

*Commentary on the National Out-of-Hours
Quality Requirements and their
Performance Management*

October 2004
Gateway Number 3921

Introduction

In June 2002, the Department of Health published national Out-of-Hours Quality Standards which all organised providers of out-of-hours services were required to meet. Those Standards were designed for a situation in which GP-led organisations (Co-ops and deputising services) provided out-of-hours primary medical services. In light of the introduction of the new GP contracts and contractual opportunities, it was clear that the Standards need to be reviewed to become an integral part of the new contracting world.

In addition, in July 2004 the new *National Standards for Better Health* were published, with which all those who provide services to NHS patients will be required to comply. In a number of areas these new Standards covered ground that had been covered by the original Out-of-Hours Quality Standards, and further revision of the original Quality Standards was therefore necessary.

The end result is a new, shorter list of National Quality Requirements, published on 14th October 2004, and to take effect from 1st January 2005. From that date, all those who provide out-of-hours services to NHS patients (including GP practices that have chosen not to transfer responsibility to provide out-of-hours services), will have to comply with the out-of-hours Requirements and from 1 April 2005, the Standards for Better Health (now referred to as Standards).

This document provides a commentary to PCTs on these new Out-of-Hours Quality Requirements, and sets out an approach to the way in which they might most effectively performance manage compliance against them.

A NOTE ON DEFINITIONS:

Throughout this document the term 'provider' is used to mean any organisation providing OOH services under GMS, PMS, APMS or PCTMS. Thus this may be:

- An organised provider of OOH services with whom a PCT has an APMS contract to provide OOH services.
- A PCT that provides the services itself under PCTMS.
- A GMS or PMS practice that chooses *not* to transfer responsibility for the provision of OOH services and either provides the service itself or sub-contracts the service to another provider.



Principles of Performance Management

In the past, the accreditation of organised providers of OOH services and the regular reporting on performance that was associated with accreditation, provided a ready-made process to assure the quality of OOH services. With the end of accreditation, PCTs will want to achieve this quality assurance through the manner in which they performance manage their OOH contracts, and the principles that lay behind accreditation may prove just as relevant in this new environment.

Four principles are especially relevant:

- **Evidence:** Compliance with the Requirements (and Standards) can only be demonstrated through the production of appropriate evidence. In many cases such evidence can be submitted in writing or electronically, but there are other areas which cannot be adequately tested in this way. Periodic face-to-face meetings with the provider and its staff, provide the only sure way of making a comprehensive and accurate assessment of the quality of the service that is being provided.
- **Multi-professional team:** During accreditation, a multi-professional team (including one lay person) visited the provider, met with the staff and patients and made their own independent assessment of the quality of the service that was being provided. That experience confirmed the widely held view that a team of well-informed outsiders will invariably identify opportunities for quality improvement that are, by definition, unclear to insiders.
- **Regular reporting:** The nature of the demands that arise in the OOH period is such that regular reporting on a number of key standards is necessary to ensure the ongoing safety of the service. In this regular reporting, it is critically important that the data is disaggregated in such a way as to reveal the manner in which the service performs at different times of the day and days of the week, notably at peak times such as Saturday mornings and the third day of a Bank Holiday weekend.
- **PCT responsibility:** Reporting is, however, a two-way process, and there is just as much a responsibility on the commissioning PCT to respond promptly and constructively to the reports that it receives as there is on the provider to submit those reports. Indeed, at the heart of effective performance management is a partnership between the PCT and the provider from whom it commissions the service, and it is only by investing time and energy in that partnership that the quality of the service will be assured.

The twin principles of regular reporting and regular face-to-face visits occupy an equally central role in the approach that has recently been implemented in respect of the Quality and Outcomes Framework for practices.

Translating these principles into practice

PCTs will want to develop their own particular ways of performance managing their contracts with the organisations from whom they commission OOH services. However, any effective approach will involve regular reporting, backed up by regular face-to-face meetings. These meetings provide an opportunity to test the veracity of the reporting and for the commissioner and provider to explore together how they can further improve the quality of the service that is provided to patients.

