General Practice Out-of-Hours Services

Project to consider and assess current arrangements

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Introduction

In June 2009, the Care Quality Commission (CQC) began an investigation into the provision of out-of-hours primary care services in five PCTs by Take Care Now (TCN). The CQC’s enquiry was prompted by the tragic death of a patient in February 2008 after he was administered 100mg of diamorphine by a locum doctor from Germany. In October 2009, the CQC issued an interim statement on this investigation, which prompted David Colin-Thomé to write to PCTs, and the Minister of State for Health, Mike O’Brien, to ask us to jointly lead a short piece of work to review the local commissioning and provision of out-of-hours services.

We know from our combined 70 years experience as doctors that the quality of out-of-hours services in many areas is good. We believe that there are many dedicated clinicians and managers who strive to offer a high quality and responsive service to around 7 million patients who contact GP out-of-hours services in England each year. However, we acknowledge that the quality of services varies unacceptably and that there are providers and commissioners who need to improve to prevent those occasions where the care offered falls far below that which is acceptable.

The review has seen us undertake a series of visits to out-of-hours providers and commissioners across the country involved in the Primary Care Foundation’s benchmarking exercise. These visits were a chance for us to understand the different models of out-of-hours provision and a valuable opportunity to talk to the clinicians and managers who commission and provide these services. During these visits, we saw several examples of good practice; however, we also saw examples where improvement is needed from both commissioners and providers. Interestingly, both sets of examples were spread across all of the organisations we saw. Whilst this meant that we observed no organisations with generally poor commissioning and provision it also meant that none demonstrated exceptional commissioning and provision. We therefore hope our recommendations and observations on good practice will act as a helpful guide for all commissioners and providers continuing to strive towards excellence and contribute to other developments such as the introduction of Responsible Officers, the Duty of Cooperation and Revalidation.

The findings from our visits are supplemented by evidence received from out-of-hours providers as part of an NHS Alliance questionnaire and further work on the findings from the March 2009 Tackling Concerns Locally review of the PCT Performers List system. We were also fortunate to receive valued support and guidance from an advisory group of experts including representatives from the BMA, RCGP, NHS Alliance, National Association of Primary Care, out-of-hours providers and PCTs. We are grateful to them for giving their time to this work.

1 Annex A
2 Estimated from data collected by the Primary Care Foundation out-of-hours benchmark
3 Annex B
Throughout the visits, we sought to ask open questions about the local service provision. In return, we found individuals willing to be honest about the successes and challenges in their own area and open to suggestions about how they could further improve the service they offered. We wish to acknowledge the many people who gave their time to help us in this review.

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Department of Health

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Chairman of Council  
Royal College of GPs
Executive Summary

Since April 2004, GPs have been able to transfer responsibility for provision of out-of-hours care to their local Primary Care Trust (PCT). All out-of-hours services should comply with the Department’s National Quality Requirements, which aim to ensure that patients have access to high quality and responsive care regardless of where they live. It is the responsibility of PCTs to ensure that providers comply with these requirements.

Our report involved us visiting five sites across the country to assess the commissioning and provision of out-of-hours services. We spoke to commissioners and providers about the local service and reviewed the data and evidence they shared with us regarding their services. Further to this, a questionnaire was sent to all providers in the NHS Alliance Out of Hours Providers Leadership Group requesting information about their use of locum GPs. We also had many conversations with colleagues around the country, and drew on the experience of our advisory group to clarify the most important current challenges in service commissioning and provision, and to describe what “good” looks like. Our findings and recommendations are therefore concentrated in three areas, which are summarised below.

Commissioning and Performance Management of GP Out-of-Hours Providers.

The sites visited demonstrated a mix of service provision including PCT providers, ambulance services, social enterprises and commercial providers who have grown out of co-operative arrangements. Whilst some of the areas seemed to have very productive and collaborative working arrangements between commissioners and providers we did witness examples of providers having difficulty integrating into the health community and with less than ideal relationships with commissioners.

We witnessed varying levels of challenge from PCTs regarding performance management of providers. In general, we found that there was less rigour in this arrangement when the PCT’s own provider arm was responsible for delivering the service, whilst interestingly some of the most rigour was demonstrated where excellent relationships existed between a social enterprise and a PCT. We were also surprised to see some services still not achieving compliance with the National Quality Requirements 5 years after their introduction. Despite PCTs stating that they hold services to account for these performance difficulties we would expect to see all services routinely achieving these requirements. We also discovered limited involvement of practice based commissioning (PBC) consortia or clinicians other than the Medical Director in the monitoring of services. The areas visited all monitored the National Quality Requirements but the level of interrogation of these differed with some focussing on summary “traffic light” reports whilst others examined trends and detailed breakdowns of data. Some areas had also developed commendable quality frameworks and care quality indicators to
accompany the NQRs. In nearly all areas, the PCT did not include performance of the service as a regular item on the PCT Board’s agenda.

Our suggestions for what good looks like and our recommendations in terms of commissioning, performance management and patients focus on relationships and integration, performance management and quality.

**Selection, Induction, Training and Use of out-of-hours Clinicians (including the use of locum GPs)**

Our findings and recommendations in this area should be considered against the backdrop of the particular circumstances that clinicians in out-of services encounter. These being; unfamiliar patients, initial assessment often being completed on the phone, colleagues who may not be well-known to the clinician prior to the shift, unfamiliar surroundings/equipment and a higher proportion of vulnerable patients with urgent care needs often more complex than those generally found in daytime general practice as these patients are not known to the clinician.

We discovered that most providers did not make an assessment of the clinical skills or competence of their clinical staff, and did not use any clinical scenario questions in their interviews (if they even conducted interviews). They instead relied on checking of qualifications and Medical Performers List status (where applicable). Whilst all providers did induct and the majority monitored or shadowed new staff, we were concerned that a clinician could already have treated patients before any concerns over their clinical ability were highlighted through that induction process. All providers had established approaches for dealing with the poor performance of clinicians and we were given examples of where clinicians had been referred to the PCT and GMC for this reason.

Induction processes also varied considerably between providers with some seeming rather more extensive than others. We also found a variety of approaches to the skill-mix of clinical staff in different services with varying proportions of GPs, nurses and other specialist practitioners. We believe it is worth emphasising that the reason for employing different kinds of clinicians is to ensure that the patient is seen by the most appropriate clinician for their condition. It is not about reducing the use of GPs.

We also found that some PCTs had very limited awareness of the processes followed by providers for selection and induction of their staff. Half of the providers we visited used locums although the instances appeared rare and many used regular doctors who were known to them. All providers reported that they had good relationships with local GPs, which was the key to ensuring that these clinicians were willing to work in the out-of-hours period, along with ensuring that GP Registrars received comprehensive training, which would encourage them to continue working for the service once qualified.

To supplement our visits a survey about locum use was conducted by the NHS Alliance and received 24 replies. The survey found that the majority of
providers did not use locums, and those who did, tended to have long-term relationships with particular agencies and individual doctors. There was variation however in the vetting of locums by providers including in the approach to inductions. Of most concern was the fact that between them, 6 providers used 15 different agencies.

Our suggestions for what good looks like and our recommendations focus on selection, induction and the use of locum agencies.

**Management and Operation of PCT Performers Lists**

The provisions of the Performers List Regulations ensure that all general practitioners must be included in a list held by a PCT before they can perform primary medical services. The list system is intended to provide a framework to protect patients from unsuitable or inefficient practitioners, and to enable PCTs to intervene at an early stage. In 2007, the Department of Health set up a review group to consider the working of the Performers List system. The outcome of the review was published in *Tackling Concerns Locally: the Performers List system, A review of current arrangements and recommendations for the future* in March 2009. The Department will be implementing the Performers List review over the coming months and we consider that many of the recommendations will improve the regulation of doctors providing out-of-hours services and the quality of care provided.

PCTs generally accepted that the public should be able to assume that the doctors who they see or speak to out-of-hours are as well qualified and experienced as the doctors they would see during a daytime consultation. We heard of misunderstandings about whether the GMC could conduct language tests in respect of doctors from the EEA. This led to uncertainties amongst PCTs of the circumstances in which they should be checking the knowledge of English of applicants to their Medical Performers Lists and how this issue should be handled. Where checks of language knowledge were made, different approaches were taken. At the very least, all doctors should be able to converse with patients or their helpers; be able to read and understand the BNF; talk to pharmacists and other healthcare professionals; and, be able to arrange admissions to hospitals. There was also some confusion over whether doctors could be admitted to a list if they needed to improve their knowledge of English. The Department of Health needs to issue guidance.

Our findings on induction processes are given in the previous section. In addition, we consider that PCTs should ensure that all doctors who have not provided primary medical services in the NHS previously be required to complete a period of individually tailored induction before starting to perform primary medical services.

Finally, we have made a recommendation concerning the exchange of information where a PCT takes action under the Performers List.
Terms of reference

In response to the Care Quality Commission’s interim findings, the Minister of State for Health asked us to:

“…undertake a short piece of work to review the commissioning and provision of out-of-hours services nationally”.

