

*Raising Standards for Patients
New Partnerships in Out-of-Hours Care*

An Independent Review of
GP Out-of-Hours Services in England
Commissioned by the Department of Health

October 2000

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Foreword

The Review Team is pleased to submit its Report, *Raising Standards for Patients. New Partnerships in Out-of-Hours Care*.

The Report proposes a flexible, national model of integrated out-of-hours provision, which will deliver consistent standards of high quality care to patients across the country. Those Quality Standards will be secured in an accountability framework which is both robust and transparent, and the new model of service will be underpinned by appropriate funding and organisational changes.

Two basic principles are at the heart of this new approach:

- 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; 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.

The model of integrated out-of-hours provision that is set out in this Report will require significant changes in attitude and expectation, quite as much as changes in organisation and administration. But lest this seems a recipe for revolutionary change, it is important to emphasise that all our proposals are grounded firmly in current best practice. New organisational partnerships already exist in a number of different parts of the country; new forms of inter-professional co-operation and collaboration have developed as those working in the same organisation have built trust and confidence in each other's skills and competences; more and more of the organisations that provide out-of-hours services record and report on their work in the manner that is described in the Quality Standards. In short, by taking full account of what has already been achieved, the Review Team was able to formulate its proposals, secure in the knowledge that its recommendations are both realistic and achievable.

Finally, and not least for that reason, I wish to record my warm thanks to all those who have supported the work of the Review: Dr Nicholas Reeves and Dr Ian Trimble for their work and support in the central team; Dr Val Lattimer for guiding us through the evidence; the members of the Reference Group; all those individuals and organisations who made submissions to the

Review; and, perhaps most important of all, those working in the delivery of out-of-hours services up and down the country who were willing to share their knowledge and their experience so freely with members of the Review Team.

A handwritten signature in black ink, appearing to read "David Carson". The signature is fluid and cursive, with a long horizontal stroke at the end.

Dr David Carson
Leader of the Review Team

Introduction

On 2 March 2000, the Minister of State for Health announced a Review of all arrangements of GP out-of-hours cover across England (the full terms of reference of the Review are set out in Annex One on page 47). The aim of the Review was to identify ways of bringing the standards of all out-of-hours services up to the standard of the very best, and to make recommendations to the Minister on any priority actions that need to be taken to improve those services.

The Review was to:

- Consider all arrangements for out-of-hours provision including GP Co-operatives, commercial services and practice rotas.
- Examine the approach that each adopts to quality assurance, training, the availability and use of clinical and non-clinical personnel and the use of different models of skill-mix, organisation, protocols, record keeping and quality assurance.
- Ascertain their accessibility and responsiveness, consistence of response and treatment, geography, equity in resource distribution, efficiency and value for money.
- Examine the role played by Health Authorities in monitoring the quality of the Out-of-Hours Development Fund.
- Identify the potential for developing integrated services with NHS Direct (including Walk-in Centres and Social Services) and recommend organisational models and practice including quality standards that might address current and future patient needs.
- Examine whether we are getting best value for money from the existing spend, and whether it is best targeted.

Dr David Carson (Head of Primary Care Strategy and Performance at East London and the City Health Authority) led the Review, supported by Dr Ian Trimble (Chair of Nottingham City North and West PCG) and Dr Nicholas Reeves (historian and part-time Lay Member of the Acton and Central Ealing PCG Board). Academic support was provided by Dr Valerie Lattimer (MRC Fellow at the University of Southampton), and Ms Vicky Wright (a Management Trainee from the Surrey Thames PCG) was seconded from her current post to provide additional support.

The Review began with a careful analysis of the research literature, examining all recent studies of out-of-hours provision in order better to understand the major features of the current position (see Annex Two on pages 50-66). But, wide-ranging and helpful as that evidence was, a number of important questions remained unanswered and, to answer those questions, a questionnaire was sent to all Health Authorities; the Review Team also carried out an extensive programme of visits to current providers of out-of-hours services. In these three different ways, therefore, the Team developed and refined its understanding of the out-of-hours services, ena-

bling it in particular accurately to identify current best practice. This served the important purpose of enabling the Review to ensure that all its recommendations were firmly grounded in an accurate understanding of current realities – every one of its proposed Quality Standards, for example, is already being achieved by an existing provider.

The Review Team took advice from an External Reference Group, which drew together representatives from an appropriate range of professional and lay organisations (the members of that Group are set out in Annex Three on page 67), and took further advice from a wide range of other organisations.

1: Current Provision

General Practitioners in the UK are responsible for the care of their patients twenty-four hours a day. With most primary care taking place during the day, 'out-of-hours' care has traditionally been defined as the evenings, nights and weekends, periods when GPs continue to provide a service for patients who identify an urgent need for medical care. Increasing demands for out-of-hours care in the 1970s and 1980s placed the system of 24-hour care under increasing strain and, by 1992, many GPs in England aspired to opt out of the responsibility for out-of-hours care entirely.

Notwithstanding that earlier history, however, the years since have seen considerable innovation in the delivery of out-of-hours services, with new approaches being developed that were better able both to meet patients' needs and to manage demand. Indeed, in finding solutions to the crisis of the mid 1990s, GPs demonstrated a remarkable willingness to reconsider local arrangements for providing cover, and that new imagination and flexibility resulted in unparalleled co-operation between practices in the provision of out-of-hours cover, much of which found expression in the formation of GP Co-operatives.

Thus, as a result of those new developments, GPs can now fulfil the terms of their current contract by choosing from a variety of different forms of out-of-hours cover. The four options open to each individual GP are:

- Providing the service themselves.
- Joining a practice rota.
- Joining a GP Co-operative.
- Employing a deputising service.

Traditionally, the majority of GPs who did not offer their own out-of-hours service employed a deputising service to provide that service on their behalf but, with the growth of GP Co-operatives over the last five years, the pattern of provision has changed significantly. Thus, today, only about a third of GPs employ a deputising service, while the majority of the remaining two-thirds belong to GP Co-operatives. Moreover, the movement from one provider to another has been paralleled by equally significant changes in the manner in which out-of-hours services have been provided, and many of the initiatives pioneered in the new GP Co-operatives are now being introduced by other providers as well.

New developments in out-of-hours care

The first of these changes was the introduction of Primary Care Centres, resourced out-of-hours to enable patients to be seen in a properly equipped centre. The advantages of such an approach are obvious for, not only are there significant economies of scale (one GP working in a Primary Care Centre can see many more patients than if s/he visits each of them separately in their own homes), the Centre is much better suited to effective patient assessment and diagnosis, within a safe working environment. And, while some patients were initially surprised by the request to travel to such a Centre out-of-hours, recent research into patient satisfaction suggests that consultations in such Centres achieve very positive ratings.

Secondly, while all providers of out-of-hours services employ staff to handle patients' calls, a growing minority also offer nurse or GP telephone triage and consultation. The benefits of this second development are just as important, both because they allow the clinical urgency of patients' calls to be properly assessed and also because it quickly became clear that a very significant proportion of patient requests for out-of-hours care could in fact be met by a telephone consultation, without the need for the patient to travel to a Primary Care Centre, or for a GP to visit the patient at home. Nurse telephone consultations within a GP Co-operative have already been shown to be at least as safe and effective as GP telephone consultations, and it has become increasingly clear that, for those providers who offer such a service, up to half of all patient requests for out-of-hours care can be appropriately met in this way. Nurse telephone consultations of this kind were pioneered in GP Co-operatives and, more often than not, nurses developed these skills in an environment in which they had quick and easy access to GPs working alongside them. Indeed, this kind of active and willing partnership between professionals (whose working relationships had traditionally been constrained by strict lines of demarcation) has been a striking feature of the new style of working that has been developed out-of-hours.

Partnership of a different kind has been the hallmark of an even more recent development. NHS Direct was originally conceived as a national advice and information line, but it immediately became clear that some 70% of its calls were made out-of-hours, and it did not take a great deal of imagination to recognise the enormous potential benefits that could be achieved (for patients and providers alike) if NHS Direct could be effectively integrated with existing out-of-hours service provision. New partnerships between GP Co-operatives and local NHS Direct sites have already been developed in six different sites, and a significant number of further projects to deliver integrated out-of-hours provision are already in an advanced state of planning. In all these examples, NHS Direct handles the calls and triages the patient's needs – the local GP Co-operative or deputising service provides the telephone or face-to-face medical services for those callers whose clinical needs can only be met in this way.

Not only do these developments mirror the inter-professional partnership working that had been pioneered within the GP Co-operatives, their success has been a direct product of a collaborative and co-operative approach to building a partnership between different organisations. All the parties to such a partnership have their own distinctive and important role to play, and only by developing a structure in which all those different roles are given proper recognition can such an approach succeed. The fact that NHS Direct is a national organisation might have made it difficult for it to develop partnerships of a kind that take proper account of the special needs

of a particular locality, but where such attempts to develop an integrated provision have been successful, they have (without exception) been the product of just this kind of local negotiation, through which all the parties develop a real sense of ownership of the new partnership to which they now belong.

One further innovation is also making a contribution to the way in which patients access care out-of-hours. The first Walk-in Centre was opened in January 2000 to provide a nurse-led service to deal with minor illness and treatments, and to further encourage patients to manage their own health, and by the end of 2000 a total of 40 such centres will have opened across the country. Because the majority are open from 7.00 a.m. until 10.00 p.m., seven days a week, there is ample opportunity for them to make their own distinctive contribution to the delivery of care out-of-hours and, recognising this opportunity, a number of GP Co-operatives have been actively involved (either on their own or in partnership with others), in the development of particular centres. At the very least, this will allow for the seamless transfer of patients from the centre to the out-of-hours medical services, where a particular patient's needs merit this; in the longer run, there is abundant opportunity to co-locate Walk-in Centres and out-of-hours Primary Care Centres. Once again, partnership and co-operation signposts the way to an approach that offers patients a faster, more convenient access to the services they need, in a manner that makes the best possible use of the scarce resource of the clinicians who provide those services.

Thus, in all these ways, the old pattern of meeting the vast majority of patients' requests for out-of-hours care by a home visit by a GP has disappeared. The needs of very many patients are now met safely and appropriately by a telephone consultation with a nurse or a GP and, of the remainder, the majority are seen face-to-face in a Primary Care Centre; a significant minority are still visited at home by a GP. The size of that minority varies from locality to locality and from provider to provider but, over the last five years, the number of home visits relative to all other out-of-hours contacts has fallen consistently. There will always be those whose clinical needs out-of-hours can only be met in their own homes, but only a comparatively small minority of patients' needs require to be met in this way.

The role of Accident and Emergency Departments

There remains one further element in the current provision of out-of-hours services, for while professionals recognise only too clearly the powerful distinctions between 'primary' and 'secondary' care, many members of the public draw no such clear distinctions. Indeed, it has long been the case that many patients in inner-city urban areas have accessed primary care out-of-hours through the gateway of the Accident and Emergency Department in their local hospital and, notwithstanding a variety of initiatives designed to change this behaviour, there is no evidence to suggest that patients understand any better than they ever did that such Departments are ill-equipped to meet their needs. Thus they wait for many hours to be treated by staff whose training and experience is wholly different from that of a primary care physician. Yet even here, new partnerships have broken through traditional professional barriers, developing a better way of meeting the needs of these patients. Accident and Emergency consultants, working with GPs and nurses in the locality served by the hospital, have developed a service in which all patients attending Accident and Emergency are triaged at the door; those with 'primary care' needs are

directed to a service resourced by local GPs and nurses and the remainder are referred to a Department of Emergency Medicine.

Thus, just like the innovations that were pioneered in the GP Co-operatives, a willingness to think outside the boundaries of traditional custom and practice and to work together with professionals from other disciplines and traditions, has resulted in a new kind of partnership which provides a better service for everyone. Patients receive the treatment they need from the clinician best trained to deliver it, with the minimum of delay, and the clinicians benefit by working in an environment in which their existing skills and competencies are augmented and enhanced by working alongside others from a different professional tradition.

2: Basic Principles

In embarking on this review of out-of-hours services, the Team identified at the outset four fundamental principles on which its work would be based:

- In re-examining the way in which such services can be best developed, the Review Team has sought throughout to look at out-of-hours provision *from the point of view of the patient*, developing an approach in which the proposed model of service meets the needs of the patient, rather than (as so often in the past) the patient being required to meet the needs of the model of service.
- All patients should have access to the same high quality, out-of-hours services, regardless of the part of the country in which they live, or the particular GP practice with which they are registered.
- The purpose of out-of-hours' services in primary care will remain what it has always been, namely to meet those urgent patient needs that cannot safely be deferred until the patient's own GP practice is next open.
- The provision of family doctor services will continue to be based on the patient list system, with GPs retaining 24 hour responsibility for their list.

While the Review did, of necessity, engage with the needs of the many millions of patients who constitute the majority of the population, the Team was acutely aware that there are a number of minority groups whose needs could easily be overlooked – any out-of-hours service that uses the telephone as the first point of contact, for example, presents formidable problems for patients whose first language is not English. Thus, in developing recommendations that would meet the needs of the many millions who use out-of-hours services, the Review has also paid careful attention to those minority groups whose special needs may need to be addressed in other ways.

Working from those basic principles, the Review Team has formulated a set of particular recommendations which are discussed in the following sections:

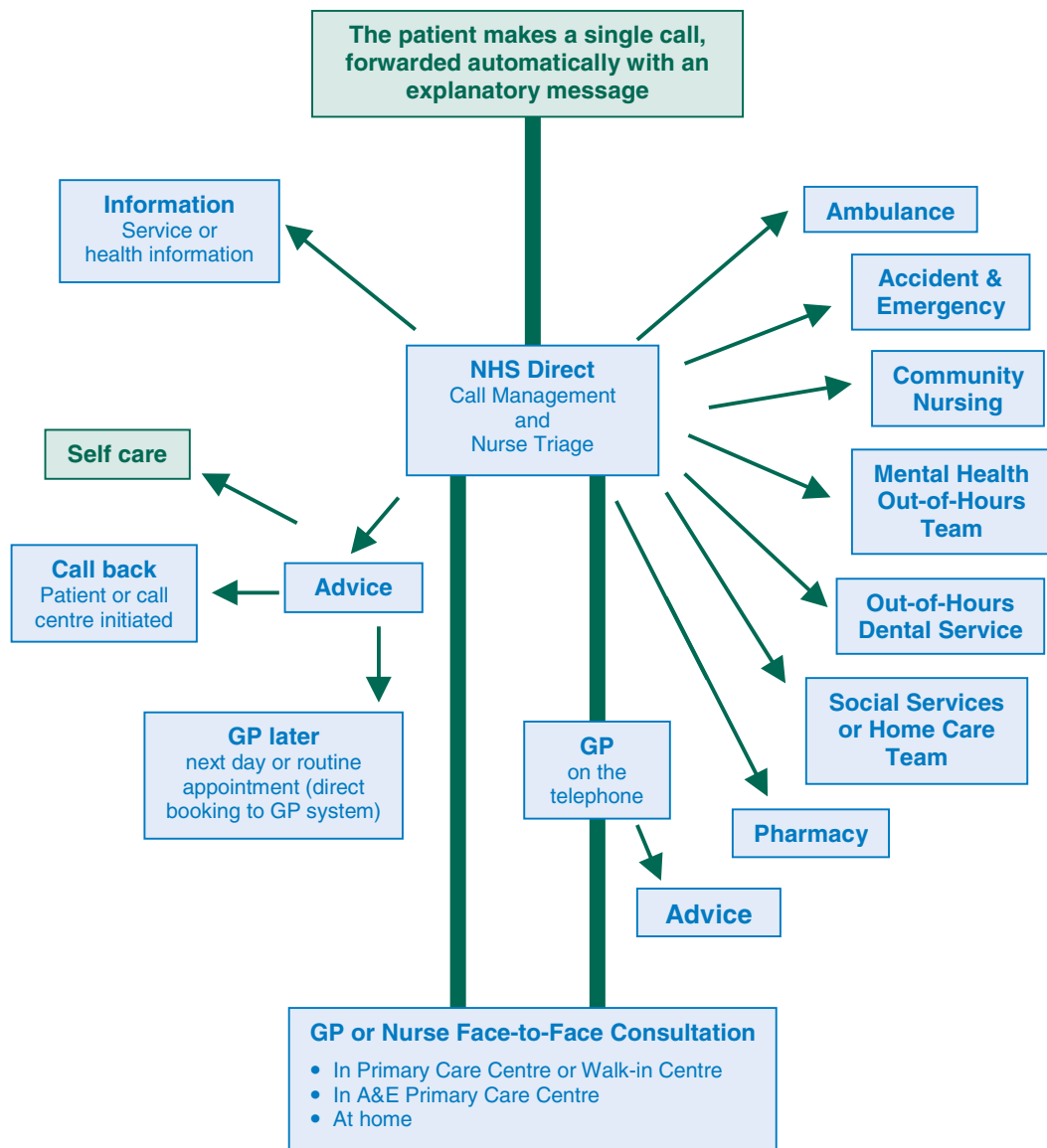
- Section Three sets out the model of out-of-hours care, while Section Four examines the flows of information that this model will require.
- Section Five outlines the Quality Standards which all out-of-hours providers will have to achieve.
- Sections Six, Seven and Eight, examine respectively the framework for local accountability, the integrated planning, and the funding that is associated with the model. These are presented as three separate sections, but they are of course inter-dependent and should be read as such.

- Section Nine discusses issues of recruitment and retention of staff, Section Ten explores the particular problems associated with the supply of medicines out-of-hours, while Section Eleven outlines a timescale within which the recommendations of the Review might be implemented.

Note: Throughout the remainder of the Report, the term PCT/G is used as shorthand for the existing primary care organisation. Where a Primary Care Trust (PCT) is yet to emerge, the roles and responsibilities ascribed to PCT/Gs will be assumed jointly by Primary Care Groups (PCGs) and Health Authorities.

3: A Model of Out-of-Hours Care

Throughout its work, the Review Team has attempted to look at out-of-hours services *from the point of view of the patient*, and the integrated model that is proposed, puts the patient experience at its very heart. Diagrammatically, the model looks like this:



The patient perspective

Looked at from the perspective of the patient, the most important features of the proposed model of out-of-hours provision can be identified as:

- Fast, fair and convenient access for all: the patient's initial request is satisfied *within a single call* (the solid green lines in the diagram opposite). Thus, the patient (or a person calling on the patient's behalf) either calls NHS Direct or the GP practice where, out-of-hours, the call is automatically routed to NHS Direct.
- When the call is first answered, the patient's details are recorded and, in a very small minority of cases, where the patient's initial description of his or her symptoms is such that urgent medical attention is needed, an ambulance is called.
- For all other callers, there are then two possible outcomes to the call:
 - The nurse or GP concludes the patient episode on the telephone – where *both a nurse and a GP* participate in this telephone consultation, the software makes the results of the initial nurse triage available to the GP, obviating the need for a second triage by the GP.
 - The nurse or GP who completes the telephone consultation, negotiates (where necessary) with the patient a time at which to come in to a Primary Care Centre or Walk-in Centre or to be visited at home.
- While the single call that is at the heart of this model will save time and unnecessary repetition of information for all patients, it will be of particular benefit to those who find access to telephone services difficult where the need to make multiple phone calls causes particular difficulties.
- Because NHS Direct is a national service, working to common clinical standards across the country, the needs of all patients who access out-of-hours services will be triaged in a consistent, and consistently safe manner. Some of the most striking variations in current practice are to be found in the response to the patient's initial call, and in this model those variations will disappear.
- There are a small number of patients (those receiving palliative care, for example) whose particular needs can be established in advance and, with appropriate identification on the NHS Direct database, their calls will not be triaged but will be passed directly to those services that can meet their needs.