As a result of the introduction of the new contractual arrangements and service redesign, PCTs will need to be mindful of the impact these changes may have on performance especially in the medium term as the new services bed in. Against this backdrop, regular reporting and face-to-face visits will be a critically important feature of any effective approach to performance management.

Such an approach might include:

- requiring providers to submit regular monthly reports on all those National OOH Quality Requirements that require regular reporting (namely Requirements 2, 4, 5, 6, 8, 9, 10 and 12);
- arranging quarterly meetings at which any issues that arise from the regular reporting can be discussed; and
- organising annual visits to the provider, in which a small multi-professional team (perhaps a PCT manager, a clinician and a lay person) verifies and inspects current achievements and explores with the provider how together they can further develop and improve the service in the future.

Whatever approach is adopted, it is vital that the PCT and the provider reach a clear and explicit agreement about the nature and frequency of regular reporting, meetings and visits, and the circumstances in which these arrangements might be changed. Thus, for example, PCTs may want to reserve the right to require more frequent reports where they have serious concerns about the quality of the service that is being provided, and the provider may also want to initiate an early meeting where it has concerns about the support it is receiving from other organisations (including the PCT).

Effective performance management will always be a two-way process, and the obligations that rest with the PCT are quite as critical as those which the contract will place on the provider. In particular, appropriate, constructive and timely responses to the reports submitted by the provider are just as important as the original report. It is only through discussion, dialogue and partnership that continuous quality improvement in the OOH service will ever be achieved.



Managing Different Contracts

The approach described above fits most straightforwardly with an APMS contract in which the PCT contracts with a separate organisation to deliver all or part of its OOH service. For both PCTMS and GMS/PMS contracts a number of further points need to be made:

PCTMS Contracts:

Where the PCT provides the service itself, the duties laid on providers in the OOH Quality Requirements will apply to that part of the PCT that is providing the service. It will have a duty to report to that different part of the PCT that is responsible for managing the quality of OOH services on its compliance with the Quality Requirements and, in order for such an arrangement to work, the PCT will need to ensure the robust and effective separation of those who provide the service and those who are responsible for the quality of the service that is provided. In this way, the PCT will ensure that reporting and performance management will be as rigorous as it would be if the service was being provided by an organisation outside the PCT, and the StHA will performance manage the process to ensure that PCT-provided services comply fully with the OOH Quality Requirements.

GMS and PMS Practices providing their own OOH service:

Under the new primary care contracts, individual practices providing their own services also have to meet the Quality Requirements. It is recognised that practices could only report on Requirement 8 by investing in costly telephony and it would be hard to justify making this investment; they should *not* therefore be required to report on this particular Requirement. Practices will however be able to report on their compliance with all the other access requirements, provided clinicians delivering care in the OOH period include timings in their usual clinical notes. Thus, they would need to record the time they received the call, the time it ended, and the time at which any face-to-face consultation took place. More broadly, PCTs will need to reach a clear and explicit understanding with practices about the frequency and manner in which they will report on their compliance with the Quality Requirements, exploring in particular ways in which this might best be integrated into the PCT's overall performance management of the services provided by the practice.



GMS and PMS Practices sub-contracting their own OOH service

Sub-contracting OOH services is subject to specific rules which were set out in *Delivering Investment in General Practice, Implementing the new GMS contract*, published by the Department of Health in December 2003. Arrangements for PMS providers will be as agreed in their local contracts.

The rules make it clear that any GMS contractor who provides OOH services will normally have to obtain permission from their PCT before they sub-contract those services to another OOH provider. PCTs will be able to withhold (or subsequently withdraw) this permission if they are not satisfied that the terms of the contract, including compliance with the national Quality Requirements, will be met.

GMS Contractors who want to sub-contract will need formally to apply in writing for permission, giving details of the provider and the proposed arrangements. This does not apply to occasional, short-term arrangements, nor to sub-contracts to locum doctors, informal rotas or to other GMS or PMS practices that provide out-of-hours services. PCTs will be expected to respond as soon as possible to a contractor's request to sub-contract, and normally within 28 days.