This report seeks to,

1. Establish what good out-of-hours services look like in terms of commissioning and provision, particularly for the patient
2. Complement the investigation into TCN by the CQC
3. Make recommendations to improve commissioning and performance management of GP out-of-hours services
4. Make recommendations to out-of-hours providers and PCTs for the selection, induction and training processes for staff working in out-of-hours services
5. Make recommendations about the use of locum GPs and locum agencies
6. Make recommendations about the management of the Medical Performers List
Summary of recommendations

Commissioning and Performance Management

1. PCTs should review the performance management arrangements in place for their out-of-hours services and ensure they are robust and fit for purpose. This includes the frequency of the contractual review meetings with providers, and the seniority of staff attending these meetings (including clinicians). There should be a quality review meeting separate to the contractual review attended by senior clinicians from both organisations and other appropriate senior clinicians. In particular, we want PCTs to involve local GPs in the process. This can be achieved by working with their Local Medical Committees, RCGP groups, Faculties, clinical executive groups, local and with practice-based commissioning consortia. Nonetheless, providers need to be clear that they are accountable for the delivery of services. Clarity of accountability is particularly important where provision is split between two or more providers.

2. PCTs should supplement the core National Quality Requirements (NQRs) with a suite of locally developed quality indicators, which include requirements to monitor clinical outcomes trends, patient reported outcomes and undertake more intensive patient and stakeholder feedback surveys. Consideration should be given to quality incentive payments linked to these local KPIs.

3. In line with National Quality Requirement 5, PCTs and providers should review the current arrangements in place for receiving patient experience reports. PCTs should also consider how other feedback received on the service (whether formally via complaints, or informally via the PALS service etc) could be incorporated into performance management arrangements. They should also ensure that they are regularly sourcing feedback from other stakeholders such as local GPs, A&Es and ambulance services, and examining trends in incidents reported. If feedback indicates any trends, PCTs should ensure they follow these up immediately.

4. PCTs should support out-of-hours providers to become a valued and integral part of the local health economy, ensuring that they have a place on any local urgent care boards or networks. This would include ensuring the provider is able to develop integrated care pathways with other parts of the system including A&E and ambulance services to ensure delivery of an integrated, efficient service.

5. PCTs and out-of-hours providers should benchmark their services in ensuring the validity of their performance data. For instance, this could include participation in the Primary Care Foundation Benchmarking exercise. Benchmarking will enable PCTs to consider whether the
resources allocated to the service are sufficient to ensure delivery of productive and high quality services.

6. The Primary Care Foundation should continue to work with participating PCTs, providers and the Department of Health to ensure that the recommendations of their recent benchmark review are implemented, whilst taking into account the findings of this, and the forthcoming CQC report. In particular, there needs to be assurance that commissioners and providers are consistently interpreting the NQRs.

7. SHAs should monitor action taken by PCTs in response to this report and in carrying out appropriate performance management of out-of-hours providers. Ideally, the safety and performance of out-of-hours services and actions arising from this report should be a standing item on PCT, SHA and out-of-hours provider Board agendas for the next 6 months. Boards may then wish to review the frequency of updates they receive.

8. The Department should strongly consider the development and introduction of an improvement programme for PCTs to support their commissioning and performance management of out-of-hours services. This should include support to ensure they are effectively monitoring the National Quality Requirements and other key clinical indicators to ensure that the out-of-hours service is safe, effective, efficient and responsive.

Selection, Induction, Training and use of out-of-hours clinicians (including use of locums)

9. PCTs and Providers should continue to work with post-graduate deaneries to ensure the provision of a comprehensive, consistent and well-structured training programme for GP Registrars, which complies with COGPED guidance, and with the Department of Health letter of 17th December 2009.

10. The RCGP should review the guidance concerning GP Registrars’ training in out-of-hours and should update this as necessary. This work should involve engagement with the necessary stakeholders including COGPED.

11. Out-of-hours providers should consider the recruitment and selection processes in place for clinical staff to ensure they are robust and that they are following best practice in this area. This includes evidence of a detailed knowledge and skills outline for staff which sets out the generic qualifications and appropriate experience, skills (including telephone assessment) and knowledge required to work in the out-of-hours service and should be applied to all locums as well as staff who regularly work for the provider.

12. Out-of-hours providers should consider the contents of their induction process to ensure that it is comprehensive and is completed before any staff work a first shift for the service. This induction process should be tailored according to the needs of the individual staff member, and would be more detailed for staff who have not previously worked in the local area.
or in the out-of-hours service. Special consideration should be given to induction requirements for staff who do not usually work in the UK. The induction process should be followed up by appropriate shadowing and mentoring arrangements, particularly for less experienced staff.

13. PCTs should review whether recruitment, induction and mentoring requirements for the out-of-hours provider are set out adequately in their contract with the provider, and satisfy themselves that these are passed through to any sub-contractor or agency, which the provider engages.

14. Providers should co-operate with other local and regional providers (both in and out-of-hours) to share any concerns over staff working excessive hours for their respective services. PCTs and providers alike should also encourage clinical staff to share information about their working arrangements with all organisations that they work for, and providers should ideally put this requirement in their clinicians’ contracts.

15. Out-of-hours providers should consider the adequacy of their clinical governance arrangements (including those for clinical audit) and should consider undertaking trend analysis of clinical performance for common and/or high impact conditions as part of these audits. These could be used to form part of an internal or external benchmark of clinical performance to help raise standards. PCTs should also ensure they consider the cost of the provider undertaking these audits as part of recommendation 5.

16. PCTs should regularly check that all the locum and sessional staff on their Medical Performers List have appropriate access to appraisal and continuing professional development (CPD).

17. Out-of-hours providers should consider the benefit of signing agreements with locum agencies for preferred provider status to ensure consistency in the quality of any locums required.

18. The Department of Health and Care Quality Commission should ensure that when registration of out-of-hours providers is introduced in 2012, that the requirement for organisations to source workers who are fit to practise should include those workers sourced by the provider from a locum agency.

Management and operation of Medical Performers Lists

19. The Department of Health should work closely with the GMC to consider to what extent PCTs could rely on the checks of identity and medical qualifications under the GMC’s registration procedures. The Department should consider streamlining the requirements in the Regulations for the checking of such documentation by PCTs.

20. The Department of Health should, as a matter of urgency issue guidance to PCTs to assist them in making decisions about whether or not a doctor
has the necessary knowledge of English to be admitted to their Medical Performers Lists.

21. The Department of Health should consider issuing guidance to PCTs about the circumstances in which PCTs may wish to informally invite applicants for inclusion in their Performers List to discuss their applications with the PCT.

22. In implementing the recommendations of the recent Performers List review, the Department of Health should consider whether all the requirements of the Regulations are appropriate for GP Registrars.

23. PCTs should ensure that all doctors who have not provided primary medical services in the NHS previously be required to complete a period of individually tailored induction before starting to perform primary medical services.

24. The Department of Health should review how the exchange of information between PCTs and the GMC can be improved.
Commissioning and Performance Management of GP Out-of-Hours Providers

a) Background

Before 2004, GPs were responsible for ensuring the provision of primary care out-of-hours services, although according to the National Audit Office 2006 report, *The Provision of Out-of-hours Care in England* this was mostly delegated to GP co-operatives or the private sector\(^4\). Indeed, at the beginning of 2004, less than 5% of GPs provided out-of-hours services themselves, though many provided care as part of corporate arrangements. Before 2004 we did not understand much about the overall pattern of care nor about the quality, costs or outcome of that care. However, there was anecdotal evidence that the quality of care varied considerably between providers and across geographical areas. In early 2000, a rising number of complaints and negative reports in the media led the Health Service Commissioner (Ombudsman) to raise his concerns with the Department of Health. There were also growing concerns at that time about the impact these issues were having on the recruitment and retention of GPs.

The Department therefore commissioned a review from Dr David Carson to look at quality and recommend how services could be improved. The report of the ‘Carson Review’ in 2000, along with the NHS Plan, helped lay the foundations for our current out-of-hours services.

As part of the agreement under the GMS contract along with parallel PMS arrangements introduced in April 2004, GPs were able to transfer responsibility for provision of GP out-of-hours care to their local Primary Care Trust (PCT). Since January 2005, PCTs have had a legal responsibility to make sure patients receive reasonably required primary medical services during the out of hours period (18.30 to 08.00 on weekdays and 24 hours per day on weekends and bank holidays) where practices have chosen not to retain responsibility.