Integration, multi-professional and multi-agency working

In formulating this approach, the Review took account of a number of submissions that strongly supported an integrated model of out-of-hours provision, a view confirmed by many of the providers visited by the Review Team. There is a very considerable body of knowledge and experience within existing GP out-of-hours providers, much of which has already resulted in new, more integrated approaches to the delivery of the service and, not least for this reason, it is vital that none of this is lost in the transition to the new model. Nowhere is this more clear than in those areas where NHS Direct and existing GP out-of-hours providers have already

developed an effective partnership, for the patients served by these new partnerships have seen significant improvements in the quality of service to which they have access, improvements that are mirrored in better conditions of work and enhanced job satisfaction for those who work in the service. Key features of this new approach include an ability more effectively to manage demand at peak periods with a larger number of staff, and a willingness to share freely the knowledge and experience that already resided in the established out-of-hours provider and the developing NHS Direct site. Within such a partnership approach, the Team was especially impressed by the particular advantages that derive from locating GPs and nurses in such a way that they can easily and quickly communicate with each other, for this enables a level of trust and understanding to develop that can break through the often arbitrary barriers that have so often separated professionals in the past. Indeed, establishing trust and understanding is the precondition for making the most appropriate use of the skills and competencies of all the members of the out-of-hours team.

Where such multi-professional partnerships are well-established, it is not uncommon for all to agree that nurses can properly make decisions about home visits or attendances at Primary Care Centres, without further reference to a GP. Moreover, this approach will soon be taken a step further, with the recognition that the needs of some patients may be met most appropriately by a face-to-face consultation with a nurse (whether in a Primary Care Centre or in the patient's home) rather than a GP. Individual nurse members of the out-of-hours team have particular skills which are especially well-suited to meeting the needs of particular patients; making best use of the resources of the whole team means creating opportunities for those nurses to use those skills. Thus, where nurse telephone consultations are already a well-established feature of out-of-hours provision, the Review envisages that they will soon become an important feature of face-to-face consultations as well.

The integration envisaged in the model does not stop at making the best possible use of existing GP out-of-hours resources, however, for it proposes also the building of new partnerships across a much wider range of traditional divisions between different parts of the health service, and between health and other services. Better communication between the ambulance service and GP out-of-hours services, for example, may enable the needs of patients making Category C calls to be more appropriately met by GP out-of-hours services. A patient could be referred to the community nursing or mental health out-of-hours' team, and the Review Team has been impressed by the fact that where a well-organised, out-of-hours community nursing service (properly integrated with the GP out-of-hours service) is available, the quality of response to patient needs was both more appropriate and effective.

Exactly the same principle applies to building new partnerships with those who provide social care. It has long been recognised that, in the absence of appropriate social care, a patient may be admitted to hospital as the only short-term way of meeting their needs, and access to that care is just as important out-of-hours as it is at any other time. Across the country, the provision of out-of-hours social care, and indeed community nursing and specialist mental health provision, is not consistent and, while this Review cannot make recommendations about the way in which these other services are provided, the model proposed here will only achieve its full potential when those other services are in fact available in every locality.

In short, an integrated model of out-of-hours provision will provide patients with fast, fair and convenient access to care, enabling all the available services to be used in the most appropriate and effective manner to meet those needs.

Recommendation One:

A new model of integrated out-of-hours provision should be accessed by patients via a single telephone call, routed in the first place through NHS Direct passed, where necessary, to the appropriate provider of out-of-hours services in that locality.

Hard-to-reach groups

The telephone has been the medium through which patients have traditionally accessed out-of-hours services, and its ever more central position in contemporary society makes such an approach only more appropriate. On the other hand, the Review Team was acutely aware that there are some groups for whom telephone access may act more as a barrier than a bridge to out-of-hours services. Most obviously, those who speak little or no English may not even consider using the telephone for this purpose; those with hearing impairment will only be able to telephone NHS Direct with appropriate telephone technology at both ends of that exchange; more widely, cultural barriers to using the telephone as a medium through which to share private medical information with an unseen individual, may (in effect) disbar some older people and some ethnic minority groups from out-of-hours services.

In exploring how these and similar problems might be overcome, the Review Team has been impressed with the strenuous efforts that NHS Direct is already making to develop innovative and imaginative solutions to what are, in reality, difficult and intractable problems. On language, provided the caller is able to identify *in English* the name of the language in which they wish to conduct their call, the service can already very quickly identify an interpreter for more than one hundred different languages; it may be possible in future to employ voice recognition and translation software to obviate the necessity of the caller making the initial request in English. For those with hearing impairment, NHS Direct is currently taking advice from the Royal National Institute for Deaf People on how best to modify its existing telephone technology to meet the needs both of the comparatively small numbers of people who are profoundly deaf and of the much larger numbers of people with less severe forms of hearing impairment.

In addition to these technological solutions, each NHS Direct site is currently investigating how best to work with its own local community to break down the cultural barriers that may prevent particular communities from using its service. There are a wide variety of different ways in which these difficult cultural problems could be tackled, and some solutions may involve the imaginative use of print and other media to present information about the service in a form that is properly tailored to that local population. It is very likely, however, that many sites will have to identify staff to work directly with those communities, accessing existing groups and networks, slowly building the trust and understanding that will make the service truly available to all.

Difficult as all these problems are, the pivotal position of NHS Direct in the model proposed here, enables solutions to be developed that would be quite beyond the scope of any individual provider. The existing provision of translation services is a clear example of this; the expertise on which NHS Direct has been able to draw in working with the Telephone Helpline Association and a wide variety of community and special interest groups is an equally clear illustration of the unique potential that its national role allows it to exploit. In short, while the nature of these problems is such that they will never be solved entirely, the role that NHS Direct will play in a fully integrated model offers the prospect of very much more progress than could ever be achieved by individual providers each attempting to solve these problems locally.

Recommendation Two:

NHS Direct should continue to pay particular attention to meeting the special needs of hard-to-reach groups, and GP out-of-hours providers should take early advantage of these initiatives so that these groups are not disadvantaged while accessing the GP component of out-of-hours care.

Meeting the peak demands

Any service that has to cope with fluctuating demand, always encounters special difficulties at periods of peak demand, and the Review Team recognises that there will be substantial problems for those very short times during the year (Christmas, New Year, Easter and other Bank Holidays) when patient demand escalates far beyond the normal weekly variations. Indeed, there have been marked improvements in recent years, and many GP out-of-hours providers have demonstrated that they can in fact respond effectively to these short-term surges in demand. That said, looking at provision as a whole, it is clear that these exceptional peaks still present formidable problems, but with the completion of the national roll-out of NHS Direct in the autumn of 2000 a more robust solution can be found. For, when NHS Direct is a truly national service, its various call centres will be networked in such a way that the total call handling capacity in the system will be significantly greater than the sum of its individual parts. Thus, the existence of such a virtual network will provide an incomparably more effective response to those short-term surges in demand, and detailed modelling demonstrates that the new capacity will indeed be sufficient. Add to this, the full integration of GP out-of-hours capacity proposed here, and the flexibility and responsiveness of the system as a whole will be strengthened still further.

Answering the calls is only part of the problem, however, for each call must then be handled safely and appropriately, and here the results of the current NHS Direct software procurement process are critical. The decision support software that will be available in every site by April 2001 will reduce dramatically the length of time that it will take for each call to be completed, without sacrificing any of the clinical rigour that characterises the existing support. Indeed, the next generation of NHS Direct software will be both clinically safer and also capable of much more rapid modification and development. Thus, where necessary, a new clinical algorithm

could be developed and implemented within hours, allowing the service to respond much more quickly and effectively to a new situation.

Yet neither of these technological changes would, in themselves, allow the integrated out-of-hours service effectively to meet the most challenging escalations in demand, and the third element in the equation is, in a sense, the most important of all. Some existing GP out-of-hours providers have already demonstrated their ability to deliver a safe and reliable service at these times, and in some areas a limited number of GP practices have opened at times of greatest demand to limit the pressure on out-of-hours providers. Thus, in developing the new model, it is vital that none of that knowledge and experience is lost; all the members of a particular local partnership will need to draw freely on each other's experience. For this is indeed the essence of a fully integrated approach, planned with a careful recognition of all the resources available in a given locality. It creates entirely new opportunities to make the very best use of *all* the human resources that are available in that locality. New flexibilities will be a direct product of the growing trust and confidence between all the participants in this integrated service, and it is this that will allow the provision to be managed in such a way that it can indeed respond effectively at periods of peak demand.

Primary Care Centres

The other aspect of the model to which the Review wishes to draw particular attention is the all-important role of the Primary Care Centre. As we have already made clear, current best practice already provides patients with appropriate local access to such Centres out-of-hours, and the model proposed in this Review will only work if Primary Care Centres are made available across the country.

At first sight, this might suggest a major programme of new provision but, in reality, there are many ways in which much better use could be made of existing resources. As we have already indicated, new partnerships between Accident and Emergency Departments and their local GPs can be developed; a Primary Care unit within such a Department creates opportunities to provide a much improved service, while making much better use of the existing clinical resources. New partnerships between cottage hospitals and local GPs open up comparable opportunities in rural areas. Historical divisions between GP Co-operatives and deputising services have sometimes resulted in the provision of rival Primary Care Centres in very close physical proximity, while in other areas patients have had to travel many miles to the Centre used by their GP when a Centre resourced by another provider may be just around the corner. And finally, the emergence of Walk-in Centres provides yet another opportunity for imaginative and cost effective solutions to the problem.

Whatever form the local solution takes, however, one further aspect of the role of the Primary Care Centre needs particular emphasis. In the past, patients' access to urgent medicines out-of-hours has been confused, time-consuming and inconsistent but, as more and more patients access out-of-hours care at Primary Care Centres, a solution to that longstanding problem can at last be found: those medicines can be made available to patients at the same time and in the

same place as their out-of-hours consultation. A more detailed discussion of the form that this solution will take can be found in Section Ten below.

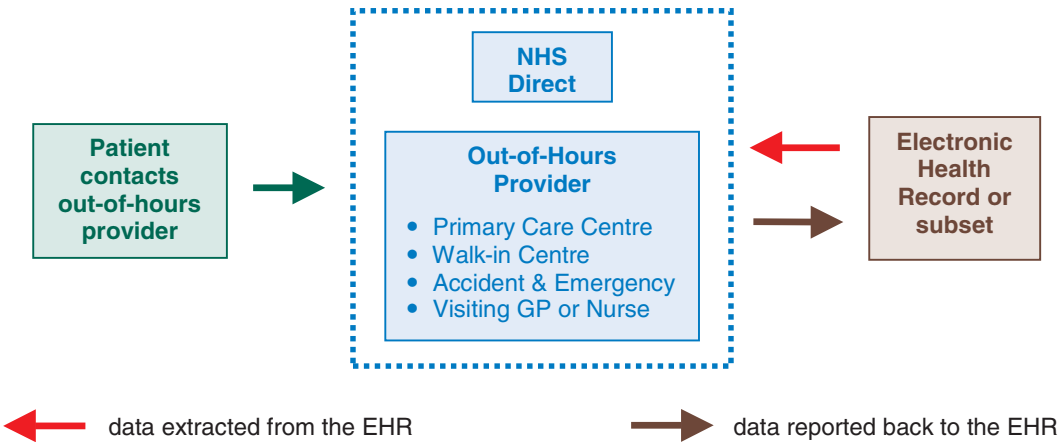
Thus, a central responsibility of those who plan out-of-hours services locally will be to ensure that sufficient Centres are made available in the locality for which they are responsible to meet the Quality Standards set out in this Report. Further discussion of the way in which local out-of-hours services will be planned can be found in Section Seven below.

Recommendation Three:

Sufficient Primary Care Centres should be provided to enable out-of-hours providers to meet the Quality Standards set out in this Report.

4: Information Flows

The integrated model described above can only work if data are shared safely and promptly between all the appropriate individuals and organisations and, while the Review Team recognises that much work remains to be done before the Electronic Patient Record becomes a reality, this work is currently being addressed as part of the implementation of *Information for Health*. Once that work has been completed, it will be possible to move data electronically between the various clinical systems and, when this has been achieved, an optimal model for the way in which data relating to out-of-hours patient care will need to flow around the system can be described. That model can most easily be represented in the following diagram:



Thus, when the patient makes initial contact, the call handler, nurse or GP would have access (in real time) to the patient's Electronic Health Record, or some subset of that Record. Following the initial triage, details of that triage, together with the original Record, would be transferred electronically to the out-of-hours provider. Once the individual patient's needs have been met (whether by the NHS Direct nurse, or by the out-of-hours provider) a report of the outcome would then be transferred electronically to the Electronic Health Record.

The Review Team understands that concerns about security and confidentiality have led many to argue that only a subset of the Record should be made available outside records held in GP practices but, whatever method is used, patients will have to give their consent to data being accessible in this way. The data can be made available via the GP System, a central server or a 'smart card' – whatever particular method is chosen, data will have to be encrypted and be coded according to a standard clinical coding system. Equally, if central server or 'smart card' technol-

technology is adopted to facilitate rapid access to clinical data, it will be important to ensure that the Electronic Health Record subset is regularly updated.

In addition to meeting the day-to-day needs of primary care providers, the existence of the electronic records described above will allow for the extraction of anonymised data, itself an essential pre-requisite for the proper monitoring and evaluation of out-of-hours activity. All the Quality Standards set out in Section Five below have been developed with data collection in mind and many out-of-hours providers already collect this information; all that is proposed here is a common format for those data.

The preceding paragraphs describe the optimal model which will be in place in the medium term but, in the period before that model is in place, the recording of clinically-coded data within the IT systems of out-of-hours providers and other sections of the NHS will start to take place. As these developments will ultimately form the building blocks from which the Electronic Health Record will be built, it is essential that these emerging systems develop in a way that is mutually compatible, enabling that sharing of clinical data that is at the heart of this optimal model.

The Review Team is acutely aware, however, that for certain particular groups of patients, it would not be appropriate to wait until the new electronic exchange of data is in place. Thus, NHS Direct, out-of-hours providers and GP practices should develop methods to ensure appropriate three-way exchange of information for patients:

- With terminal illness.
- With complex acute clinical needs.
- With mental health problems.
- With any other special needs.
- Who access their care through arrangements made under HSC 2000/001: *Tackling Violence Towards GPs and Their Staff*.

Finally, the minimum standards set out in *Good Medical Practice for General Practitioners* can only be achieved if out-of-hours providers supply to GPs, by 9.00 a.m. on the next normal working day, full and comprehensive clinical data for all out-of-hours consultations. While this requirement will be much easier to achieve with complete electronic exchange of data, its implementation cannot wait until then, and all providers will need to use existing technology to meet this requirement in the short term. Thus, all immediate and future data transfer systems will have to conform to current regulations regarding Data Protection and Confidentiality (Caldicott).

Recommendation Four:

When the Electronic Health Record is in place, a three-way exchange of data between NHS Direct, out-of-hours providers and GP clinical systems should be established. In the interim, all providers should report all out-of-hours consultations to GPs by 9.00 a.m. the next normal working day. Systems for the three-way sharing of clinical data for patients with special needs should be established in advance of the implementation of the Electronic Patient Record.

5: Quality Standards

The review of the research literature set out in Annex Two reveals just how limited our current understanding of the present quality of out-of-hours provision is and, without the routine recording of data across a wide range of aspects of that provision, it will remain all but impossible to make any accurate judgements about the quality of that care. Moreover, recent investigations by the Health Service Ombudsman have demonstrated the existence of particular examples of wholly inadequate care and, while existing data provide no sense of how typical or untypical those cases may be, the requirement that all providers of out-of-hours services will have to meet a set of minimum standards of care will go a very long way towards ensuring that such cases do not recur in future.

In thinking about the form that the standards should take, the Review Team has set out to ensure that all out-of-hours services are delivered to the same, national quality standards. And, while the formulation of such explicit and wide-ranging standards represents a new departure for primary care, such an approach is entirely consistent with the aims and objectives of the 'new NHS' and the principles of good clinical governance. Many organisations already routinely monitor the standards of service delivery and, in order to achieve consistent quality, all those who play their part in the delivery of out-of-hours services should do the same. There may be additional costs associated with the introduction of such monitoring, both in terms of capital investment and training, but such investment is entirely justified in ensuring that all services are provided to the standards of the best.

Through its detailed discussions with existing out-of-hours providers, the Review Team is satisfied that, within the framework of an integrated provision of out-of-hours services, all of these Standards are realistic and achievable. Indeed, some existing organisations are already very close to meeting the majority of the Standards proposed here. But it is important to emphasise that these Standards are not 'set in tablets of stone'. The nature of the data that will be accumulated as a result of providers reporting on their performance in relation to these Standards will create a much clearer and more detailed picture of the character of out-of-hours provision and, in the light of that new data, there will be every reason to explore ways in which the Standards can be further refined and developed.

Recommendation Five:

The Quality Standards set out in this Report should be met by all providers within a timescale specified in Section Twelve.

In order to be able to meet these standards, providers of out-of-hours services will need to be able to record:

- The numbers of telephone calls that are abandoned by the caller.
- The length of time taken to answer the call.
- All the communications that take place when the call is answered.
- Accurate details of all clinical consultations, recorded in an appropriate IT clinical system.

Recommendation Six:

All providers of out-of-hours services should put in place appropriate systems for call abandonment, time taken to answer the call, call recording and the recording of all clinical consultations.

The ability to report on the standards for call handling and clinical prioritisation will pose particular problems for those GPs who continue to provide their own out-of-hours service, either entirely on their own, or through a practice rota. The Review Team recognises this difficulty but, if their out-of-hours calls were handled by NHS Direct (in the manner proposed in the fully integrated model), then those problems would be resolved. NHS Direct should therefore pay particular attention to establishing effective links with those GPs who wish to continue to offer their own out-of-hours services, thereby making it easier for them to meet the Quality Standards set out below.

In developing a set of Quality Standards to ensure that patients across the country can access the same minimum quality of care out-of-hours, the Team has grouped the standards in three separate areas:

- Clinical Governance.
- Service and Organisational Models (including links to NHS Direct).
- Access and Triage.

Clinical Governance

While many of the principles that underpin Clinical Governance out-of-hours are the same as in-hours, there is a particular need to ensure that those delivering these services (many of whom fulfil other roles in-hours) pay appropriate attention to the special skills and competencies that are required to deliver effective out-of-hours services.

In the first instance, the monitoring of professionals' clinical activity that is required by these standards will identify those professionals whose performance is significantly at variance from that of their peers. But, as routine monitoring develops over time, a cumulative database of patterns of performance will start to emerge, and this will in turn allow for a more rigorous and systematic analysis of those standards.

People:

1. All professionals involved in out-of-hours care must be eligible to be employed within the relevant parts of the NHS including General Medical Services.
2. The annual appraisal of individual professionals involved in out-of-hours care will include the assessment of out-of-hours skills. For GPs, this will take place within the proposed appraisal system that will be part of the revalidation of all GPs; for other staff, it will be part of the routine systems developed by all out-of-hours providers.
3. Personal Development Plans should include the development of skills related to out-of-hours activity. These may include telephone triage skills development.