Where the GMS contractor plans to sub-contract to a provider with which the PCT is familiar (for example an out-of-hours provider with which it already has a contract) then this is likely to be largely a formality, unless there are concerns about the provider's ability to cope with the additional workload.

Where the provider is unfamiliar – or is one about which the PCT has other concerns – the PCT will want to assure itself that the proposed provider will be able to deliver an appropriate service. The PCT may, if necessary, request further information before making a decision, and it may also attach conditions to its approval.

Although PCTs may not have a direct, contractual relationship with providers to whom GP practices sub-contract, they are nevertheless responsible for ensuring the quality of OOH services that are provided to all their patients, and they will therefore need to satisfy themselves about the quality of the service that is provided in this way. The national Quality Requirements require practices to report regularly to the PCT on the quality of their OOH services and this would include services that are being provided on their behalf by sub-contractors. It would make much better sense for the practice, provider and PCT to agree that responsibility for reporting on the quality of the service should rest with the provider, although ultimate responsibility for providing the service would rest with the practice.

Whatever form of reporting is agreed, PCTs will need to ensure that, where that reporting reveals shortcomings in the quality of the service being provided, appropriate remedial action is promptly taken.



Compliance

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

- **Full Compliance:** Normally, a provider would be deemed to be complying fully with a Requirement where average performance was within 5% of the target. Thus, where the target is 100%, average performance of 95% and above would be deemed to be compliant.
- **Partial compliance:** Where average performance was between 5% and 10% of the Requirement, a provider would be deemed to have complied partially with the Requirement and the PCT would explore the situation with the provider and identify ways of improving performance. Thus where the target is 100%, average performance of between 90% and 94.9% would be deemed to be partially compliant.
- **Non-compliance:** Where the average performance was more than 10% short of the target, the provider would be deemed not to have complied with the Requirement, and the PCT would specify the timescale within which the provider would be required to achieve compliance. Thus, where the target is 100%, average performance of 89.9% and below would be deemed to be non-compliant.

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 PCTs 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:

- A provider might achieve an average of 96% (where the target is 100%), and thus be deemed to be fully compliant. But closer inspection would reveal that on a Sunday morning this might regularly drop to around 85% and, in such circumstances, it could be deemed to be partially compliant.
- A provider might achieve an average of 91% (where the target is 100%), and thus be deemed to be partially compliant. But closer inspection would reveal that on a Saturday afternoon this might regularly drop to around 75%. In such circumstances it could be deemed to be non-compliant.

Furthermore, wherever a provider is not in full compliance with a particular Requirement, the PCT 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 PCT would be looking for evidence of ongoing improvement over time and, in the absence of such evidence, would downgrade its assessment of compliance accordingly.

Reporting

The Department of Health is updating and refining the existing reporting template to assist providers submit regular reports on their performance.

Commentary on each Quality Requirement

PCTs will only be able to performance manage the quality of the OOH service that is being provided, if they have access to appropriate data that demonstrates the level of compliance which the provider is able to achieve. In order to help with this, Annex One offers a commentary on each Quality Requirement, providing additional explanation or comment (where appropriate) and drawing attention to particularly important or problematic aspects of compliance.



Standards for Better Health and the original OOH Quality Standards

A number of the *Standards for Better Health* define requirements which were described in the original OOH Quality Standards, and these are set out in Annex Two.

ANNEX 1

Commentary on the National Out-of-Hours Quality Requirements

QUALITY REQUIREMENT 1

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

COMMENTARY:

DEFINITIONS:

A provider is any organisation providing OOH services under GMS, PMS, APMS or PCTMS.

Regularly: Initially, it would be prudent for a PCT to require monthly reports, supported by quarterly face-to-face meetings with the provider. Once a service has become well-established, and the provider has clearly demonstrated its ability to deliver a high quality service, quarterly reporting will normally be appropriate. What is important is that the PCT and the provider reach a clear agreement about the frequency of regular reporting, and the circumstances in which more frequent reports might be required.