*The National Quality Requirements*\(^5\)

All out-of-hours primary medical services must comply with the National Quality Requirements, which aim to ensure that patients have access to high quality and responsive care, regardless of where they live. Out-of-hours providers must deliver services that meet the quality requirements as a contractual obligation. The requirements are set out in Annex C:

The latest Primary Care Foundation benchmark (covering 90 out-of-hours contracts) reveals that compliance with these requirements is mixed. The majority of participants audit clinical patient contacts and complaints monthly and review patient experience quarterly. 70% of PCTs using the benchmark also meet their providers at least quarterly to review their contract. There is


\(^5\)Annex C
compliance with the requirements covering call engagement and abandonment rates, the identification of immediately life-threatening calls and face-to-face contacts with emergency or routine cases. However, nationally there is not compliance with the requirements that calls should be answered within 60 seconds, urgent calls assessed within 20 minutes, less urgent calls assessed within 60 minutes, and urgent cases seen face-to-face within 2 hours.

**Benchmarking**

In 2007, the Department commissioned the Primary Care Foundation to develop the audit tool used by the National Audit Office in their 2006 report into a benchmarking toolkit, which was piloted in PCTs. The benchmarking tool can assist PCTs in improving the quality of care and increase the scope of potential efficiencies through effective benchmarking. The main indicators within the benchmarking toolkit are cost, productivity, process, outcomes, performance and patient experience.

A review of the first two benchmark rounds has recently been produced by the Primary Care Foundation and is available on their website[^6]. There is a wealth of detail contained within this report, which we believe is of great value to commissioners and providers alike when they are considering the performance, safety and quality of their out-hours service in detail. The review goes into detail about the variety of service models in existence and the challenges and intricacies of out-of-hours provision, due to the sheer volume of data that the benchmark has access to (there is more data currently available on out-of-hours services than many other NHS services). In particular, we would draw attention to the following items:

- Patients value responsiveness of services. If patients perceive an out-of-hours service as responding quickly they are also likely to think that it provides good care. The review found a correlation between services rated highly in the recent IPSOS MORI patient survey and those rated as compliant with NQRs for patient assessment in the benchmark.

- Commissioners and providers do not appear to use the data contained within the GP patient survey to perform manage or quality assure their out-of-hours service, or to assess satisfaction with providers bidding for their services who offer care in other areas. We note that the recent IPSOS MORI figures show that only 66% of patients rate the quality of care as good in out-of-hours services.

- A variety of different models exist for the provision of out-of-hours care which include varying systems of dual provision, call streaming and integration with other urgent care services. These raise issues, which require attention from providers and commissioners in terms of unproductive dual assessment, safety of initial assessment and clarity of responsibility. Whatever form the service takes, the National Quality Requirements must be delivered.

[^6]: [http://www.primarycarefoundation.co.uk/page1/page19/page19.html](http://www.primarycarefoundation.co.uk/page1/page19/page19.html)
Some providers are interpreting the National Quality Requirements incorrectly, and this is not challenged by commissioners. In some instances, this means that services reporting compliant performance are underperforming. Likewise, some integrated models have developed in such a way that whilst patients may experience a more streamlined service, providers are not able to code and report the data in such a way that they can demonstrate compliance with the NQRs.

There is great variability within services concerning individual clinician performance. Providers and commissioners need to understand the detail of this variability to assure themselves of the safety and quality of the service. Providers should also ensure that individual clinicians receive detailed feedback on their own performance.

The Department has had good feedback from the NHS on the value of the benchmarking exercise. We would encourage those who have yet to join this benchmarking exercise to do so, or to ensure that they have other robust mechanisms in place for effectively benchmarking their out-of-hours services. We acknowledge that the benchmark has to continually evolve and take account of the ever-changing landscape of out-of-hours provision and the recommendations of this report as well as those expected in the forthcoming CQC investigation report. Therefore, our list of recommendations includes a requirement for the Primary Care Foundation to continue to work in partnership with PCTs and providers in the benchmark, and the Department to ensure that the useful recommendations of their benchmark review are implemented, whilst taking into account the findings of this, and the forthcoming CQC report.

b) Evidence from discussions with commissioners and providers

Our site visits provided us with a wealth of evidence on the current arrangements for commissioning and performance management of out-of-hours services.

Several areas reported that they had productive and collaborative working arrangements between commissioners and providers, regardless of the type of provider. We observed this in two sites that represented two quite different models of provision – the one an in-house PCT provider and the other a large social enterprise provider. In each case, it appeared that, where both organisations had made a commitment to developing strong relationships, it paid dividends in terms of the integration of the provider into the local health community. It further enabled the provider to deliver a service integrated with other urgent care services that benefitted patients. In one of these areas the relationship had actually been strengthened by the PCT conducting a rigorous re-tendering exercise for the service, which the provider felt had encouraged them to improve the robustness of their approach. On other site visits, we saw that providers had difficulty developing a productive relationship with the PCT with one stating that they felt the PCT did not understand their service, whilst
another stated that they would welcome a more robust relationship to help their organisation improve. Another provider indicated that integrating with their relevant health partners was an issue and that engagement with the local ambulance service was a particular difficulty.

We saw a variety of costs for the services we visited ranging from the very expensive (as defined in the PCF benchmark) to the very cheap. Generally, there appeared to be little relationship between the cost of the service and the quality. Interestingly, a provider which used only doctors and call handlers in its service was much cheaper (and more productive) than a service which used a majority of specialist nurses along with some doctors. We also found one example of a cheap service, which did not meet several NQRs. We were told that the PCT had awarded the contract at a lower cost than that which the provider had bid for. At this cost, the provider stated that they were unable to deliver a compliant service. This is of concern to us and we would urge PCTs to consider whether the resource allocated to the out-of-hours service is sufficient for the delivery of a safe and effective service. It would also be beneficial for them to consider the value added by their OOH service to the wider health economy (e.g. cheaper services may refer more patients to hospital whereas expensive services may complete more care episodes themselves).

There appeared to be varying levels of challenge between commissioner and provider in terms of performance management. In one area where the social enterprise provider and the PCT had developed an excellent collaborative relationship, it was refreshing to see that there was a healthy level of challenge regarding performance. Contract meetings were attended by Directors from both organisations and there was rigorous monitoring of a comprehensive set of performance information by the PCT, which was welcomed by the provider. This information included reports from the provider’s Chief Executive, Medical Director, Operations Director and Finance Director, accompanied by detailed performance reports, complaints analysis, NQR breach analysis, patient experience data and clinical quality data.

However, where a PCT’s own provider arm was responsible for delivering the out-of-hours service there was less rigour. Whilst the NQRs were monitored and there was evidence of quality measurement we saw poorer examples of the data considered and also found senior clinical staff who worked sessions for the out-of-hours service integrally involved in performance management and case record review for the commissioner. Whilst we acknowledge that clinicians are adept at playing both a commissioning and providing role, we felt that some degree of separation was required to demonstrate rigour and transparency. We were also surprised to find that some services we visited were failing to achieve some of the NQRs, 5 years after their introduction. Whilst commissioners had requested action plans and improvement trajectories, it is particularly worrying to note that some telephony access indicators are routinely not being met.

We also witnessed one example where both commissioners and providers failed to interrogate, discuss or understand performance information available
to them. Each party gave significantly different responses when pressed on the issue, which led us to question whether it had been discussed in review meetings. We also witnessed limited involvement of PBC consortia (or clinicians other than PCT Medical Directors/PEC Chairs) in the commissioning and performance management of out-of-hours services; we feel that this is an area where clinical involvement in the commissioning of these services can be easily improved.

On the provider side, we saw strong clinical leadership from the medical directors we met whilst we also saw one excellent example of pharmacist leadership with the provider having an excellent relationship with the PCT pharmacy team and regular meetings of a joint medicines management group.

There was considerable variety in the way in which the performance of services was reviewed. The more robust commissioners had monthly meetings with providers whilst two of the sites met quarterly. Whilst all areas regularly reviewed performance against the NQRs, a wider performance review including trends and quality information was not evident in some areas, with other areas monitoring a vast amount of information. One provider generated an exception report every time an NQR was missed, which involved a full clinical case review. This information was then shared with the commissioner. Some commissioners appeared satisfied with a high level “traffic lighted” report of the NQRs for the last reporting period, whilst others insisted on examining trends in performance, looking at detailed staffing information, and requesting sight of audits, complaints and case record reviews. A few had developed versions of quality frameworks or care quality indicators for the out-of-hours service and had separate clinical quality boards for the service – we believe that this approach demonstrates good practice.

There was also variation in the review of patient experience with a mix of monthly and quarterly surveys. However, one service had moved to an annual survey – we feel that despite the positive results gained this is not a sufficiently regular review to enable issues in the service to be identified.

We saw little evidence that out-of-hours was included regularly on the PCT Board agenda except where performance had been identified as a cause for concern or where there had recently been a change in provider. This tells us that out-of-hours is not a high priority for PCTs when compared with other agendas such as A&E, ambulance services and 18 weeks despite the fact that poor performance in the out-of-hours service can have significant knock on effects in many other parts of the healthcare system. It would also feature as a key area of concern in a risk assessment of clinical services. We were therefore not clear on how PCT boards gained assurance of the quality of the OOH service delivered to their population. Furthermore, no PCTs mentioned the role of the SHA in assuring the effective contract or performance management of out-of-hours services.

