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

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…Promoting our county
…Providing for our communities
…Protecting our future

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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.

<u>Engaged and abandoned calls:</u>

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

<u>Time taken for the call to be answered by a person:</u>

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.

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[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.