a good site.

Q: Which option do you think is best and why?

Q: Do you think there are other options we have missed?

SECTION 5

Can we afford a New Building for Children's' Services?

If this consultation supports the proposal for a new specialist facility, then obviously we have to know whether it is affordable.

The answer at this stage is that we believe we can afford it, but in order to test this, we need to decide exactly which services to include. The consultation process and the feedback you give us will help shape that decision. Then we can develop a Business Case to test out in detail whether the building costs and ongoing running costs are affordable.

The amount of money we can spend on this project will inevitably be limited. We have explained below some of the possible sources of funding.

It may be that we find we can afford a building with most but not all of the services which we originally had in mind. We therefore need your views on what would be the most important services to include in this sort of new children's' services building.

Paying for a New Building

We estimate that a new building of this sort will cost in the order of £4 to £5 million to build, plus land costs if applicable.

Working with Herefordshire Council

If this option is supported, then we shall work in partnership with Herefordshire Council, whose social care and education staff will be an integral part of the centre, to explore our options for putting the funding together for the construction costs.

New NHS Money

The Department of Health via Strategic Health Authorities, allocates new capital funds to pay for new buildings and equipment. The PCT receives a block allocation of capital each year, but this is less than £1 million and also has to pay for a long list of other projects and equipment replacements across the PCT. The PCT can also bid for extra capital money from the Strategic Health Authority. However, such a bid would then have to compete with others from NHS Trusts throughout the West Midlands. Also, we would then have to pay significant ongoing charges (called capital charges) each year, because we had received a large block of capital money. This source of money is therefore still an option, but not the most likely one.

Working with a Partner

Another approach would be for us to work with a partner organisation who could construct the building for us and then provide related services like maintenance and security. This approach is being taken in many NHS schemes now. The partner could be from the independent sector. In this option, the partner might be able to identify new and alternative sites for the building, which meet our requirements.

If current PCT buildings become surplus as a result of a new facility (eg Child Development Centre) it may be possible for them to be sold and the proceeds go towards the new buildings costs.

Running Costs

We would be able to spend the money that we already invest each year in the services we might put into the new building. This totals about £1.3 million per year.

If the building also provides space to be used by other organisations, for example accessible training or conference facilities that are at a premium in Hereford, there should be income from that to help offset building running costs.

Affordability

Building and running a new children's' services building has to be affordable within what we have to spend now and in the future.

This consultation will help to decide what we want in the building if the proposal is supported, and its size and scope. From that we will complete a Business Case early in 2007, to test what we can afford.

SECTION 6

What would make a good site?

If it is accepted that a single site would act as a base and provide some aspects of core and additional services, where would the best site be? The site would need to be easily accessible and provide a 'one stop' service.

It is usually assumed that Hereford City is the most accessible place for the most people because of roads and public transport, but we would like your views.

A number of activities will go on in the building including:

- One to one consultations – an appointment you have with one professional.
- One to many consultations – an appointment you have with several professionals.
- Single professional assessments – assessment of a child by one professional.
- Multi-professional assessments – assessment of a child by several professionals.
- One to one interventions/treatment – treatments or care by one professional of one child.
- Group interventions/treatment – treatments or care to a group of children.

- Professional meetings – meetings of professionals.
- Care planning meetings – meetings of professionals.
- Counselling
- Teaching, training, seminars
- Co-location of staff

The building would therefore need:

- Car parking
- Clinical and non-clinical rooms
- Various sizes of meeting rooms
- Large area for assessment
- Indoor and outdoor nursery
- Office space
- Staff rooms
- Conference/training facilities
- Storage
- File Storage
- Staff toilets

Facilities need to enhance the experience for the children visiting and their parent/carers.

This would include adequate and appropriate

- toileting facilities
- waiting areas
- play areas
- toileting and changing facilities
- Quiet room – beverage making facilities

Q: What else should be included on the site? And how many of each of the above do we need?

Q: Where would the best location be to allow for easy accessibility to all the children of Herefordshire?

Q: If the site was in Hereford City, would it matter if it was close to the middle of town?

Q: Is there any site that you think would be inappropriate?

Q: What specifically should we take into account when selecting a site?

Q: Which of the following are the most important? (put 1 next to the <u>most</u> important, 2 to next important etc).

- easy access to public transport
- car parks nearby
- safe drop off and pick up space
- room for external play space

SECTION 7

What is the vision?

A one-stop shop where parents of children with additional needs (those with serious developmental problems and disabilities) can:

- meet with all the professionals involved in their child's care
- obtain advice and support from specialists
- meet with other parents for mutual support

A one-stop shop where children can:

- have their assessments and treatments tailored around their needs, in a child-friendly building purpose-built to cater for them

Q: Do you see a different vision? Or is there something to be added to this vision?

SECTION 8

The Consultation Process

Why consult?

Herefordshire PCT intends to engage actively with the people who use Specialist Children's Services, our staff, the Health Overview & Scrutiny Committee (OSC), PCT Patient & Public Involvement Forum (PPIF), partner organisations and other interested parties in developing the proposals for children's services.

We want to hear peoples' views about the ideas set out in this document, so that we can develop services that children and parents really want. We hope to be able to provide an opportunity for people to give their views, either by telling us at a meeting, or in writing via the feedback sheet provided in the back of this document.

How will we consult?

We have included questions throughout the document, based on what we think are the key issues. We hope that people will at least give their views on these; however we will be happy to receive feedback about any part of the proposals.

For many the easiest way will be to complete the response form at the back of the document, answering the questions, and adding any other issues they wish to, then to post the form back to us using the FREEPOST address on the form.

However previous consultations have shown that is best to go to where people meet already; as a result we hope to attend existing school councils, parent and carer groups and other existing meetings to discuss the proposals.

If you do not attend any meetings, but would still like to discuss the developments rather than respond in writing, or you have an existing meeting you would like to

invite a PCT representative to, please contact the Patient Advice & Liaison Service (PALS) on 01432 262016 and we will arrange a convenient time for you.

We will develop consultation displays for each main existing site where specialist childrens' service are, which will include an outline of the key issues, confirmation of the consultation start and finish dates, a stock of consultation documents, a mechanism for returning completed feedback sheets and contact details for people wish to discuss the proposals with us.

We will meet with the Chairmen of the OSC and PPIF as early as possible to discuss the proposals and regularly update them as to the feedback we receive. We will make the relevant staff available to discuss the proposals and the consultation at their formal committee meetings as required.

We will discuss the developments with our staff, through existing team meetings and briefings and where necessary arrange specific forums to discuss the potential impacts of any changes.

When will the consultation happen?

The Consultation will be formally launched on 25th September 2006 and run for 13 weeks until the 22nd December 2006. All responses received before 5pm on the 22nd December will be taken into account. The consultation will be formally launched through the local media and through the displays in existing sites.

How will I know what has happened?

The responses will be collated before Christmas and the final report will be completed by late January 2007. This report will be based on the feedback you give and will include the final recommendation to the PCT board. We will send a copy of the report to each of the participating groups, partner organisations, staff teams and any individual who requests a copy.

The Board will make a decision on the proposals in the report at their meeting in the spring – we will publicize the relevant date. Board meetings are held in public at the Primary Care Trust Headquarters, Vaughan Building, Ruckhall Lane, Belmont, Hereford, HR2 9RP.

Children's Specialist Services Consultation – feedback questionnaire

QUESTION	RESPONSE
Q: (see page 6) Do you think there would be benefits from including some or all of these "core" services in a new central facility? Please explain.	☐ ☐ ☐ ☐
Q: (see page 6) What other core services do you think should or could be provided, based at a central facility?	
Q: (see page 7) Do you think there would be benefit from including some or all of these "additional services" in a new central childrens' facility? Please explain.	
Q: (see page 7) What other additional services do you think should or could be provided at a central facility?	
Q: (see page 7) Do you think there would be benefits from including acute hospital (eg County Hospital) outpatient services and diagnostics, like x-ray with the other services described above?	
Q (see page 7) What other additional services do you think should or could be provided if the new facility was very close to Hereford County Hospital – for example, any other childrens' services at the County Hospital?	
Q: (see page 7) Which services do	

Please put this form in the box provided at any of our existing Children's Service Sites or post it back free of charge to:

Consultation, FREEPOST NATW599, PO Box 64, Hereford, HR4 0BR

"A STRONGER LOCAL VOICE"

Report By: Director of Adult and Community Services

Wards Affected

County-wide

Purpose

1. To consider a response to the Department of Health (DoH) document, 'A Stronger Local Voice - A Framework for Creating a Stronger Local Voice in the Development of Health and Social Care Services'.