Finally, whilst all the areas we visited had at some point participated in the Primary Care Foundation Benchmark there were varying accounts of how the PCTs and providers had used this information. One PCT had withdrawn from the survey, stating that it did not take account of the integrated service model
operating in the area and preferred not to discuss the issue further with the Primary Care Foundation. Another PCT had not discussed the results of the benchmark with its provider. Other areas stated that they found it a very valuable exercise when assessing relative performance of their service. One area stated that the benchmark had made them stop and think about their service and had highlighted several areas where further work was needed. The opportunity to discuss issues with other PCTs in the benchmark also appeared to be a positive. We were left with the overall impression that whilst the benchmark requires continual development and further review it remains a valuable tool available to PCTs.

c) What good looks like

In this section, we have attempted to describe for PCTs what “good” looks like in the commissioning and performance management of out-of-hours services, particularly from a patient perspective. It was gathered from our visits to PCTs and providers, and from wider discussions with colleagues and the advisory group.

Relationships and Integration

- The out-of-hours service is commissioned to meet the needs of the local population, and reflects the views of local public engagement and/or consultation. It is also complementary to other services available (e.g., 8-8 primary care centres, Minor Injuries Units, Urgent Care Centres) so that patients are clear on their service options. The integrated urgent care service model delivered in Durham and Darlington would be a good example of an integrated service.
- Any procurement of the service is professionally run and allows adequate time for a robust process (it is advisable that this should be a minimum of 9 months for procurement and a further 6 months for the new service to mobilise).
- Commissioners support the integration of out-of-hours providers into the local health economy, by encouraging membership of local urgent and emergency care networks and partnership working with other stakeholders such as A&E, ambulance services and urgent care centres to enhance quality and efficiency. However, whatever form the service takes the NQRs must be delivered.
- A good relationship between the commissioner and provider will see encouragement and support from commissioners to foster partnership working, with a backdrop of a robust contractual and performance management framework.
- In turn, the provider will engage with the commissioner in honest and open discussions about performance.
- There will be good relationships between the commissioner, provider and GP practices in the area, which supports any necessary discussions about episodes of patient care and ensures good GP participation in OOH work.
- Local GPs and PBC consortia are involved in the assessment and/or feedback of out-of-hours service performance with appropriate Local Medical Committee involvement.
• Good relationships exist between PCTs, OOH providers and post-graduate deaneries to ensure a high quality OOH training programme is delivered for GP Registrars

**Performance Management**

• There will be regular meetings between commissioners and providers (the frequency of which will be appropriate to the current circumstances but will be at least quarterly). These will be attended by senior members of each organisation.

• Providers will be required to submit regular reports on compliance with contractual requirements, which will include, but will not be limited to the National Quality Requirements. This dataset will include trend analysis and benchmarking information in order to track progress over time.

• A good contract will also contain additional key performance indicators, which could measure items such as appropriateness of referrals and treatment (via retrospective audit), percentage of patients who had to receive a callback, the percentage of patients who were dealt with by self-care advice and the requirement to conduct “mystery shopper” surveys.

• The PCT board will be actively involved in the performance management of out-of-hours services and will receive regular performance reports, with the SHA providing additional oversight.

• PCT managers responsible for commissioning and performance managing the service will be clear on when to escalate issues with the service to the appropriate Director or PCT Board.

**Quality**

• Good commissioning of out-of-hours services will have a focus on quality.

• Commissioners will ensure that providers have robust policies and procedures in place regarding clinical governance. If more than one provider is involved in the out-of-hours service there will be shared, documented clinical governance processes and the providers will meet together regularly with a sole focus on clinical governance issues. Ideally there should be an accountable lead provider.

• Quality and safety will be key agenda items at the contract meetings between commissioners and providers, but ideally, they will be the focus of separate quality board meetings attended by senior clinicians and managers from commissioners and providers, as well as local GPs and PBC consortia.

• Discussions at such meetings will be focussed on ensuring that lessons are learned and assuring commissioners that providers have appropriate systems in place to record such items and monitor trends

• Commissioners will be au-fait with arrangements in place for clinical audit, which should extend beyond the RCGP toolkit. There will be trend analysis of clinical performance for common and/or high impact conditions as part of these audits, which could then be used to form part of an internal or external benchmark to help raise standards.

**Patient Perspective**
• The patient is aware that OOH services exist in the local area, and knows how to contact them, either via phone or walk-in (multiple access routes are desirable)
• The patient can access a website that contains up to date local service information as an alternative or supplement to calling the service
• Any call is answered promptly by a call handler or clinician who the patient can easily understand
• The OOH service is able to access the patient record, or a summary of it with appropriate patient consent
• An appropriate clinical assessment is conducted either over the phone or in person after an immediately life threatening condition is ruled out. The patient understands the process and is guided through it by the clinician
• The clinician conducting the assessment is appropriate for the patient’s presenting condition. Appropriateness could be measured in local patient surveys.
• After appropriate phone assessment, the patient is offered advice, a home visit or an appointment at a primary care centre (PCC) within appropriate timescales as dictated by the presenting condition. However, referral to another service such as dental, mental health or community nursing may be required, and should be executed swiftly
• The assessing clinician has a good knowledge of the patient’s local area and services (or easy access to this information) which allows them to decide on the most appropriate outcome for the patient
• The patient presenting via the phone is dealt with, where possible in one call. If a call-back is necessary the patient is aware of the timescale for this and knows how to contact the service if their condition worsens
• If there are delays to call-backs then a “comfort call” is made to the patient (although the frequency of such calls should be audited and reported to the commissioner)
• If advice is given it is clear, comprehensive and contains instructions for what to do if the condition persists
• If a PCC appointment is necessary, the patient understands where the centre is and how to reach it. If required and beneficial, patient transport is offered (e.g. rural area)
• For a home visit or PCC the patient is seen by an appropriate clinician who can be easily understood
• If medication is required on a home visit it is dispensed from the provider’s stocks
• Medication required at a PCC is available from an on-site pharmacy wherever possible
• The patient experiences a seamless pathway of care regardless of the number of clinicians or organisations involved in providing care
• The patient is offered an opportunity to provide feedback on their care episode either in real time or by retrospective completion of a questionnaire or telephone survey
• Data from the consultation is available by 8am the next working day to the registered practice to enable them to initiate any necessary follow-ups.

**d) Recommendations**
Commissioning and Performance Management

1. PCTs should review the performance management arrangements in place for their out-of-hours services and ensure they are robust and fit for purpose. This includes the frequency of the contractual review meetings with providers, and the seniority of staff attending these meetings (including clinicians). There should be a quality review meeting separate to the contractual review attended by senior clinicians from both organisations and other appropriate senior clinicians. In particular, we want PCTs to involve local GPs in the process. This can be achieved by working with their Local Medical Committees, RCGP groups, Faculties, clinical executive groups, local and with practice-based commissioning consortia. Nonetheless, providers need to be clear that they are accountable for the delivery of services. Clarity of accountability is particularly important where provision is split between two or more providers.

2. PCTs should supplement the core National Quality Requirements (NQRs) with a suite of locally developed quality indicators, which include requirements to monitor clinical outcomes trends, patient reported outcomes and undertake more intensive patient and stakeholder feedback surveys. Consideration should be given to quality incentive payments linked to these local KPIs.

3. In line with National Quality Requirement 5, PCTs and providers should review the current arrangements in place for receiving patient experience reports. PCTs should also consider how other feedback received on the service (whether formally via complaints, or informally via the PALS service etc) could be incorporated into performance management arrangements. They should also ensure that they are regularly sourcing feedback from other stakeholders such as local GPs, A&Es and ambulance services, and examining trends in incidents reported. If feedback indicates any trends, PCTs should ensure they follow these up immediately.

4. PCTs should support out-of-hours providers to become a valued and integral part of the local health economy, ensuring that they have a place on any local urgent care boards or networks. This would include ensuring the provider is able to develop integrated care pathways with other parts of the system including A&E and ambulance services to ensure delivery of an integrated, efficient service.

5. PCTs and out-of-hours providers should benchmark their services in ensuring the validity of their performance data. For instance, this could include participation in the Primary Care Foundation Benchmarking exercise. Benchmarking will enable PCTs to consider whether the resources allocated to the service are sufficient to ensure delivery of productive and high quality services.
6. The Primary Care Foundation should continue to work with participating PCTs, providers and the Department of Health to ensure that the recommendations of their recent benchmark review are implemented, whilst taking into account the findings of this, and the forthcoming CQC report. In particular, there needs to be assurance that commissioners and providers are consistently interpreting the NQRs.

7. SHAs should monitor action taken by PCTs in response to this report and in carrying out appropriate performance management of out-of-hours providers. Ideally, the safety and performance of out-of-hours services and actions arising from this report should be a standing item on PCT, SHA and out-of-hours provider Board agendas for the next 6 months. Boards may then wish to review the frequency of updates they receive.