Record keeping and auditing:

1. Out-of-hours records will be maintained with reference to the standards set out in *Good Medical Practice*. Nursing records will be maintained with reference to UKCC guidelines on record keeping.
2. A sample of call records will be audited routinely in order to assess their adequacy and completeness, to appraise the clinical quality of the call management process and to monitor the flow of information within and between provider organisations. A procedure for assessing a random sample of calls (for example 1% per month) will be developed for use by all providers and will be based on current examples of good practice, including methods for multidisciplinary peer review. Clinical records will be continuously audited via a sampling method measuring standard of record keeping in relation to each professional. 1% of each clinician's records will be audited.
3. The audit process will enable providers to review aspects of individual professional performance (such as referral patterns and prescribing practices) and organisational performance (including consistencies and inconsistencies in call disposition: calls triaged by a nurse / nurse and doctor, calls resulting in a home visit, calls resulting in attendance at a Primary Care Centre). These data will facilitate feedback to individuals, and will inform the preparation of summary reports to Health Authorities and PCT/Gs.
4. The reporting of performance will be open within the organisation, and the collated information of subscribing contractors will be reported to the local Health Authority.

Complaints and Patients' Satisfaction Data

1. All out-of-hours providers will comply with the NHS complaints procedure.
2. All providers will monitor and audit complaints in relation to individual staff.
3. All providers will always investigate and review all significant events¹ and all reports on such events must include clear recommendations; all reports will be submitted to the appropriate monitoring body.

¹ A significant event is an occurrence that is significant or pivotal in either a desirable or undesirable way and which, if not discovered or corrected in time, did or could lead to patient morbidity or mortality. This definition is based on Barach P. and Small S.D., 'Reporting and preventing medical mishaps: lessons from non-medical near miss reporting systems', *British Medical Journal* 320:759-763.

4. All providers must demonstrate that they are continuously monitoring patient satisfaction and taking appropriate action on the results of that monitoring.

Individual GPs and GP rotas

1. Individual GPs and practices not taking part in a Co-operative or deputising arrangements will report their service to the same standards.

Service and Organisational Models (including links to NHS Direct)

The structure of out-of-hours services envisaged by the Review will require the closest possible co-operation between the many different organisations (or individuals) that will be involved in the delivery of the service. It is thus crucial both that there are explicit Service Level Agreements for each of these inter-relationships and that robust methods of monitoring these Service Level Agreements are developed.

1. All accredited organisations must have clear mechanisms for accepting delegated responsibility (including indemnity cover) for the patients for whom they make provision out-of-hours, and they must further demonstrate their ability to match their capacity to meet the (changing) demand for those services.
2. All accredited organisations must report quarterly to the Health Authority with evidence that they are continuing to meet the Quality Standards.
3. Service Level Agreements will include standards for both parties to the agreement – e.g. NHS Direct and the out-of-hours provider.
4. There must be rapid and effective transmission of out-of-hours patient data from NHSD to the service provider, and from the service provider to the GP practice, as defined in Recommendation 4.
5. All out-of-hours providers must be represented in, and play an active role within, the local emergency planning system.
6. All out-of-hours providers must be members of Local Winter Planning Groups and Emergency Care Liaison Groups – these groups must include:
 - 6.1. The appropriate GP Co-operatives.
 - 6.2. GP rotas.
 - 6.3. Deputising services.
 - 6.4. NHS Direct (the relevant regional hub).
 - 6.5. Local PCT/Gs.
 - 6.6. The Health Authority.
 - 6.7. Local Ambulance Services.
 - 6.8. The local Accident and Emergency Departments.
 - 6.9. Walk-in Centres (if appropriate).
 - 6.10. Social Services.
 - 6.11. The Local Pharmaceutical Committee.
 - 6.12. Lay representation.

7. All out-of-hours providers must examine all significant events and report the outcomes of those reviews to the local Health Authority.
8. Out-of-hours service providers must be able to supply full clinical details of consultations to the host GP by the start of the next working day.
9. All out-of-hours providers must have clinical and organisational systems which are continuously able to report these standards.
10. All out-of-hours organisations that employ staff and are stewards of public funds must comply with standard NHS corporate governance standards.
11. All organisations providing or employing clinical staff must be able to support the requirements of revalidation for medical staff.
12. All organisations must meet NHS human resources standards for continuing personal development and the accreditation of staff.
13. All employment practices must conform to NHS human resources standards.

Access and Triage

In determining the detailed standards set out below, special attention was paid to a number of particular issues:

- Problems that require rapid intervention that must be identified as such and passed to the Ambulance Service.
 - Response times must be determined by clinical need.
 - Response times must be agreed after negotiation between the clinician and the patient during the initial telephone consultation.
 - Intervention times must be agreed after negotiation between the clinician and the patient.
 - All encounters with the patient must be appropriately recorded, so that every aspect of the out-of-hours service can be properly audited.
1. Call engaged and abandonment standards (an abandoned call is defined as one where the caller discontinues the call after 30 seconds, allowing time to listen to a message which may be played before the call is answered):
 - 1.1. No more than 0.1% of calls engaged.
 - 1.2. No more than 5% calls abandoned.
 2. Time taken for the initial call to be answered by a person:
 - 2.1. 90% answered within 30 seconds.
 - 2.2. All answered within 90 seconds.
 3. Identification of immediate life threatening conditions:
 - 3.1. 90% of immediate life threatening conditions identified within 1 minute.
 - 3.2. All life threatening conditions identified within 15 minutes.
 - 3.3. 90% of immediate life threatening conditions passed to the Ambulance Service within 1 minute.
 - 3.4. All life threatening conditions passed to the Ambulance Service within 15 minutes.

4. Definitive telephone triage and disposal (excluding those patients who access a Primary Care Centre, Accident and Emergency Department or Walk-in Centre direct, without preliminary telephone triage – see 7. below):
 - 4.1. 90% complete within 20 minutes.
 - 4.2. All complete within 30 minutes.
5. Time to episode complete (disposal):

Visiting standard:

 - 5.1. Emergency: Within 1 hour.
 - 5.2. Urgent: Within 2 hours.
 - 5.3. Less urgent: Within 6 hours.
6. Patients to be informed of timescale during initial consultation, including time to visit at home or appointment time at Primary Care Centre or Walk-in Centre, and *always* contacted if an agreed home visit is delayed or if an appointment time at a Primary Care Centre is delayed.
7. For those patients who have not been triaged on the telephone and who access a Primary Care Centre, Accident and Emergency Department or Walk-in Centre direct:

Time from arrival to initial contact:

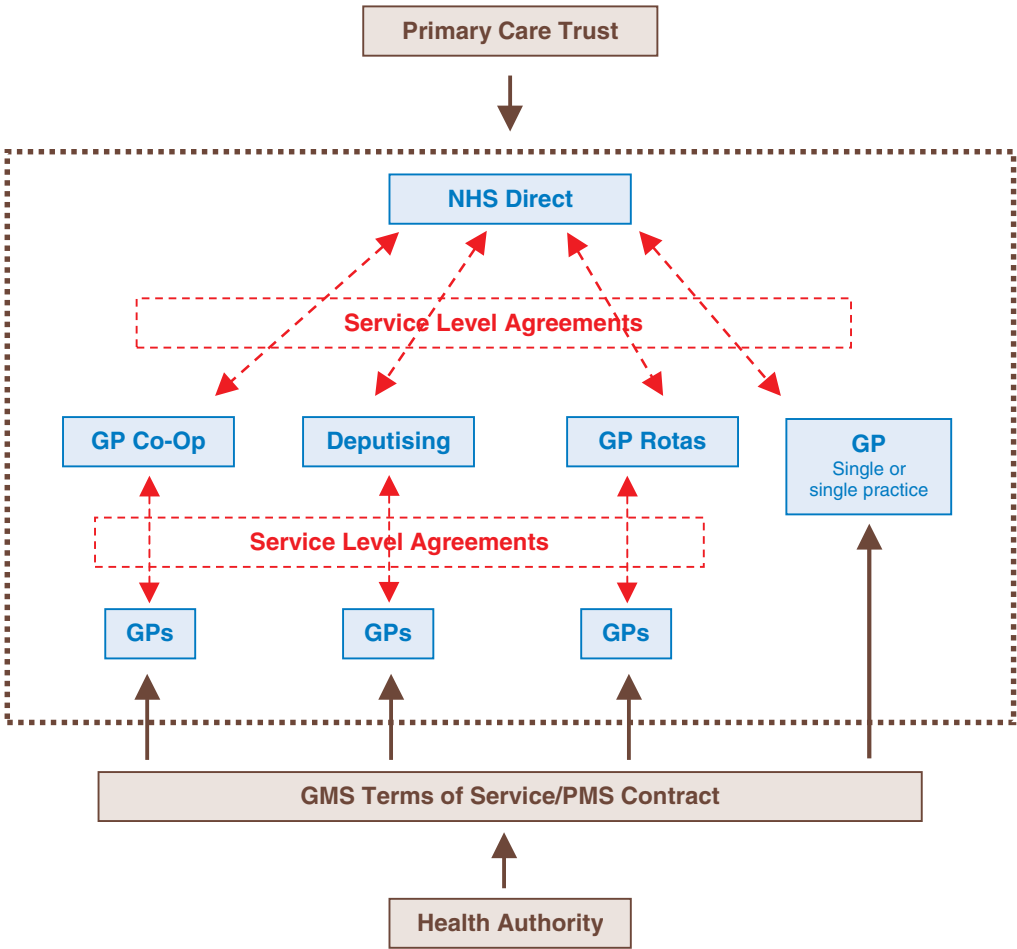
 - 7.1. 90% of initial triage completed within 5 minutes.
 - 7.2. All initial triages completed within 10 minutes.

Time from initial contact to consultation:

 - 7.3. 90% of patients offered consultation within 45 minutes of arrival.
 - 7.4. All patients offered consultation within 60 minutes of arrival.
8. Non English speaking users:
 - 8.1. 90% provided with translation service within 10 minutes of initial contact.
 - 8.2. All provided with translation service within 15 minutes of initial contact.
9. Patients with impaired hearing:
 - 9.1. A dedicated telephone number will be provided for text phone users to enable them to access the service.
 - 9.2. Appropriate technology will be installed in NHS Direct call centres to enable callers with less severe hearing impairment to access the service.

6: A Framework of Local Accountability

National Quality Standards are, in the end, only as good as the framework of local accountability that is developed to ensure that they are met by the organisations and individuals involved in their delivery and, at the heart of this proposed framework are a series of Service Level Agreements indicated by the dotted red lines in the diagram below. Moreover, this structure will be underpinned by the local PCT/G, whose function is not only to ensure that the provision of high quality, out-of-hours services in its locality is planned in such a way that it deliver 'best value' for the local health economy, but also that all parties properly fulfil their obligations under the Service Level Agreements (the dotted brown line below):



The strengths of such an approach derive from the fact that Service Level Agreements impose duties and obligations on both parties to the agreement. Thus, while NHS Direct is a national organisation, accountable nationally to the NHS Executive, the Service Level Agreements proposed in the diagram above enable local providers to hold it accountable locally for the services that it delivers. In the same way, the Agreements enable NHS Direct to ensure that each of the very different providers of out-of-hours services in a given locality meets its common (national) standards. In exactly the same way, the Agreements impose mutual duties and obligations on individual GPs and the organisations with which they contract to provide their out-of-hours services. And at the heart of all these Agreements are the Quality Standards set out in this Report, Standards which will ensure that all patients (regardless of the part of the country in which they live, or the particular GP practice with which they are registered) have access to the same high quality provision of out-of-hours care.

Finally, the robust character of these Agreements is underpinned by the requirement for both parties to report their performance to the PCT/G on a quarterly basis, enabling the PCT/G to be satisfied that the terms of the Service Level Agreement are indeed being met; the PCT/G will then report these outcomes to the Health Authority annually. An example of such a Service Level Agreement is included in Annex Four.

Recommendation Seven:

Service Level Agreements incorporating all the Quality Standards should be established, between NHS Direct and all providers of out-of-hours services, and between GPs and all providers of out-of-hours services. Compliance with these Agreements should be monitored by the PCT/G with responsibility for planning out-of-hours services in that locality and should be reported to the Health Authority.

Accreditation

Powerful as such Agreements are, however, they only make sense if the provider of out-of-hours services is already in a position to offer a service that is capable of meeting the Quality Standards set out in Section Five above. In order to ensure this, the Review proposes that the Health Authority will take responsibility for accrediting all the organisations (GP Co-Operatives, Deputising Services and GP Rotas) that might provide out-of-hours services in its area. The Authority would have to be satisfied, therefore, that these organisations had developed robust systems to deliver effective clinical and corporate governance and that they held appropriate indemnity cover for the provision of those services.

The model described above makes no attempt to define the size of any of the out-of-hours providers, but in many of its visits the Review Team has been impressed by the argument that there is in reality an irreducible minimum below which it would prove very difficult to provide a service that met those Quality Standards; very small providers would invariably find it impossible to develop the infrastructure that is in reality a precondition of achieving those Standards. Thus, while individual Health Authorities will in the end have the responsibility for deciding

whether or not to accredit a particular provider, they would (of necessity) need to be absolutely certain that a small GP Co-operative, deputising company or GP Rota would in fact be in a position to resource an out-of-hours service capable of meeting those Standards.

Once an organisation had been accredited, the Health Authority would then be responsible for ensuring that the performance of the organisation met the Quality Standards. All Standards have equal status and any assessment of whether or not they are being met must take account of the provider's performance across the full range. In the first instance, audit data would be reported quarterly to the PCT/G, with an annual report by the PCT/G to the Health Authority, but PCT/Gs will have a duty to report to the Health Authority if, at any time, they have serious concerns about the ability of an individual provider to meet those Standards.

Once such a report has been made, if the Health Authority is satisfied that the provider is indeed failing to meet the Standards, a remedial notice will be issued, requiring the provider to meet the Standards within a maximum of six months. If, at the end of six months, the Standards are still not being met, accreditation will then be withdrawn and the provider will no longer be able to provide services for GMS contractors or PMS sites. In such circumstances, responsibility for the provision of those services will revert to the GPs who had delegated their out-of-hours responsibilities to that provider although, in almost all circumstances, the Health Authority and the PCT/G, working with those GPs, would have made sure that appropriate alternative arrangements for the proper provision of out-of-hours services would have been put in place.

Individual GPs who provide their own out-of-hours services (either on their own or through a practice rota), or who belong to a small, informal GP rota, and who are working within GMS rules, will be required to meet exactly the same Quality Standards, for it is only in this way that real equity of provision for patients will ever be achieved. They will report their performance directly to the Health Authority. The PMS contracts of those GPs who also deliver their out-of-hours services in this way will be amended so that they too include the requirement to meet and report on the Quality Standards. In either case, Health Authorities will be charged with responsibility for taking appropriate action wherever an individual GP fails to meet the Standards.

While we do not wish to prescribe the mechanism that the Health Authority would use to discharge this role, it must include effective lay representation in addition to the usual health professionals, for it is only in this way that it will be able to discharge a proper level of accountability to the wider community that it serves. An obvious source of such lay representation could be the Lay Members of Primary Care Group Boards or the Non-Executive Directors of Primary Care Trust Boards, lay people with a real understanding of primary care in the locality. Regional Offices of the NHS Executive would be responsible for managing the performance of Health Authorities, but the most important characteristic of the proposed framework is the new opportunity that it creates for effective *local ownership* of the provision of out-of-hours services, an appropriate recognition of the local partnerships that will characterise the new model of the integrated provision of out-of-hours services.

Fundamental as such lay participation will be to delivering an effective form of accreditation, it is equally important that (wherever appropriate) the new mechanisms for lay scrutiny of the work of the NHS envisaged in *The NHS Plan* pay proper attention to services provided out-of-hours. In particular, the role envisaged for the new Patients' Forums, which will be established in every Primary Care Trust, provides an important opportunity to give local people the opportunity to scrutinise and comment on the quality of the services in their own area and, in setting the agenda for these new organisations, PCT/Gs must ensure that proper attention is focused on the delivery of care out-of-hours.

In discharging the accreditation function, an individual Health Authority may find that it is asked to accredit a large organisation that wishes to provide out-of-hours services in a number of different localities, spread across more than one Health Authority. In such a situation, there would be little sense in each of these Health Authorities attempting to accredit the same organisation separately, for not only would this generate unnecessary costs in time and resources, it might even result in the same organisation being accredited by one Health Authority, while failing to achieve accreditation with another. Wherever such a situation occurs, therefore, all the Health Authorities involved should identify a single lead Health Authority to accredit the organisation on their behalf.

Finally, the Review Team is aware of the considerable variations that have sometimes arisen when Health Authorities have been charged with responsibility for administering what were intended to be national standards. Given the critical importance of achieving equity of provision across the country, the Review recommends that detailed guidance for Health Authorities be developed, to enable them to implement their new powers of accreditation in a manner that is indeed truly consistent.

Recommendation Eight:

Health Authorities should be responsible for the accreditation of all organised out-of-hours providers and should monitor the quality of out-of-hours services provided by those GPs who do not use such providers. Detailed guidance should be developed for the manner in which accreditation is to be implemented.

In summary, the accountability framework proposed here has three central features:

- All organisations offering an out-of-hours service will have to be accredited by their local Health Authority.
- Service Level Agreements between NHS Direct and all providers of out-of-hours services, and between those providers and GPs, will allow all the 'players' in a locality to hold each other accountable for the services each delivers.
- PCT/Gs will monitor compliance with these Service Level Agreements, with data reported to the PCT/G quarterly; the PCT/G will in turn report these data to the Health Authority annually.

In addition, the PCT/G will have overall responsibility for the planning of out-of-hours services in its locality, and the nature of that role is set out in Section Seven below.

7: An Approach Integrated with Other Local Providers

The majority of patient demands for primary care out-of-hours have been handled by GP practices and the different organisations that work on their behalf but, in many urban areas, a significant number of patients use their local Accident and Emergency Department as their source of primary care out-of-hours – some studies show that as many as 40% of those who present out-of-hours are in fact in need of primary care. Moreover, where patients have access to a Walk-in Centre, they may well start to use it in the same way.

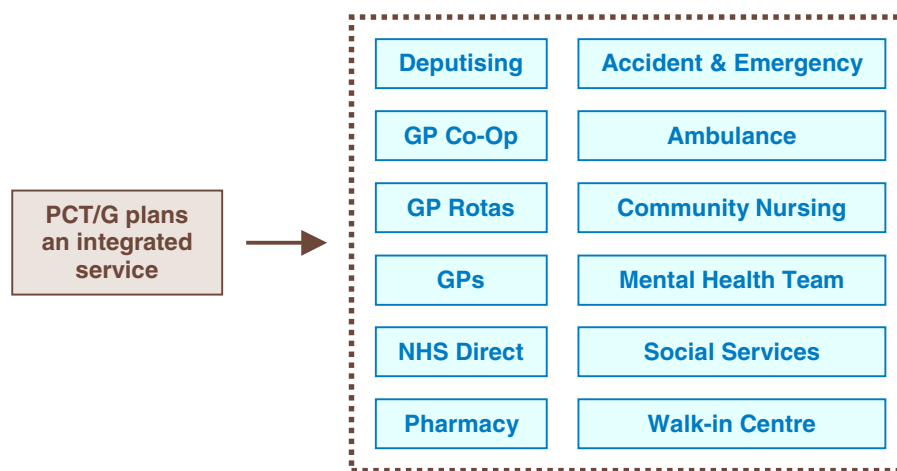
While the traditional approach has sought to characterise such patient behaviour as 'inappropriate' (and has attempted to challenge the attitudes that lay behind that behaviour), the fact remains that significant numbers of people in urban areas continue to attempt to access 'primary care' out-of-hours through their local Accident and Emergency Department – indeed, some data suggests that the number of people who act in this way is rising. Thus, true to the principle of making the provision fit the needs of patients, the Review Team is convinced that it makes sense to look again at the way in which the NHS responds to those particular needs, and two aspects of current provision provide the foundations on which to do just that. First, many current providers resource local Primary Care Centres out-of-hours and, whereas traditionally all patients who needed a face-to-face consultation were visited in their home, patients are increasingly encouraged to attend at such a Centre. And secondly, in an approach to which we have already made reference (see page 5 above), some Accident and Emergency Departments have been reconfigured to make separate and appropriate provision for those who need primary care on the one hand, and those truly in need of emergency medicine on the other.

