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To: Health Overview and Scrutiny Committee – 30 October 2009

Subject: Item 4. Briefing Note. Primary Care Out of Hours Services

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Introduction

"'Out of hours period' means -

(a) the period beginning at 6:30pm on any day from Monday to Thursday and ending at 8am on the following day,

(b) the period between 6:30pm on Friday and 8am on the following Monday, and

(c) Good Friday, Christmas Day and bank holidays;

'out of hours services' means services required to be provided in all of part of the out of hours period which would be essential services if provided by a provider of primary medical services in core hours."[1]

Out-of-hours care can include some or all of the following:

- GPs working in A&E departments, NHS walk-in centres or minor injury units (MIUs),
- teams of healthcare professionals working in places such as primary care centres, A&E, MIUs or NHS walk-in centres,
- healthcare professionals (other than doctors) giving home visits after a detailed clinical assessment, and
- ambulance services moving patients to places where they can be seen by a doctor or a nurse in order to reduce the need for home visits.[2]

Background

In 2000, the Department of Health (DoH) commissioned a review of out-of-hours (OOH) services (referred to as the Carson Review). Its recommendations, combined with the NHS Plan, established the foundations for current OOH services.

Prior to April 2004, GPs had a responsibility to provide urgent medical care during the out-of-hours period. In practice, many GPs delegated OOH provision to a third-party. A National Audit Office (NAO) report in 2006 states that at the beginning of 2004, "approximately 70 per cent of GPs had

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[1] Department of Health, The Primary Medical Services (Out of Hours Services) Directions 2006, 22 December 2006, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_063687

[2] Taken from NHS Choices, http://www.nhs.uk/conditions/Out-of-hours-services/Pages/Definition.aspx?url=Pages/what-is-it.aspx

delegated the responsibility to a GP co-operative, and around 25 per cent to a commercial provider."[3]

The introduction of a new General Medical Services (GMS) contract on 1 April 2004 allowed GPs to opt out of the responsibility for organising OOH care entirely. Where they did opt out, GPs gave up £6,000 per annum on average and the responsibility passed to their Primary Care Trust (PCT). The DoH "increased its out-of-hours development funding to around £3,500 per GP to help establish the new service, giving an average total of £9,500 for every GP opting out."[4] About 90% of GPs decided to opt out. The same NAO report adds, "at April 2005, the Department's understanding, based on data gathered from Strategic Health Authorities, was that some 75 per cent of service provision was PCT-organised or contracted through co-operatives of various types, with the remaining 25 per cent provided by commercial providers, ambulance trusts and others, with NHS Direct supplying initial call handling and triage for many providers."[5]

At the same time as the new GMS contract, in April 2004, NHS Direct was created in April 2004 out of 22 separate organisations. Originally established as a Special Health Authority, it became an NHS Trust in 2007. Along with the 24-hour helpline and website, NHS Direct also provides services to other NHS and healthcare organisations.[6]

From January 2005, OOH providers have had to comply with national quality requirements. The requirements are contained in Appendix 1.

Healthcare Commission Urgent and Emergency Care Review 2007/08

In September 2008, the Healthcare Commission (which has subsequently become part of the Care Quality Commission) produced the report *Not just a matter of time. A review of urgent and emergency care services in England*[7].

This review looked at OOH GP services along with A+E services, emergency ambulance services and touched on urgent GP services as well. It carried out a detailed review of these services for 2007/08 and the report contains the following overview of OOH GP services across the whole of England:

- "During 2007/08, out-of-hours GP services received 8.6 million calls and completed 6.8 million medical assessments (there is no good national data on the long-term trend in the use of these services, but these levels are broadly similar to those in 2006/07).

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[3] National Audit Office, *The Provision of Out-of-Hours Care in England*, p.9, 5 May 2006, http://www.nao.org.uk/publications/0506/the_provision_of_out-of-hours.aspx#
[4] Ibid, p.6.
[5] Ibid, p.11.
[6] Further information on NHS Direct can be found here: http://www.nhsdirect.nhs.uk/article.aspx?name=AnnualReport2009
[7] Care Quality Commission, full report available at: http://www.cqc.org.uk/_db/_documents/Not_just_a_matter_of_time_-_A_review_of_urgent_and_emergency_care_services_in_England_200810155901.pdf

- They carried out 2.9 million assessments by telephone, 0.9 million assessments on home visits and 3 million assessments where the patient attended a primary care centre.
- Around 1.5% of the calls they deal with are classed as 'life-threatening' and 15% are classified as 'urgent'.
- The total cost of these services is around £400 million a year (or £8 per person)."[8]

A detailed report was also produced on each PCT. Again the results only apply to the year 2007/08 and look at the wide range of 'urgent and emergency care' services.

Trusts were given an overall score comparing them to other Trusts. The scores were:

- Best performing.
- Better performing.
- Fair performing.
- Least well performing.

Trusts were also given a score from 1 and 5 against 36 indicators. A score of 3 meant the Trust met the national standard, or achieved average performance. Scores over 3 meant the Trust had exceeded the required standards or were above average. Scores below 3 meant it was performing below these levels. The indicators were grouped under three broad questions. They are set out in the table below.