8. The Department should strongly consider the development and introduction of an improvement programme for PCTs to support their commissioning and performance management of out-of-hours services. This should include support to ensure they are effectively monitoring the National Quality Requirements and other key clinical indicators to ensure that the out-of-hours service is safe, effective, efficient and responsive.
Selection, Induction, Training and Use of out-of-hours Clinicians (including use of locum GPs)

a) Background

Staff working for out-of-hours organisations deliver a service that can have marked differences to the type of care delivered in GP practices Monday-Friday 8am to 6.30pm. They treat patients who are not known to them, often without access to their medical records. Furthermore, their initial contact and assessment of these patients is invariably on the telephone. They may work in settings that are not like their usual surgery or place of work, and they use unfamiliar equipment. They may work in an area unfamiliar to them, and with colleagues who they have never worked with before. In addition, they may deal with a higher proportion of patients who are in need of urgent care, and are therefore particularly vulnerable. These may be the young, the elderly, or those with chronic or terminal conditions. Out-of-hours services therefore will have a high risk assessment scoring. For all of these reasons it is imperative that staff are selected, inducted and trained using rigorous and effective procedures.

PCTs and employers can provide induction to ensure an individual doctor is competent to practise in the intended job. If the PCT considers a doctor is unsuitable or admitting him would be prejudicial to the efficiency of the services, it may refuse to include the doctor on the Performers List.

This applies even though the doctors will be on the GMC GP’s Register and their qualifications in general practice will have been checked by the GMC. The PCT will not know at the time it admits a GP to its list whether the doctor is to work in a practice, in an out-of-hours service or as a locum.

b) GP Registrar Training

Ensuring that GP Registrars are trained comprehensively and consistently in delivering out-of-hours services is key to ensuring that doctors have the necessary skills to work safely in this high-risk area. Furthermore, if Registrars have a robust, structured and enjoyable training experience in an area where good relationships exist between the PCT, Provider and deanery, we believe that they would be empowered to continue to work in the service once qualified. This will ensure that local, suitably skilled doctors are working in the out-of-hours service, and should remove the need for providers to offer intensive induction for doctors who are not familiar with the local area, the unique nature of out-of-hours care, or both.

We believe it is appropriate to draw attention to the letter\(^7\) sent to all PCT Chief Executives by Clare Chapman, the Department of Health’s Director for Workforce on 17 December 2009 concerning the required increase in GP

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\(^7\)http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_110331
Registrar training sessions, as this supports the points we make above. Furthermore, the out-of-hours training section of the RCGP website\(^8\) provides comprehensive information for PCTs, Providers and post-graduate deaneries on the contents of a well-structured, comprehensive and consistent OOHs training programme for GP Registrars. Our report recommendations therefore take account of this important issue.

c) Evidence from discussions with commissioners and providers

Our site visits provided us with a valuable insight into the selection, induction and training of clinicians involved in delivering out-of-hours services.

We found limited evidence that providers were assessing the clinical skills or competence of staff before recruiting them to perform clinical duties. The majority appeared not to use a clinical scenario type approach to interviews. Instead, the process appeared to be one of standard interview (although some providers did not interview at all) and a check of items such as Performers List status, formal clinical qualifications, work history etc. In some instances providers simply relied on the checks that had been conducted for the application to the PCT Performers List. Some providers did not request references, or even if they did, did not chase the non-return or check the provenance of these. Some providers did require staff to have significant experience in primary care or in delivering out-of-hours care but this was not universal. Whilst this form of recruitment may mirror that which is usually undertaken in primary care we are concerned that it is not always sufficient for out-of-hours services. As we have previously stated the types of patients and the circumstances found in out-of-hours are markedly different to those presenting in routine primary care environments and providers should therefore assure themselves that their staff are clinically competent for the situations in which they will find themselves. Most providers stated that they closely monitored new clinicians in their first few shifts, both by shadowing and mentorship arrangements, and that case reviews and audit were undertaken frequently for these staff. However, it is possible that by the time this occurred, clinical errors will already have been made. One provider did not supervise new clinicians, instead asking them to ‘buddy-up’ with the other clinician on shift and sending new GPs to home visits unsupervised. This was of concern to us as we would expect that GPs new to working in a service (whether experienced in other general practice work or not) should be shadowed in their first few shifts.

We observed a variety of approaches taken in organising the skill mix of the out-of-hours services we visited. Call handling and clinical triage was typically undertaken by a mix of call handlers and nurses, with doctor support for advice as required, although one provider used only doctors after the initial call handling. Interestingly, this service was not more expensive than those that used mainly nurses, presumably because it was more productive. However, it was the face-to-face aspect of treatment, which interested us

\(^8\) http://www.rcgp-curriculum.org.uk/nmrcgp/wpba/out_of_hours.aspx
most. The majority of services appeared to have a mix of staff attending to patients who required a primary care centre appointment or home visit. Typically, this mix included GPs, nurses, and advanced practitioners who were variously described as ‘nurse practitioners’ ‘emergency care practitioners’ or ‘specialist practitioners’. Despite the differing terms, these definitions all appeared to describe nurses with advanced qualifications and the ability to prescribe. In the majority of cases, these practitioners appeared to be allocated to appointments and visits according to the presenting condition of the patient, and a doctor was always sent if the patient’s condition appeared to indicate this was necessary. However, we did see one service where home visits were only provided by advanced nurse practitioners, albeit with a back up of a GP on call to provide phone advice or visit if necessary. In view of the complexity and multiple pathology of many of those patients that require a home visit this could be an area of concern.

We believe it is worth emphasising to both commissioners and providers alike that ‘skill-mix’ should refer to a patient being offered an appointment with the most appropriate clinician for their presenting condition. It should also be noted that the National Quality Requirements refer to patients being guaranteed a consultation with a GP if there is a clinical need. We would not expect to see ‘skill-mix’ being used to save money or to substitute the necessary use of GPs in an out-of-hours service.

We observed variation in induction arrangements for clinical staff new to the service. Some providers had comprehensive plans, which were delivered by fellow clinicians and incorporated training on the IM&T system, prescribing arrangements, organisational policy, local information, and local services/referral routes etc. Others appeared less developed and were delivered by the shift supervisor or involved the new clinician reading lots of policies and procedures. However, the majority of providers had robust shadowing and monitoring arrangements in place for when new clinicians were working. We were also given detailed explanations of the call and case review processes used by organisations, and details of the clinical audit processes used, most of which followed the RCGP toolkit, although one organisation preferred to use their own audit tool. Two organisations had also purchased the services of an external audit agency to ensure that their approaches to risk management, information governance, standards for better health and general organisational culture were subject to external scrutiny. This is an approach we would recommend as good practice to all providers.

Areas had similar approaches to the poor performance of clinicians. One commissioner stated that their concern with locum use was that the provider would not tackle the poor performance and would simply not book the doctor again as it is difficult to engage a PCT in the issue if they are not local. However, the majority of areas did have formal processes in place between provider and commissioner which allowed the provider (either formally or informally depending on the circumstances) to alert the PCT to their concerns. One provider gave a recent example of a GP being referred back to the PCT for poor performance whilst another gave examples of where a poor performance in an audit exercise had resulted in a referral to the PCT and one
instance where the GP was suspended from out-of-hours duty and referred to the GMC.

PCTs varied in their understanding and awareness of provider recruitment and induction policy. We found limited evidence that commissioners knew or questioned if the provider had an established skills outline in place for clinicians and some were not able to describe the induction process that clinicians underwent at all. However, one PCT had a very detailed understanding of the processes employed whilst another went as far as to vet all clinicians who the provider wished to recruit. Whilst we are not advocating that commissioners should become integrally involved in their provider’s recruitment or selection of staff, we do believe that for the reasons outlined earlier, PCTs should have an understanding of the processes used, and should include this area in their regular contractual review meetings.

Half of the areas visited stated that they used locums to deliver their service. However, most stated that this was a rare occurrence and that when this occurred they used known doctors who had worked for them many times before. Rather than resort to locum use another site brought in its own Polish doctors to cover shifts, which it sourced itself and used for a week at a time. The provider reported that these GPs were popular with patients and were a valued part of the team. One site refused to use locum doctors from agencies or any GP who did not work in the local area, relying instead on a back up rota of local GPs if a clinician fell ill at short notice. We also heard of concerns about locum and sessional staff, working in OOH services and elsewhere in primary medical services, not being covered by NHS arrangements for appraisal and CPD. We are hopeful that this situation will be remedied with the introduction of Responsible Officers. Locum doctors working in primary medical services will relate to the Responsible Officer for the PCT in whose list they appear. It is important that OOH providers support the development of their staff ensuring they are kept up to date and provide assistance in preparing information that they will need for appraisal and revalidation.

All areas reported that they had good relationships with local GPs, which meant they had a good supply to work in the service, although one provider was concerned that the approaching retirement of several regular GPs may be a concern and was planning to re-engage with the local GP community to source more support. It should be noted that we did not examine staffing rotas in the services we visited due to constraints on our time to complete this work, so relied on provider and commissioner suggestions about the supply of GPs for the service.