PCTs have a duty to commission OOH services that comply with the OOH Quality Requirements and regular reporting on performance measured against those Requirements is the only way of ensuring that an appropriate, high quality service is delivered. Such reporting will only be effective, however, where there is a prompt and appropriate response from the PCT(s) to whom the report is made. Regular reporting is designed to safeguard and improve the quality of the service that is provided to patients, and ongoing development of this kind will invariably involve effective partnership working between the provider and the PCT(s).

PCTs providing their own OOH services: Where the PCT provides its own OOH service, particular arrangements will need to be made to ensure that such reporting is robust and rigorous. The simplest way of doing this to ensure adequate separation of that part of the organisation that provides the OOH service and that part of the organisation that is responsible for the quality of OOH services provided to the PCTs' patients. In this way, the PCT will be able to manage the quality of the service that is provided in much the same way as a service that is provided by an external organisation.

QUALITY REQUIREMENT 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.

COMMENTARY:

This Requirement relates to two different aspects of the transfer of patient data.

Data to the patient's practice: Under the new GMS and PMS contracts, weekday core hours start at 08:00 and providers will therefore need to ensure that appropriate clinical information about all patients contacts taking place during the OOH period (including a clear recommendation for further action where appropriate) is sent to the practice by 08:00. On those occasions when a OOH clinical consultation has not been completed in time for a complete report to be made at 08:00 (for example where a clinician is visiting a patient in their own home, or where a patient called the service at 07:55), providers must ensure that these consultations are reported as soon as possible thereafter. Ideally such reports should be made electronically, but where this is not possible, fax or paper reports will have to be used; providers will need to ensure that such reports are clear and legible. Where reports are made by fax, providers and practices will need to agree how to ensure that the practice is able to receive faxes at the time when the reports are made. Reports in respect of **temporary residents** may be problematic as the patient's practice may be unknown or may be outside the area covered by the provider. Where no other arrangements have been made, providers should submit these reports to the contracting PCT which will then ensure that the report is sent to the patient's own practice. It is expected, however, that providers and PCTs will agree an effective local process to ensure that clinical data is passed to the patients' own practice in a timely and appropriate way.

Data transferred between providers: In the developing networks of unscheduled care, it will become increasingly common for the traditional GP OOH service to be provided by a number of different organisations. In such circumstances, the prompt and effective transmission of data between partner organisations is critical to the success of the service. Providers therefore need to agree both the mechanism for transferring information, and the responsibilities of each organisation that may be involved at different stages in the patient pathway. PCTs must therefore work with all partner organisations to put in place a system that will ensure that sufficient clinical information is passed from one provider to another, both to facilitate the best possible clinical care, and to ensure that the patient is not required to repeat information which has already been provided.

QUALITY REQUIREMENT 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).

COMMENTARY:

For certain groups of patients, appropriate care can only be delivered where the OOH provider has access to detailed, up-to-date information about the patient's needs and wishes and the manner in which they are to be met. The most obvious example of this is terminally ill patients, where the primary health care team will have agreed with the patient and/or their carer an anticipatory care plan which sets out the manner in which the patient's changing needs are to be met. A provider with access to this information will be able to respond to that patient's needs in a manner that is consistent with the care that is being provided in-hours. There are a variety of different ways in which this information can be made available to the provider (with handover forms being one of the most effective).

While palliative care patients represent perhaps the most obvious group of patients who will benefit from such an approach, there are many other patients with pre-defined care plans, whose needs will be much better met in the OOH period where the provider is properly briefed about their needs. Thus patients with chronic disease, with serious allergic reactions, mental health problems or other special needs would all fall into the same category.

In addition, there are quite different groups of patients about whom OOH providers also need information in advance, namely those patients who may pose a threat to the clinicians who treat them. Examples of this second group of patients include patients with personality disorders and violent patients (for whom the PCT will have made special arrangements).