Financial implications

2. The DoH is making funds available to community groups to help them develop their local LINk (Local Involvement Network). Money will also be allocated to the Council for consultation with local organisations to identify the most appropriate arrangements for hosting the LINks. The amount of funds being made available is unknown at this time.

Background

3. There is currently a Patient and Public Involvement Forum (PPIF) for every NHS trust and primary care trust. In Herefordshire, there are therefore separate PPIFs for the PCT and the Hospitals Trust. There is also the Regional Ambulance Trust. These groups have a range of functions including the monitoring and review of the health service.

4. The DoH plan to replace PPIF's with LINks which will cover coterminous areas with every local authority with social services responsibilities – rather than be associated with specific organisations. For Herefordshire, this means that the 2 existing PPIF's will be replaced by one new LINk.

5. The DoH state that LINks will 'build on the role of patient forums by creating a strengthened system of user involvement, and promote public accountability in health and social care through open and transparent communication with commissioners and providers', all of which will help achieve the Government's commitment to:

    1. Develop a health and social care system planned around the needs of individual people and those of the wider community;

    2. Create health and social care services that are, regardless of who provides them, user-centred, responsive, flexible, open to challenge, accountable to communities and constantly open to improvement; and

    3. Develop decision-making to the local level. Some 80% of the NHS budget is now devolved to PCT's, meaning that priorities are decided locally.

Response from Health Scrutiny Committee

6. The DoH has asked for responses to their document, 'A Stronger Local Voice' and has provided a series of questions to help shape these responses. This section therefore lays out the five DoH questions and draft responses for the Committee's consideration. (Copies of the full document have previously been circulated to Members of the Committee.)

7. *Question 1: (a) What arrangements can we put in place to make sure that there is a smooth transition to the new system? (b) How can we build on existing activity in the voluntary and community sector?*

   Draft response: (a) The legislation to establish the new LINks must be in place before any moves to 'disband' the PPIF's are made. The role, remit and scope of the LINks must be clearly laid out well in advance of the forums being established. (b) As a first step, there should be an audit of 'existing activity in the voluntary and community sector'. Once this activity has been mapped, a judgement can be reached on how best to build upon it, as well as the most effective methodologies to employ.

8. *Question 2: What do you think should be included in a basic model contract to assist local authorities tendering for a host organisation to run a LINk?*

   Draft response: i) The need for an individual to guide / train / steer the LINk with regard to national policy / direction, etc. ii) The requirement for LINk members to have experience / knowledge of involvement / consultation practices. iii) The need for clear 'terms and conditions' for LINk members. iv) The requirement for clear reference to work practices that reflect current policies on equality / diversity. v) The requirement for LINk members to undertake regular review, training and development. vi) The requirement for easy access to legal advice. vii) Details of the financial resources being made available to local authorities to establish and maintain the LINks.

9. *Question 3: How can we best attract members and make people aware of the opportunities to be members of LINks?*

   Draft response: i) Ensure that the role and remit of the LINk is clear. ii) Ensure that the role and remit (and level of commitment) of individual LINK members is clear. iii) Promote the potential power to effect actual changes. iv) Use existing networks to raise awareness of opportunities. v) Ensure that the timetable allows a sufficiently long period for awareness raising to take place effectively. vi) Ensure that the awareness raising materials are relevant to rural areas (such as Herefordshire) and not biased towards large urban areas. vii) Consider some form of 'rewards or recognition scheme as an incentive.

10. *Question 4: What governance arrangements do you think a LINk should have to make sure it is managed effectively?*

    Draft response: There must be a clear line of responsibility / accountability to an independent organisation for the LINk and for the individual members of the LINk. (This could be the Strategic Health Authority or the new merged Health and Social Care Regulators body).

11. *Question 5: What is the best way for commissioners to respond to the community on what they have done differently as a result of the views they have heard? For example, should it be part of the proposed PCT prospectus?*

    Draft response: Yes, it should be part of the prospectus, but the reports should be more frequent. Other forms of communication should also be used including the local media and the voluntary sector. Information should also be relayed to the LINk and to the Health Overview and Scrutiny Committee.

Next Steps

12. The document 'A Stronger Local Voice' clearly states out that the local authorities are the 'host organisations' for the LINks. It states that, as host organisation, the local authority will:

    i. Develop the LINk;

    ii. Recruit members to the LINk;

    iii. Establish good communication arrangements; and

    iv. Support the development and management of a governance structure.

13. The DoH document also makes reference to the role of Overview and Scrutiny Committees (OSC's). OSC's will be 'encouraged to focus their attention on the work of commissioners, but there is no intention to limit their role'. The rationale provided for OSC's particular focus on the commissioning role is that they are best placed to ask commissioners about:

    i. How they involve local people in the decisions that they have made and how they have decided local priorities;

    ii. What evidence that have to support the decisions; and

    iii. The actions they are proposing to take to address failings, concerns and gaps in service.

14. It is suggested that OSC reviews will have the most impact if they focus on the decision-making activities of PCT's and local authorities, in particular scrutinising how well they have met the requirements of the revised duties to involve, consult and respond. It is further suggested that the best way for the OSC's to access the widest range of views and experiences will be for them to have strong relationships with their LINk.

15. There is much for the Scrutiny Committee to consider in this DoH report. It is therefore proposed that a further report is prepared for a future meeting of the Committee once the relevant legislation has been passed, and there is more detail available upon which to base proposals for Herefordshire's way forward in this matter.

RECOMMENDATIONS

THAT (a) the proposed response to the DoH's document, 'A Stronger Local Voice' as set out above be approved;

and

(b) a further report be presented to a future meeting once the related legislation has been passed.

BACKGROUND PAPERS

- 'A Stronger Local Voice: A framework for creating a stronger local voice in the development of health and social care services' – Department of Health (July 2006)

HEREFORDSHIRE COUNCIL

Review of Communication in the Local Health Service

Report by the Communication Review Group – August 2006

For Presentation to the Health Scrutiny Committee on 5th September 2006

…Putting people first
…Promoting our county
…Providing for our communities
…Protecting our future

Quality life in a quality county

Background

1. In considering its work programme in October 2003 the Health Scrutiny Committee agreed to establish a number of sub-groups, one of which would focus on communication and morale issues. A number of communication issues were raised during the consultation exercise on the provision of Ear, Nose and Throat Services in 2004 that re-emphasised the need to consider the area of communication. At its meeting of 16th June 2005, the Committee discussed the scope of all the reviews it was undertaking and agreed that they should be broken down into a series of smaller, sharper, shorter reviews. The agreed scoping document for this Review of Communication is at Appendix A.

2. The Review Group has based its recommendations on evidence provided in discussions with managers, staff, union representatives and members of the Herefordshire Primary Care Trust (HPCT), Herefordshire Hospitals NHS Trust (HHT), Patient Advisory Liaison Service (PALS) and the Patient and Public Involvement (PPI) Forum.

3. As the review progressed it became clear, through the discussions, that the primary source of information being generated was relevant to the issue of internal communication. It was the feeling of the Review Group that communication with patients and public could not improve without greater consideration of the internal communication issues within each organisation. The Review Group's findings are set out below.

(a) Ensure the message gets to everyone

4. Communication needs to be two-way and involve everyone. HHT and HPCT both adopt a similar approach in using team briefs and regular staff meetings; the HPCT has TrustTalk and the HHT has weekly meetings with the Chief Executive open to all staff. However, the consensus seemed to suggest that team briefs and meetings were primarily organised for the benefit of Managers. Whilst accepting that communication should be an element of good leadership, the front-line staff that are most likely to be in contact with the public are often left out of the loop.