We did note that in areas where there was an excellent relationship between the providers, PCTs and the deanery, and where a robust package of OOH training was delivered for GP Registrars, these GPs were more likely to continue to work for the service once qualified. This ensured continuity of provision by local doctors who were trained adequately in the delivery of out-of-hours care.
Finally, we found that most providers did not have an accurate picture of how many hours their GPs were working in other jobs, either in or out-of-hours. Whilst we appreciate that providers rely on clinicians to monitor themselves, some providers could perhaps have considered this issue more. One provider stated that they had recently prevented a single-handed GP from working for them after discovering he was attempting to work several overnight shifts, and that as a matter of routine they looked out for warning signs such as tired clinicians, mistakes being made on the clinical system or GPs changing their shift patterns. This approach is one we would recommend to all providers.

d) Evidence from NHS Alliance questionnaire

To assist us in understanding the use of locums in out-of-hours services we sought the assistance of the NHS Alliance’s out-of-hours provider network through an anonymised questionnaire.

24 organisations responded to the request from a sample size of 76. 75% of these (18) said that they never used locum agencies. 25% (six) said that they did occasionally use locum agencies. The survey therefore suggests that most out-of-hours providers who replied to the questionnaire manage their service in such a way as to avoid using support from locum agencies. Many felt that if there was a good relationship with local GPs, this should be unnecessary. Others who do use locums indicated that they had developed long-term relationships with individuals who come in to provide cover. One example is a provider who has brought in individual Polish GPs for five years who come over for a week at a time and receive excellent feedback and plaudits from service users.

Of greater concern is when unknown individuals are sourced at short notice, especially if the out-of-hours provider relies on the checks carried out by a locum agency rather than interviewing the clinician concerned and inducting them themselves. This appears to be relatively uncommon but there was variation in the extent to which providers vetted and inducted the locums sourced by agencies. Some providers identified a long list of checks and requirements, with which any locum employed by them would have to comply. Further to this, they indicated that they would interview and assess the locum following their standard procedures for regular staff. Others specified fewer requirements and left the checking of these to the agency. Induction arrangements for locums also differed between the six. Some specified a full induction and intense supervision on the initial clinical sessions, whilst others simply referred to provision of handbooks, policies and induction packs.

Of most concern to us was the wide range of locum agencies used by a small numbers of providers. The six providers used 15 different agencies between them, and no two providers used the same agency. Although some of the providers stated that they had seen the agency code of conduct, it is less clear whether and how these agencies are regulated.

e) What does good look like
In this section, we have attempted to describe for PCTs and providers what “good” looks like in the selection and induction of staff to work in out-of-hours services, including the use of locums.

**Selection/Training**
Commissioners should:
- Assure themselves that providers recruit appropriately qualified and trained staff, and that there is an appropriate skill mix. This includes requirements for doctors to be on an English Medical Performers List (preferably locally), have UK in-hours GP experience (preferably locally) and good command of the English language.
- Ensure that it is a contractual requirement for providers to work with the post-graduate deanery to develop a comprehensive training programme for GP Registrars
- Consider the value of stipulating that staff with local knowledge and experience of local in-hours should work in the out-of-hours service. This will ensure that patients receive appropriate care and signposting in line with local services and protocols.

Providers should:
- Ensure that they comply with all relevant legislation and with the commissioners’ contractual requirements when recruiting, selecting and training staff (including GP Registrars).
- Have a robust selection process governed by a knowledge and skills framework for all staff. This should cover qualifications and eligibility requirements and sight of references as well as an interview process covering knowledge, experience and a review of clinical skills. The process used in Nottingham incorporating a comprehensive assessment of the individual clinician is an example of best practice.

**Induction**
- Commissioners mandate a robust induction process from their providers, with particular reference to the induction of staff unfamiliar with the area or the provider. This assures them that staff working in the out-of-hours period are familiar with all necessary policies and procedures, and with the local area.
- As part of the induction providers satisfy themselves that GPs have a good command of the English language and are familiar with relevant UK and local procedures, which may differ from their usual place of work.
- Provider induction processes include a thorough demonstration of and training in the clinical system to be used, and prescribing processes including any local formulary and the use of controlled drugs. A more individually tailored induction process will be used when a GP is working a first shift in the UK or is not familiar with the geographical area.
- There are robust shadowing arrangements in place for an appropriate number of shifts, and mentoring support is available when required. An initial audit and case review process will be conducted after the first few sessions worked

**Use of locum agencies**
• The use of locum agencies is the exception rather than the norm, and is only required for instances such as unexpected sickness leave.
• If the use of an agency is unavoidable, providers try to use a preferred agency with whom they have a well-established working relationship with.
• Providers have a signed agreement in place with the agency and have seen the agency code of practice
• Any recruitment requirements of the provider, or requirements mandated to the provider by the PCT are passed through to the agency
• The provider understands what checks the agency conducts, and sees evidence of these
• The provider’s knowledge and skills outline for clinical staff should also apply to any locum staff.
• Locums go through the same induction, shadowing and mentorship process as regular staff

f) Recommendations

1. PCTs and Providers should continue to work with post-graduate deaneries to ensure the provision of a comprehensive, consistent and well-structured training programme for GP Registrars, which complies with COGPED guidance, and with the Department of Health letter of 17th December 2009.

2. The RCGP should review the guidance concerning GP Registrars’ training in out-of-hours and should update this as necessary. This work should involve engagement with the necessary stakeholders including COGPED.

3. Out-of-hours providers should consider the recruitment and selection processes in place for clinical staff to ensure they are robust and that they are following best practice in this area. This includes evidence of a detailed knowledge and skills outline for staff which sets out the generic qualifications and appropriate experience, skills (including telephone assessment) and knowledge required to work in the out-of-hours service and should be applied to all locums as well as staff who regularly work for the provider.

4. Out-of-hours providers should consider the contents of their induction process to ensure that it is comprehensive and is completed before any staff work a first shift for the service. This induction process should be tailored according to the needs of the individual staff member, and would be more detailed for staff who have not previously worked in the local area or in the out-of-hours service. Special consideration should be given to induction requirements for staff who do not usually work in the UK. The induction process should be followed up by appropriate shadowing and mentoring arrangements, particularly for less experienced staff.

5. PCTs should review whether recruitment, induction and mentoring requirements for the out-of-hours provider are set out adequately in
their contract with the provider, and satisfy themselves that these are passed through to any sub-contractor or agency, which the provider engages.

6. Providers should co-operate with other local and regional providers (both in and out-of-hours) to share any concerns over staff working excessive hours for their respective services. PCTs and providers alike should also encourage clinical staff to share information about their working arrangements with all organisations that they work for, and providers should ideally put this requirement in their clinicians’ contracts.

7. Out-of-hours providers should consider the adequacy of their clinical governance arrangements (including those for clinical audit) and should consider undertaking trend analysis of clinical performance for common and/or high impact conditions as part of these audits. These could be used to form part of an internal or external benchmark of clinical performance to help raise standards. PCTs should also ensure they consider the cost of the provider undertaking these audits as part of recommendation 5.

8. PCTs should regularly check that all the locum and sessional staff on their Medical Performers List have appropriate access to appraisal and continuing professional development (CPD).

9. Out-of-hours providers should consider the benefit of signing agreements with locum agencies for preferred provider status to ensure consistency in the quality of any locums required.

10. The Department of Health and Care Quality Commission should ensure that when registration of out-of-hours providers is introduced in 2012, that the requirement for organisations to source workers who are fit to practise should include those workers sourced by the provider from a locum agency.
Management and Operation of Performers Lists

a) Background

The provisions of the Performers Lists Regulations\(^9\) ensure that all general medical practitioners in England must be included in a list held by a PCT before they can perform primary medical services. The Medical Performers List represents a consolidation of the Medical Services and Supplementary Medical Lists which previously existed for GMS, PMS and sessional doctors.

The Performers List system enables PCTs to assure the suitability of all general practice doctors, dentists and optometrists who intend to undertake NHS Primary Medical, Dental or Ophthalmic Services in their area through admission, suspension and removal procedures. The list system is intended to provide a framework to protect patients from unsuitable or inefficient practitioners, and to enable PCTs to intervene at an early stage for practitioners whose performance is beginning to fall away from the required standards.

In 2007, the Department of Health set up a review group to consider the working of the Performers List system. The outcome of the review was published in *Tackling Concerns Locally: the Performers List system, A review of current arrangements and recommendations for the future* in March 2009. The review team concluded that the Performers List system fulfilled a useful function in protecting patients, but that there was considerable scope for improving the operation of the system and for achieving more consistent standards in its application. The Department will be implementing the Performers List review over the coming months and we consider that many of the recommendations will improve the regulation of doctors providing out-of-hours services.

We also noted that during the next stage of its inquiry into Take Care Now’s provision of services, the CQC will give further consideration as to how doctors are admitted to Medical Performers Lists and the Department will need to take these on board in addition to the recommendations we have made. Finally, we hope that our recommendations will enhance and complement other changes such as the introduction of Responsible Officers, the GMC’s licences to practise, and revalidation, which are designed to safeguard the public.

