

RAISING STANDARDS FOR PATIENTS NEW PARTNERSHIPS IN OUT OF HOURS CARE

THREE YEAR PLANNING GUIDANCE

Introduction

1. PCTs (or PCGs and Health Authorities where PCTs do not yet exist) to develop a three year implementation plan, to deliver the relevant targets in the NHS Plan and the Out-of-Hours Review *"Raising Standards for Patients New Partnerships in Out-of-Hours Care"*. Further information attached to this guidance:

- describes the targets to be achieved nationally; (annex A)
- sets out the performance management framework against which achievement of targets will be measured; (annex A)
- includes examples of delivery mechanisms; (annex A)
- Includes a suggested aide memoire for the implementation plan. (annex B)

Action

2. PCT/Gs to:

- develop a 3 year implementation plan setting out planned activity and the resources being committed to deliver key national and local out-of-hours targets. This plan to include a stocktake of existing out-of-hours services and a plan to achieve the Review Recommendations and Quality Standards by 2004. Further guidance on this plan is provided in Annex A and a suggested aide memoire for the implementation plan is attached as Annex B.
- submit their stocktake of existing services to their HA by the 31 December 2001;
- submit their full 3 year implementation plans to their HA by 28 February 2002;
- As the first point of contact for access to out of hours care, GPs should be central and integral to the planning and development of out of hours services. For example, PCT Executive Committees should be involved in the development of PCT out of hours implementation plans to ensure the engagement of all GP practices.

3. Health Authorities should:

- ensure plans are considered as part of SaFF process;
- demonstrate how the PCT proposals fit with the strategic direction for capacity planning in their area;
- demonstrate full population coverage of single call access and associated quality and reporting systems by 2004;
- agree the overall timetable with NHS Direct locally;
- submit their HA wide plans to their Regional Office by 15 March 2002.

4. Regional Offices should:

- assess HA plans and determine the appropriate allocation of the Out of Hours Implementation Fund. Further guidance will be issued for the allocation of this resource.
5. This guidance applies equally to GMS GP practices and PMS providers.

Enquiries

6. Any queries about the implementation plans or allocation of financial resources should be addressed to Regional Office Primary Care OOH leads:

Northern & Yorkshire	Joyce Lovell
Trent	Phil DaSilva
Eastern	Gordon Miller
London	Pippa Bagnell
South East	Sarah Blow
South West	Trevor Neatherway
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Background

1.

The NHS Plan target for out of hours care is:

“By 2001, there will be new quality standards and closer integration too between NHS Direct and GP out-of-hours services. By 2004 a single phone call to NHS Direct will be a one-stop gateway to out-of-hours healthcare, passing on calls, where necessary, to the appropriate GP co-operative or deputising service.”

2. This target builds on the report of the Independent Review of GP Out of Hours Services (Raising Standards for Patients. New Partnerships in Out of Hours Care) published in October 2000, together with the Department of Health's response. The aim of the Review was to identify ways of bringing the standards of all out of hours services up to the standard of the very best so all of the Review recommendations are currently being provided somewhere in the country.
3. The Review makes 22 recommendations for the future provision of out of hours services and it will clearly take time to achieve the full model of integrated service provision set out in the Review. The report sets out that:
 - Out-of-hours providers will need to be accredited (due April 2002);
 - PCT/Gs will need to plan the provision of services in their area in consultation with their constituent practices; (this guidance) and
 - those providers with no experience of an integrated service will need time to learn from the experience of those who have already pioneered such services (out-of-hours exemplars to start November 2001 and March 2002) .
4. Recommendation 22 states: “the fully integrated model of out-of-hours provision set out in this Report should be achieved by all GPs and out-of-hours providers by 2004.”

General Principles of Planning

5. All PCTs will have to demonstrate how out of hours provision will integrate with other service providers to work across boundaries (many have local A&E / WiC / PCCs and county or city wide visiting services). Where out-of-hours providers cover more than one PCG/T or HA area, an integrated approach to working with the out-of-hours provider is recommended. On this basis, a lead organisation approach to planning and commissioning may be appropriate.
6. When developing the local approach to provision of out of hours services the PCT/G will need to map all of the available services and infrastructure in addition to the core GP service. This includes community nursing, A&E, walk in centres, minor injury units, ambulance service, social care provision, specialist mental health and palliative care services as well as existing out of hours primary care centres.

7. Patient attendances, case mix and infrastructure should be mapped for each existing service and an integrated plan for the provision to the population needs to be prepared. This will include mapping patient flows and case mix/morbidity to the skill mix of available staff making the best use of all skills and competencies available. It should also identify staff development needs to support the delivery of the service more effectively. Account should be taken of the expectation of new entrants to the GP service in relation to out of hours services.
8. PCTs will need to give consideration to the current various models of out of hours provision, paying particular attention to any overlap with in hours services. Future planning should be developed with constituent practices to ensure an appropriate local service supports both the local population and the practitioners providing the service.
9. In order to ensure full delivery of the Review recommendations, workforce planning issues need to be addressed as part of the implementation plan. Links should be made with local Workforce Confederations to ensure workforce planning is in line with service planning.
10. The implementation plans should consider the 22 recommendations made in the Review.