On the other hand, such an approach is still extremely unusual; almost always, the barriers that traditionally separated Accident and Emergency Departments from those who provide out-of-hours primary care services are still firmly in place. With only a little imagination, however, it would be possible to develop a model in which all out-of-hours services (whether presently located in the primary or secondary sector) could be reconfigured in such a way that, between them, they would be very much better placed to meet the needs of patients. Thus, wherever appropriate, Primary Care Centres would be located alongside a local Accident and Emergency Department, with all patients triaged at the door, and referred either to the Primary Care Centre or the Department of Emergency Medicine.

Indeed, a common, consistent response to *all* patient demands for out-of-hours care could be provided, with nurses in Walk-in Centres, Accident and Emergency Departments, Primary Care Centres and NHS Direct using exactly the same software-based protocols to formulate appropriate responses to those demands. Such an integrated, consistent approach may represent something of a radical departure for an organisation which has, on occasion, shown itself un-

willing to cross traditional, long-established boundaries but, in our judgement, the substantial improvements in both the quality of patient care and the efficiency of provision that this would deliver provide abundant justification for such a change.

In order to achieve such a level of integration, all out-of-hours services in a given locality should be planned as a single, integrated service and, given the reconfiguration of primary care that will continue to take place over the next couple of years, the responsibility for such integrated commissioning will rest with the local Primary Care Trust. Such an approach can be represented diagrammatically:



In fact, the basis for such an approach can already be found in the work that Health Authorities have already done in their Winter Planning Groups, where all the key 'players' already come together (including for example: GP Co-operatives, GP rotas, deputising services, NHS Direct, local PCT/Gs, the Health Authority, local Accident and Emergency Departments, Walk-in Centres, the Local Pharmaceutical Committee and Social Services); indeed, in some Health Authorities, Winter Planning Groups (which, of necessity, have a short-term focus) have given rise to Emergency Care Liaison Groups. PCT/Gs might well work through such a Group to plan an integrated out-of-hours provision in its locality, which will properly meet the needs of the local population. In determining how to deliver this responsibility, PCT/Gs will need to consult with their Local Medical Committees about the role that they might most appropriately play in this developing situation.

Such an integrated approach will bring to an end some of the anomalies of the current position where, for example, an Accident and Emergency Department and a Primary Care Centre can be located in close physical proximity, and yet offer quite separate, autonomous services to their patients. Moreover, better communication and co-operation between existing providers of out-of-hours services, will create new opportunities for the more effective use of scarce resources. It has become clear from a number of the Review Team's visits that out-of-hours providers are finding it increasingly difficult to recruit appropriate medical staff, and the changing expectations of new entrants into General Practice may well exacerbate this trend (see also Section Ten below). Thus an approach that plans out-of-hours provision by taking account of *all* the resources that are available locally, will be able more effectively to resolve this problem.

In parallel to these new partnerships across the PCT/G, however, it is equally important that comparable partnerships are built at the level of the relationship between NHS Direct and its local out-of-hours providers, to ensure that the Clinical Governance agenda is effectively delivered. Thus each NHS Direct site will need to develop a Clinical Steering Group that brings together medical and nursing staff from both NHS Direct and GP out-of-hours providers who work with that site. The Group would monitor and evaluate the clinical outcomes of its services and the way in which those services are delivered, paying particular attention to the rigorous analysis of any significant events. It would develop a joint Complaints Procedure for all those involved in the delivery of out-of-hours services, and also develop appropriate methods for assessing patient satisfaction and taking action on the results of that assessment.

In formulating their approach to the provision of out-of-hours services in the area for which they are responsible, PCT/Gs will also need to take into account two additional aspects of the situation. Like every other NHS organisation, the PCT/G is charged with responsibility for ensuring 'best value' in both financial and service terms for the resources that it deploys in the local health economy, and the provision of services will always have to be achieved within the parameters of a defined budget. In that context, an undue proliferation of small providers may well undermine the ability to provide high quality services at a reasonable price and, thus, even if a particular provider has been accredited by the Health Authority as being fit for purpose, the PCT/G will have to exercise careful judgement about which providers best meet the needs of the local health economy as a whole. Moreover, when considering any proposed changes in existing provision, the PCT/G will once again have to take account of the impact such changes may have on the wider health economy. The Review Team has been made aware of just how destabilising even quite small changes in provision can be, and it will be an important part of the new role of the PCT/G to avoid this happening. On the other hand, there is nothing in the Review's recommendations that will inhibit a new provider from presenting proposals as to how it could improve on the quality of services that are currently provided, and there is every reason why the PCT/G would want to look very carefully at just such a proposal.

Secondly, PCT/Gs must take an appropriate strategic view of the provision of services in the wider health economy outside its own immediate boundaries. As yet it is far from clear what patient population the typical PCT/G will serve, and an individual PCT/G may well find that it is working with a major out-of-hours provider whose services are made available to patients across more than one PCT/G. In such circumstances, it will be very important for neighbouring PCT/Gs to consult with each other in the provision of services – they may indeed decide that they want to develop a more formal relationship for this part of their work, with one PCT/G taking the lead on their behalf.

Recommendation Nine:

A fully integrated out-of-hours service should be planned by the PCT/G in each locality, bringing together all appropriate service providers.

Recommendation Ten:

A Clinical Steering Group should be established by each NHS Direct provider Trust to deliver the Clinical Governance agenda.

Contracts and arrangements between practices and out-of-hours providers

The majority of practices now use some form of organised out-of-hours care, devolving their responsibility to a GP Co-operative, a deputising service or taking part in a local extended rota. These contracts are typically negotiated practice by practice but, in the absence of clear, measurable standards, the inevitable result is considerable inconsistency of provision. They may also represent a significant potential threat to the stability of out-of-hours provision in a given locality, where even the larger providers may be vulnerable to the consequences of a small number of GPs changing their out-of-hours provider at will. Not least because it is aware of this danger, the Review Team has been especially impressed by approaches in which GPs have come together to contract jointly with their local deputising service. For, by working collaboratively in this way, these GPs have secured very many of the same benefits that derive from the model of medium-sized GP Co-operatives, both in terms of economies of scale but also, and even more important, in terms of the rigour of the quality standards that they have been able to put in place.

Although the Review Team cannot recommend that this model must provide the basis for the relationship between practices and out-of-hours providers, it is evident that such arrangements have clear advantages for both practices and patients. Thus, individually negotiated arrangements must, at the very least, be as consistent with the local plan for integrated out-of-hours care and with the Quality Standards, as those arrangements negotiated collectively. Equally, individually negotiated arrangements involving the devolution of out-of-hours responsibilities to a third party can only be entered into with accredited providers, and must be approved by the PCT/G.

Recommendation Eleven:

Every arrangement involving a GP devolving out-of-hours responsibilities to an out-of-hours provider, whether negotiated individually or collectively, should only be entered into with an accredited provider and should be approved by the PCT/G.

The approach set out in the integrated model also takes proper account of an important change that has invariably been associated with the development of GP Co-operatives. At present, GPs assume 24-hour responsibility for the care of their patients, but in practice many GPs have devolved the out-of-hours portion of that responsibility to another organisation, in which they may or may not play a part in staffing its services. The Review recommends that the individual GP 'contract' is amended to allow a GP to devolve responsibility for the out-of-hours element of the contract to an *accredited organisation* (in addition to existing arrangements for transferring responsibility to another GP on the medical list). By definition, such organisations will only be accredited by the Health Authority if they can demonstrate that they are meeting appropriate standards of service delivery and care and that they have put in place robust and acceptable arrangements for indemnity cover. Moreover, should it be demonstrated that any such organisation is failing to meet these standards, then the Health Authority (which holds each GP's contract) will, in the last resort, return the 24 hour responsibility to the individual GP. In almost all

circumstances, however, the Health Authority (working closely with the PCT/G and the GPs), would have made sure that alternative arrangements for the proper provision of out-of-hours services would have been put in place.

Recommendation Twelve:

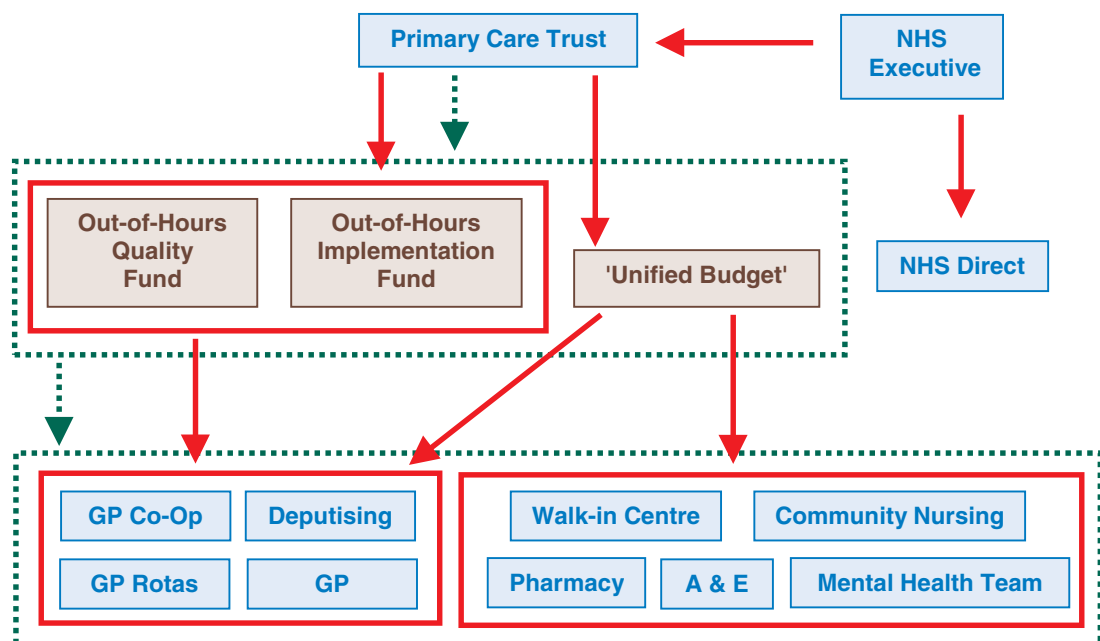
The GP 'contract' should be modified to allow a GP to devolve responsibility for the out-of-hours element to an *accredited organisation* with appropriate indemnity cover, but where that organisation fails to meet appropriate standards of service delivery and care, the Health Authority should, in the last resort, return the 24 hour responsibility to the GP.

8: Funding the Model

The terms of reference of this Review are such that it would not be appropriate for it to make detailed recommendations about the level at which its new model of integrated out-of-hours services will be funded. The Department of Health will wish to respond to the recommendations set out in this Report, exploring in particular their financial and regulatory implications. On the other hand, the broad principles on which its integrated model of out-of-hours service provision should be funded are clearly matters on which the Review is entitled to comment, and the Review Team has identified a number of general principles that all organisations and individuals who provide those services must follow:

- All services must conform with the principles of 'best value'.
- Funds must be allocated in such a way that all patients have access to the same high quality out-of-hours services, regardless of where they live.
- There must be transparent and open information about the way in which all out-of-hours services are funded.

In addition to these basic principles, the Review has looked carefully at the way in which the funding of the integrated model might most appropriately be administered, and the proposed new pattern of allocating these resources can be set out most easily in the following diagram – the solid red lines represent the funding flows; the dotted green lines represent a fully integrated package of funding (a level of integration to which some PCTs already aspire):



The implementation of this model of integrated provision will result in approximately half of all calls concluding with NHS Direct. Thus, as out-of-hours providers will no longer carry this workload, they will be able to redirect existing out-of-hours resources to support the new activity required to meet the Quality Standards. In addition, the Review Team is persuaded that existing providers will be able to achieve further economies of scale in relation to call handling and basic audit activity, provided that there is a rationalisation of the remaining call management, information technology and audit functions. This may require the merger of some smaller organisations and the bringing together of some other functions to meet the Quality Standards.

In reviewing existing provision, the Team has looked especially closely at the way in which Health Authorities have administered the Out-of-Hours Development Fund and it is clear, both from the data that we have collected from Health Authorities, and from the discussions that we have had with local providers, that current arrangements have not always resulted in the development of a quality service or in the infrastructure required to develop such a service. Equally, it is clear that very many out-of-hours providers have found the annual cycle of decisions about the allocation of the Fund enormously problematic – planning that is constrained within a twelve month timescale might be seen by some as a contradiction in terms. Thus the Review recommends that out-of-hours providers will in future enjoy the security of a three-year rolling funding allocation, subject always to the constraints that derive from the effective monitoring of their performance against the Quality Standards – an approach that is directly analogous to the Long Term Service Agreements being developed between PCTs and other providers.

Given the central role that PCTs will play in the planning of out-of-hours services in their locality, it makes sense to recognise this in the arrangements that are made to administer the funding of those services. The Review therefore proposes that PCTs should administer and allocate the funds that support out-of-hours provision, a proposal that satisfies the principle of transparency and openness, as all PCTs are obliged to publish detailed annual accounts.

Finally, while existing financial support for out-of-hours services will be retained, it needs to be targeted much more explicitly to achieve the significant improvements in quality which are at the heart of this Report, and we therefore recommend that the Out-of-Hours Development Fund be renamed the 'Out-of-Hours Quality Fund' and any expenditure which serves to support and improve the quality of out-of-hours service provision will be a legitimate call on that fund.

Recommendation Thirteen:

The Out-of-Hours Development Fund should be renamed the Out-of-Hours Quality Fund, allocated and administered by PCTs as part of their overall planning of out-of-hours provision, within a three year rolling funding allocation. Any expenditure which serves to support, improve and maintain the quality of out-of-hours service provision should be a legitimate call on that fund.

Individual GPs offering their own out-of-hours services

GPs who provide their own out-of-hours services and who both meet and report on the Quality Standards will be able to access the Out-of-Hours Quality Fund.

Recommendation Fourteen:

GPs who do not delegate responsibility for their out-of-hours services should be able to access the Out-of-Hours Quality Fund, provided that they are able to report compliance with the Quality Standards.

'Items of Service' payments

In the light of the radical changes in the character of out-of-hours services that have taken place in recent years (described above in Section One), one aspect of the way in which these services are presently funded no longer makes sense. The 'Item of Service' payments that are associated with face-to-face consultations were created at a time when the vast majority of out-of-hours care took this form; today, more than half of all requests for out-of-hours care are safely and appropriately met on the telephone, and yet such consultations attract no payment at all. Moreover, while such payments do represent a crude measure of the level of out-of-hours demand that falls on a particular GP or practice, the changing character of service delivery makes them less and less appropriate and it is at least theoretically possible that there might come a time when such payments would act as a perverse incentive, encouraging some GPs to consult face-to-face when a telephone consultation would in fact represent a much better use of this scarce resource.

For all these reasons, the Review has concluded that it makes no sense to retain a separate 'Item of Service' payment.

Recommendation Fifteen:

'Items of Service' payments should cease, and these monies should be redistributed, taking proper account of the differential demands on practices for out-of-hours services.

Implementation

Given the particular, short-term needs that will have to be met to enable some providers of out-of-hours services to invest in the IT and organisational systems that are a precondition of a quality service, a proportion of out-of-hours funding should be used to create an Out-of-Hours Implementation Fund.

Recommendation Sixteen:

A proportion of out-of-hours funding should be used to create an Out-of-Hours Implementation Fund.

Rural provision

It has long been argued that the provision of out-of-hours services in rural areas necessarily incurs higher costs (especially in terms of additional infrastructure costs associated with problems of geography and transport) and, in recognition of these claims, an additional £2 million was identified in the Out-of-Hours Development Fund in the financial year 1999/2000 to offset those additional costs. Not least for this reason, the Review Team has looked especially carefully at the issue, trying to identify whether there are indeed additional rural costs and, if so, precisely what they are.

A careful analysis of the existing data serves only to emphasise the limits of our existing understanding of the costs of this particular aspect of health service provision. For while it is possible to make comparisons between the costs of the out-of-hours services provided by different GP Co-operatives, comparisons which reveal as much as an eightfold variation, the current data do not allow rurality to be identified as an independent determinant of demand. Thus in sharp contrast to both age and social deprivation, which have both been clearly shown to be important variables, significantly affecting the levels of demand and thus the costs of provision, the existing data simply do not allow the costs associated with rurality to be isolated in the same way. That said, it is certainly possible that out-of-hours providers meeting the needs of elderly, deprived populations in rural areas may face the highest level of demand of all, yet even here the data does not presently exist even to confirm such a proposition, let alone identify those out-of-hours providers who are in fact having to meet those demands.

Part of the problem with current data derives from the fact that no less than three-quarters of all GP Co-operatives serve rural or mixed rural/urban populations and it is thus difficult to isolate the rural dimension from the other elements in the service provided that determines their costs. More important, the character and extent of the out-of-hours service that individual Co-operatives provide differs widely, and with such disparities in character of provision it is impossible to make any sensible comparisons. Indeed, looked at simply in terms of activity (contact rates per 1000 patients per annum), there are as striking differences between different rural providers as there are between rural and urban providers.

That said, if the Quality Standards recommended in this Report are adopted, the data that will accumulate as out-of-hours providers report on those Standards will provide, for the first time, an appropriate common denominator against which to start to make realistic comparisons between different providers. And once meaningful comparisons can be made, then it will at last be possible to start to disentangle the true nature of the costs that are associated with the provision of out-of-hours services to different populations in different parts of the country. The Review recommends therefore, that at the earliest possible opportunity, a careful and rigorous analysis

of the data about out-of-hours activity is carried out, with a view to identify what the different factors are that determine levels of demand. Armed with that data, it will then be possible to allocate the monies that are available to fund out-of-hours services in a manner that accurately reflects real differences in demand for those services.

Recommendation Seventeen:

As soon as practicable, the data that derives from out-of-hours providers reporting on the Quality Standards should be analysed to identify the actual determinants of demand, with a view to allocating out-of-hours funds in a manner that takes proper account of real differences in costs of provision and levels of activity.

9: Recruitment and Retention of Staff

Recruiting and retaining high quality staff is at the heart of any successful delivery of service, and meeting this particular challenge in the provision of out-of-hours services will probably prove more difficult than meeting the financial challenges contained in the recommendations of this Report. That said, the Team has been particularly impressed by the imaginative approaches to workforce planning and development that are already taking place across the service, and it is already clear that innovative solutions to these problems can both meet the needs of the service and the needs of the staff themselves.

A particularly good example of such an approach has been the use of General Practice nurses in carrying out the triage function in GP Co-operatives for, not only has this broadened the experience of those nurses, adding an important extra dimension to their portfolio of skills and competencies, it has also created a larger pool of skilled staff on which the service can draw at times of greatest demand. Building on examples like this, it would not be difficult to envisage a situation in which nurses could rotate between a wide variety of different services, including for example, General Practice nursing, NHS Direct, Accident and Emergency nursing and community nursing. Rotations like this would result in a new, multi-skilled nurse, who would combine telephone and face-to-face triage skills, with more conventional, 'hands on' clinical skills. And the end result of that would be a core of nurses, well-placed to offer effective triage in daytime General Practice and Accident and Emergency services.