For all of these patients with special needs, what matters is that systems are developed to ensure that appropriate and up-to-date information is always made available to the OOH provider. Information that is out of date is almost as inadequate as no information at all, and it is thus critically important that a local system is developed which ensures that these special patient notes are always kept up to date. The AdastrA system that is widely used by OOH providers has a facility for highlighting special notes whenever those patients' computerised OOH records are accessed



and those notes can be entered and amended directly by the patients' practice to ensure that they are up-to-date. The PCT(s), the provider and the local primary health care teams need to develop and agree an effective system, in which the responsibilities of each partner organisation to all the others is clear and unambiguous.

QUALITY REQUIREMENT 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.



COMMENTARY:

Rigorous and effective clinical audit is one of the most important ways of testing the quality of the service that is being provided, and of identifying the areas in which the quality of the service can most effectively be improved. It is at the heart of any effective process of continuous quality improvement (CQI) and its importance in ensuring the clinical safety of the service cannot be overstated.

Clinical audit was identified in the original OOH Quality Standards, and all existing providers will therefore already have experience of these audits. This new Quality Requirement, however, includes two important changes from the way in which the original Standard was framed:

- It recognises that the clinical performance of the provider is not determined exclusively by the work of clinicians – other members of staff (most importantly call handlers) make their own important contributions as well. Thus, in defining the range of staff whose work will be audited, providers need to be sure that they have included all categories of staff whose work contributes to the clinical performance of the organisation.

- It redefines the basis on which the sample should be constructed, replacing the original percentage of all consultations with the requirement that the sample is constructed in such a way that it reviews the clinical performance of all those working in the service. One of the characteristics of OOH services is that some individuals may only work for the organisation intermittently and for comparatively short periods of time, and if the audit takes the form of a random sample of all consultations, then the work of these individuals may never be included.

In terms of the conduct of the audit, a peer review of cases with individuals is the most appropriate learning vehicle. This should be led by a senior clinician experienced in this field. Learning from cases is a very potent form of education and the approach should encourage reflective practice using a combination of random and problem case analysis in addition to monitoring performance indicators.



As a minimum, a survey should look for clinicians whose performance is unusual and then use this as a means of discussing their performance. External use of data to judge performance has many dangers - indeed most experts in quality would warn against it; it often leads to defensive behaviour if simple numbers are analysed without proper consideration of their meaning, so it should be done in a sensitive and discursive manner. The sharing of data within the OOH provider is a good marker of an open

and honest culture. For some this information might need to be anonymised at first but as time goes by should be identifiable.

While audits within individual provider organisation are essential, as providers increasingly work in partnership across a network of unscheduled care provision, it is as important to audit the patient experience across the network as a whole. Clearly individual provider organisations are in no position to complete these audits, but it is essential that they cooperate fully with the contracting PCT in ensuring that complete episodes of care are appropriately audited. PCTs therefore also have a responsibility to ensure that such 'whole systems' audits are completed, although they may of course commission an OOH provider to discharge this responsibility on their behalf.

While anonymity is an important characteristic of all of this audit work, if an audit reveals significant concerns about the performance of an individual, those concerns must be reported to the PCT. Where the individual is a doctor, this report must go to the responsible PCT (i.e. the PCT on whose performers' list the patient is identified), although it should also be shared with the contracting PCT, where the two are different. Moreover, because clinicians may increasingly work for a number of OOH providers, PCTs must also consider sharing information with the StHA and could seek the advice of the Local Medical Committee about how such arrangements could best be implemented.

QUALITY REQUIREMENT 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 co-operate fully with PCTs in ensuring that these audits include the experiences of patients whose episode of care involved more than one provider organisation.

COMMENTARY:

There are a number of different ways in which providers can explore patient experiences of the services they provide, ranging from questionnaires and surveys, through to focus groups and interviews. PCTs and their Patient Forums have considerable experience of exploring the character of patients' experience of local NHS services, and it would clearly make sense for providers to draw on this local expertise in developing an effective strategy regularly to sample patients' experience.

