National Quality Requirements in the Delivery of Out-of-Hours Services

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Introduction

1. From 1st January 2005, all providers of out-of-hours (OOH) services have been required to comply with the national OOH Quality Requirements, first published in October 2004. The recent report by the National Audit Office[1] (NAO) identified a number of problematic aspects of the current Requirements and, since then, the Department has worked with the Royal College of General Practitioners (RCGP) to review the Quality Requirements in the light of these observations.
2. While the NAO Report identified some areas of misunderstanding or misinterpretation of the current Requirements and demonstrated further that some particular Quality Requirements remain challenging (particularly at periods of peak demand), none of its discussions with providers or commissioners revealed any sense that the Quality Requirements were either inappropriate or unachievable. The Department will not therefore be making any changes to the Quality Requirements that were published in October 2004; for ease of reference, they are reproduced below.
3. On the other hand, there is a need to clarify a number of aspects of particular Quality Requirements (including some important confusions about compliance). A number of these issue were addressed in the *Commentary* that was published at the same time as the Quality Requirements, and while this *Introduction* provides additional clarification, it should still be read in conjunction with that *Commentary*.[2].
4. Consolidated guidance drawing together this *Introduction* with a revised and updated version of the *Commentary* will be published later in the summer.

Compliance

5. In a number of areas, providers have to demonstrate 100% compliance (see in particular Quality Requirements 8, 9, 10 and 12). In many circumstances, achieving compliance at all times would require a disproportionate provision of resources and, for that reason, compliance with these standards is defined as follows:

    5.1. **Full Compliance:** Normally, a provider would be deemed to be fully compliant where average performance was within 5% of the Requirement.. Thus, where the Requirement is 100%, average performance of 95% and above would be deemed to be fully compliant.

    5.2. **Partial compliance:** Where average performance was between 5% and 10% below the Requirement, a provider would be deemed to be partially compliant and the commissioner would explore the situation with the provider and identify ways of improving performance. Thus where the Requirement is 100%, average performance of between 90% and 94.9% would be deemed to be partially compliant.

    5.3. **Non-compliance:** Where the average performance was more than 10% below the Requirement, the provider would be deemed to be non-compliant and the commissioner would specify the timescale within which the provider would be required to achieve compliance. Thus, where the Requirement is 100%, average performance of 89.9% and below would be deemed to be non-compliant.

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[1] *The Provision of Out-of-Hours Services in England*, London, 2006

[2] The *Commentary* is available at http://www.dh.gov.uk/Urgentcare : click on 'Out-of-Hours' in the menu on the left-hand side of the page and, in the new page that opens, click on 'Key Policy Documents' – scroll down to 'New quality requirements for out-of-hours services'

6. All the above measures record average performance, and this can conceal wide variations in practice from day to day, and at different times within the day. It is therefore important that commissioners look behind the averages to see whether there is any recurring pattern which reveals a more serious situation. Where further analysis reveals an inability to put in place sufficient resources on a particular day or a particular time of the week or both, the provider could be deemed to be partially or non-compliant. Thus, for example:

    6.1. A provider might achieve an average of 96% (where the Requirement is 100%), and thus be deemed to be fully compliant. But closer inspection would reveal that on a Sunday this might regularly drop to around 85% and, in such circumstances, it could be deemed to be partially compliant.

    6.2. A provider might achieve an average of 91% (where the Requirement is 100%), and thus be deemed to be partially compliant. But closer inspection would reveal that on a Saturday morning this might regularly drop to around 75%. In such circumstances it could be deemed to be non-compliant.

7. Furthermore, wherever a provider is not in full compliance with a particular Requirement, the commissioner will want to be clear that performance has not reached a plateau from which no further improvement is taking place. Thus, in this circumstance, the commissioner would be looking for evidence of ongoing improvement over time and, in the absence of such evidence, would downgrade its assessment of compliance accordingly.