On the other hand, the Review Team is also aware of growing problems of recruiting and retaining doctors to work in out-of-hours services, not least as new entrants into the profession aspire to a more limited definition of their role. Equally, the demands of care for patients in General Practice become increasingly complex, and those GPs who still provide their own out-of-hours care are finding it increasingly difficult to balance the demands of night and day working. Indeed, it is for all these reasons that the Review Team's determination to achieve the more effective use of scarce resources, should be implemented as quickly as possible – the further growth of GP Co-operatives and the more appropriate use of deputising services represents two especially important ways in which more effective use of these scarce resources can be achieved.

Important as such developments will be, however, the central human resource problem will never be solved if the traditionally rigid lines of demarcation between different clinicians are maintained. The Review therefore recommends strongly that all involved in the delivery of out-of-hours care look again at the roles that are currently played by their staff, exploring whether the many skills and competencies of their staff (especially their nurses) are in fact being used to the full. We understand that there is marked reluctance in some areas of the country to embrace

these changes, but we are convinced that, if change does not occur, then those areas will find it increasingly difficult to attract staff.

Recommendation Eighteen:

All out-of-hours providers should re-examine the way in which they use their staff, exploring in particular whether their current procedures allow nurses to make full use of their many skills and competencies, with a view to developing a new way of working in which the resources of *all* the staff who work in the out-of-hours team are used to their fullest advantage.

10: The Supply of Medicines

Access to appropriate medicines out-of-hours has always been problematic and, after consulting widely, the Review Team is clear that the current situation is far from satisfactory. In essence the problem derives from the fact that patients with acute illness may need to start their medicine without delay and an initial supply needs to be provided either at the time of the consultation, or very soon thereafter.

Traditionally, GPs solved this problem by providing a small supply of that medicine from their own resources, leaving the patient with a prescription for the remaining course of treatment. But because there has been no agreed method for identifying and supplying these medicines, there have been marked variations in the range that each individual GP has carried. Indeed, in some cases GPs have had recourse to 'free' starter packs provided by pharmaceutical companies, creating a situation in which new or more expensive drugs may have been prescribed where, in normal circumstances, the GP would have prescribed a cheaper or more well-established product. A number of organised providers have attempted to solve this problem by identifying a standard formulary for out-of-hours drugs, but overall the pattern of supply remains patchy and inconsistent. Moreover, whatever the particular local arrangements, there are also occasions when the patient needs a drug that the GP does not carry, and complex and time-consuming procedures (often involving the police as well as a pharmacist) have to be followed to supply that medicine.

In sum, the present position is confused, complex and inconsistent and, in line with the Review's determination to ensure that patients across the country have access to the same high quality of provision, a new approach to out-of-hours medicine supply is long overdue. The starting point lies in the recognition that the majority of patients who need medicines urgently are already being seen in a Primary Care Centre and thus, from the patient's point of view, it would be incomparably better if the full course of their medicine could be dispensed in the Centre, thereby obviating the need for a further trip to a community pharmacist the next day. Indeed, some out-of-hours providers, working in partnership with a local community pharmacist, have attempted to develop just such a service, only to be told that the current regulations prohibit this.

While changing those regulations is one of the steps that will have to be taken to implement a 'one stop' approach, it will be just as important to develop an appropriate formulary for out-of-hours medicines, ensuring that the new providers carry a sufficiently wide range of drugs to meet the vast majority of out-of-hours needs (including the particular needs of terminally ill patients). For if that work is done successfully, then the number of occasions when it will be necessary to access additional medicines from a community pharmacy out-of-hours can be

substantially reduced. That said, such occasions will, of necessity, occasionally arise, and the PCT/G and the Health Authority will need to develop a proper strategy to ensure that all out-of-hours providers have quick and easy access to the on-call pharmacist.

Recommendation Nineteen:

Other than in exceptional circumstances, patients should be able to receive the medication they need at the same time and in the same place as the out-of-hours consultation.

Recommendation Twenty:

The existing remuneration and contractual arrangements for out-of-hours providers and pharmaceutical services should be reviewed and, where appropriate, modified to allow for the provision of all appropriate medicines in the manner set out in Recommendation Nineteen.

11: Timescale for Implementation

All the work that has been done thus far suggests that the new model of integrated out-of-hours provision set out in this paper can be achieved within a reasonable timescale, and none of the visits that the Review Team has made to existing providers has revealed any unforeseen obstacles that might stand in the way of achieving that objective. That said, there are marked differences between different providers' ability quickly to meet all the Quality Standards set out in Section Five of this Report: some providers could meet all those standards tomorrow, while very many more will need to complete a properly planned programme of development before they would be in a position to do this.

Recruiting appropriate high quality staff is one aspect of implementation that could pose problems, and we have already drawn attention to the fact that some providers are already experiencing difficulties in recruiting appropriate medical staff for their services. Real as such difficulties are, the experience of those providers who have solved this problem suggests that a more imaginative approach to the balance of professionals engaged in the provision of out-of-hours services can in fact provide the answer. An out-of-hours service that was wholly dependent on doctors to provide its clinical services (whether on the telephone or face-to-face) will almost certainly find it more and more difficult to solve this problem; a service that employs an appropriate mix of nurses and doctors will, in almost all circumstances, be able to recruit sufficient appropriate staff to provide the high quality proposed in this Report.

Taking all this into account, the Review concludes that out-of-hours providers can start to report on the Quality Standards from April 2001. Different providers will face different challenges in meeting those Standards and, while it is important that all the necessary changes should be implemented as quickly as possible, particular priority must be given to implementing those Standards which ensure the clinical safety of the service.

Recommendation Twenty-One:

Out-of-hours providers should start to report on the Quality Standards set out in this Report from April 2001.

It will clearly take longer to achieve the full model of integrated service provision set out in this Report. Out-of-hours providers will need to be accredited, PCT/Gs will need to plan the provision of services in their area, and those providers with no experience of an integrated service

will need time to learn from the experience of those who have already pioneered such services. That said, the Review is confident that the fully integrated model can be in place by 2004.

Recommendation Twenty-Two:

The fully integrated model of out-of-hours provision set out in this Report should be achieved by all GPs and out-of-hours providers by 2004.

Annex One: Terms of Reference for the Review

1. The Minister for Health, Mr John Denham, has requested a review of all arrangements of GP out of hours cover across England. The aim of the review is to identify ways of bringing standards of all out of hours (OOH) services up to the standard of the best, and make recommendations to him on any priority actions to improve services.

OBJECTIVE

2. The Review will:
 - consider all arrangements for out of hours provision including GP Co-operatives (co-ops), commercial services and practice rotas;
 - examine the approach that each adopts to quality assurance, training, the availability and use of clinical and non-clinical personnel and the use of different models of skill-mix, organisation, protocols, record keeping and quality assurance;
 - examine the role played by HAs in monitoring the quality of the OOH Development Fund;
 - ascertain their accessibility and responsiveness, consistency of response and treatment, geography, equity in resource distribution, efficiency and value for money;
 - identify the potential for developing integrated services with NHS Direct (including Walk-in Centres and Social Services) and recommend organisational models and practice including quality standards and their enforcement, that might address current and future patient needs;
 - examine whether we are getting best value for money from the existing spend on the OOH Development Fund, and whether it is best targeted.

METHOD/APPROACH TO REVIEW

3. It will be conducted by a small review team led by Dr David Carson. An external reference group comprising of key stakeholders will meet at regular intervals.
4. The key areas of work will be -
 - a. Identification of best practice in existing service (co-ops, deputising, rotas, small rural practices).

- b. Review of evidence relating to out of hours care to ensure recommendations have an evidence base.
 - c. Exploration of existing NHS Direct relationships with Primary Care and identify best reproducible practice.
 - d. Medicine supply arrangements.
 - e. Identify existing cost base and resource utilisation within co-ops, deputising and rotas.
 - f. Develop explicit standards in relation to:
 - i. Access
 - ii. Service & Organisational Models (including links to NHS Direct)
 - iii. Clinical Governance (including critical event analysis, audit, continuous quality monitoring.)
 - iv. Continuous Professional Development & Accreditation of staff
 - v. Outcomes.
 - g. Develop an outline accountability framework for the standards.
 - h. Develop recommendations in relation to financial framework to ensure incentives are aligned.
5. Each member of the team will lead and work on specific areas with support from DOH staff and academic network. Testing of identified recommendations will occur with the reference group throughout the review. Data to be gathered and later testing of recommendations via structured telephone interviews (with academic advice on structure/process). An early request for views and models will be made to a limited list of organisations. A key principle will be the involvement of non-professional people and organisations at all stages of the process.
6. A report, with recommendations, will be presented to MS(H) by **31st August 2000**.

ISSUES

7. Key issues will be -
- a. A flexible national model which can be implemented locally without compromising standards.
 - b. An accountability framework which is robust and transparent.
 - c. Professional acceptance of an integrated approach including NHS Direct.
 - d. Identifying possible recommendations for NHS Direct Model development to foster local working partnerships.
 - e. Professional acceptance of explicit governance process.

CONSTRAINTS

8. The following areas will fall outside the scope of the review –
- a. Services provided within “normal working hours”.
 - b. Out of Hours Dentistry.

LIST OF INTERVIEWEES

9. Interviewees will include the following:

- NAGPC
- GPC
- Deputising services
- Consumers Association
- NHS Direct (all types of existing models)
- GPs
- Rota
- Rural
- Inner city
- Health Authorities
- Providers identified by early research who have good models and also those with models that seem to be having difficulties.
- PCG
- PCT
- A&E Dept
- Existing OOH Pharmacy supplier
- Social Services.

Annex Two: Review of the Research Literature

Primary care research is considered to be an emerging discipline within the health sciences¹ and a relatively substantial UK literature concerning issues in out-of-hours general practice care has developed since the 1970s. Much of the literature has addressed patterns of demand and activity, and service organisation. Early studies tended to be descriptive, small scale (commonly focused on a single site) and drew on data collected over short time periods, but these studies were important in describing a picture of out-of-hours primary care, and in identifying questions for further research. Fewer studies have used comparative methods, or have addressed patient expectations, experience or satisfaction with out-of-hours care, and fewer still have measured health outcomes associated with different patterns of service delivery. A seminal review of the out-of-hours literature was published in 1994² and we have considered this together with publications over the last ten years in order to better understand the features of the current provision.

Method

A literature search of published material since January 1990 was undertaken in May 2000 using the on-line services Medline, Embase, EconLit, CINHALL, British Nursing Index and HMIC. The review aimed to address the question ‘what evidence is there of the effectiveness, safety and acceptability of different models of out-of-hours primary care?’ There are few randomised controlled trials in this area, and given the available timescale the review was not designed as a ‘systematic review’.³ Thesaurus and free text search terms used included: *family practice, out-of-hours care, out-of-hours primary care, 24-hour primary care, after surgery hours, demand for out-of-hours care, GP co-operatives, deputising services, night visits, home visits, call handling, telephone triage, out-of-hours triage, telephone advice, telephone consultation, inappropriate calls* and *rural general practice*. On-line searching was supplemented by manual searching of recent journals and grey literature. All texts identified by on-line search were obtained except where it was clear from the title or abstract that they were unsuitable. Texts were selected for review if they were published between January 1990 and May 2000 in a peer reviewed journal; were written in English; and reported primary research, or primary analysis of routinely available data. An overview of the themes in the literature is summarised below, followed by a synopsis of key papers.

Need and demand for out-of-hours care

The collection of routine activity data by GPs about their out-of-hours work has enabled a number of studies to describe patterns of demand.⁴⁻¹¹ Current estimates suggest that on average, a registered population of 1,000 patients will generate approximately 160 out-of-hours calls per annum⁷ though it should be noted these estimates are normally based on the number of

calls received by service providers and do not take account of abandoned calls. In any year, out-of-hours contacts are likely to be made by approximately 10% of the registered population¹² and, although the majority of callers will make only one contact, some patients need to use the service more frequently.¹³ Patterns of demand can be predicted with reference to the literature, with peaks occurring during early evenings, and high demand on Saturdays and Sundays during the day and the evening. Demand on Sunday mornings typically exceeds that at any other time in the week. High levels of demand are also observed on public holidays, though these time periods are often excluded in analyses of demand as they are atypical. There is some evidence that during the peak millennium period, extended opening of general practice surgeries on public holidays contributed to the overall approach to managing demand.¹⁴ The proportions of patients receiving telephone advice, attending a Primary Care Centre or receiving a home visit vary between providers¹⁵⁻²⁰ though rates of home visiting have shown the most marked variation.

The proportions of calls concerning children under four years and people over 75 years of age are generally greater than their numbers in the population would suggest.^{7,12} Women tend to make more contact with out-of-hours services than men,²⁸ with approximately a third of all callers calling about themselves, with the remaining two-thirds calling on behalf of another adult or about the care of a child. Determinants of demand are not entirely understood, but it appears that variation in the need for out-of-hours care is largely explained by deprivation (typically associated with strong demand) and age-related vulnerability.^{7,9,21-23} Patient expectations about the role of out-of-hours services may also exert some influence on demand and, where the public do not have good access to information about how out-of-hours care is organised, attendance at an Accident and Emergency Department, for example, becomes a reasonable option. Assessment of urgency by General Practitioners varies^{24,49} and estimates suggest that between 20% and 40% of out-of-hours attendances at Accident and Emergency Departments are for primary care health problems.²⁵⁻²⁸ Broad consensus around the most common health concerns prompting out-of-hours calls has emerged^{24,48} but in a qualitative study of patients' accounts of calling the doctor out-of-hours, the presence of symptoms was not the only factor to determine a call; other factors, including past experiences of using health services, were important.²⁹

The organisation of out-of-hours care

General Practitioners appeared to experience increasing strain as the demand for out-of-hours care rose dramatically in the 1980s and 1990s.^{2, 30-32} Views on the organisation of out-of-hours care at this time revealed an eagerness to consider new approaches to organising services, even though there was little evidence of the comparative effectiveness of different models.³⁰ Such comparisons remain few in number today, but what data there are highlight differences in response times, prescribing rates and patient satisfaction between providers.^{8,18,19} A survey of the standards set by Family Health Service Authorities for deputising services in 1994³³ and a survey to assess the organisation of out-of-hours primary care services¹⁷ revealed wide variation in demand and types of provision. Accurate, contemporary data on the number and characteristics of organised providers of out-of-hours care in England are not routinely collected.

Nurse telephone triage and consultation have been introduced by a small number of providers of out-of-hours primary care. The literature on the safety and effectiveness of telephone triage and consultation is limited, though when supported by clinical decision support software, nurse

triage (tested in a randomised controlled trial in the environment of a GP Co-operative) has been shown to be at least as safe and effective as usual care.^{12,34} Nurses typically manage 50% of out-of-hours calls without referral to a GP, and enable patients with urgent needs to be prioritised. In contrast, there is no published evidence of the safety or effectiveness of receptionist or call handler triage. Incomplete assessment and early closure of a call before an informed decision can be made have been identified as factors contributing to 'poor' telephone consultation amongst a range of health professionals.³⁵ The extent to which levels of experience and relevant training influence competence on the telephone is not clear, though one study found that nurses with at least ten years clinical experience made more consistent decisions than did nurses with less experience.³⁶

Expectations, experience and satisfaction with out-of-hours care

The validity of the notion 'satisfaction', as a single concept, and the merits and limitations of alternative approaches to measuring it have been discussed in the wider literature.³⁷⁻⁴⁰ Reports of patient and caller satisfaction with out-of-hours care have shown the high levels of satisfaction typical of many studies of health care interventions, but few have identified specific sources of satisfaction or dissatisfaction.^{16, 41, 42} One validated out-of-hours satisfaction questionnaire⁴² has been used in a range of settings, but there is a tendency for evaluators to design their own instruments, or modify existing ones without proper tests of validity and reliability. Recent evidence suggests that patients may be less satisfied with the way in which their care was managed out-of-hours (at a Centre, or over the telephone for example) where this was at odds with their prior expectations.¹⁶ Further work is needed to determine patient preferences for different models of out-of-hours care and to assess the responsiveness of out-of-hours services to patients with special needs. People whose first language is not English may be unaware of the existence of out-of-hours services, may experience difficulties communicating with health professionals and may experience delays in gaining access to health care,⁴³ and the reporting of community oriented approaches to service development is welcome in this context.⁴⁴

Health outcomes, costs and subsequent use of health services

Little is known about the relationship between the organisation and delivery of out-of-hours care and health outcomes for individual patients. It remains important to understand how patterns of service provision affect the quality and outcomes of care, but study design in this area is difficult, not least because service providers do not use a common method of coding and recording data concerning presenting complaint, provisional diagnosis and call outcome. Out-of-hours providers can be expected to have data concerning the call disposition, but arguably, the episode of care extends beyond this. Measurement of health outcomes involves follow up of patients and the co-operation of other agencies. For example, health outcome was measured using the SF36 questionnaire in a comparison of care provided by different out-of-hours providers,¹⁹ and a study of nurse telephone consultation found no increase in the number of patients seeking daytime surgery appointments within three days.⁴⁵ Typically, 5% of patients re-

ceiving out-of-hours care are admitted to hospital as an emergency,^{7,9,12} but little is known about the timeliness and appropriateness of care leading to out-of-hours admission. A cost analysis from an NHS perspective of nurse telephone consultation based on data from a randomised controlled trial in one General Practice (GP) Co-operative, showed that reduced emergency admissions to hospital determined a reduction in costs for the NHS.⁴⁶

Several economic analyses and economic evaluations of out-of-hours primary care are currently in progress in the UK. The published literature is currently limited, and evidence relates mainly to GP Co-operatives. The extent of financial support received and predicted to be needed for GP Co-operatives was assessed in a questionnaire survey.⁴⁷ Detailed case studies of seven co-operatives as part of the National Health Technology Assessment Programme reported up to an eightfold variation in overall operating costs of Co-operatives¹⁶ and the incremental costs of providing a county-wide GP Co-operative service have been reported.⁴⁸ Without evidence of effectiveness however, comparisons on the basis of cost alone are misleading.

Discussion

Recent work on the demand for and supply of out-of-hours care in populations covered by GP Co-operatives has provided a useful baseline against which the impact of further development and previous activity can be assessed.⁷ Indeed, if out-of-hours call rates for the period 1987-1989² (130 to 176 per 1,000 patients per annum) are compared with recent estimates⁷ (159 per 1,000 patients per annum) it is difficult to argue for a continued rise in demand for out-of-hours primary care. However, though much research has centred on out-of-hours care organised in Co-operatives, and occasionally in deputising services, it may be misleading to assume that the picture is similar across the country. Levels of demand may be similar (accepting the important impact of deprivation on demand), but processes and outcomes of care for the patients of General Practitioners operating practice rotas or providing their own out-of-hours care are not well reflected in the literature.

A previous review of the literature² noted a lack of data on costs and a paucity of evaluative studies comparing different models of care. It appears that some progress has been made, and two major trials of out-of-hours primary care have been reported since 1994. Economic evaluation remains underdeveloped, however, and more detailed cost analyses are needed to account for the early evidence of wide variation in the overall costs of out-of-hours care provision. Evaluations of different service models and the care pathways they create are required in order to build an evidence base which can inform clinical practice in the out-of-hours setting. In particular, there is an urgent need for studies that venture beyond the measurement of routine variables, and relatively crude outcome measures such as hospital admission and death. This will only be possible as more appropriate outcome measures for primary care, including intermediate outcome measures, are validated.