Following the example of the questionnaires that are available to monitor the experience of patients in GP practices, two new questionnaires are being developed which will take account of the particular circumstances in which OOH services are provided. Further details of these OOH questionnaires will be published on the OOH website as soon as they are available. (<http://www.out-of-hours.info>)

While audits within individual provider organisation are essential, as providers increasingly work in partnership across a network of unscheduled care provision, it is just as important to audit the patient experience across the network as a whole. Clearly individual provider organisations are in no position to complete these audits, but it is essential that they cooperate fully with the contracting PCT in ensuring that the totality of the patients' experience is appropriately audited. PCTs therefore also have a responsibility to ensure that such 'whole systems' audits are completed, although they of course commission an OOH provider to discharge this responsibility on their behalf.

Whatever approach a provider develops to audit the patient experience of its service, it is important that providers take appropriate and effective action on their findings. While managers and clinicians may believe that they can best judge what form this action should take, the existence of these findings provides a particularly good opportunity to start to involve patients in the decision-making processes within the organisation. The existence of the findings resolves



difficult issues around the representativeness of particular patients, and experience suggests that patients invariably have a novel and distinctive approach to the manner in which the organisation can most effectively respond to the findings. 'Critical Friends' groups in GP practices provide an excellent example of the way in which this can work – further information about this approach can be found on <http://www.ex.ac.uk/cfep/active.htm>

QUALITY REQUIREMENT 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.



COMMENTARY:

The details of the NHS Complaints procedure are set out at <http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/ComplaintsPolicy/fs/en> and every provider must operate a complaints policy that is consistent with this process. As with clinical audit, complaints must be audited in such a way that enables weaknesses in the performance of individuals properly to be addressed and, where complaints reveal significant concerns about an individual, those concerns must be reported to the PCT. Where the individual is a doctor, this report must go to the responsible PCT (i.e. the PCT on whose performers' list the patient is identified), although it should also be shared with the contracting PCT, where the two are different.

From the end of July 2004, every patient who complains to an organisation which provides services that are funded by the NHS has the right to ask for their complaint to be reviewed by the Healthcare Commission if they are not satisfied by the way in which it has been handled locally. Patients must be advised of this right at the time they make the initial complaint.

Details of the manner in which the Healthcare Commission will handle these requests are set out in: <http://www.healthcarecommission.org.uk/assetRoot/04/00/81/94/04008194.pdf>

It is the provider's responsibility to operate an effective complaints process, but it is important that a single individual sees all the complaints for, in this way, they will be able to identify any recurring

patterns in the form or character of those complaints and, where this happens, prompt the organisation to take appropriate action. In common with clinical audit and the audit of the patient experience, complaints provide a third invaluable source of data about the quality of the service that is being provided, and it is for this reason that providers must report regularly to their PCT on the number and character of the complaints they have received, and the action (including the timescales) they have taken to resolve those complaints.

Reports on complaints must be shared in confidence with all the relevant PCTs which will always include the contracting PCT and the PCT in whose area the patient lives. Where the complaint involves a clinician, this report must also go to the responsible PCT (i.e. the PCT on whose performers' list the patient is identified).

QUALITY REQUIREMENT 7

Providers must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service. They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand.

COMMENTARY:

Demand is variable but there is much evidence to show that the changing pattern of demand for OOH services is broadly predictable. Providers therefore need to be able to demonstrate that they both understand the pattern of these variations, and that they have planned the staffing of their service to meet these changing demands. While such an approach will work in most circumstances, providers also need to be clear about what actions they will take when it becomes clear that demand is outstripping capacity. What criteria will be used to determine whether additional staff (or other resources) are needed, and how will they be able to ensure that they can call on those extra staff (or other resources) at short notice?

In addition to this kind of planning, providers also need to make contingency plans for more radical failures in their service. Many providers are now heavily dependant on their telephony and IT systems – how would they continue to provide a service to their patients were they to experience a failure in either or both of those systems? And how would they cope if they were confronted by some wholly unanticipated event which made it impossible for the organization to work normally?