Evidence from discussions with commissioners and providers

PCTs generally accepted that the public should be able to assume that the doctors who they see or speak to out-of-hours are as well qualified and experienced as the doctors they would see during a daytime consultation. It was also accepted that not all doctors would be equally effective in an out-of-

\(^9\) The National Health Service (Performers Lists) Regulations 2004 SI 2004 No 585 (as amended)
hours setting as they would in the daytime surgery where there is immediate support of colleagues available.

The out-of-hours services which we visited ranged from one which only used contractors from local practices to one where services were provided by other professionals in the team (not covered by the Performers List arrangements) and (with suitable supervision) GP Registrars.

The PCT has two ways of ensuring the quality of the practitioners providing out-of-hours services. First through their responsibilities for admitting the doctors to their Medical Performers List (though they may have to rely on another PCT if the doctor is listed elsewhere). Secondly through any requirements it has made in the contract (see comments above and the recommendation already made). It is therefore vital that PCTs make effective use of their listing powers and all PCTs carry out their responsibilities with equal effectiveness.

**Checking of medical qualifications**
We heard of lingering concerns about the effectiveness of the GMC’s checking of medical qualifications. In general we believe that this mistrust is misplaced. All doctors are seen by the GMC in person (this is not the case when PCTs are considering Performers List applications). The GMC is therefore able to verify the identity of the doctor and to take a photograph. The educational qualifications are checked to ensure they are genuine, are recognised by the GMC and relate to the person applying for registration. The original documentation is scanned into the GMC’s computer system. PCTs are not universally in as good a position as the GMC to make these checks.

The Performers List review questioned the duplication of this checking of qualifications by PCTs. We consider that it would be reasonable for PCTs to be able to rely on the check they make that the doctor is on the GP Register to confirm that he has a recognised qualification in general practice and that there may be no need for further scrutiny of original medical degree certificates. In the future, there are prospects for PCTs to be able to download the GMC’s images of the documentation if they want them for their own records and the photographic image of the doctor would give them additional assurance against impersonation.

One PCT we visited encouraged applicants to attend their offices with their application and supporting documentation. Another offered a face to face meeting with the applicant where further information or clarification was required. Alternatively the matter might be followed up on the telephone. This gave these PCTs the opportunity to discuss the completeness of the information provided informally and to explain if further information might be necessary, for example, where references did not appear to cover the doctor’s recent clinical experience; there were discrepancies in the doctor’s names on different documents; or there was no indication as to the doctor’s knowledge of English and English was not his first language. We consider that this may be a useful approach and the Department may wish to consider issuing guidance about these sorts of voluntary, informal discussions.
**Language knowledge and communication**

There are clear misunderstandings about the GMC’s ability to conduct language tests in respect of doctors from the EEA. Under EU law\(^{10}\) they cannot do this. Some PCTs were uncertain of the circumstances in which they should be checking the knowledge of English of applicants to their Medical Performers Lists and how this should be handled. Some PCTs have specific questions about language knowledge in their application forms. Whilst the Department of Health has issued guidance recently on its website in respect of dentists, there is no equivalent guidance for doctors in primary care.

We found that there were different approaches to how a PCT checked the language knowledge of applicants to its Medical Performers List. However, it was agreed that all doctors should be able to converse with patients or their helpers; be able to read and understand the BNF; talk to pharmacists and other healthcare professionals; and, be able to arrange admissions to hospitals. Under the Performers Lists Regulations PCTs must be satisfied about a doctor’s knowledge of English\(^{11}\) and they may therefore require evidence of language knowledge and should do so in appropriate cases.

The regulations provide for a postal application procedure: there are no powers in the regulations for a PCT to require an applicant to attend for an interview or to take a language test. Indeed, it is up to the applicants to decide how they can demonstrate that they have the necessary knowledge of English.

There was also some confusion over whether doctors could be admitted to a list with conditions that they rapidly improve their knowledge of English by attending an English language course. We understand that under the present Performers List regulations a PCT must refuse entry to its list if it is not satisfied that the applicant has the necessary knowledge of English.

We concluded that there is too much variance of approach across PCTs. The Department of Health will need to consider:

- whether guidance for migrant doctors on meeting language knowledge requirements is needed and who might provide it;
- what guidance can be given to PCTs to assist them in making decisions about whether or not a doctor has the necessary knowledge of English to perform primary medical services in the PCT’s area.

The Department should issue guidance if considered necessary.

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\(^{10}\) EU law provides for the mutual recognition of qualifications held by EU nationals (and this applies to all EEA nationals). Language proficiency requirements of the host state cannot be a barrier to this recognition. The Medical Act 1983 (as amended) gives effect to the EU law and does not permit the GMC to test for English language ability as a preliminary to registration.

\(^{11}\) Regulation 6(2)(b) states that a PCT must refuse to include a doctor on its list if “it is not satisfied he has the knowledge of English which, in his own interests or those of his patients, is necessary in performing the services, which those included in the relevant performers list perform, in its area;”
Training and Induction
As noted in a previous section of this report, the Department has recently issued guidance about improving training in out-of-hours provision and that this should be included in contracts. We were pleased to see evidence that GP Registrars received comprehensive training in the out of hours setting and we hope this will encourage them to continue working for these services once qualified.

The Performers List review identified some problems with the listing of GP Registrars and it is important that the opportunity to remedy these matters, if required, is taken. One PCT suggested that some of the requirements of the regulations were not relevant for GP Registrars and also the need to apply again for inclusion in a list when fully qualified, as a GP, seemed unnecessary; the Department may wish to explore this further.

We have already made recommendations about the provision of induction. All doctors entering out-of-hours services for the first time will need to receive tailored induction training by the provider. The scope of the induction may need to be broader for doctors who are unfamiliar with the UK health services. The Performers List review recommended that:

> There should be a formal induction process to help new performers settle into local health economies. This would be tailored to the needs of the individual but would typically cover both local and (for those who had not previously worked in primary care in the UK) national elements.

We consider that PCTs should ensure that all doctors who had not provided primary medical services in the NHS previously, complete a period of induction training before starting to perform primary medical services.

Disciplinary processes
We have already discussed in the section on Selection, Induction, Training and Use of out-of-hours Clinicians some aspects of tackling performance issues for staff only doing sessional or out-of-hours work. There was also some uncertainty about how PCTs should handle concerns about individual practitioners’ misconduct and capability when the events occurred outside the area covered by the PCT in whose list the performer appeared. Similar concerns were raised resulting from the relationship between the PCT as commissioner and the provider as employer – which organisation had the prime responsibility to take action? We understand that these issues are being addressed in the guidance being issued in 2010 by the National Clinical Assessment Service. We have therefore not made a recommendation on this matter.

Exchange of information
The Performers List review made a number of recommendations on the exchange of information. There are currently a number of requirements in the Regulations for the notification of decisions (for example where a PCT takes decisions to refuse admission, impose conditions, suspend or remove a doctor). In our view, PCTs should also be made aware of applications which
have been made for inclusion on a Medical Performers List but which are then withdrawn by the applicant.

We consider that PCTs need to be confident that they have access to complete, up-to-date and relevant information about doctors applying for inclusion on their lists and doctors already on their lists. We look to the work being carried out by the Department to introduce the new duty of co-operation as well as the GMC’s review of its Registers to improve the exchange of information. In the meantime, PCTs should be diligent in notification of their decisions as required by the Regulations.

c) What does good look like?

In addition to our findings from our visits we have also looked at the issues addressed by the Performers List review before making conclusions about what good looks like.

During our visits we had reflected back to us the view that PCTs undertook their Performer Lists responsibilities with a varying level of skill and diligence. We look forward to the results of the CQC report on this aspect.

Good commissioners:

- ensure that the administration of their Medical Performers List is adequately resourced;
- do not admit general practitioners with inadequate language skills.
- actively support appraisal and ongoing development of all GPs on their list, including locums and sessional doctors
- actively manage their list to remove doctors who do not provide services in their area;
- pick up and take action on information about poorly performing doctors from a variety of sources during the monitoring of contracts;
- Ensure their arrangements for sick doctors cover locums, sessional doctors and those only performing out-of-hours services.

Good providers:

- follow good employment practices when recruiting and appointing doctors;
- alert the PCT when taking disciplinary action or a doctor leaves their employment without performance issues being resolved first;
- are responsible for ensuring that the people they employ have the required knowledge and skills including language competency for posts for which they are applying.

d) Recommendations

1. The Department of Health should work closely with the GMC to consider to what extent PCTs could rely on the checks of identity and medical qualifications under the GMC’s registration procedures. The
Department should consider streamlining the requirements in the Regulations for the checking of such documentation by PCTs.

2. The Department of Health should, as a matter of urgency issue guidance to PCTs to assist them in making decisions about whether or not a doctor has the necessary knowledge of English to be admitted to their Medical Performers Lists.