Delivery Mechanisms

11. The out of hours implementation agenda is ambitious, but it outlines a service fit for the 21st century. Partnership and collaborative working will be vital to the delivery of this agenda. Current NHS initiatives will need to be considered in the implementation of the Review. Such initiatives and partners will be able to offer support in delivering the Review recommendations. The following paragraphs provide examples of such existing initiatives:

NHS Walk-in Centres

NHS Walk-in-Centres provide patients with quick access to nurse-led advice, information and treatment for minor injuries and illnesses. Where they exist they can contribute to improvements in access to and convenience of primary care services, by helping to reduce inappropriate attendance's to GP practices, thereby freeing up capacity amongst GPs to see those patients with more complex needs more quickly.

The relevant PCG/Ts should consider how best to utilise NHS Walk-in-Centres in terms of their integration with wider primary care services and in the context of providing advice and treatment out of hours. All NHS Walk-in-Centres can supply medicines under Patient Group Directions and are therefore useful in the provision of medicines out of hours.

NHS Direct

NHS Direct is working in partnership with local OOH providers to integrate systems, via the out of hours Exemplar programme. 22 sites will go live in November 2001 with a further 12 in March 2002, providing integrated service provision for 10 million patients. A national evaluation of the programme will commence in November 2001, in order that early lessons can be shared with the rest of the NHS

Palliative Care

Cancer networks are charged with producing service delivery plans which will set out a three year strategic action plan for cancer services including access to palliative care services. This will include a review of out of hours support both from the specialist palliative care providers and primary health care teams. Where 24 hours community nursing does not exist PCTs should consider developing services where appropriate.

Stocktake of services

12. It is important for the stocktake to have local ownership so it should be developed by building on existing partnership working. Where this does not currently exist the first step will need to be the establishment of an appropriate group of people to consider the local issues. It is essential that all constituent practices are fully involved in the planning and development process. PCTs must take account of the needs of the population and the cover requirements of every practice.
13. The stocktake should include overlaps in provision of service and relationships between existing providers and cover existing service provision and benchmarking it against the Review recommendations.
14. PCTs should submit their stocktakes to their local Health Authority by 30th December 2001. The aide memoire attached as Annex B can be used as a template for this initial stocktake.

Implementation Plan

15. Plans should then demonstrate how the PCT will move from its current position (stocktake) to meet the Review recommendations. This will need to pay particular attention to the best possible use of resources locally, in line with Primary Care Investment Plans, Health Improvement Plans and Service and Financial Frameworks. 3 year implementation plans should be developed identifying the action and resources needed to move towards full compliance with the Review recommendations.
16. PCTs should submit their full 3 year implementation plans to their HA by 28 February 2002

Health Authority action

17. Health Authorities must demonstrate how the proposals fit with the strategic direction for capacity planning in their area, produced via HSC2001/014. Local Capacity Planning Groups should consider inviting their local out of hours providers to join their regular meetings. These should include the human resources required to deliver the plans.
18. Health Authorities should submit their PCT stocktake and implementation plan to their Regional Office by 15 March 2002. This submission should include Health Authority commentary on the overall fit with the strategic direction for capacity planning in the area.

Regional Office Response

19. Regional Offices should assess HA plans and determine the appropriate allocation of the Out of Hours Implementation Fund. Further guidance will be issued for the allocation of this resource.

Funding

20. The existing Out of Hours Development Fund should be used to support out of hours providers in reaching the recommendations and standards defined in the Review. Proposals for the future distribution of the Out of Hours Development Fund (to be renamed Out of Hours Quality Fund) will involve changes to Regulation to remove existing restrictions and devolve the fund to PCTs. The combining of funding streams to support an integrated service will allow a more effective integration of previously separate primary and secondary care staff and resources.
21. Regional Offices will have access to a central Out of Hours Implementation Fund to support PCTs, working with their Out of Hours providers, in delivering the recommendations and standards defined in the Review. The allocation of this resource is subject to supplementary guidance that will be made available to Regional Offices for distribution of the 2002/03 implementation fund.