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Synopsis of key studies

Author/date [ref. no.]	Method	Process / outcome measures and results
Salisbury <i>et al</i> 2000 [7]	Observational study of demand for and supply of out-of-hours care from GPs in England and Scotland using a representative sample of 20 co-operatives, their routine data and interviews with managers.	Numbers and distribution of calls adjusted for population, patient age & sex; proportions of patients consulting by telephone, at home, at primary care centre; response times; hospital admission rates. Call rate excluding Bank Holidays was 159 per 1,000 patients per year with little seasonal or within week variation. Calls concerning children < 5 years outnumbered those concerning adults by 4:1. Patients living in deprived areas made 70% more calls than patients living in non deprived areas. 45% calls were managed by telephone advice, 24% by home visit, and 30% by attendance at a centre. 60% calls were responded to within 30 minutes, 83% within 1 hour. 5.5% patients were admitted to hospital.
Lattimer <i>et al</i> 2000 [46]	Cost analysis from an NHS perspective of nurse telephone consultation based on data from randomised controlled trial.	Costs and savings to the NHS during the trial year. Additional cost of providing nurse telephone consultation for a population of 97,000 was £81,237 per annum. This determined a £94 422 reduction of other costs for the NHS arising from reduced emergency admissions to hospital. In comparison with usual care, patients managed by nurse telephone consultation were less likely to be admitted to hospital, and less likely to have short (1-3) day stays. Additional savings for general practice arose from reduced travel to home visits and fewer surgery appointments within three days of a call.
Free <i>et al</i> , 1999 [43]	Qualitative study of the experiences and perceptions of members of Vietnamese community groups in seeking out-of-hours health care.	In six focus groups conducted in Cantonese and Vietnamese, participants revealed that they did not know about GP out-of-hours arrangements. Key problems were in communicating with health professionals, their answering or interpreting services. Some had needed to use the 999 service. Commonly, participants had experienced delays in gaining access to health care and confusion concerning advice and medication.
Vedsted and Oleson, 1999. [13]	Four year follow up study (1990-1994) of frequent attenders to an out of general practice in Aarhus, Denmark using data from the Public Health Insurance database.	Adults having four or more out-of-hours contacts in a calendar year (10% all attenders) were defined as frequent attenders. Attendance was measured over a four year period. Age above 50 years significantly predicted future frequent attendance. This group generated 42% of contacts in 1990 and 33% in 1991. 25% contacted at least once in the following years.
Shipman and Dale, 1999 [24]	Audit of all out-of-hours contacts to 25 practices during 4 months in 1995-6. GP assessment of the urgency of each call.	Assessment of urgency and type of service received. 1027 of 1862 contacts (67%) were rated as having a physical, psychological or social need for urgent help. 55% visits were retrospectively rated medically necessary, of these most were for physical problems. 60.7% home visits, 36.9% telephone consultation, 2.4% surgery attendance.
O'Donnell <i>et al</i> , 1999 [20]	Cross sectional study of patient contacts with GEMS over one week in 1996 to investigate social variation in use of an out-of-hours patient transport service.	Time of first contact; patient age; socio demographic category derived from postcode; numbers attending centre and using free transport, receiving home visits or telephone advice. Of 3193 contacts, 54% attended centres, 23% received home visits 14% received telephone advice and an ambulance was sent to 2%. Contact rate equivalent to 158 contacts per 1,000 per annum. Significant interactions were observed between socio-economic category and age group (60% higher contact rates for children and adults from deprived areas). Elderly people in affluent areas had 38% higher use than those in deprived areas. Adults and elderly people from deprived areas most likely to receive a home visit. Lack of association between socio demographic category and centre attendance attributed to provision of transport.

Author/date [ref. no.]	Method	Process / outcome measures and results
Thompson <i>et al</i> , 1999 [45]	Randomised controlled trial of the management of overnight calls using nurse telephone consultation. (Parallel trial with Lattimer <i>et al</i> , 1998).	As for main trial plus number of patients attending daytime surgery within three days of a call. 59% calls were managed by the nurse alone. Reductions observed in the proportions of calls managed by GP telephone advice, and ending in a home visit. Nurse managed as high a proportion of calls at night as during evenings and weekends, without more patients attending daytime surgery.
Lattimer, <i>et al</i> , 1998 [12]	Randomised controlled trial (blocked design) of nurse telephone consultation in a GP Co-operative compared with usual care, in a population of 97,000. Study powered to determine equivalence in the incidence of potential adverse events.	Death within 7 days of contact with the service, emergency hospital admission within 24 hours and within 3 days; attendance at A&E within 3 days; number and management of calls. Nurses managed 49.8% of calls during intervention periods, without referral to a GP. Fewer deaths and emergency admissions in the intervention arm were within limits defined for equivalence. Equivalence also observed in the number of A&E attendances.
Brogan <i>et al</i> , 1998 [48]	Prospective cross sectional survey and cost description of patient contacts with out main of hours services over 2 months to determine use and incremental costs of out-of-hours services in Buckinghamshire.	Contacts with patients and cost of out-of-hours services (general practices, accident and emergency departments, ambulance services and community nursing services). In general practice, call rate per annum was equivalent to 197 per 1,000 patients. 35% calls were managed by home visit, 37% by surgery attendance and 28% by telephone advice. 51% contacts occurred between 7-10 pm. GPs rated 5% contacts as urgent, 55% as necessary, 26% as could have waited until the next day and 14% as unnecessary. Upper respiratory tract infection, diarrhoea and vomiting, ear infections, chest infections, abdominal pain were amongst the most common patient problems. Estimated costs of providing GP Co-operative care across the county were equivalent to £5190 / 1,000 population per annum.
Carlisle <i>et al</i> , 1998 [22]	Six month study of the out-of-hours activity of 6 general practices and the A&E department in Nottingham to determine relationship of activity to deprivation and distance from A&E	Contact rates for GP and accident and emergency services calculated by electoral ward; Jarman and Townsend deprivation scores and distance of electoral wards from A&E department. Wide variations between electoral wards in both general practice and accident and emergency events were observed. Deprivation scores explained more than half of the variation, out-of-hours activity was highest in deprived inner city areas. Highly deprived areas close to A&E generated high levels of activity for general practice and A&E services, with no evidence of substitution between services. The Jarman score explained 46% of the variation in the GP contact rates and 43% of the variation in A&E contact rates.
Christensen and Oleson, 1998. [4]	Before and after comparison 5 years after of the 1992 reform of out-of-hours general practice in Denmark in which GP telephone triage was introduced.	Number of out-of-hours services; GP workload, service costs; patient satisfaction. Proportion of calls managed by telephone consultation almost doubled, to 48%. Surgery consultations were largely unchanged, but home visits were greatly reduced (18%). Fewer doctors (50% versus 70%) were working more than 5 hours per week. Overall patient satisfaction in 1995 was high (72%).
Cragg <i>et al</i> 1997 [18]	Randomised controlled trial. Comparison of care provided by practice doctors and doctors from deputising services. Care provided to 2152 patients. Survey response rate 71%.	Health status (assessed using Anglicised SF36 questionnaire plus interviewer version), patient satisfaction, subsequent health service use. No differences were observed in change in health, overall health status or subsequent use of health services. Patients seen by deputising services were less satisfied with the care they received. Process measures: response to call, time to visit, prescribing, hospital admissions. Practice doctors more likely to give telephone advice and to visit more quickly than deputising doctors. Less likely to prescribe, were more likely to prescribe generic drugs, and less likely to prescribe antibiotics. Organisation of doctors in large groupings may reduce patient satisfaction.

Author/date [ref. no.]	Method	Process / outcome measures and results
Salisbury, 1997 [8]	Observational study of two out-of-hours services in London, a GP Co-operative and a deputising service. Care provided to 5812 patients (3920 calls to the co-operative and 1892 calls to the deputising service), all those calling during an eight week period.	Rates of home visiting, telephone advice and attendance at a primary centre; hospital admission rates, prescribing rates and response times. Deputising doctors visited 76% patients and gave telephone advice to 19%. In contrast co-operative doctors visited 32% patients and gave telephone advice to 58%. Higher admission rates for GP Co-operative patients are attributed to the observation co-op GPs were more likely to admit patients who were visited. Response times, median time to visit 65-75 minutes.
Salisbury 1997 [41]	Postal questionnaire survey of patients receiving care from a GP Co-operative and from a deputising service (n=2312).	Overall and specific satisfaction with out-of-hours care. Overall satisfaction was similar. Patients having contact with deputising services were less satisfied with the explanation and advice they received and with waiting times for visits. Patients over 60 yrs were more satisfied and differences in satisfaction between age and ethnic groups were observed.
Shipman <i>et al</i> , 1997 [28]	Audit of out-of-hours services in 21 London practices and 2 local A&E departments, interviews with 82 patients who attended A&E.	Differential use of services, time of contact, age profile of patients and nature of presenting complaints. A&E and general medical services were used differently. Musculo-skeletal problems constituted largest group of complaints for A&E attenders. More families with children under 10 years contacted a GP, with respiratory, digestive and viral or non-specific problems being prevalent. Women more likely to contact a GP and men to attend A&E. Perceived access, quality and availability of service important when choosing a provider.
McKinley <i>et al</i> , 1997 [42]	Development and testing of a questionnaire to measure patient satisfaction with out-of-hours medical care.	Validity (content) and reliability (internal test-retest) of a 32 item questionnaire. Levels of reliability were satisfactory across 7 scales (Likert 5 point): satisfaction with communication and management, doctors' attitude, continuity of care, delay until visit, access to out-of-hours care, initial contact person, telephone advice.
Lattimer <i>et al</i> , 1997[34]	Pilot study of nurse telephone triage in out-of-hours primary care to test feasibility.	Triage outcome and pattern of referral, caller satisfaction. 38% calls were managed by the nurse alone. 39% calls concerned children. 87% callers were satisfied or highly satisfied with the service.
Jessop <i>et al</i> , 1997 [47]	Postal questionnaire survey of all 98 GP Co-operatives registered with the National Association. Response rate 68%.	Number of GPs in co-operative, extent of support received and predicted to be needed from out-of-hours development fund; provision of home visiting, telephone advice and consultation at base; employment of non-medical staff; mechanisms for monitoring and reporting quality; contact with Community Health Councils (CHCs); patient participation in co-op development. Respondents were 5476 GPs covering 11.4 million patients. Most co-operatives had been established since 1995, median value for members was 82. 91% organisations had received support from the out-of-hours development fund, average receipt £108,000 and would need further funding on average of £152,000 in the following year. Most employed non-medical managers and 28% employed nurses. Half had contact with CHCs, none had involved patients in service development.
Hopton <i>et al</i> , 1996. [29]	Qualitative study of patients' accounts (46) of calling the doctor out-of-hours, using semi-structured interviews.	Respondents described the problem in terms of symptoms Presence of symptoms was the main reason for calling, but other factors were important: feelings and concerns about specific illnesses; responsibility for others; previous attempts to manage the problem; past experiences of using health services, including 'past frights' in which illnesses had turned out to be more serious than expected, lack of confidence in or good experiences of health professionals.

Author/date [ref. no.]	Method	Process / outcome measures and results
Court <i>et al</i> , 1996. [49]	Questionnaire survey of 720 general practitioners to identify factors influencing decision to visit out-of-hours.	Appraisal of the likelihood of 13 factors identified by focus group influencing decision to visit. Five most important factors were the patient, or someone on their behalf saying that the situation was urgent, not wanting to miss an urgent condition, demand for a visit, patient said to be unfit to travel, wanting to avoid complaints.
Dale <i>et al</i> , 1996. [44]	Needs assessment using rapid appraisal methods of out-of-hours care in a multiethnic socially deprived inner city district of London.	Strengths and weaknesses of out-of-hours services and suggestions for improvement. Wide range of health, social and non-statutory services already available but dissatisfaction was widespread. Problems concerned access, availability, demand for services and inter-agency communication. Concurrence around areas for development included the need for an out-of-hours co-operative, primary care emergency centres and telephone triage and advice.
Lattimer <i>et al</i> , 1996 [30]	Questionnaire survey of general practitioners in two primary care research networks about their views on the future provision of out-of-hours care.	Intention to reduce or opt out of on call; plans for changing out-of-hours arrangements; most important changes needed to out-of-hours care; willingness to try and perceived strengths and limitations of primary care emergency centres, telephone triage services and co-operatives. 83% respondents willing to try at least one option, primary care emergency centres most popular. New alternatives would need to reduce time on call and workload and maintain continuity of care. 61% hoped to reduce time spent on call, 25% wished to opt out completely. GPs keen to try alternative arrangements despite lack of evidence of effectiveness.
Heaney and Gorman, 1996 [11]	Cross sectional study of calls to 8 general practices in Midlothian over 10 weeks, prior to the opening of a primary care emergency centre.	Numbers of calls, call disposition, numbers referred to A&E or for hospital admission. Estimated call rate was 265 per 1,000 patients per annum. 63% patients received a home visit (of these 18% attracted night visit fee), 8% were seen in surgery, 29% received telephone advice alone. 15% patients were referred to hospital. Doctors rated 61% calls as necessary, 29% as unnecessary and were unsure about the need for 9% calls.
Majeed <i>et al</i> , 1995 [5]	Ecological study of night visiting rates in general practice.	Variation in night visiting rates based on night visit fees claimed over 1 year in a London Family Health Services Authority. Annual night visiting rates varied from 3 per 1,000 to 75 per 1,000 patients. One third of the variation between practices could be explained by differences in % practice population under 5 yrs, % reporting chronic illness variables associated with social deprivation. No association found between visiting rates and % population aged 35-54 years, distance between surgery and nearest A&E.
Cragg <i>et al</i> , 1994 [15]	Cross sectional survey of all callers to a deputising service switchboard operating primary care centres in 5 areas of England. 1000 patients agreeing to attend and 1,000 patients not agreeing to attend were studied. Questionnaire for self completion administered to all attenders at the centres.	Demography, clinical details and social circumstances of all patients; satisfaction of those agreeing to attend a centre. Standardised attendance rate was 22.4%, most patients invited to attend were not able or not willing to do so. Factors affecting attendance included access to a car, perceived severity of illness affecting ability to attend, location of facility and distance to travel. Largest group of attenders were young children brought by parents. Satisfaction amongst attenders was high, most would attend again in similar circumstances. Short waiting times were highly valued.

Author/date [ref. no.]	Method	Process / outcome measures and results
Cragg and Hallam, 1994. [33]	Telephone survey investigation of the standards set by 81 FHSA's for deputising services.	Procedures for notification to use deputising services, procedures for monitoring use and compliance with 1984 guidelines on the use of deputising services. Most authorities required GPs to notify them of intention to use a deputising service but only 21 collected data on timing and extent of use. Arrangements for liaison between authorities and between authorities and deputising services varied greatly, as did the level of service monitoring. Response time was most frequently monitored quality standard, setting and monitoring of more comprehensive standards is recommended.
Hallam and Cragg, 1994 [17]	Telephone survey of 97 FHSA's to assess the use and organisation of out-of-hours services in primary care.	Rate of use of out-of-hours care, methods of provision, role of authorities. Mean number of night visits per unrestricted principal was 35.3 per 1,000. Higher rates observed in authorities covering large towns or cities. 81 authorities had at least one commercial deputising service. In almost half the authorities, 75% GPs had consent to use deputising, not all did.
Baker <i>et al</i> , 1994 [21]	Study of routine FHSA data to compare trends in night visiting before and after the 1990 contract for general practitioners.	Mean number of night visits; % GPs with consent to use deputising services; % night visits by deputies from 1987-1990 and for % change between years. FHSA's were clustered according to deprivation and population age profile. Effect of the new contract had been to increase visiting in FHSA's with high elderly populations and in the most affluent authorities. Reduced reliance on deputising services was observed.
Carlisle <i>et al</i> , 1993 [23]	Study of the impact of Jarman and Townsend deprivation scores and unemployment rates on night visiting in different electoral wards within one general practice	Night visit rate correlated with measures of deprivation. Annual night visit rate was 33 per 1,000 patients, but a 2.8 fold variation in visit rates was observed between electoral wards (19.6 – 55.3 per 1,000). Children under the age of 5yrs and adults over 64 yrs were more likely to receive a visit than their numbers in the population might suggest. Townsend score and unemployment rate were significantly associated with the night visiting rate.
Salisbury, 1993 [9]	Analysis of night visit claim forms for one FHSA in 1991-1992 to describe the time distribution of visits and to evaluate trends for the period 1982-1992.	Times of visits, proportion performed by deputies, trend in number of visits (adjusted for extended claimable hours in 1990 contract). Extended hours accounted for one third of the increase in visiting. Rates of visiting had doubled in over 10 years, with 31.5 night visits per 1,000 in 1992. Use of deputies had fallen by half since 1989. Results suggest long term rising demand.
McCarthy and Bollam, 1990 [6]	Comparative study of telephone advice in out-of-hours consultations in 13 general practices in north London during one month.	Numbers of calls, call management and disposition; relationship between call management and use of deputising services. Variation observed in the frequency of calls being managed by telephone advice (5-57%) and by home visit (20-65%). Practices with high use of telephone advice were less likely to use deputising services.
Pitts and Whitby, 1990 [10]	Analysis of out-of-hours workload in one general practice (list size 13,309) over a year based on a written log of contacts	Contact rate and night visit rate per 1,000. Percentage of calls managed by telephone advice or by home visit. Jarman scores indicated main residential areas were not deprived, yet contact rates were 273/1,000. Authors suggest that high visit rate more associated with demand for a 24 hour service than with social deprivation. 46% calls were managed by telephone advice, mean rate of admission to hospital was 4.9%. Doctors visiting rate varied from 41% to 78% calls received.

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Annex Four: A model Service Level Agreement

An example of a draft Service Level Agreement between one NHS Direct site and its local out-of-hours provider, in which the different roles and responsibilities of both parties to the agreement are clearly set out, is reproduced below. This is an example of a current Service Level Agreement which would have to be modified to meet the Quality Standards set out in this Report.

Introduction

This service level agreement recognises the co-operation and goodwill between NEMS and East Midlands NHS Direct; and recognises the best intentions of both parties to facilitate quality and responsive healthcare services for the population of the East Midlands. Both parties further agree to work together to develop ongoing improvements in the provision of care, to ensure that the population of East Midlands receive seamless, joined up health care, from the appropriately skilled person, at the appropriate time, in the appropriate place. The parties to this agreement recognise that responsibilities are to be met according to Health Service Circular 1999 / 235 Annex A, and summarised in Annex D (copy of which attached); dated 3rd November 1999. The service agreement addresses the following:

1. **Parties to the agreement**
2. **Definitions**
3. **Operations**
4. **Confidentiality**
5. **Call reception**
6. **NHS Direct responsiveness**
7. **NEMS responsiveness**
8. **Resilience**
9. **Quality of advice**
10. **Communications**
11. **Contacting primary care services**
12. **Complaints / audit**
13. **Peak load management**
14. **Publicity**
15. **Monitoring**
16. **Amendments to agreement**
17. **Signatories**

1. Parties to the agreement

This agreement is made between NHS Direct (East Midlands) – Nottingham Community Health Trust (hereinafter referred to as "NHS Direct") and Nottingham Emergency Medical Service (hereinafter referred to as "NEMS").