5. Unfortunately, many staff meetings seem to take place at times that are inconvenient, or impossible, for the majority of staff to attend. To exacerbate this situation, there is a lack of dissemination of information to those unable to attend, and of feedback to those that do attend. Consequently key messages are failing to be delivered to **all** staff, which then results in a lack of clear, consistent and reliable information being passed to patients and public.

   Greater consideration needs to be applied in arranging, and varying, the times of meetings so that more staff are given the opportunity to attend meetings. In addition, there need to be improvements in the dissemination of information so that more staff are aware of what is being discussed so that they can communicate the correct message.

   It was apparent that the HPCT and HHT recognise the importance of good communication, and efforts were being made, but it is suggested that more needs to be done to ensure that good ideas become good practice. An example would be the practice introduced

by the HHT of 'zonal management walkabouts'. The hospital has been divided into zones and each member of the hospital's management team allocated a zone, into which they should take the time to walkabout, talking to staff and patients and making himself or herself visible. Rotation of allocated zones takes place periodically to ensure that members of management team become recognisable to all staff. The Review Group considered the walkabouts to be a good opportunity for genuine two-way communication to take place, and possibly an approach that could be adopted by all organisations. However, through discussions with staff and union representatives, there was a lack of knowledge that the walkabouts were happening. Whilst not doubting the potential benefits of the walkabouts, this could be an example of the message only getting through to a few. Perhaps variation of the times of the walkabouts would have a more significant impact on the success of this approach.

4. Communication needs to be structured

i. Evident through the discussions was that there is a great deal of informal communication taking place between the HPCT, HHT and PALS, with regular meetings between the Chief Executives of the HPCT and HHT. However, this is very much voluntary and possibly personality dependent. It is felt that, in order to secure continued good communication in the future, the current arrangements should be formalised.

5. More emphasis on communication as part of staff training

i. Discussions with PALS established that communication was included in staff training and as part of everyone's induction so that staff were able to deal with patient and public comments on the spot, and complete a form so that monitoring and evaluation can take place as to the nature of the comment/request. There were also plans for the development of half-day training sessions. However, there was some doubt, expressed by PALS, as to whether staff were being proactive enough in dealing directly with patients and the public, as well as completing the necessary forms.

6. Make communication the responsibility of all

i. In operating a Public Relation Team, and relying on PALS, both the HPCT and HHT are in danger of becoming over-reliant on these small teams, and failing to recognise that all staff have a role to play in the successful communication of key messages about the services that they deliver. All staff need to be kept informed about general issues that they may need to communicate to patients and public.

ii. Whilst PALS are involved in management meetings of the HPCT, there needs to be greater appreciation that public relations and communication are not wholly the same thing, and that there is a need for integration with those at the top to ensure that the organisations are proactive in what they

communicate, and not reactive. Only if people have the necessary information are they able to adequately respond to questions that they are asked.

7. Consider the 'external customer'

i. In considering the views of patients and public, and acting as the link to the HPCT and HHT, the Review Group feel that PALS should be commended for the work that they have done thus far. The Review Group also wishes to recognise the excellent start that the PPI Forum has made. However, in terms of recognising the views of patients and public and keeping them informed there is still much work to do. Whilst accepting that PALS has a duty, in representing the HPCT and HHT, in responding directly to requests made by patients and public, there is still a lack of acknowledgement that the PPI Forum provides a valuable link to understanding the needs and views of patients and public.

ii. The Review Group suggests that there needs to be an increase in effort to ensure that there are processes in place to include the PPI Forum in decisions that affect patients and public, that will allow the PPI Forum to fulfil its function in providing advice and information to patients and their carers about services. Similarly, enforcing the argument that communication needs to be two-way, the PPI Forum should continue to obtain the views from local communities about health services and make suitable recommendations and reports based on them.

REVIEW:	COMMUNICATION	
Scrutiny Committee:	Health	**Chair:** Councillor W J S Thomas
Lead support officer:	Director of Social Care and Strategic Housing	

SCOPING STATEMENT AND TIMETABLE

Terms of Reference
To review the Health Service wide communications strategy and procedures to assess their effectiveness.

Desired outcomes
• To make suitable recommendations, based on the existence of a Communications Strategy, to improve the lines of communication across NHS organisations in Herefordshire. • To express a view on the leadership/management approach to communication that has been adopted.

Key questions
• Is there a Communications Strategy across NHS organisations in Herefordshire? • What are the current procedures? • How are staff and patients kept informed of developments? • Are staff and patients consulted and involved in decision-making? • What are the levels of cohesiveness across the organisations locally? • What views do staff hold on Communications, as recorded in the staff opinion surveys? Is the trend improving?

Timetable	
Activity	*Timescale (activity completed by)*
Agree approach	1st December (to submit Scoping Statement to Health Scrutiny Committee)
Collect data	June 2005
Agree list of 'witnesses' to interview	June 2005
Interview witnesses	August – September 2005
Analysis of data and witness evidence	October 2005
Prepare recommendations	October 2005

Report to Health Scrutiny Committee	December 2005

Members	**Support Officers**
Councillor Mrs W U Attfield Councillor Brig. P Jones CBE (Chair of Review Group) Councillor J B Williams Mr C G Grover	Policy Assistant

HEREFORDSHIRE COUNCIL

Review of Communication

Report by the Communication Review Group – September 2006

For Presentation to the Health Scrutiny Committee on 5th September 2006

…Putting people first
…Promoting our county
…Providing for our communities
…Protecting our future

Quality life in a quality county

Background

1. In considering its work programme in October 2003 the Health Scrutiny Committee agreed to establish a number of sub-groups, one of which would focus on communication and morale issues. A number of communication issues were raised during the consultation exercise on the provision of Ear, Nose and Throat Services in 2004 that re-emphasised the need to consider the area of communication. At its meeting of 16th June 2005, the Committee discussed the scope of all the reviews it was undertaking and agreed that they should be broken down into a series of smaller, sharper, shorter reviews. The agreed scoping document for this Review of Communication is at the end of this report.

2. The Review Group has based its recommendations on evidence provided in discussions with managers, staff, union representatives and members of the Herefordshire Primary Care Trust (HPCT), Herefordshire Hospitals NHS Trust (HHT), Patient Advisory Liaison Service (PALS) and the Patient and Public Involvement (PPI) Forum.

3. As the review progressed it became clear, through the discussions, that the primary source of information being generated was relevant to the issue of internal communication. It was the feeling of the Review Group that communication with patients and public could not improve without greater consideration of the internal communication issues within each organisation. The Review Group's findings are set out below.

a. Ensure the message gets to everyone

4. Communication needs to be two-way and involve everyone. HHT and HPCT both adopt a similar approach in using team briefs and regular staff meetings; the HPCT has TrustTalk and the HHT has weekly meetings with the Chief Executive open to all staff. Whilst an audit of 250 of the 1,400 HPCT staff indicated that key messages were being delivered through the Team Brief, feedback during a meeting with staff of the HHT suggested that meetings and Team Briefs were generally directed at managers. Unfortunately, many meetings take place at times that are inconvenient, or impossible, for the majority of staff to attend. To exacerbate this situation, there is a lack of dissemination of information to those unable to attend, and of feedback to those that do attend. Consequently key messages are failing to be delivered to **all** staff, which then results in a lack of clear, consistent and reliable information being passed to patients and public. Whilst accepting that communication should be an element of good leadership, the front-line staff that are most likely to be in contact with the public are often left out of the loop.

5. Greater consideration needs to be applied in arranging, and varying, the times of meetings so that more staff are given the opportunity to attend meetings. In addition, there needs to be improvements in the dissemination of information so that more staff are aware of what is being discussed so that they can communicate the correct message.

