Quality Standards in the Delivery of GP Out-of-Hours Services

June 2002

Introduction

In March 2000, the Department of Health commissioned an independent review of GP out-of-hours services. The Review published its Report - *Raising standards for patients. New partnerships in Out-of-Hours Care* (http://www.doh.gov.uk/pricare/oohreport.htm) - in October 2000 and, in accepting all of its twenty-two Recommendations, the government endorsed its view that a new, integrated out-of-hours service could be developed by 2004. Those twenty-two Recommendations were supported by a series of explicit Quality Standards (set out in Section Five of the Report) and together they will ensure that, by the time the Report is fully implemented, patients across the country will have access to the same high quality service. In particular, they will ensure that those organisations outside the NHS that play such a central role in the delivery of GP out-of-hours services will conform to the same standards of provision that currently apply within the NHS.

In order to clarify the character of the new, integrated out-of-hours service, those aspects of the Recommendations that impact on the Quality Standards have been incorporated here into a single, consolidated list. By its very nature, the out-of-hours service is delivered by a variety of different organisations and individuals and thus not every Quality Standard set out here will be relevant to all. A separate document, *The Roles and Responsibilities of those engaged in the delivery of Out-of-Hours Services* (http://www.doh.gov.uk/pricare/rolesandresponsibilites.htm), makes clear the different roles and responsibilities of GPs, Primary Care Trusts and Organised Providers of Out-of-Hours Services.

The Quality Standards set out here are grouped in three broad areas:

- Clinical Governance
- Service and Organisational Models
- Access and Clinical Assessment

Clinical Governance

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

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

People:

1. All professionals involved in out-of-hours care must be eligible to be employed within the relevant parts of the NHS including General Medical Services and Personal Medical Services.
2. The annual appraisal of individual professionals involved in out-of-hours care will include the assessment of out-of-hours skills. For GPs, this will take place within the proposed

appraisal system that will be part of the revalidation of all GPs; for other staff, it will be part of the routine systems developed by all out-of-hours providers.

3. Personal Development Plans should include the development of skills related to out-of-hours activity. These may include telephone clinical assessment skills development.

Record keeping and auditing:

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

Communications within the NHS:

8. Out-of-hours providers must be able to supply full clinical details of all consultations to the host GP by the start of the next working day and providers will monitor the flow of information within and between provider organisations.
9. There must be rapid and effective transmission of out-of-hours patient data between NHS Direct, other service providers and the GP practice.
10. There should be a system for transmission of information about patients with special needs (including terminal care, violent and vulnerable patients) from the practice to the provider.

Complaints, Significant Events and Patients' Satisfaction Data

11. All out-of-hours providers will comply with the NHS complaints procedure.
12. All providers will monitor and audit complaints in relation to individual staff.
13. All providers will always investigate and review all significant events[1] and all reports on such events must include clear recommendations; all reports will be submitted to the PCT responsible for the area in which the event took place.

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

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

Individual GPs and GP rotas

15. Individual GPs and practices not taking part in a Co-operative or deputising arrangements will not be required to report quarterly to their PCT on the quality of the service they provide but, where a PCT has serious concerns about the quality of that service, it can require an individual GP to make such a report (on an exception basis). The records that GPs will need to maintain to provide such an exceptional report are described in *The Roles and Responsibilities of those engaged in the delivery of GP Out-of-Hours Services* and this can be accessed at http://www.doh.gov.uk/pricare/rolesandresponsibilites.htm.

Service and Organisational Models

The structure of out-of-hours services envisaged by the Review will require the closest possible co-operation between the many different organisations (or individuals) that will be involved in the delivery of the service.