2. Definitions

- 2.1 In this agreement, the following expressions shall have the following meanings: -
- 2.2 "NHS Direct" shall mean NHS Direct (East Midlands) – hosted by Nottingham Community Health Trust
- 2.3 The "Health Information Service" linked with NHS Direct and providing service to NEMS patients will be included within all the references to "NHS Direct".
- 2.4 "Agreement Manager" shall mean NHS Direct's nominated Manager for this Agreement.
- 2.5 "NEMS" shall mean Nottingham Emergency Medical Service.
- 2.6 "Authorised Officer" shall mean the Officer empowered by NEMS to act as Control Officer for this Agreement.
- 2.7 "Agreement Standard" shall mean such a standard as complies in each and every aspect with all relevant provisions of this Agreement.
- 2.8 "The Services" shall mean providing call handling and nurse triage support for all "Out of Hours" calls received from patients of NEMS practices.
- 2.9 Reference to time shall be construed during the period of summer -time to be British Summer Time and otherwise Greenwich Mean Time.
- 2.10 Patient summary file shall mean the data set as agreed between NEMS and NHS Direct.

3. Operations

- 3.1 NHS Direct shall provide the services from its Call Centre at Victoria Health Centre and Inham Nook, Nottingham or any other location agreed between the parties.
- 3.2 The Call Centre will be appropriately equipped to enable service provision.
- 3.3 NHS Direct shall permit access into the NHS Direct premises for any person authorised by NEMS for the purpose of inspection without prior notice at any reasonable time. Access is to be sought via the on call NHS Direct manager.
- 3.4 All decisions relating to any aspect of NHS Direct operations which may effect NEMS must be discussed with the NEMS Management or Board at the time or prior to any alteration to the service, staffing organisation or procedures, except where that alteration is in line with previously agreed contingency or escalation procedures.
- 3.5 All decisions relating to any aspect of NEMS operations which may affect NHS Direct must be discussed with the NHS Direct Management or Board at the time or prior to any alteration to the service, staffing organisation or procedures, except where that alteration is in line with previously agreed contingency or escalation procedures.
- 3.6 Minutes of joint meetings and decisions made will be recorded and circulated to the NHS Direct and NEMS Boards.

4. Confidentiality

NHS Direct staff shall regard all information, including patient information, relating to NEMS patients, staff, systems and operations as confidential. Information should only be released to third parties with the express approval of an NEMS approved officer under established procedures e.g. complaints procedure.

5. Call Reception

To ensure that out of hours calls can be identified NEMS will ensure that patient calling the out of hours service will have their calls transferred by an automatic call divert facility to a dedicated telephone number agreed with NHS Direct.

6. NHS Direct Responsiveness

6.1 Time in which the phone will be answered

- 6.1.1 NHS Direct will ensure that telephone calls from patients "Out of Hours" will be answered in line with the quality standards identified in the monitoring reports required of NHS Direct management.
- 6.1.2 NHS Direct will ensure that 90% of all telephone calls from patients "Out of Hours" will be answered within 30 seconds.
- 6.1.3 NHS Direct will ensure that all telephone calls from patients "Out of Hours" will be answered within 90 seconds.

6.2 *Time to speak to a nurse (if required)*

- 6.2.1 NHS Direct will ensure that 90% of calls requiring "Nurse Triage" will be commenced within 5 minutes of the call being received.
- 6.2.2 NHS Direct will ensure that all calls requiring "Nurse Triage" will be commenced within 15 minutes of the call being received.
- 6.2.3 NHS Direct will ensure that nurse triage of "all urgent calls" will be commenced within 5 minutes.

6.3 *Time to speak to an interpreter (if required)*

- 6.3.1 NHS Direct will ensure that 90% of calls requiring an interpreter will be commenced within 15 minutes of the call being received.
- 6.3.2 NHS Direct will ensure that all calls requiring an interpreter will be undertaken within 30 minutes of the call being received.

6.4 *Abandoned calls*

- 6.4.1 In the operation of the integrated NHS Direct-NEMS service an abandoned call will be defined as a call that is abandoned after 30 seconds.
- 6.4.2 The level of abandoned calls shall be no more than 3-5% of all calls received.
- 6.4.3 The method of recording will be based on hourly volumes of calls received with a procedure in place to establish and report the percentage of calls abandoned.

7. NEMS Responsiveness

- 7.1 NEMS is required by East Midlands NHS Direct to have satisfactory quality standards in place that govern the speed of response of its GP services.

7.2 Doctor Advice

90 % of doctor-patients telephone consultations will commence within 30 minutes of the time of receipt of the indication of a doctor advice outcome at the NEMS operations centre.

100 % of doctor-patients telephone consultations will commence within 45 minutes of the time of receipt of the indication of a doctor advice outcome at the NEMS operations centre.

Where there is likelihood that the standards above will not be achieved the patient will be informed, the reason explained and the likely delay estimated.

7.3 PCC Attendance

90 % of patients' consultations will commence within 30 minutes of the time of arrival at the PCC.

100% of patients' consultations will commence within 45 minutes of the time of arrival at the PCC.

Where there is likelihood that the standards above will not be achieved the patient will be informed, the reason explained and the likely delay estimated.

7.4 Home Visits

75 % of home visits will commence within 1 hour minutes of the time of receipt of the indication of a home visit outcome at the NEMS operations centre.

100 % of home visits will commence within 3 hours minutes of the time of receipt of the indication of a home visit outcome at the NEMS operations centre.

Where there is likelihood that the standards above will not be achieved the patient will be telephoned, the reason explained and the likely delay estimated.

8. Resilience

8.1 *standing arrangements for service resilience*

- 8.1.1 East Midlands NHS Direct will provide a continuous information, advice and onward referral service to members of the public 24 hours a day, every day of the year.

- 8.1.2 The integrated nurse triage service will be available 7 days a week according to the schedule below, or at any other times agreed between NEMS and the Director of East Midlands NHS Direct:

Monday to Friday	1830 hours to 0830 hours the following day
Thursday	1200 hours to 0830 hours the following day
Saturday	1200 hours to 0830 hours the following day
Sunday	0830 hours to 0830 hours the following day
Bank Holidays	0830 hours to 0830 hours the following day

8.1.3 'Immediate Care' Outcome

Where a call is assessed by a call handler (according to protocol) or a nurse advisor to require an immediate care response, the call handler or nurse advisor will make arrangements for a 999-ambulance response and the caller informed.

8.1.4 'Speak to Provider' Outcome

- A) A call will be assessed by the Nurse Advisor and electronically passed to NEMS if speak to provider outcome is reached.
- B) The TAS assessment will be closed when the patient summary file is retrieved by the Adatastra Software system.
- C) In the event of electronic delivery failure, the patient summary report will be faxed to NEMS on the appropriate fax number or delivered via an appropriate manual system if fax inoperative.

8.1.5 'Urgent GP Care' Outcome

- A) Call will be assessed by the Nurse Advisor.
- B) The Nurse Advisor will negotiate where the individual caller needs to be seen according to address, location and NEMS visiting criteria (*Appendix 1*) i.e. Home visit or patient to visit Primary Care Centre (with or without patient transport, according to agreed criteria, *Appendix 2*) or telephone advice from a doctor.
- C) The TAS assessment will be closed when the patient summary file is retrieved by the Adatastra Software system.
- D) In the event of electronic delivery failure, the patient summary report will be faxed to NEMS on the appropriate fax number or delivered via an appropriate manual system if fax inoperative.

8.1.6 NEMS duty doctors will not ordinarily change the call outcome disposition and will not do so without informing the nurse advisor who has consulted the reference patient, or the team leader if the nurse advisor is not available.

8.1.7 Any calls received from patients who disagree with the outcome or recommendations or who insist on speaking to a Doctor or who cannot locate their nearest Primary Care Centre, will be passed to NEMS for onward transmission to the appropriate Primary Care Centre for GP resolution.

8.2 service arrangements with telecoms and IT suppliers.

8.2.1 NHS Direct will utilise the appropriate systems in the provision of the service. Details of the equipment specification and associated maintenance agreements are to be available to NEMS. The Clinical Decision Support Systems operated will be the TAS system unless or until another system is defined by the National Procurement Process specification for decision support systems.

8.2.2 East Midlands NHS Direct will maintain rapid response contracts with all its suppliers of operation-critical software and hardware.

8.2.3 East Midlands NHS Direct will operate extremely resilient and constantly tested IT systems. These will include diverse telecom routing with two independent service providers; both analogue and digital services; generator back up with uninterruptible power supply (UPS); dedicated UPS for individual file servers and PCs; two duplicated and geographically separate communications rooms; two duplicated and mirrored file servers.

8.2.4 All IT systems will be subject to a rigorous back up regime.

8.2.5 All IT systems will be subject to rigorous security protocols, according to NHS and industry best practice.

8.2.6 NHS Direct shall not transfer or assign any part thereof and shall not subcontract any part of the provision of the services without prior consultation.

8.3 for urgent attention in the event of service failure

8.3.1 In the event of total failure of the information technology and or clinical decision support system, calls would be dealt with as described in the Nurse Training Module for emergency procedures (*Appendix 3*).

8.3.2 Subject to appropriate IT and training development, calls may be directed to NHS Direct in TAS or other linked site. This would occur following an agreed procedure between NHS Direct and NEMS.

8.4 arrangements for transferring calls to another NHS Direct provider

8.4.1 Notwithstanding the above, in the event of a total or partial failure of systems on site, East Midlands NHS Direct will transfer all or part of its workload on to all or some of its partner NHS Direct sites elsewhere in

the country. This transfer will be actioned within 5 minutes of a failure. This transfer will be regularly tested. Undifferentiated patient contacts from the integrated NEMS-NHS Direct service will be the last group of calls to be transferred, and then only after discussion with the NEMS on call manager.

8.4.2 Key to such a procedure would be assurances that partner NHS Direct sites or any other provider could adhere to 7.1, 7.2, 7.3 and a similar signed Service Level Agreement.

8.4.3 All partner NHS Direct sites will be copied with this SLA together with the contact details that will allow for the continual transfer of referrals through to NEMS. These referrals in instances of total site failure may be routed via an East Midlands NHS Direct remote site to maintain the specificity of local arrangements.

9. Quality of advice

9.1 details of staff qualifications

9.1.1 East Midlands NHS Direct will employ fully qualified and trained staff to provide its services. Its nurses all have 4 years of post-registration experience.

9.1.2 NHS Direct shall employ sufficient staff to ensure that the services are provided at the agreed times and in all respects of the Service Level Agreement standard.

9.1.3 NHS Direct Staff will be required to adhere to the agreed standards of NHS Direct.

9.1.4 NHS Direct shall ensure that every person employed in and about the provision of the services is at all times properly and sufficiently trained and instructed with regards to:

- The task or tasks that person has to perform
- The time scales and urgency to which they have to perform
- Adherence to all relevant provisions of the Service Level Agreement
- All relevant procedures and governance standards as may be agreed by NEMS
- The need for those working in the National Health Service to observe the highest standards of courtesy and consideration.

9.1.5 A Continuous Quality Improvement Programme will be implemented by NHS Direct.

9.2 details of decision support systems used

9.2.1 The East Midlands NHS Direct centre will use only an approved clinical support system as described in the national specification.

9.2.2 East Midlands NHS Direct will use the TAS decision support software supplied by Plain Software unless or until another system is defined by the National Procurement Process specification for decision support systems. This is subject to both local and national quality assurance and audit, with sitting panels of eminent professionals monitoring the assessments and protocols used, and developing them in line with latest evidence.

9.3 details of training

9.3.1 NHS Direct will have an accredited training system in place which will ensure a high quality of service delivery. (*Appendix 4*)

9.3.2 Training is given to all nurses and health information advisors, and assistant health information advisors on communications skills, the use of the technology employed in the call centre, use of the information databases, and a familiarisation course covering the other NHS providers of East Midlands and other social and voluntary organisations. More detailed training is given to nurses on the skills of clinical triage processes and the TAS decision support software.

9.4 details of audit and performance management

9.4.1 Accountability for performance is met through NHS management structures and to local services and the local population through the stakeholder group and the Clinical Steering Group (*Appendix 5*) respectively and in line with the common Clinical Governance Framework (*Appendix 6*).

9.4.2 All calls will be data recorded, 1% of which will be reviewed by medical and nurse specialists of the clinical governance team which will have NEMS representation.

9.4.3 A retrospective audit carried out to ensure that the appropriate protocols have been followed. All symptom-based calls must be undertaken using the approved clinical decision support system.

9.4.4 All instances where clinical staff have overridden protocols will be reviewed by medical and nurse specialists.

9.4.5 The individual patient encounter record will provide a full audit trail for all assessments.

- 9.4.6 A fully approved audit trail will have two defined elements: -
- Clinical
 - Operational
- 9.4.7 Clinical is defined as all aspects relating to Clinical Governance from the time the call is received until the call is concluded with an end point decision.
- 9.4.8 Operational is defined as the recording of all times relating to each separate element of the operation of NHS Direct-NEMS within the service provided.
- Time call received
 - Time basic patient data concluded
 - Time Nurse triage commenced
 - Time Nurse triage concluded with end point decision
 - Time full data package transferred to NEMS
- 9.4.9 Monthly live supervision of all staff will be undertaken using a documented monitoring system.
- 9.4.10 Voice Recorded Data: 1 % of all recorded calls to be reviewed by medical and nurse specialists and a retrospective audit carried out on a weekly basis to ensure the correct training procedures have been followed.
- 9.4.11 NHS Direct will provide NEMS with weekly and monthly reports showing all calls received "Out of Hours" from the NEMS patient base classified by outcomes.
- 9.4.12 NHS Direct shall insure against its full liability. NHS Direct shall, upon request, produce to NEMS documentary evidence that the insurance cover is being properly maintained.
- 9.4.13 Upon application to the Director, NHS Direct will allow NEMS internal and other nominated Auditors access to papers relating to this Service Agreement for the purpose of audit.

10. Communications

10.1 format and timescales for data transfer

- 12.1.1 NHS Direct will transfer immediately on the end point being reached the result of the triage to NEMS by way of electronic transfer. These calls will be monitored to ensure transfer has been concluded satisfactorily.
- 10.1.2 All calls to be time monitored from receipt of call to transmission to NEMS.

10.2 content including minimum data set

Every contact will carry a unique reference number to allow for audit and the communication of information on a confidential basis.

Patient data to the extent provided by the caller - full name, full address and post-code (current and home), date of birth, gender, (current and home) phone number, GP (own and temporary if not local).

Clinical data - patients own symptoms, protocol outcome, nurse assessment, details of any follow up that East Midlands NHS Direct deem should be considered by the patient's own general practitioner.

Operational data - time call received, time basic patient data concluded, time Nurse triage commenced, time Nurse triage concluded with end point decision, time of any subsequent contact by a nurse, time full data package transferred to NEMS.

10.3 confidentiality issues

All calls received "Out of Hours" from the NEMS patient base by automatic call divert via the dedicated NEMS line, are classified as calls being transferred to NHS Direct by GP's under their "Terms and conditions of service".

10.4 consultations which resulted in a primary care referral and those which did not

- 10.4.1 All primary care referrals must have full details transmitted to NEMS for onward transmission.
- 10.4.2 Data recorded of details of Self Care referrals dealt with during "Out of Hours" may be transmitted, if requested to NEMS by the following morning (before 0800 hours) for onward transmission to GP practices by NEMS.
- 10.4.3 Data details of triage outcome referrals which refer patients to contact their own GP outside the "Out of Hours" time-scale must be transmitted to NEMS by the following morning (before 0800 hours) for onward transmission to GP practices by NEMS.

10.5 ***urgent and routine referrals***

- 10.5.1 Data recorded of details of Urgent referrals to 999 or A&E Departments must be transmitted to NEMS by the following morning (before 0800 hours) for onward transmission to GP practices by NEMS.
- 10.5.2 Data recorded of details of routine referrals which are not included in any of the above categories must be transmitted to NEMS by the following morning (before 0800 hours) for onward transmission to GP practices by NEMS.

10.6 ***special needs patients***

A database of patients in the community who have special needs will be maintained by NHS Direct and NEMS. These patients will be identified by their registered GPs, who will notify NEMS in the first instance. NEMS will communicate the patient details and the terms of the dedicated response required for the nominated patient to NHS Direct electronically using a dedicated proforma (*Appendix 7*). Receipt will be confirmed by telephone with the duty team leader.

11. Contacting primary care services

11.1 ***Nurse Triage End Points***

- 11.1.1 After NHS Direct have received an "Out of Hours" call from a patient and a Nurse Triage has taken place the following end points will be reached:
- GP - Face to Face Home Visit
 - GP - Face to Face Centre Visit
 - GP - Face to Face Centre Visit with Patient Transport
 - GP - Telephone Advice
 - GP - Triage or Re-triage - Refused/Reassessment
 - Nurse - Self Help
- 11.1.2 The above end points together with full patient data including protocol decision will be immediately and electronically transmitted to NEMS for onward transmission to the patient's registered GP.
- 11.1.3 NHS Direct and NEMS will develop a structure that allows for feedback so that the appropriateness of the complete patient pathway through NHS Direct and NEMS can be assessed, including timings and clinical effectiveness.

12. Complaints/audit

12.1 ***A joint complaints procedure***

- 12.1.1 A joint complaints procedure will be required to be maintained between NEMS and East Midlands NHS Direct (*Appendix 8*). This will follow standard NHS complaint procedures. NHS Direct and NEMS will handle complaints via the respective complaints officers and procedures of the two organisations. Each will liaise closely with the other over the complaint process and complaints received will be reported for comment to the respective boards at monthly intervals.
- 12.1.2 NHS Direct will notify NEMS of any complaint involving the NEMS service immediately upon receipt of the complaint.
- 12.1.3 NEMS will notify NHS Direct of any complaint involving the NHS Direct service immediately upon receipt of the complaint.
- 12.1.4 A joint follow through procedure will be established to ensure all complaints are concluded within a satisfactory timeframe. All endeavours are required of both parties to ensure responses to complaints are made in full within 20 working days of receipt of any complaint. In the event of a critical incident or potential critical incident, both NEMS and East Midlands NHS Direct need to be able to accept the role of an independent NHS review of the incident, that may be required by NHS Direct Local, National or Regional Management.
- 12.1.5 East Midlands NHS Direct will establish systems for the early notification of both positive and inappropriate outcomes.
- 12.1.6 East Midlands NHS Direct will establish a rapid response procedure for the notification of any potential critical incidences.

12.2 *arrangements for audit including a system for notifying inappropriate referrals*

12.2.1 A formal set of criteria to be agreed jointly for the analysis of data.

12.2.2 Mechanism for analysis of data should include both NHS Direct and NEMS call outcome monitoring.

12.3 *feedback on clinical outcomes.*

12.3.1 NEMS GP's comments on all referrals should be checked against protocol end points, if found to be at variance on an inappropriate number, then a mechanism of reporting and training modification needs to be in place to improve performance.

12.3.2 Evaluation of the nurse triage service procedures and outcomes should be reported to NEMS at quarterly intervals

12.3.3 Any recommendations from NEMS Medical Managers regarding the evaluation of nurse triage outcomes would be referred to the Clinical Steering Group for NHS Direct. *A time-scale for response and review of outcomes needs to be established.*

12.3.4 East Midlands NHS Direct will provide detailed information on the outcomes it refers into NEMS, and requires of NEMS to provide detailed final outcomes on these same referrals.

12.4 *costs relating to audit*

Agreed costs relating to NHS Direct audit undertaken by NEMS Management or Board members will be met from NHS Direct budgets.

13. Peak load management

13.1 *steps to be taken to match capacity to demand*

13.1.1 NHS Direct in consultation with NEMS will project future demands using historic data so that staffing in the call centre for non-exceptional circumstances is adequate to meet demand.