6. It was apparent that the HPCT and HHT recognise the importance of good communication, and efforts were being made, but it is suggested that more needs to be done to ensure that good ideas become good practice. An example would be the practice introduced by the HHT of

'zonal management walkabouts'. The hospital has been divided into zones and each member of the hospital's management team allocated a zone, into which they should take the time to walkabout, talking to staff and patients and making himself or herself visible. Rotation of allocated zones takes place periodically to ensure that members of management team become recognisable to all staff. The Review Group considered the walkabouts to be a good opportunity for genuine two-way communication to take place, and possibly an approach that could be adopted by all organisations. However, through discussions with staff and union representatives, there was a lack of knowledge that the walkabouts were happening. Whilst not doubting the potential benefits of the walkabouts, this could be an example of the message only getting through to a few. Perhaps variation of the times of the walkabouts would have a more significant impact on the success of this approach.

b. Communication needs to be structured

7. Evident through the discussions was that there is a great deal of informal communication taking place between the HPCT, HHT and PALS, with regular meetings between the Chief Executives of the HPCT and HHT. However, this is very much voluntary and possibly personality dependent. It is felt that, in order to secure continued good communication in the future, the current arrangements should be formalised.

c. More emphasis on communication as part of staff training

8. Discussions with PALS established that communication was included in staff training and as part of everyone's induction so that staff were able to deal with patient and public comments on the spot, and complete a form so that monitoring and evaluation can take place as to the nature of the comment/request. There were also plans for the development of half-day training sessions. However, there was some doubt, expressed by PALS, as to whether staff were being proactive enough in dealing directly with patients and the public, as well as completing the necessary forms.

d. Make communication the responsibility of all

9. In operating a Public Relation Team, and relying on PALS, both the HPCT and HHT are in danger of becoming over-reliant on these small teams, and failing to recognise that all staff have a role to play in the successful communication of key messages about the services that they deliver. All staff need to be kept informed about general issues that they may need to communicate to patients and public.

10. Whilst PALS are involved in management meetings of the HPCT, there needs to be greater appreciation that public relations and communication are not wholly the same thing, and that there is a need for integration with those at the top to ensure that the organisations are proactive in what they communicate, and not reactive. Only if people have the necessary information are they able to adequately respond to questions that they are asked.

e. Consider the 'external customer'

11. In considering the views of patients and public, and acting as the link to the HPCT and HHT, the Review Group feel that PALS should be commended for the work that they have done thus far, the PCT having won the NHS Alliance Award for PPI work for the last 2 years. The Review Group also wishes to recognise the excellent start that the PPI Forum has made. However, in terms of recognising the views of patients and public and keeping them informed there is still much work to do. Whilst accepting that PALS has a duty, in representing the HPCT and HHT, in responding directly to requests made by patients and public, there is still a lack of acknowledgement that the PPI Forums of both the HHT and HPCT provides a valuable link to understanding the needs and views of patients and public alike.

12. The Review Group suggests that there needs to be an increase in effort to ensure that there are processes in place to include the PPI Forum in decisions that affect patients and public, that will allow the PPI Forum to fulfil its function in providing advice and information to patients and their carers about services. To enable this to happen there is a need for improved links between the PALS and PPI Fora. Similarly, enforcing the argument that communication needs to be two-way, the PPI Forum should continue to obtain the views from local communities about health services and make suitable recommendations and reports based on them.

Recommendation

(a) that the recommendations set out above be approved; and

(b) the response of Primary Care Trust and the Hospitals Trust to the Review be reported to the first available meeting of the Committee after the Trust has approved its response, with consideration then being given to the need for any further reports to be made.

REVIEW:	COMMUNICATION	
Scrutiny Committee:	Health	**Chair:** Councillor W J S Thomas
Lead support officer:	Director of Social Care and Strategic Housing	

SCOPING STATEMENT AND TIMETABLE

Terms of Reference
To review the Health Service wide communications strategy and procedures to assess their effectiveness.

Desired outcomes
• To make suitable recommendations, based on the existence of a Communications Strategy, to improve the lines of communication across NHS organisations in Herefordshire. • To express a view on the leadership/management approach to communication that has been adopted.

Key questions
• Is there a Communications Strategy across NHS organisations in Herefordshire? • What are the current procedures? • How are staff and patients kept informed of developments? • Are staff and patients consulted and involved in decision-making? • What are the levels of cohesiveness across the organisations locally? • What views do staff hold on Communications, as recorded in the staff opinion surveys? Is the trend improving?

Timetable	
Activity	*Timescale (activity completed by)*
Agree approach	1st December (to submit Scoping Statement to Health Scrutiny Committee)
Collect data	June 2005
Agree list of 'witnesses' to interview	June 2005
Interview witnesses	August – September 2005
Analysis of data and witness evidence	October 2005
Prepare recommendations	October 2005

Report to Health Scrutiny Committee	December 2005

Members	**Support Officers**
Councillor Mrs W U Attfield Councillor Brig. P Jones CBE (Chair of Review Group) Councillor J B Williams Mr C G Grover	Policy Assistant

SCRUTINY REVIEW OF GP OUT OF HOURS SERVICE

Report By: GP Out of Hours Services Review Group

Wards Affected

County-wide

Purpose

1. To consider the findings of the GP Out of Hours Service Review Group following its review of the GP Out of Hours Service.

Financial implications

2. No resource implications have been identified in relation to this item.

Background

3. On 16th June 2005, the Committee discussed the scope of all the reviews it was undertaking and agreed that they should be broken down into a series of smaller, sharper, shorter reviews. Following discussion with the Primary Care Trust it was suggested that review focusing specifically on the GP Out of Hours Service would be helpful.

4. The final report of the review and its key findings is appended.

RECOMMENDATION

That (a) the Committee considers whether it wishes to agree the findings of the review of the GP Out Of Hours Service for recommendation to the Primary Care Trust;

and

(b) **subject to (a) above, the response Primary Care Trust's response to the Review be reported to the first available meeting of the Committee after the Trust has approved its response, with consideration then being given to the need for any further reports to be made.**

BACKGROUND PAPERS

- None

HEREFORDSHIRE COUNCIL

Review of GP Out of Hours Service

Report by the GP Out of Hours Service Review Group – August 2006

For Presentation to the Health Scrutiny Committee on 5th September 2006

…Putting people first
…Promoting our county
…Providing for our communities
…Protecting our future

Quality life in a quality county

CONTENTS

Introduction

1. In the summer of 2005 the Health Scrutiny Committee decided to break down reviews it had already scoped into a series of smaller reviews. The Review of GP out of hours services was then commissioned following discussions with the Herefordshire Primary Care Trust (PCT) to identify work where it would be possible for the Committee to add value. The PCT's position was that it wanted all stakeholders to express a view on the service and, if it was thought that the current system was not working, to suggest what alternatives might be considered.

2. The Committee appointed Councillor Mrs W.U. Attfield, G.Lucas, Ms G.A. Powell and W.J.S. Thomas (Chairman) to serve on the Review Group.

3. The terms of reference were: To evaluate the effectiveness of the delivery of the GP out of hours service in Herefordshire.

4. The desired outcomes were:

   - To make recommendations on the future delivery of the out of hours service in Herefordshire
   - To make recommendations for ensuring and improving access to the out of hours service within Herefordshire.

5. The scoping statement for the review is attached at appendix 1 to this report.

6. The Review coincided with the PCT inviting expressions of interest for provision of the out of hours service with effect from 1st April, 2006 following the expiry of the contract with the existing provider on 31st March, 2006. In these circumstances it was considered inappropriate for the Review Group to investigate the detailed performance of the existing provider and rather to focus on the lessons which had been learned and what features a successful out of hours service might incorporate.

7. The principal work of the Review was conducted between August and December 2005. To try to contribute in a timely fashion to the Primary Care Trust's consideration of future provision some of the Review Group's thoughts emerging from its work, which had at that time been substantially completed, were submitted to the PCT in December. These form the basis of the majority of the recommendations at the end of this report.

8. This final report reflects the conclusions reached at that time and sets them in context. The Review Group would wish to emphasise that this is a complex area of work and would not claim that its report is comprehensive. It does, however, hope that it provides some useful and impartial observations on the service and the rationale behind the way in which it has developed.