8. Where a provider is commissioned to deliver services for a number of different PCTs, it is important that its compliance data is disaggregated by PCT area. Data averaged across the PCTs could conceal wide variations in the quality of service provided in each locality, and it is only by reporting performance for each separate PCT population that commissioners will be able to assess the quality of the service that is being provided to their patients.

9. Those responsible for writing a service specification and the resulting contract, need to ensure that both these documents include the detailed approach to compliance set out in paragraphs 4 through 8 above.

10. The Quality Requirements provide a clear and consistent way of assessing performance. Regular and accurate reporting of the precise levels of compliance with each Requirement will enable the commissioner and the provider together to identify what action is needed in those areas where performance falls short of the standard that service users should expect.

Definitive Clinical Assessment

11. This term is used in Quality Requirements 9 and 10 and there appears to be some confusion as to its meaning. Definitive clinical assessment is an assessment carried out by an appropriately trained and experienced clinician (not a call-handler) on the telephone or face-to-face. The adjective ‘definitive’ has its normal English usage, i.e. ‘having the function of finally deciding or settling; decisive, determinative or conclusive, final’.[3] In practice, it is the assessment which will result either in reassurance and advice, or in a face-to-face consultation (either in a centre or in the patient’s own home).

[3] *Oxford English Dictionary, Second Edition*, Oxford, 1989.

Focusing more clearly on quality and patient experience

12. Quality Requirement 4 requires providers regularly to audit the clinical quality of the service they provide by auditing the work of each and every individual working within the organisation who contributes to clinical care. The Department is aware that some providers have had difficulties in delivering effective clinical audit and has commissioned the Royal College of General Practitioners to develop a new toolkit to support this particular Requirement. The toolkit will be published in the autumn of 2006.

13. Quality Requirement 5 requires providers to audit patients' experience of the service and the *Commentary* that was published alongside the Quality Requirements made it clear that this is very different from traditional tools for measuring patient satisfaction. Thus, an effective questionnaire designed to explore the patient experience of the service will range much more widely than satisfaction, looking at patients' access to the service (including the timeliness with which the service responded to their needs), the character and quality of their telephone encounters with the service, the character and quality of any face-to-face consultation, the environment within which face-to-face consultations take place and so on.

14. As the original *Commentary* emphasised, however, patient questionnaires are only one of a variety of tools which providers could employ better to understand the quality of the service they provide. While public and patient involvement has become increasingly common in other NHS organisations, it has (as yet) played little role in OOH organisations. Useful as questionnaires and focus groups and other methods of sampling experience may be for exploring patients' firsthand experience of the services they have used, none create the transformational opportunities presented by involving members of the public directly in the decision-making processes at the heart of the service. Effective public and patient involvement, coupled with regular audits of the patient experience could constitute a particularly powerful way of giving reality to Quality Requirement 5.

Matching capacity to demand

15. The NAO data showed that the overwhelming majority of PCTs reported very high levels of compliance with Quality Requirement 7 (the obligation to plan capacity to meet predictable fluctuations in demand), while at the same time reporting very low levels of compliance with those Quality Requirements that are designed to measure the match between capacity and demand (Quality Requirements 8, 9, 10, 11 and 12).

16. Both commissioners and providers will want to reflect on this mismatch in the data. Evidence from individual services suggests that it is at periods of peak demands that providers struggle to achieve compliance with the access Requirements, and yet Quality Requirement 7 explicitly sets out an obligation to plan effectively to meet those peaks in demand.

Conclusion

Nothing in the work that the NAO did in its review of OOH services suggested that the Quality Requirements were either inappropriate or unachievable. Regular and accurate reporting of performance against the Quality Requirements will ensure that the ongoing dialogue between commissioners and providers will be meaningful and well-informed, but its primary purpose is to give the service provider regular, accurate data about the quality of that service and thus provide a firm foundation on which to deliver further improvements in the quality of the service in future.

The National Quality Requirements

1. Providers[4] 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.

[4] 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.