Performance Management and Monitoring

22. The 3 Year Implementation Plan will support achievement of the Health Improvement Programme and completion of the SaFFs. Accordingly, the plan will need to set out the PCG/Ts planned activity and the resources being committed to out-of-hours services. In addition, the Implementation Plan will need to include evidence of the PCG/Ts progress towards delivering the other infrastructure and workforce investment set out in the NHS Plan.
23. From 2002/03 the PCG/Ts 3 Year Out-of hours Implementation Plan will form a component of its Accountability Agreement with the local Strategic Health Authority. Through this agreement PCG/Ts will be monitored by Strategic Health Authorities on their progress towards the achievement of the access targets.
24. Health Authorities should also demonstrate how the proposals support the strategic direction for capacity planning in their area.
25. Following national criteria, Regions will be responsible for allocating the out-of-hours Implementation Fund for direct investment via health economy plans to support full implementation by 2004.

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NEW PARTNERSHIPS IN OUT OF HOURS CARE**

**AIDE MEMOIRE FOR INITIAL STOCKTAKE
TO SUPPORT 3 YEAR IMPLEMENTATION PLANS**

These plans should be developed in a style common to the PCT in order that they fit with the style of other local plans. Notwithstanding, plans must consider each of the 22 recommendations of the Review and should address the following issues:

1. Where are we now?
2. What needs to happen to achieve the recommendation?
3. How will we get there?
4. What resources will it take?

It is anticipated that the initial stocktake will cover points 1 and 2, and that the full implementation plan will cover points 3 and 4.

Listed below is each Recommendation lifted from the Review. Some of the recommendations require further guidance or a change in legislation and where this is the case, no PCT action is expected at this stage.

The points under each of the recommendations should be used as a prompt for considering local issues. Most of the bullets refer to points 1 and 2 i.e. where are we now? and what needs to happen to achieve the recommendation? However some of the points will act as prompts for the second part of the exercise, i.e. how will we get there? and what resources will it take? Local discretion should be used to determine which of these points are appropriate for consideration in the initial stocktake.

Recommendation 1

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

The stocktake for this recommendation should include:

1. Name of NHS Direct site
2. Names of OOH providers locally, including those GPs providing their own OOH services
3. Names of providers currently integrated with NHS Direct
4. Are integrated sites achieving the Review Quality Standards?
5. If no, has the action plan to achieving standards been approved by DoH OOH/ NHS Direct Teams?
6. Names of sites not currently integrated with NHS Direct
7. Has timetable for integration been agreed?
8. What needs to happen before integration can take place?

Recommendation 2

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

The stocktake for this recommendation should include:

1. Has NHS Direct mapped the special needs of hard to reach groups?
2. Have OOH providers identified, to the best of their knowledge, local special needs groups and agreed core handover information with specialist teams? (e.g. palliative care handover form)
3. Who are the special needs groups? For example, palliative care patients, mental health users, asylum seekers.
4. What special access requirements do identified groups have?
5. Can groups access service currently?
6. If no, what changes to the service need to be made in order for access to be improved?

Recommendation 3

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

The stocktake for this recommendation should include:

1. What is the population coverage of the PCT area?
2. How many primary care centres currently exist?
3. Is there a Walk in Centre within the PCT area?
4. Is there a primary care provision from the local A&E?

Recommendation 4

When the Electronic Health Record is in place, a three way exchange of data between NHS Direct, out of hours providers and GP clinical systems should be established. In the interim, all providers should report all out of hours consultations to GPs by 9am the next normal working day. Systems for the three way sharing of clinical data for patients with special needs should be established in advance of the implementation of the Electronic Patients Record.

The stocktake for this recommendation should include:

1. An assessment of electronic systems in OOH providers
2. The planned rate of integration with NHS Direct?

Recommendation 5

The Quality Standards set out in the Review should be met by all providers within a timescale specified in Section 12

The stocktake for this recommendation should include:

1. Are call abandonment rates currently recorded?
2. If yes, what is the %? (no more than 5% should be abandoned)
3. If no, what needs to happen to record this data?
4. Is the length of time to answer call recorded? (no more than 0.1% should be engaged, 90% answered within 30 seconds and all within 90 seconds)
5. Are the calls recorded?
6. Are accurate details of all clinical consultations recorded in an appropriate IT clinical system?

Recommendation 6

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

The stocktake for this recommendation should include:

Clinical Governance

1. Are professionals involved in OOH care eligible to be employed within the NHS inc. GMS?
2. Are OOH records maintained with reference to standards set out in Good Medical Practice?
3. Is a sample of call records audited routinely? (1% per month)
4. Is the reporting of performance open within the organisation?
5. Is the NHS complaints procedure complied with?
6. Are complaints in relation to individual staff monitored and audited?
7. Are significant events investigated, reported and reviewed with clear recommendations?
8. Are significant events reported to the appropriate monitoring body?
9. Is patient satisfaction monitored?

Service and organisational models

1. Do accredited organisations have clear mechanisms for accepting delegated responsibility?
2. Do SLAs exist between NHS Direct and OOH providers?
3. Are OOH providers represented on local capacity planning groups?
4. Can OOH providers supply full clinical details of consultations to the host GP by the start of the next working day?
5. Do organisations providing or employing clinical staff support the requirements of revalidation?
6. Does employment practice conform with NHS Human Resources standards?