9. The Review Group would like to thank those who submitted evidence to the Review and participated in it.

Method of Gathering Information

10. The Review Group received a considerable amount of documentation from the PCT, written representations from a number of other parties, interviewed the Deputy Chief Executive of the Primary Care Trust and representatives of Primecare the Out of Hours Provider (its Group Medical Director, the local Area Relationship Manager and the local Medical Director for Primecare (also a local

GP) and visited the Provider's premises at Birmingham and Gaol Street Hereford.

11. A summary of the principal documentation considered as part of the Review and witnesses interviewed is presented in Appendix 2.

Background

What is Out of Hours?

12. The General Medical Services Contract, agreed in 2003 and in force with effect from 1 April 2004, defines the out of hours period as from 6.30 pm to 8.00 am on weekdays and also the whole of weekends, bank holidays and public holidays. This accounts for two-thirds of every week. In Herefordshire the out of hours service by agreement between the PCT and the GPs applies between 6.00pm to 8.00pm on weekdays.

13. The contract allowed GPs to opt out of providing out of hours care if they so wished with effect from 1 January 2005. Along with nearly every practice in England and Wales all of the 24 Herefordshire practices took up this option and on 1st November, 2004 the PCT took over the legal responsibility for the out of hours care for all Herefordshire residents.

Why were GPs allowed to opt out?

14. The House of Commons Health Committee report on GP Out of Hours Services (fifth report of Session 2003-04) reported that:

"Following concerns raised by the Health Services Ombudsman an independent review of arrangements for GP out-of hours cover was commissioned by the Department of Health and published in October 2000: Raising Standards for Patients New Partnerships in Out –of -Hours- care (the Carson report). The report identified a future model of out of hours care in which Primary Care Trusts would develop an integrated network of unscheduled care provision, bringing together providers of out of hours services to work collaboratively with other health and social care providers such as A&E and ambulance services. The report also identified core quality standards to which all out of hours services should be delivered in the future.

In addition to questions being raised over the quality of out of hours provision, there was growing concern within the medical profession that the requirement to provide out-of hours care was contributing to low morale amongst GPs and that the existing default responsibility for all GPs to provide 24 hour care for their patients made general practice unattractive for many prospective and current GPs."

15. The two basic principles at the heart of the new approach recommended in the Carson report were:

- Patient Access to out of hours care should be as simple and straightforward as possible – one telephone call providing effective and timely advice, and, where necessary, a face to face consultation at a time and place agreed with the patient. No multiple phone calls, no double triage (analysis and prioritisation of calls), just prompt, professional and appropriate responses to the myriad different needs of patients out-of hours.

- All those professionals involved in the delivery of care out-of hours, regardless of the sector of the service in which they work should work together co-operatively and collaboratively to deliver the best possible service to patients and to make the most effective use of resources.

How is the out of hours service provided?

16. At the time of the Review the out of hours service was commissioned by the Herefordshire Primary Care Trust from Primecare, a commercial company which described itself on its website as, the UK's leading provider of 24 hour, seamlessly integrated healthcare services. The Review Group was informed that at that time Primecare provided 12.5% of out of hours coverage in the UK.

17. The contract ran from 1 November 2004 until 31 March 2006, at a cost to the PCT £1.8 million per year.

18. Following a tendering process the PCT approved the award of a new Contract to Primecare in December 2005 running from 1st April, 2006 to 31st March, 2008. The cost of this contract is approximately £2.2 million per year.

19. A summary of what is provided under the contract is set out in the section below on "what is provided by Primecare?"

Why Primecare?

20. Until September 2003, Herefordshire had little integrated out of hours provision in place, with individual practices being responsible for making their own provision. There was a large Hereford City co-operative covering approximately 42% of the County's population.

21. The options available for the provision of out of hours services were for each individual GP to provide the service themselves; join a practice rota; join a GP co-operative; or employ a deputising service

22. The PCT decided that it "did not have the skills, experience or desire to deliver this service itself. It took the initiative to work with GPs to develop a service specification and arrangements to ensure that all GPs could be relieved of out of hours responsibilities but made it clear that if local GPs wished to work in the service they could. A tendering process was conducted and, Primecare was subsequently awarded a 16 month contract until 31st December 2004." A further contract was then awarded until 31st March, 2006 followed by a new Contract running from 1st April, 2006 to 31st March, 2008 as described in the previous section.

What is provided by Primecare?

23. Primecare manage call handling, doctor/nurse triage (analysis and prioritisation of calls) and the local operational management of the out of hours services for all the GP practices in the County as a deputising service. Primecare is required to provide cover for the whole of the Herefordshire PCT population needing care in Herefordshire including inpatients at the Community Hospitals, the Hillside Unit (providing respite care and now dedicated stroke services) and the Minor Injury Units. (From April 2006 the provision of dental out of hours services is also included.)

24. There is a single local rate phone number which callers can ring or to which they are directed out of hours. This is received at Primecare's call-handling centre at Brimingham. All calls are recorded and are required to be answered within 60 seconds of an introductory message which should be no longer than 30 seconds long. Possible outcomes of calls are for them to be transferred for telephone medical triage (analysis and prioritisation) by a Doctor or Nurse; for a direct booking of a face to face consultation or, in a few cases, referred to the Hospital Accident and Emergency Unit or to the 999 emergency number. A summary out of hours specification from April 2005 which led to the

development of the substantive detailed specification included the contract itself is attached at Appendix 3.

25. The specification provides that the provider must demonstrate the ability to provide capacity to meet predictable fluctuations in demand and to have robust contingency plans in place.

26. Face to face assessment is provided through home visits, Primary Care Centre and Community Hospital Attendance. A home visit has to be provided where this is clinically or socially necessary. In Herefordshire there are two mobile clinicians available during the out of hours period.

27. The aims of the Contract with Primecare at the time of the Review were:

- To ensure that any person who contacts a primary health care service in the PCT Area during the Out of Hours Period receives seamless healthcare from the most appropriate professional, at the appropriate time and appropriate place.

- To ensure that the Services are provided in a manner that is operationally stable, clinically safe, quality focused, patient-centred and cost-effective.

- To recognise the co-operation and goodwill between the PCT and Provider and best intentions of all parties to work together to deliver ongoing improvements in the provision of care.

- To outline and identify pathways that will move the PCT towards its longer term plan for the delivery of a fully integrated service for unscheduled care during the out of hours Period and in doing so, set out a common delivery policy and purpose.

28. The aims under the new contract are broadly similar. The new Contract, however, is significantly different in many respects. It builds on lessons learned under the previous contract, widens the level of service and has an increased focus on ensuring value for money.

How well does the Service provided by Primecare operate?

29. As mentioned in the introduction to this report it was considered inappropriate for the Review Group to investigate the detailed performance of the existing provider and rather to focus on the lessons which had been learned and what features a successful out of hours service might incorporate.

30. National Quality Requirements apply to the provision of out hours services. Until 31 December 2004 Primecare was required to meet the quality standards set out in the document entitled: “Quality Standards in the Delivery of GP out of hours Services (published June 2002) and from 1 January 2005 meet the 21 standards set out in the document entitled National Quality Requirements in the Delivery of Out of Hours Services (an extract is attached at appendix 4).

31. The Review Group was advised that in the period November, 2004 to June 2005 the provider had been fully compliant with 15 of the standards and partially compliant with 6. The PCT has said that it regards performance as satisfactory, and within the National Quality Standards, accepting occasional fluctuations.

32. The Review Group was informed at the time of the Review that comparative information on performance in delivering the out of hours service was not available. Comparative information was subsequently collected by the National

Audit Office which produced a report in May 2006. This is discussed later in this report.