Table showing scores for urgent and emergency care

PCT	**Eastern and Coastal Kent[9]**	**Medway[10]**	**West Kent[11]**
Overall	Better performing	Better performing	Better performing
Can people access services in a timely fashion, and in ways which meet their	2.79	3.08	3.07

[8] Ibid, p.12.
[9] Full breakdown of indicator scores and report available at: http://2008ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?widCall1=customWidgets.content_view_1&cit_id=5QA&element=SR_UEC&subtype=technical
[10] Full breakdown of indicator scores and report available at: http://2008ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?faArea1=customWidgets.content_view_1&cit_id=5L3&element=SR_UEC&subtype=technical
[11] Full breakdown of indicator scores and report available at: http://2008ratings.cqc.org.uk/findcareservices/informationabouthealthcareservices/overallperformance/searchfororganisation.cfm?widCall1=customWidgets.content_view_1&cit_id=5P9&element=SR_UEC&subtype=technical

needs?			
Are services working together to provide effective care?	3.15	3.08	2.62
How well are urgent and emergency care services managed?	3.56	3.33	3.89

Primary Care Foundation

In April 2009, a Department of Health backed study was produced by the research organisation Primary Care Foundation. According to a Health Service Journal article, this found, "GP out of hours services are costing more than three times more per patient in some parts of England than in others. The research organisation Primary Care Foundation has found out of hours provision costs less than £3.50 per head in the cheapest areas, and more than £12 in the most expensive. . . . Most variation is due to individual contractual arrangements set up by PCTs, the foundation said. This includes differences in types of service provided, such as requirements for more primary care centres to be open at particular times in some areas. There was also wide variation in cost per case, from £30 in some areas to £100 in others."[12]

Care Quality Commission Review into Take Care Now

In June 2009, the Care Quality Commission (CQC) announced it would be carrying out a review of the provision and commissioning of out-of-hours GP services run by an organisation named Take Care Now. Specifically, the review was triggered by the death of a patient treated by a locum doctor from Germany working for Take Care Now through a locum agency.

Five Primary Care Trusts commissioned services from Take Care Now – NHS Suffolk, NHS Worcestershire, NHS Great Yarmouth and Waveney, and NHS South West Essex (in partnership with East of England Ambulance Service). The locum was also admitted onto the performers list of Cornwall and the Isles of Scilly PCT, in July 2007, but did not work for the PCT.

The full report is expected early in 2010. On 2 October 2009, the CQC released a progress statement on the Take Care Now enquiry[13].

In its press release the CQC quoted Cynthia Bower, the CQC Chief Executive:

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[12] Health Service Journal, *Study reveals three-fold cost variation in GP out of hours services*, 9 April 2009, http://www.hsj.co.uk/news/primary-care/study-reveals-three-fold-cost-variation-in-gp-out-of-hours-services/5000264.article#

[13] Care Quality Commission, 2 October 2009, http://www.cqc.org.uk/_db/_documents/Interim_statement_on_TCN__FINAL.doc

> “GP out-of-hours services provide vital care to people outside of normal surgery hours. As commissioners of these services, PCTs need to ensure people receive safe, quality care around the clock.
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> "Our visits to the five trusts that commission Take Care Now's services showed they are only scratching the surface in terms of how they are routinely monitoring the quality of out-of-hours services. If their monitoring is not robust enough, they may not be in a position to spot early indications of potential problems or poor care.
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> "Although we are still in the early stages of our enquiries, we believe this may point towards a national problem. We are therefore encouraging PCTs across the country to scrutinize in more detail the out-of-hours services they commission.
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> "PCTs need to dig deeper and keep a closer eye on important areas such as: efficiency and quality of call handling and triage; the number of unfilled shifts; the proportion of shifts covered by non-local doctors; the induction and training those doctors receive; and the quality of the decisions made by clinical staff. It's not just about monitoring numbers of people treated, or how much this costs. It's about examining the finer detail of the actual care patients receive, to ensure the service is safe and meeting people's needs.
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> "We have shared our findings with the Department of Health, which is today writing to all PCTs across the country asking them to make it a priority to review their monitoring arrangements for out-of-hours services.”[14]

On the same day a letter was sent out to all primary care trusts from the Department. This letter contained the following:

> “While the scope of CQC’s current enquiry is limited to a specific number of PCTs and a particular provider, the Department strongly supports these recommendations which are relevant to **all commissioners.** PCTs should have robust performance management arrangements in place to ensure their OOH service, like any other commissioned services, is delivering against contractual requirements, and world class commissioning will support PCTs to achieve this.”[15]

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[14] Care Quality Commission, 2 October 2009, http://www.cqc.org.uk/newsandevents/pressreleases.cfm?cit_id=35381&FAArea1=customWidgets.content_view_1&usecache=false

[15] Department of Health, Dear colleague letter, 2 October 2009, http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_106349

Appendix - The National Quality Requirements[16]

1. Providers must report regularly to PCTs on their compliance with the Quality Requirements. (A provider is any organisation providing OOH services under GMS, PMS, APMS or PCTMS).

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

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[16] Department of Health, *National Quality Requirements in the Delivery of Out-of-Hours Services*, July 2006, pp.5-7, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_073808.pdf

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.

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.