Access and Triage

1. Is identification of immediate life threatening conditions identified? (90% identified within 1 minute, all within 15 minutes. 90% passed to Ambulance Service within 1 minute, all within 15 minutes)
2. Is telephone triage and disposal completed? (90% within 20 minutes, all within 30 minutes)
3. Do those patients who have not been triaged on the telephone who access A+E, PCC or a WIC directly, receive initial contact 90% initial triage within 5 minutes, all within 10 minutes?
4. Is initial contact to consultation within 45 minutes of arrival?
5. Is everyone offered consultation within 60 minutes of arrival?
6. Are visiting standards met? (Emergency within 1 hour, Urgent within 2 hours and less urgent within 6 hours)
7. Are patients contacted if delay occurs?
8. For non-English speaking users are 90% provided with translation within 10 minutes and all within 15 minutes?
9. For patients with impaired hearing is a dedicated phone number provided for text phone users?

Recommendation 7

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

The stocktake for this recommendation should include:

1. Do they exist?
2. What are current arrangements for referral of patients from NHS Direct?
3. How will operational management of the system work both now and in the future?

Recommendation 8

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

Await future separate guidance on accreditation

Recommendation 9

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

The stocktake for this recommendation should include:

1. Is the OOH service planned as a single, integrated service?
2. Does local planning encompass: All GP practices, Deputising services, GP co-ops, GP rotas, GPs, NHS Direct, Pharmacy, A+E, Ambulance Services, Community Nursing, Mental Health, Social Services, Walk In Centres?

Recommendation 10

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

The stocktake for this recommendation should include:

1. Has a clinical steering group been established?
2. Does this group comprise appropriate membership?
3. Are there operational links to GP services?
4. Is appropriateness of referral monitored?

Recommendation 11

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

With the changes to Health Authorities, responsibility for the accreditation of organised providers of out of hours services will rest with PCTs. In order to avoid any obvious conflicts of interest, no PCT will be allowed to accredit a provider within its own locality, and consortia of PCTs will therefore work together to accredit providers.

Await future separate guidance on accreditation

Recommendation 12

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

Await future separate guidance

Recommendation 13

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

Until these changes have been made, Health Authorities should use the current regulations which allow for flexible use of the current Out of Hours Development Fund.

Future use of the Out of Hours Quality Fund will be subject to future separate guidance

Recommendation 14

GPs who do not delegate responsibility for their out of hours services should be able to access the out of hours quality fund, provided that they are able to report compliance with the quality standards.

Await future separate guidance

Recommendation 15

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

Await future separate guidance

Recommendation 16

A proportion of out of hours funding should be used to create an out of hours implementation fund.

During 2001/02 £28m was made available nationally to support the development of the Exemplar programme. £20m was invested in NHSD with the balancing £8m invested in Primary Care. It is anticipated that further resources will be available in 2002/03 and 2003/04 to support full implementation of the Review.

Await future separate guidance

Recommendation 17

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

National evaluation of the Exemplar programme considering a rigorous analysis of the OOH activity data will identify the different factors that determine levels of demand. This will then allow allocation of resources in a manner that accurately reflects real differences in demand for those services.

Recommendation 18

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

The stocktake for this recommendation should include:

1. Is there a workforce plan for Primary Care?
2. Does this consider known GP retirements?
3. Is workforce planning being considered in conjunction with the Workforce Confederation?
4. Is there 24 hour access to community nursing?
5. Has consideration been given to the use of other Health Care Professionals in the delivery of out of hours care?
6. Are there opportunities for joint recruitment initiatives, e.g. job rotation?
7. Are nursing staff being used for triage in Primary Care?

Recommendation 19

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

Nationally, a pharmacy sub-group is considering the implications of this recommendation. This will include looking at existing remuneration and contractual arrangements for OOH providers and pharmaceutical provision.

Await future separate guidance

Recommendation 20

The existing remuneration and contractual arrangements for out of hours providers and pharmaceutical services should be reviewed and, where appropriate, modified to allow for the provision of all appropriate medicines in the manner set out in Recommendation 19.

Nationally, a pharmacy sub-group is considering the implications of this recommendation. This will include looking at existing remuneration and contractual arrangements for OOH providers and pharmaceutical provision.

Await future separate guidance

Recommendation 21

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

The stocktake for this recommendation should include:

1. Are all OOH providers reporting on quality standards?
2. Where full compliance with quality standards does not exist, is there an agreed action plan for moving towards the standards?
3. Are the quality standard reports shared with appropriate key stakeholders e.g. PCTs?

Recommendation 22

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

PCTs need to be planning to ensure a fully integrated model of OOH services will be in place by 2004, in order to deliver the NHS Plan target and the recommendations of the Out of Hours Review.