33. The Review Group also noted that in the period November 2004 to June 2005 there had been 29,632 patient contacts with a total of 66 complaints received (0.23% of patient contacts)

34. However, the Review Group also noted the findings of the Local Health Services Survey Report for 2005 produced on behalf of the Heatlhcare Commission which identified in the section on aspects in need of management action (which "draws attention to groups of patients often in a minority here practice and performance might be improved) that "more than one in five of the patients trying to contact their GP surgery out of hours said that they could not get through to anyone on the phone"; and "a clear majority of the patients who contacted the surgery out of hours said the main reason they did so was not dealt with to their complete satisfaction" (although the Review Group also noted the importance of the word "complete" in this context in that the text of the report states that "42% of those who contacted their GP surgery out of hours were happy that the reason for contact had been dealt with satisfactorily; there were other significant groups who disagreed. 16% said they were not satisfied with the response and a further 42% of this group said that they were only partly satisfied that the reason for their call had been dealt with."

35. The Review Group understands that the PCT has investigated these findings but is somewhat puzzled by them. It is advised that Primecare record all calls received, the time taken to answer them and the number of callers who hang up before their call is answered. The PCT has therefore found it difficult to reconcile the survey's findings with the evidence provided by Primecare. It is suggested that the question asked in the survey, "The last time you called the surgery out of hours , did you get through to someone?" is perhaps capable of misinterpretation in that whilst callers would not get through to someone actually at the surgery out of hours the call would automatically be directed to Primecare. The Review Group has been assured that the position is subject to ongoing monitoring and review by the Out of Hours Steering Group.

The Review Group's Key Findings

36. The Review Group's visit to Primecare's Operational Centre at Birmingham enabled it to observe and experience at first hand the operation of the out of hours service. This visit helped to put in context and confirm the comments made about the Service to the Review Group by representatives of Primecare. In particular the Review Group was reassured by

- the professionalism of those Primecare staff with whom it met;
- the capacity and resilience of the Primecare service;
- the measured, factual and professional approach to handling calls;
- the mechanisms in place to review the way in which calls were being handled;
- the commitment to ongoing training and improvement.

37. The general tenor of the evidence provided to the Review Group was that the out of hours service had improved and become more robust over time and that where problems did occur there was a commitment to putting them right. It was also suggested to the Review Group by the GP Advisor to the PCT that when

concerns were expressed these were about "specific patient circumstances rather than generic concerns about the entire Primecare system." Evidence provided about the action taken in response to complaints included success in encouraging more local doctors to work in the service; using regular doctors who became familiar with local policies and procedures and began to consider themselves part of Herefordshire's unscheduled care services; rostering additional doctor resource at peak and Bank Holiday periods in addition to the Doctors Primecare was contracted to supply; the fact that Primecare alerted the PCT to all potential complaints and adverse clinical incidents immediately, whether the possible incident related to Primecare performance or not; and that Primecare continually reviewed and updated its clinical governance and complaints procedures.

38. The Review Group thought that it was important that in developing the service in the future the service was tailored to the particular needs of Herefordshire. The following features were highlighted to the Group by Primecare as having been developed specifically to meet the requirements of Herefordshire: Doctor triage pre-midnight, nurse and Doctor triage post-midnight (this recognises that there are few calls after midnight), premier line call-handling (the best service offered by Primecare in this context, a dedicated line giving priority to Herefordshire Callers), the provision of computers in cars to improve communication and the quality of patient records; a well established registrar training scheme, the provision of 4x4 vehicles to cover difficult terrain and cross-border collaboration with adjoining out of hours providers.

39. The Review Group was mindful of the reasons why GPs were allowed by the new Contract to opt out of providing an out of hours service and the evidence submitted to it of the important benefits to the morale and wellbeing of GPs which this had brought. However, it was also very apparent from the evidence that stability of the workforce involved in delivering the out of hours service, both clinical and non-clinical, was important. The Group welcomed the increasing numbers of Herefordshire GPs who were devoting some of their time to the service, and the quality of service which could be provided as a consequence. If more GPs could be encouraged to devote a small proportion of their time to the service it appeared that this would be of clear benefit to patients whilst keeping the burden on individual Doctors at a manageable level.

40. It was also interesting that when the Review Group visited the clinic at Gaol Street, Hereford out of hours that there were two Herefordshire GPs on duty and that a GP Registrar was also in attendance. The Group understands that GP registrars attend for training purposes and that the scheme is working well in Herefordshire.

41. The Review Group was concerned by the cramped accommodation at Gaol Street for Primecare's administrative staff (a matter it understands has been acted upon by the PCT with improved accommodation provided). The Review Group had the benefit of the report of a visit by the Patient and Public Involvement Forum which also commented on the cramped accommodation in addition to making a number of constructive criticisms and suggestions for improvement to be addressed separately by Primecare and the Primary Care Trust. These included reference to access to availability of refreshments, alarm systems, road signage, on-site parking, potential co-location with accident and Emergency Unit, filing of care plans with the out of hours service in addition to palliative care plans and the availability of information on pharmacy services.

42. The Review Group did not go into the detail of the financing of the out of hours service and recognised the financial pressures on the service and the balance which needs to be struck between meeting needs and meeting wants. However, it is also clear that replacing some 120 Herefordshire Doctors eligible to provide out of hour cover (with up to 12 on call) with a system where two

Doctors are on call (with two further doctors providing a triage service pre-midnight and a dedicated nurse post-midnight) requires careful monitoring, evaluation and review.

43. The Group also received information on issues relating to out of hours community nursing and the difficulties being experienced in providing that service. The Group noted the intention of the PCT to work to develop this service in future.

44. The Review Group was also asked to check if adult social care workers had any views on the out of hours service. Only one team reported any concerns. These related to two specific cases.

45. In terms of access to the Service the Review Group was advised by Primecare representatives that there did not appear to be any particular problems in providing the service associated with geography, the key was an effective working relationship with the PCT. As referred to above the Local Health Services Survey Report for 2005 identified amongst its aspects in need of management action the fact that more than one in five of the patients trying to contact their GP surgery out of hours said that they could not get through to anyone on the phone. The PCT's comments on this point are also set out above together with the assurance that there is ongoing monitoring and review.

46. The Review Group was aware of the concerns of Hereford Hospitals NHS Trust that the change in the arrangements for the provision of out of hours service had had an adverse impact on attendance at the Accident and Emergency Unit and there had been an adverse trend in the emergency admission rates to hospital. The Review Group can not really comment on this point except to note that the Hospitals Trust stated that "it is hard to definitively state that this is purely due to the changes of out of hours services. What we can state is the plausibility that the changes have contributed to the situation faced within the County Hospital." The Review Group has noted the view of the PCT that there is no hard evidence and that the Department of Health had the same view. It has also noted the arrangements Primecare has in place to monitor and review referrals. Primecare has advised that "the PCT receives a breakdown of the outcome of every referral to A & E/999. Approximately 2% of calls receive this disposition from a population of callers contacting the service with urgent problems 98% do not".

47. The Review Group noted the action taken by the Primary Care Trust to publicise the out of hours service. It also noted that careful consideration had been given and continued to be given to the what level of publicity was appropriate, bearing in mind the need to avoid the service designed to meet urgent needs being overburdened by inappropriate requests

48. In this regard the Review Group noted Primecare's comments on problems the service experienced as a result of the actions of others.

49. In Herefordshire the out of hours service is provided on the basis that it is for urgent medical problems that cannot wait until normal surgery hours and should not be used for routine appointments or repeat prescriptions. The Review Group was informed that a number of calls were received from patients who had not obtained repeat prescriptions, particularly at Bank Holidays.

50. It was also advised that difficulties were caused by patients' belief that they are entitled to a home visit for all complaints and symptoms regardless of their severity or otherwise.

51. There were also occasions when patients did not keep appointments which had been made with the out of hours service. This could be very time consuming,

with Doctors having been called out then having to call the police to gain entry to the houses of patients who had requested their services.

52. The Review Group also noted the work of the Primary Care Trust's Out of Hours Steering Group which includes representatives of the Primary Care Trust, Primecare, the Hospital Trust, the Ambulance Trust and the Patient and Public Involvement Forum. Analysis of the minutes of these meetings shows, that as might be expected in seeking to implement the complex arrangements for the new out of hours services, not everything has run smoothly. It also demonstrates regular, ongoing, careful consideration of those issues and a clear commitment to finding solutions to issues which arise.