13.1.2 Data produced will be used to predict future peaks and NHS Direct will ensure sufficient staff are available to cover such times.

13.1.3 In exceptional circumstances East Midlands NHS Direct will employ flexible pool staff (trained exactly to the same standard as permanent staff), to allow it to staff up to meet exceptional demand at short notice.

13.1.4 Potential emergency call procedures are maintained whatever the overall call volumes being experienced.

13.1.5 Should call volumes reach emergency levels, there will be call transferring arrangements in place that are regularly tested, that allow for a proportion of East Midlands NHS Direct calls to be taken a partner NHS Direct site or sites, so that the quality of service to callers is maintained.

13.1.6 When call volumes reach emergency levels, there will be call transferring arrangements in place that are regularly tested, that allow for all or a proportion of NEMS-East Midlands NHS Direct calls to be taken by NEMS, so that the quality of service to callers is maintained. (*Appendix 9*)

13.2 *steps to ensure the prioritisation of clinically urgent calls*

The criteria format to be agreed between NHS Direct medical team and NEMS medical managers in line with national guidelines.

When necessary calls will be prioritised from call handlers to nurses using strict protocols that are agreed and tested across NHS Direct sites nationally. Voice and data systems will allow potential emergency calls to be prioritised through to nurses immediately.

Calls will be prioritised by nurses into NEMS according to the protocols of the TAS decision support system. These too are subject to national verification regimes.

13.3 *steps to inform callers on occasions when normal responsiveness standards cannot be met*

13.3.1 In an emergency voice messages will be rapidly installed to alert callers of the response situation.

13.3.2 If the agreed time-scale for nurse call-backs cannot be achieved, NHS Direct should call to inform the caller that there is a delay, while at the same time ascertain whether the symptoms have deteriorated.

13.3.3 Prioritisation of calls should only be necessary in extreme situations.

13.3.4 If the overall call volumes are placing pressures on the responsiveness of the East Midlands NHS Direct services, the call handlers have a live database of outstanding calls and will inform callers of the current response situation.

14. Publicity

Publicity materials during the "Pilot" will be produced by NHS Direct with the agreement of the NEMS Board on the final wording to be used before circulation to NEMS patients.

14.1 *practice leaflets*

14.1.1 All practices will receive sufficient leaflets to enable them to both send one to each patient household and have sufficient for distribution at their surgeries.

14.2 *posters in the surgery*

14.2.1 All practices will receive sufficient posters to enable them to keep these on their surgery walls in good condition for a minimum period of two years.

14.2.2 Practices may wish to have posters in suitable alternative premises within their catchment area to ensure continued recognition of the service by patients. e.g. chemists, libraries, community centres etc.

15. Monitoring

15.1 NHS Direct will provide to NEMS weekly, and monthly reports showing the total number of calls handled and categorised by call outcome.

15.2 NHS Direct and NEMS will hold regular weekly and monthly meetings to monitor the performance of this Service Level Agreement.

15.3 NHS Direct will provide written reports to NEMS on a quarterly basis to enable ongoing reviews of service demands.

16. Amendments to agreement

Any variation to the provision of the service must be agreed, in writing, by both parties to this Service Level Agreement.

Annex Five: A List of Sources consulted by the Review Team

The following list identifies all the sources that were consulted by the Review Team in the course of its work. Relevant published sources are identified in a bibliography at the end of Annex Two (pages 50 to 54 above); all other sources, including all those out-of-hours providers visited by the Review Team, are listed here.

Organisations visited by the Review Team:

1. Out-of-Hours Providers:

- 1.1. Association of Medway Doctors on Call (MEDDOC)
- 1.2. Association of Cornwall Doctors on Call (KERNOWDOC)
- 1.3. Devon Doctors on Call
- 1.4. East Kent Co-op
- 1.5. Go To Doc, Oldham
- 1.6. HARMONI, West London
- 1.7. Healthcall Bristol
- 1.8. Healthcall Hull
- 1.9. Healthcall Leighton
- 1.10. Healthcall Mytchett
- 1.11. Healthcall Newcastle
- 1.12. Healthcall Sheffield
- 1.13. Healthcall Southend
- 1.14. Newcastle Emergency Doctors Service (NEDS)
- 1.15. Nottingham Emergency Medical Services (NEMS)
- 1.16. North Bradford Doctors Co-operative Ltd.
- 1.17. Reading Doctors on Call (REDDOC)
- 1.18. Sevenoaks and District (SEVDOC)
- 1.19. Solihull Doctors Out of Hours Service (SOLIDOC)
- 1.20. South Cheshire Primary Care Services
- 1.21. Yorkshire Pennine Doctors (PENDOC)

2. Health Authorities

- 2.1. Berkshire Health Authority
- 2.2. Herefordshire Health Authority
- 2.3. Lincolnshire Health Authority

2.4. North and East Devon Health Authority

3. Others

- 3.1. Aarhus County Out-of-Hours Services, Denmark
- 3.2. Bradford Home Treatment Service
- 3.3. Bromyard Surgery, Hereford
- 3.4. Dr Erling Kjaerulff's Practice, Aarhus, Denmark
- 3.5. Ledbury Market Surgery, Hereford
- 3.6. Lambeth, Southwark and Lewisham Immediate Access Project
- 3.7. NHS Direct Central Team
- 3.8. NHS Direct Devon and Cornwall
- 3.9. NHS Direct Northumberland
- 3.10. NHS Direct West London
- 3.11. NHS Direct West Yorkshire
- 3.12. Southampton East PCT/G
- 3.13. Surrey Oaklands NHS Trust
- 3.14. Surrey Thames Primary Care Group
- 3.15. The Research Unit for General Practice, Department of General Practice, University of Aarhus, Denmark
- 3.16. The Surgery, Meads
- 3.17. Wakefield Walk-in Centre

Submissions to the Review

1. Consumer's Association, 12 June 2000.
2. Essex County Council Social Services, 17 June 2000.
3. General Practitioners' Committee, 30 August 2000.
4. Healthcall submissions dated 4 May 2000, 12 June 2000, 13 July 2000, 14 July 2000 and 4 August 2000
5. Lambeth, Southwark and Lewisham Immediate Access Project, Department of General Practice and Primary Care, Guy's King's and St Thomas' School of Medicine, undated.
6. National Association of GP Co-operatives – submissions dated 21 February 2000, 10 April 2000, 14 May 2000, 26 May 2000, 6 July 2000 and 29 August 2000.
7. Nestor Medical Duty Services, 20 June 2000.
8. Peter Sanderson, GPC, 28 May 2000.
9. Royal College of General Practitioners, 31 May 2000 and 8 August 2000.

10. Southampton and South West Hampshire Health Authority, 14 June 2000.
11. South and West Devon Health Authority, 30 May 2000.
12. The Royal National Institute for Deaf People, 25 May 2000.
13. United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 15 June 2000.

Other Sources consulted by the Review Team

1. Bradford Home Treatment Service

- 1.1. Brief Description of the Service
- 1.2. The Team Philosophy
- 1.3. Bruce M.Z. Cohen, 'An Evaluation of the Bradford Home Treatment Service', University of Bradford, February 1999
- 1.4. Details of the Beacon Award achieved by the service.
- 1.5. A number of short articles discussing the work of the service.

2. CAPITA Conference: The Future of Out-of-Hours Care: An Agenda for Dependable High Quality Services, Monday 17th April 2000.

- 2.1. Papers presented to the conference.

3. Consumers Association

- 3.1. In an emergency (February 1999) *Health Which?*
- 3.2. In the balance (October 1998) *Health Which?*
- 3.3. NHS Direct Investigated (August 200) *Health Which?*
- 3.4. Out of Hours Care (April 1998) *Which?*
- 3.5. The Good GP Guide (September 1996) *Which?*
- 3.6. Visiting an out-of-hours clinic (April 1998) *Which?*

4. Department of Health

- 4.1. National Health Service General Medical Services Statement of Fees and Allowances Payable to General Medical Practitioners in England and Wales, 'The Red Book'.
- 4.2. National Health Service (General Medical Services) Regulations 1992 (as amended).
- 4.3. Finance Directorate Letter (95) 65 Out of Hours Development Fund – 1995/96 Spend dated 20th December 1995.
- 4.4. Finance Directorate Letter (95) 55 Cash allocation for Out of Hours Development Fund 1995/1996 dated 15th November 1995.
- 4.5. Family Health Service Letter (68) 95 General Practitioner Out of Hours Services dated 14th November 1995.
- 4.6. Finance Directorate Letter (96) 12 Out of Hours Development Fund use of 1995/1996 Allocation dated 27th February 1996.
- 4.7. National Health Service (Primary Care) Act 1997

- 4.8. Press Release dated Friday 4th June 1999 “Extra Money for GP Out of Hours Services Targeted to Rural Areas”.
 - 4.9. Winter Planning – National Content for LWPG Planning.
- 5. Devon Doctors on Call**
- 5.1. Hospital admissions.
 - 5.2. Induction.
 - 5.3. Medical Directors Role Duty Doctor Recruitment.
 - 5.4. Priority of Calls
 - 5.5. Visit Protocols.
- 6. Gloucestershire Community Health Council**
- 6.1. Chelt-Doc GP Out of Hours Emergency Service: Patient Opinion Survey, 1999.
- 7. Go To Doc, Oldham**
- 7.1. List of Service Charges.
- 8. Health Authorities**
- 8.1. Barking & Havering Health Authority**
 - 8.1.1. *Out of Hours Development Fund, 1998/9.*
 - 8.2. Berkshire Health Authority**
 - 8.2.1. *Berkshire Out of Hours Working Group: Quality Standards in GP Out of Hours Organisations.*
 - 8.3. Birmingham Health Authority**
 - 8.3.1. *Birmingham Local Medical Committee: Monitoring Arrangements for Out of Hours Services.*
 - 8.4. Cornwall and Isles of Scilly Health Authority**
 - 8.4.1. *Criteria for Quality Care Provided by the General Practice Co-operative in Cornwall outside surgery times.*
 - 8.5. East London & City Health Authority**
 - 8.5.1. *Out of Hours Development Fund, 2000-2001. Assessment of the current state of GP Out of Hours Provision in ELCHA.*
 - 8.5.2. *Out of Hours Development Fund, 2000-2001 Quality Criteria.*
 - 8.6. East Kent Health Authority**
 - 8.6.1. *Seadoc Quality Document.*
 - 8.7. East Riding & Hull Health Authority**
 - 8.7.1. *Out of Hours Development Scheme: Policy on the Use of Development Funds.*
 - 8.8. Gloucestershire Health Authority**
 - 8.8.1. *Message Link – Quality Standards for GP Out of Hours Calls.*
 - 8.9. Lambeth Southwark & Lewisham Health Authority**
 - 8.9.1. *2000/2001 Business Planning Guidance for Out-of-Hours Service Providers*
 - 8.9.2. *Out of Hours Monitoring Sub-Committee Quarterly Monitoring Form*

- 8.9.3. *Lambeth Southwark & Lewisham LMC Out of Hours Monitoring and Development Sub-Committee: Terms of Reference, Monitoring and Development Criteria, Out of Hours Service Provision Criteria and Out of Hours Development Fund Classification Criteria.*
 - 8.10. **Leicestershire Health Authority**
 - 8.10.1. *Operational / Clinical Procedures: Implementation by March 2000.*
 - 8.11. **Lincolnshire Health Authority**
 - 8.11.1. *GP Guidelines for Out of Hours Visiting.*
 - 8.12. **Merton, Sutton & Wandsworth Health Authority**
 - 8.12.1. *Guidelines for Prioritisation of Calls*
 - 8.12.2. *Joint Health Authority / LMC Deputising Services Sub-Committee Constitution and Terms of Reference.*
 - 8.13. **North Essex Health Authority**
 - 8.13.1. *Start Up Costs for New GP Coops.*
 - 8.14. **Northamptonshire Health Authority**
 - 8.14.1. *Northamptonshire Local Medical Committee: GP out of hours – Quality Framework.*
 - 8.15. **Northumberland Health Authority**
 - 8.15.1. *Standards of Out of Hours Care: An Accreditation Tool*
 - 8.16. **Oxfordshire Health Authority**
 - 8.16.1. *Draft Framework for Quality Standards for Discussion.*
 - 8.17. **Shropshire Health Authority**
 - 8.17.1. *Shropshire Health Authority / Shropshire LMC: Agreed Standards for Organisations Providing Out of Hours Emergency Care.*
 - 8.18. **Somerset Health Authority and Somerset LMC**
 - 8.18.1. *Joint Policy for Out of Hours Services 1999/2000.*
 - 8.19. **Tees Health Authority**
 - 8.19.1. *Primary Care Out of Hours Premises Based Care*
 - 8.19.2. *York Health Economics Consortium (1998) Research to Establish Patient Satisfaction with GP Out of Hours Services on Teesside: Appendices.*
- 9. Healthcall Group Ltd Medical Division**
- 9.1. Branch Monthly Quality Report
 - 9.2. Clinical Advice Telephone Questionnaire
 - 9.3. Clinical Prioritisation Guidelines
 - 9.4. Quality Manual.
 - 9.5. Healthcall Controlled Drugs List
 - 9.6. Healthcall Formulary
 - 9.7. Healthcall Leighton Draft Service Level Agreement.
 - 9.8. Healthcall 'In House' Complaints Procedure dated April 2000.
 - 9.9. Local Clinical Governance Boards

9.10. National Clinical Governance Committee – Healthcall Group

10. Immediate Access Project

- 10.1. Payne, F, Shipman C, Dale J. Patients' Experiences of Receiving Telephone Advice from a GP Co-operative (accepted for publication in *Family Practice*, July 2000).
- 10.2. Shipman C, Payne F, Dale J, Jessop L. Out of Hours Primary Care Centres: What do patients think about attending them? (accepted for publication in *Family Practice*, July 2000).
- 10.3. Managing medicines-related calls to NHS Direct Southeast London.

11. King's and Lewisham A&E Primary Care Services

- 11.1. Business Report (1999) Departments of A&E Medicine, King's Healthcare NHS Trust and University Hospital Lewisham and Department of General Practice and Primary Care Guys, King's and St Thomas' School of Medicine, London.
- 11.2. Mascarenhas C. (1998) Accident and Emergency Primary Care Services: Operational Management Systems. Departments of A&E Medicine and General Practice and Primary Care, King's College School of Medicine and Dentistry.

12. KPMG Consulting

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- 12.2. KPMG Peat Marwick, National Health Service Management Executive: Remuneration Options for the GMS Out of Hours Service, June 1994.

13. Leicestershire Community Health Council

- 13.1. Patient Satisfaction Survey of General Practice Out of Hours Provision: Leicester West Medical Co-operative, 1999.

14. London Health Authorities Chief Executives' Group

- 14.1. Complaints Procedure, Out of Area Treatments and Primary Groups, 12 March 1999.

15. MAIDDOC – Maidstone Doctors on Call

- 15.1. Annual Report 1999
- 15.2. Call Statistics
- 15.3. Report on Admissions by Tracey Seaman, April 2000

16. Manchester Emergency Doctor Service (MEDS)

- 16.1. Clinical governance.
- 16.2. Quality Criteria.
- 16.3. Contingencies.
- 16.4. Urgent Calls Criteria.
- 16.5. Guidelines.
- 16.6. Guidance for the Duty Doctor.

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- 17.1. Re: Out of Hours Rural Fund dated 26th May 2000.
- 18. MEDS – A Division of Nestor Medical Duty Services**
- 18.1. Out of Hours Review, Nestor Medical Duty Services, June 2000
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- 19. Merton Sutton and Wandsworth GP Nightline**
- 19.1. 1999 Subscribers Questionnaire Results
- 19.2. Millennium Report dated 16th March 2000.
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- 19.4. Nightline Annual Subscribers Report 1999
- 19.5. Summary of data presented to Annual Subscribers Meeting June 2000
- 20. National Association of GP Co-operatives.**
- 20.1. 'Call splitting' ideas', by Dr Mark Reynolds, July 2000.
- 20.2. Conference Reports: Newcastle (2000), Warwick (1998), Edinburgh (1997).
- 20.3. Co-operatives – Where Next? Draft for discussion from Dr Mark Reynolds MBE, NAGPC
- 20.4. Definition of Out of Hours Services. Draft for Discussion – Dr Mark Reynolds MBE NAGPC, May 2000.
- 20.5. Draft paper on the Use of Drugs in Coops, by L.P. Kelman Manager of NAGPC, July 2000.
- 20.6. 'GP Co-operatives and NHS Direct – Where Now?', a paper by Dr Mark Reynolds MBE and Logie Kelman, April 2000
- 20.7. Role of Nursing in GP Co-operatives, October 1998.
- 20.8. Report on the NHS Direct Study Day, November 1998.
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- 21. NHS Direct Central Team**
- 21.1. Consultancy Brief: NHS Direct Audit with Respect to Access by People with Disabilities.
- 21.2. Membership of the NHS Direct access issues evaluation and development group.
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- 21.4. *The Voice* – Newsletter for NHS Direct, December 1999.
- 21.5. Working with Black and Ethnic Communities (Draft 5) July 2000.
- 22. North Bradford Doctors Co-op**
- 22.1. Annual Report 1999-2000.
- 22.2. An outline of the service.
- 23. Northern Doctors Urgent Care Ltd**

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- 24. North Manchester Community Health Council**
- 24.1. Survey of people who used the “E-Merge” GP out of hours service, 1999.
- 25. Dr David Paynton**
- 25.1. Out of Hours - Key Issues, 14th June 2000.
- 26. Reading Doctors On Call (REDDOC)**
- 26.1. A Guide for Members.
 - 26.2. Analysis of patient satisfaction questionnaires.
 - 26.3. Dr Jeremy Lade, 'Making the best case for Co-operative Winter Pressures Funding'.
 - 26.4. Operations Room Staff Induction File.
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- 27. Rochdale Community Health Council**
- 27.1. Access to Out of Hours and Emergency Services in Bury and Rochdale. A report of a project from Rochdale Community Health Council, 1999.
- 28. Royal College of General Practitioners**
- 28.1. NHS Alliance and RCGP Discussion Paper on The Implications for General Practice of NHS Direct and Walk-in-Centres, December 1999. Quality in Out of Hours Care, February 2000.
 - 28.2. RCGP Outline Paper for Out of Hours, February 2000.
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 - 28.4. Response to 'Supporting Doctors, Protecting Patients', February 2000.
 - 28.5. Summary Paper – GP Out of Hours Services Working Group Report, January 1999.
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- 29.1. A comparison of models of delivery of Out of Hours Care in Scotland – Scottish Out of Hours Study Group.
 - 29.2. National Framework of Standards for Organisations Providing Out of Hours Primary Care, June 2000.
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- 30. Sheffield GP Cooperative**
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- 31. SOLIDOC, Solihull**
- 31.1. Nurse Triage Protocols
 - 31.2. Administration Protocols.
 - 31.3. Service Information.
 - 31.4. A Guide to Responsibilities and Procedures.

- 31.5. Annual Report 1999.
- 31.6. Examples of completed Patient Satisfaction Forms.
- 31.7. Examples of statistical data derived from the service provision.

32. South Thames Regional Drug Information Service

- 32.1. Notes on enquiries.

33. University of Aarhus, Denmark: Research Unit for General Practice

- 33.1. Christensen M B, Oleson F O. (2000) *Out of hours service in Denmark – Evaluation of the Reform*. The Research Unit for General Practice, Department of General Practice, University of Aarhus, Denmark. Slide presentation.



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