3. The Department of Health should consider issuing guidance to PCTs about the circumstances in which PCTs may wish to informally invite applicants for inclusion in their Performers List to discuss their applications with the PCT.

4. In implementing the recommendations of the recent Performers List review, the Department of Health should consider whether all the requirements of the Regulations are appropriate for GP Registrars.

5. PCTs should ensure that all doctors who have not provided primary medical services in the NHS previously be required to complete a period of individually tailored induction before starting to perform primary medical services.

6. The Department of Health should review how the exchange of information between PCTs and the GMC can be improved.
Annex A – Dr David Colin-Thomé letter to PCTs

Gateway reference: 12667

2 October 2009

Dear Colleague

Out of Hours (OOH) Primary Care Services: PCTs’ Contract and Performance Management Arrangements

You will be aware that the Care Quality Commission (CQC) has been conducting an independent enquiry into Take Care Now’s (TCN’s) provision of OOH GP services. The enquiry was triggered by the death of a patient in February 2008 treated by a locum doctor who practised in Germany but was employed by TCN through a locum agency to cover some shifts out of hours in East Cambridge and Fenland.

CQC’s enquiry is considering a number of issues surrounding this case including an examination of the commissioning arrangements by the primary care trusts (PCTs) that contract with TCN to provide OOH GP services for their patients, and performance management of these – particularly the governance and quality checks in place for monitoring those contracts.

CQC expects to publish its report on the enquiry early in 2010. It has today, however, issued an update which includes clear recommendations to those PCTs involved about the need to improve their routine monitoring of OOH GP services. This means more detailed scrutiny of what their providers are delivering against contractual requirements. While the scope of CQC’s current enquiry is limited to a specific number of PCTs and a particular provider, the Department strongly supports these recommendations which are relevant to all commissioners. PCTs should have robust performance management arrangements in place to ensure their OOH service, like any other commissioned service, is delivering against contractual requirements, and world class commissioning will support PCTs to achieve this.

The TCN experience highlights the particular risks associated with the management of medicines in an OOH service, especially in respect of controlled drugs. Commissioners need to assure themselves that current arrangements are robust and safe. There is a wealth of guidance on the safe and effective management of medicines in an OOH service and this is summarised at the end of this letter.

It should be a contractual requirement that OOH providers ensure that the GPs they employ are fit to practice and have been checked properly before being accepted on to their Performers List. Working in an OOH environment poses special challenges, particularly in respect of an appropriate understanding of the way in which services are delivered locally, and effective induction processes for new doctors are an essential precondition for safe practice.
To help PCTs and providers improve quality and productivity of OOHs and reduce local variation, the Department commissioned the Primary Care Foundation to develop and support a benchmarking tool. To date around 90 PCTs have signed up to participate. We have had good feedback on the value of this exercise. I strongly encourage those who have yet to join this benchmarking exercise to do so. You can find out more about the Primary Care Foundation’s benchmarking tool at http://www.primarycarefoundation.co.uk/page1/page1.html

The Royal College of GPs, and jointly, the NHS Alliance and the NHS Confederation have issued their own statements in support of CQC’s update and reinforcing the messages in it. All have set out practical ways for PCTs to strengthen their local arrangements.

If you have any immediate queries about the contents of this letter, please contact James Adedeji, Deputy Head of Urgent & Emergency Care at james.adedeji@dh.gsi.gov.uk

Yours sincerely

DAVID COLIN-THOMÉ
NATIONAL DIRECTOR FOR PRIMARY CARE

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i The CQC’s update can be found at http://www.cqc.org.uk/newsandevents/pressreleases.cfm?cit_id=35381&FAArea1=customWidgets.content_view_1&usecache=false

ii The original OOH medicines guidance that was published at the end of 2004 has detailed guidance about managing doctors’ bags in an OOH service and about access to controlled drugs. This is available at: http://www.mmnetwork.nhs.uk/medicines_supply_guidance__a_practical_guide.pdf. More recently, a toolkit was prepared for commissioners and providers to look at access to medicines. It includes further examples of different ways in which local health communities have solved the challenges around out-of-hours access to controlled drugs. This is available at: http://www.mmnetwork.nhs.uk/Master%20Medicines%20in%20Unplanned%20Medicines%20Toolkit%2026%2011%202008.pdf. Last year Macmillan Cancer Support published a toolkit for out-of-hours services which identified further examples of excellent practice in this field. This is available via the Learnzone section of the Macmillan website. Access to the Toolkit requires people to register with the Macmillan Learnzone and this can be done at: http://learnzone.macmillan.org.uk/

iii http://www.nhsalliance.org/media.asp?display=latest_press_releases

Annex B – Virtual Advisory Group Members

Dr John Canning, Chairman, GPC Contracts and Performance Sub Committee, BMA

Dr David Carson, Primary Care Foundation

Andrew Donald, Chief Operating Officer, Birmingham East and North PCT

Mary Elford, Non-Executive Director, Camidoc, and Barts and the London NHS Trust

Dr Agnelo Fernandes, Urgent Care Lead, RCGP

Dr Jonathan Marshall, GP and Chairman, NAPC

Neil Roberts, Director of Registration and Resources, GMC

Rick Stern, Urgent Care Lead, NHS Alliance

Rob Webster, Chief Executive, Calderdale PCT

Fay Wilson, Medical Director, Badger (OOH provider in Birmingham)

Nigel Wylie, Chief Executive, Urgent Care 24 (OOH provider in Liverpool)
Annex C – National Quality Requirements

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

July 2006
Gateway no. 6893
Introduction

1. From 1st January 2005, all providers of out-of-hours (OOH) services have been required to comply with the national OOH Quality Requirements, first published in October 2004. The recent report by the National Audit Office¹ (NAO) identified a number of problematic aspects of the current Requirements and, since then, the Department has worked with the Royal College of General Practitioners (RCGP) to review the Quality Requirements in the light of these observations.

2. While the NAO Report identified some areas of misunderstanding or misinterpretation of the current Requirements and demonstrated further that some particular Quality Requirements remain challenging (particularly at periods of peak demand), none of its discussions with providers or commissioners revealed any sense that the Quality Requirements were either inappropriate or unachievable. The Department will not therefore be making any changes to the Quality Requirements that were published in October 2004; for ease of reference, they are reproduced below.

3. On the other hand, there is a need to clarify a number of aspects of particular Quality Requirements (including some important confusions about compliance). A number of these issue were addressed in the Commentary that was published at the same time as the Quality Requirements, and while this Introduction provides additional clarification, it should still be read in conjunction with that Commentary.²

4. Consolidated guidance drawing together this Introduction with a revised and updated version of the Commentary will be published later in the summer.

Compliance

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

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

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

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

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² The Commentary is available at [http://www.dh.gov.uk/Urgentcare](http://www.dh.gov.uk/Urgentcare): click on 'Out-of-Hours' in the menu on the left-hand side of the page and, in the new page that opens, click on 'Key Policy Documents' - scroll down to 'New quality requirements for out-of-hours services'
6. All the above measures record average performance, and this can conceal wide variations in practice from day to day, and at different times within the day. It is therefore important that commissioners look behind the averages to see whether there is any recurring pattern which reveals a more serious situation. Where further analysis reveals an inability to put in place sufficient resources on a particular day or a particular time of the week or both, the provider could be deemed to be partially or non-compliant. Thus, for example:

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

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

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

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

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

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

**Definitive Clinical Assessment**

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

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Focusing more clearly on quality and patient experience

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

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

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

Matching capacity to demand

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

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

Conclusion

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

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

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

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

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

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

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

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

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4 A provider is any organisation providing OOH services under GMS, PMS, APMS or PCTMS
8. Initial Telephone Call:

*Engaged and abandoned calls:*

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

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

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

9. Telephone Clinical Assessment

*Identification of immediate life threatening conditions*

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

*Definitive Clinical Assessment*

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

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

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

*Outcome*

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

10. Face to Face Clinical Assessment

*Identification of immediate life threatening conditions*

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

*Definitive Clinical Assessment*

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

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

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

*Outcome*

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

12. **Face-to-face consultations** (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:
   - Emergency: Within 1 hour.
   - Urgent: Within 2 hours.
   - Less urgent: Within 6 hours.

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

APMS – Alternative Provider Medical Services
BMA – British Medical Association
BNF – British National Formulary
COGPED – Committee of General Practice Education Directors
CPD – Continuing Professional Development
CQC – Care Quality Commission
GMC – General Medical Council
GMS – General Medical Services
GP – General Practice/ General Practitioner
IM&T – Information Management and Technology
LMC – Local Medical Committee
KPI – Key Performance Indicators
NAPC – National Association of Primary Care
NHS – National Health Service
NQRs – National Quality Requirements
OOH – Out of hours
PALS – Patient Advice and Liaison Service
PBC – Practice Based Commissioning
PCT – Primary Care Trust
PCTMS – Primary Care Trust Medical Services
PEC – Professional Executive Committee
PMS – Personal Medical Services
RCGP – Royal College of General Practitioners
SHA – Strategic Health Authority
TCN – Take Care Now