Assessment of Position in the Context of the National Audit Office Report - The Provision of Out of Hours Care in England

53. In May 2006 the National Audit Office (NAO) produced a report entitled: The Provision of Out of Hours Care in England.

54. In summary its conclusions were:

- There were shortcomings in the initial commissioning process because PCTs lacked experience, time and reliable management data. There is also confusion over whether out of hours services should be restricted to urgent care.

- Out of hours providers are beginning to deliver a satisfactory standard of service but most are not yet meeting all the National Quality Requirements particularly on speed of response.

- In a survey of PCTs it was found that the actual cost of providing out of hours services are £392 million, considerably more than the £322 million allocated by the Department;

- Commissioners are entering into contracts with multiple providers and the market is maturing.

55. The Review Group has noted the report to the Primary Care Trust Board on 24 May 2006 on these matters, which was noted by the Board, and in particular its conclusions:

- "Herefordshire PCT's out of hours service provided by Primecare is a stable, effective service that meets specification at a marginally higher cost, when compared with other similar PCTs. This should be balanced against high levels of satisfaction and low levels of complaints, consistency of delivery, and the good working relations that exist between commissioner and provider. Specifically;

- Herefordshire PCTs OOH service costs marginally more, at approximately £11 per head of population, than the average £10.76 for rural PCTs. The national average is given as £8.65 but that includes major conurbations.

- Herefordshire PCT is cited as a good example of collaborative planning in developing a service specification and one of the few (39%) of PCTs that launched a competitive tender to secure a provider. The NAO data shows that Herefordshire PCT's service model is highly integrated and effective, a top performer in this performance indicator.

- Herefordshire PCT's OOH provider is shown as reaching only 60% of quality standards, the median for rural PCTs. This is attributed in part to insufficient reporting by Primecare, caused by delays in upgrading the Adastra software and associated delays in configuring the database to capture and report on its total activities. PCT reports indicate a much higher level of achievement in reaching all quality standards.

- Cost comparisons across performance indicators do not give a clear picture. However, in terms of fitness for purpose, quality, low risk, consistency of delivery, and qualitative measures not indicated in the report, the OOH service is stable, mature, and achieves very low level of complaints (99.75% complaint –free)"

56. The Review Group welcomed the PCT's conclusions and would wish to make two points in response to these conclusions and the NAO report.

57. First, in relation to the very low level of complaints, the NAO report commented that "patient surveys run by PCTs show extremely high levels of satisfaction with the service provided. However, our survey of patients' views of out of hours and other urgent care services found that they had broadly good experiences, but one in five were dissatisfied. This suggests that here may be shortcomings in patient experiences that are currently not being captured by PCTs."

58. Taken in conjunction with the findings of the 2005 Local Health Services Survey report, discussed earlier, the Review Group considers that the PCT might usefully consider whether more work could be undertaken to investigate the findings relating to patient satisfaction.

59. Second, the NAO report states that "limited progress has been made towards integration with other parts of the NHS, such as local Accident and Emergency Departments and ambulance services, but there are some individual examples of strong efforts to join up services. Further planning and commissioning of integrated services should reduce duplication and improve value for money."

60. The Review Group notes that the PCT was the highest performing PCT in terms of the level of integration achieved. However, it understands that locally work is ongoing and supports continued consideration of this issue.

Conclusion

61. The Review Group considers that the evidence presented to it shows a clear rationale for the arrangements which have been adopted for the provision of the out of hours service and a commitment to ensuring that those arrangements are effective. It hopes that its recommendations will be seen as constructive, focusing on potential areas for improvement. It also would highlight the importance of ongoing monitoring and review.

RECOMMENDATIONS

(a) That it is important that in developing the out of hours service in the future the service continues to be tailored to the particular needs of Herefordshire;

(b) That every effort be made to continue to maintain the stability of the workforce, both clinical and non-clinical;

(c) **That if possible more local GPs be encouraged to devote a small proportion of their time to the service whilst recognising completely the need to keep the burden on individual Doctors at a manageable level;**

(d) **That ongoing consideration be given to how problems the service experiences as a result of inappropriate use by the public can be overcome;**

(e) **That the PCT consider whether more work could be undertaken to investigate whether it is fully capturing the patient experience of the out of hours service;**

(f) **That further consideration be given to ways of further planning and commissioning integrated services;**

(g) **That the out of hours service continue to be subject to ongoing careful monitoring, evaluation and review;**

(h) **That the Primary Care Trust's response to the Review be reported to the first available meeting of the Committee after the Trust has approved its response, with consideration then being given to the need for any further reports to be made.**

REVIEW:	**OUT OF HOURS SERVICE**	
Scrutiny Committee:	Health	**Chair:** Councillor W.J.S. Thomas
Lead support officer:	Sue Fiennes	

SCOPING AND TIMETABLE

Terms of Reference
To evaluate the effectiveness of the delivery of the GP out of hours service.

Desired outcomes
• To make recommendations on the future delivery of the GP out of hours service in Herefordshire • To make recommendations for ensuring and improving access to the out of hours service within Herefordshire;

Key Questions

- What out of hours service is currently provided and how is it provided?
- How well do the present arrangements work?
    - Are patients satisfied that their needs are met in a timely fashion?
    - Are members of the public using the service appropriately
    - Are GPs satisfied with the Service?
    - Is the Hospitals Trust satisfied?
    - Is the PCT satisfied?
    - Is the Ambulance Trust Satisfied?
    - How does the performance of the service compare with other areas and other providers?
    - How does the cost of the service compare with other areas and other providers?
    - Is the community sufficiently informed about out of hours services?
    - Are the national quality standards being met?
    - Is there equity of access
- What improvements have been made or are planned?
- What alternative options are there for delivering the out of hours service?

Timetable	
Activity	*Timescale*
Agree scoping, witnesses, data/research required	July 2005
Undertake interviews and gather data	July to September 2005
Interrogate data/information gathered	July to September 2005
Formulate recommendations	Early September 2005
Submit recommendations	September 2005

Members	Support Officers
(Councillors Mrs W.U. Attfield, G. Lucas, Ms G.A. Powell, WJS Thomas)	Sue Fiennes Tim Brown

Principal Documentation considered by the Review Group

	Various Reports to the Primary Care Trust Board
	Report by Hereford Hospitals NHS Trust on Out of Hours Services
	Letter from GP advisor to the PCT and Chair of the Out of Hours steering group.
	Letter from Chairman of the Professional Executive Committee of the PCT – September 2005
	Minutes of the PCT Out of Hours Steering Group
	The -Provision of Out of Hours Care in England - National Audit Office May2006
	House of Commons Health Committee report on GP Out of Hours Services (fifth report of Session 2003-04)
	Raising Standards for Patients New Partnerships in Put –Of Hours- care (the Carson report) - Department of Health October 2000

Interviewees

Mr Simon Hairsnape, Deputy Chief Executive of the PCT
Dr Bill Holmes Group Medical Director (Primecare)
Frances Bridgewater Area Relationship Manager (Primecare)
Dr Andrew Knight Full time GP Principal at the Marches Surgery and local medical Director for Primecare.

Herefordshire Primary Care Trust

Out of Hours Specification from April 2005

Introduction

The Provider must fully comply with the national Out of Hours (OOH) quality standards which came into effect on 1st January 2005.

In addition the Provider must ensure that the service provided complies with Standards for Better Health.

The OOH provider will provide a service for the period 6.00pm to 8.00am Monday to Friday, all day Saturday and Sunday and all public holidays and bank holidays.

The service will cover the Herefordshire PCT responsible population e.g. all patients registered with a Herefordshire GP and all patients not registered with a GP living in Herefordshire or needing care in Herefordshire (including inpatients at the 5 community hospitals and Hillside Unit and the 4 Minor Injury Units.).