16. All accredited organisations must have clear mechanisms for accepting delegated responsibility (including indemnity cover) for the patients for whom they make provision out-of-hours, and they must further demonstrate their ability to match their capacity to meet the (changing) demand for those services and not return responsibility to subscribing GPs.
17. All accredited organisations must report quarterly to the PCT in accordance with the reporting framework.[2] Where an organisation delivers services in the area of more than one PCT, it will report separately on the appropriate part of its activity to each of these PCTs.
18. Service Level Agreements will include standards for both parties to the agreement – e.g. NHS Direct and the out-of-hours provider.
19. All out-of-hours providers must be members of Local Capacity Planning Groups – the composition of these Groups is set out in HSC 2001/014 and includes representatives of all NHS organisations including acute, ambulance, community, mental health NHS Trusts, PCTs and NHS Direct; local Councils with social services responsibilities, the whole range of local independent sector providers, the voluntary sector; and other relevant local partners..
20. All out-of-hours organisations that employ staff and are stewards of public funds must comply with appropriate NHS corporate governance standards.
21. All organisations providing or employing clinical staff must be able to support continuing registration requirements.
22. All organisations must meet NHS human resources standards for continuing personal development and the accreditation of staff.
23. All employment practices must conform to NHS human resources standards.
24. Medicines should be purchased, stored, supplied, administered and disposed of in a safe and secure manner in accordance with current legislation, licensing requirements and best practice.

[2] This can be found in Annex A of *The Roles and Responsibilities of Those Engaged in the Delivery of GP Out-of-hours Services*, Department of Health, 2002.

Access and Clinical Assessment

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

- Problems that require rapid intervention that must be identified as such and passed to the Ambulance Service.
- Response times must be determined by clinical need.
- Response times must be agreed after negotiation between the clinician and the patient during the initial telephone consultation.
- Intervention times must be agreed after negotiation between the clinician and the patient.
- All encounters with the patient must be appropriately recorded, so that every aspect of the out-of-hours service can be properly audited.

Telephone Access:

25. Call engaged and abandonment standards (an abandoned call is defined as one where the caller discontinues the call after 30 seconds, allowing time to listen to a message which may be played before the call is answered):

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

26. Time taken for the initial call to be answered by a person:

    26.1. 90% answered within 30 seconds.
    26.2. All answered within 90 seconds.

27. Identification of immediate life threatening conditions:

    27.1. 90% of immediate life threatening conditions identified within 1 minute.
    27.2. All life threatening conditions identified within 15 minutes.
    27.3. 90% of immediate life threatening conditions passed to the Ambulance Service within 1 minute.
    27.4. All life threatening conditions passed to the Ambulance Service within 15 minutes.

28. Definitive telephone clinical assessment and disposal (excluding those patients who access a Primary Care Centre, Accident and Emergency Department or Walk-in Centre direct, without preliminary telephone clinical assessment – see 31. below):

    28.1. 90% complete within 20 minutes.
    28.2. All complete within 30 minutes.

Face to Face Consultation:

29. Time to episode complete (disposal):

    Visiting standard:

    29.1. Emergency: Within 1 hour.
    29.2. Urgent: Within 2 hours.
    29.3. Less urgent: Within 6 hours.

30. Patients to be informed of timescale during initial consultation, including time to visit at home or appointment time at Primary Care Centre or Walk-in Centre, and *always* contacted if an agreed home visit is delayed or if an appointment time at a Primary Care Centre is delayed.

31. For those patients who have not been clinically assessed on the telephone and who access a Primary Care Centre, Accident and Emergency Department or Walk-in Centre direct:

Time from arrival to initial contact:

31.1. 90% of initial assessment completed within 5 minutes.
31.2. All initial assessment completed within 10 minutes.

Time from initial contact to consultation:

31.3. 90% of patients offered consultation within 45 minutes of arrival.
31.4. All patients offered consultation within 60 minutes of arrival.

Patients with special needs:

32. Non English speaking users:

    32.1. 90% provided with translation service within 10 minutes of initial contact.
    32.2. All provided with translation service within 15 minutes of initial contact.

33. Patients with impaired hearing:

    33.1. A dedicated telephone number will be provided for text phone users to enable them to access the service.
    33.2. Appropriate technology will be installed in NHS Direct call centres to enable callers with less severe hearing impairment to access the service.