The OOH quality requirements apply to services that are designed to meet the urgent needs of patients that cannot safely be deferred until the patient's own GP
practice (or a temporary GP if no GP) is next open or that a "bed fund" GP is able to attend a Community Hospital, MIU or Hillside Unit.

Volumes

It is for the Provider to assess activity volumes but as a guide the PCT expects:

- Between 700 – 2000 calls a week
- Of which between 400 – 1100 will require clinical triage
- Of which between 100 – 250 will require a home visit
- Between 10% and 20% of these calls will be a priority one visit.
- The other home visits are split between priority two and three.
- All other face to face contacts will be at a Primary Care Centre, Community Hospitals and Hillside Unit.

Specific Quality Requirements

The Providers must report daily, weekly and monthly to PCT on their compliance with the Quality Standards. A schedule of reporting will be agreed.

The Provider must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8.00 a.m. the next working day.

The Provider must have systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing

care to patients with predefined needs (including, for example, patients with terminal illness).

The Provider must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the contracting PCT. The sample must be defined in such a way that it will provide sufficient data to review the clinical performance of each individual working within the service. This audit must be led by a Provider appointed Local Medical Director who must be a GP with suitable experience in providing OOH care and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service.

The Provider must cooperate fully with PCTs in ensuring that these audits include clinical consultations for those patients whose episode of care involved more than one provider organization.

The Provider must regularly audit a random sample of patients' experiences of the service (for example 1% per quarter) and appropriate action must be taken on the results of those audits. Regular reports of these audits must be made available to the contracting PCT.

The Provider must cooperate fully with PCTs in ensuring that these audits include the experiences of patients whose episode of care involved more than one provider organisation.

The Provider must operate a complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report details of each complaint, and the manner in which it has been dealt with, to the contracting PCT. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.

The Provider must demonstrate the ability to match their capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as Saturday and Sunday mornings, and the third day of a Bank Holiday weekend. They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand.

Initial Telephone Call

All telephone conversations will be recorded.

The Provider will provide a local rate number during the whole OOH period. Calls should be answered by appropriately trained staff.

Engaged and abandoned calls:

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

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

All calls must be answered within 60 seconds of the end of the introductory message which should normally be no more than 30 seconds long.

The Provider must comply fully with the national technical links programme.

Telephone Clinical Assessment and Advice (Triage)

Identification of immediate life threatening conditions

The Provider must have a robust system for identifying all immediate life threatening conditions and, once identified, those calls must be passed to the ambulance service within 3 minutes.

Definitive Clinical Assessment

Clinical assessment and advice will be undertaken by a trained GP or appropriately qualified nurse.

The Provider must demonstrate that it has a clinically safe and effective system for prioritizing calls, and must meet the following standards:

- Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person;

- Start definitive clinical assessment for all other calls within 30 minutes of the call being answered by a person.

Outcome

At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

Face to Face Clinical Assessment

Face to face assessment will be through home visits, Primary Care Centre and Community Hospital attendances

All face to face clinical assessment will be provided by a vocationally trained GP.

The Provider will secure the appropriate GP input and ensure that the GPs are appropriately qualified and are included on a Medical Performers List of an English PCT.

A home visit must be provided where clinically or socially necessary.

Primary Care Centres must be provided at Kington, Leominster, Ross on Wye and Hereford City over weekends, bank holidays and public holidays.

The Provider will provide the administrative and support staff needed to operate these Centres.

The Provider must provide full OOH medical cover of the following community hospitals and Hillside Unit including the Minor Injury Units:

- Kington Court (10 beds and MIU);

- Leominster Community Hospital (34 beds and MIU);
- Ross on Wye Community Hospital (32 beds and MIU);
- Hillside Unit (22 beds);
- Bromyard Community Hospital (24 beds);
- Ledbury Community Health and Care Centre (14 beds and MIU).

Identification of immediate life threatening conditions

The Provider must have a robust system for identifying all immediate life threatening conditions and, once identified, those patients must be passed to the most appropriate acute response (including the ambulance service) within 3 minutes.

Outcome

At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

The Provider must ensure that patients are treated by the clinician best equipped to meet their needs, (especially at periods of peak demand such as Saturday mornings), in the most appropriate location. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP, including where necessary, at the patient's place of residence

Face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

- Emergency: Within 1 hour;
- Urgent: Within 2 hours;
- Less urgent: Within 4 hours.

Other

The Provider will arrange for, fund and administer such drugs as are immediately required and will issue an appropriate prescription for other drugs that a patient may reasonably need over a course of treatment.

The Provider will comply with all local child and adult protection procedures.

The Provider will ensure that it has capacity and capability to deliver the required training for those GP registers who are placed with any approved training practice.

Patients unable to communicate effectively in English will be provided with an interpretation service within 15 minutes of initial contact. Providers must also make appropriate provision for patients with impaired hearing or impaired sight.

The Provider must have business continuity plan and disaster recovery plan.

The Provider must be able to provide a dental out of hours service from 1st April 2006.

The Provider should make appropriate arrangements with other OOH providers in Wales, Shropshire, Worcestershire and Gloucestershire as necessary.

April 2005

The National Quality Requirements

1. Providers[2] must report regularly to PCTs on their compliance with the Quality Requirements.

2. Providers must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8.00 a.m. the next working day. Where more than one organisation is involved in the provision of OOH services, there must be clearly agreed responsibilities in respect of the transmission of patient data.

3. Providers must have systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness).

4. Providers must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the contracting PCT.
   The sample must be defined in such a way that it will provide sufficient data to review the clinical performance of each individual working within the service. This audit must be led by a clinician with suitable experience in providing OOH care and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service.
   Providers must cooperate fully with PCTs in ensuring that these audits include clinical consultations for those patients whose episode of care involved more than one provider organisation.

5. Providers must regularly audit a random sample of patients' experiences of the service (for example 1% per quarter) and appropriate action must be taken on the results of those audits. Regular reports of these audits must be made available to the contracting PCT.
   Providers must cooperate fully with PCTs in ensuring that these audits include the experiences of patients whose episode of care involved more than one provider organisation.

6. Providers must operate a complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report anonymised details of each complaint, and the manner in which it has been dealt with, to the contracting PCT. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.

7. Providers must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as Saturday and Sunday mornings, and the third day of a Bank Holiday weekend. They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand.

---

[2] A provider is any organisation providing OOH services under GMS, PMS, APMS or PCTMS

8. **Initial Telephone Call:**

Engaged and abandoned calls:

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

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

- All calls must be answered within 60 seconds of the end of the introductory message which should normally be no more than 30 seconds long.
- Where there is no introductory message, all calls must be answered within 30 seconds.

9. **Telephone Clinical Assessment**

Identification of immediate life threatening conditions

Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those calls must be passed to the ambulance service within 3 minutes.

Definitive Clinical Assessment

Providers that can demonstrate that they have a clinically safe and effective system for prioritising calls, must meet the following standards:

- Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person
- Start definitive clinical assessment for all other calls within 60 minutes of the call being answered by a person

Providers that do not have such a system, must start definitive clinical assessment for all calls within 20 minutes of the call being answered by a person.

Outcome

At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

10. **Face to Face Clinical Assessment**

Identification of immediate life threatening conditions

Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those patients must be passed to the most appropriate acute response (including the ambulance service) within 3 minutes.

Definitive Clinical Assessment

Providers that can demonstrate that they have a clinically safe and effective system for prioritising patients, must meet the following standards:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre
- Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre

Providers that do not have such a system, must start definitive clinical assessment for all patients within 20 minutes of the patients arriving in the centre.

Outcome

At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

11. Providers must ensure that patients are treated by the clinician best equipped to meet their needs, (especially at periods of peak demand such as Saturday mornings), in the most appropriate location. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP, including where necessary, at the patient's place of residence

12. **Face-to-face consultations** (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

Emergency: Within 1 hour.

Urgent: Within 2 hours.

Less urgent: Within 6 hours.

13. Patients unable to communicate effectively in English will be provided with an interpretation service within 15 minutes of initial contact. Providers must also make appropriate provision for patients with impaired hearing or impaired sight.