QUALITY REQUIREMENT 8

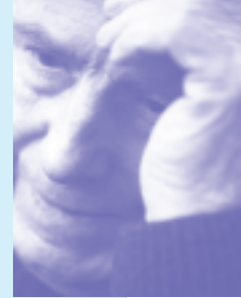
Initial Telephone Call:

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 should 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 should be answered within 30 seconds.



COMMENTARY:

DEFINITION:

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.

In comparison to the original OOH Quality Standard, the timescale within which calls are to be answered now takes account of the playing of an introductory message, albeit setting a maximum length for such a message. Where such a message is used it should make clear that the caller should anticipate a small delay before their call is answered; where no such message is used, all calls must be answered in 30 seconds.

QUALITY REQUIREMENT 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.

COMMENTARY:

There are a number of ways in which this Requirement has been modified in comparison to the original OOH Quality Standards. Firstly there are two changes in respect of identifying patients with immediately life threatening conditions:

- There is a new emphasis on the importance of a rigorous and well-developed system to enable the provider to identify all immediate life threatening conditions. Thus, call handlers and anyone else accepting the initial telephone call need to be working within clearly defined parameters, with an appropriate clinical decision support tool, and they should be trained and supported to make appropriate and safe decisions about those patients whose needs are so urgent that they should be passed immediately to the ambulance service.
- The original requirement that 90% of such calls should be passed to the ambulance service in 1 minute and 100% within 15 minutes, has been replaced with a requirement that all such calls be passed to the ambulance service within 3 minutes. However, given how important every second can be in these circumstances, providers will obviously want to ensure that such calls are passed on as quickly as possible, and it is expected that for very many calls this will be achieved long before 3 minutes.

In terms of definitive clinical assessment, there are a number of further changes:

- The Requirement is defined in terms of starting (rather than completing) the assessment. Once a patient (or their carer) is talking to a clinician the risk is being clinically managed, and it is therefore more important to ensure that the assessment begins as quickly as possible, rather than imposing a timescale within which that assessment needs to be completed.
- The Requirement takes account of the fact that some providers already have well-established, clinically safe and effective systems for prioritising calls, and that many more will develop such systems in future. It therefore recognises that where such a system is in place, the timescales which providers are required to meet can properly be defined by reference to their urgency – for urgent calls, definitive clinical assessment must start within 20 minutes; for all other calls it must be started within 60 minutes.
- Where a provider does NOT have a clinically safe and effective system for prioritising calls, definitive clinical assessment of all calls must start within 20 minutes.

PCTs will want to take great care in assessing whether or not a provider's prioritisation system is in fact 'clinically safe and effective'. In part this is a matter of assessing the quality of the system in its own right (and the PCT's Clinical Governance Lead might be particularly well-placed to do this), but PCTs will also want to monitor closely how it works in practice. In the end, its safety can only effectively be tested by looking at the outcomes of the calls that have been taken – did the system enable call handlers accurately to distinguish between urgent and less urgent calls? If it did not, providers should be required to revert back to the default position (start assessment of *all* calls in 20 minutes) until such time as they can demonstrate that they do have a safe system.



The emphasis on giving the patient clear, unambiguous information about the outcome of the assessment is critically important – lack of clarity can be, in itself, a major source of patient anxiety in waiting for a definitive response to their clinical need. Moreover, if the circumstances change (resulting, for example, in a clinical consultation – on the phone or face-to-face – taking place later than had originally been anticipated), it is vital that the service contacts the patient, explains what has happened and gives the clear information about when the consultation will take place. The absence of contact of this kind causes quite unnecessary anxiety for the patient (or their carer) and can result in their choosing to access some other form of urgent care (perhaps by calling 999 or going to an A&E Department).

QUALITY REQUIREMENT 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 patient 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 subsequent face-to-face consultation.



COMMENTARY:

Broadly speaking, this Requirement is the mirror image of Requirement 9. It is designed for those patients who access an OOH centre without first completing definitive clinical assessment on the telephone.

There is a difference in the requirement in respect of immediate life threatening conditions for, in many circumstances, it will be quicker to transfer the patient to an acute service (which may be located alongside the centre) than call an ambulance. Where this is not the case, however, an ambulance should still be called.

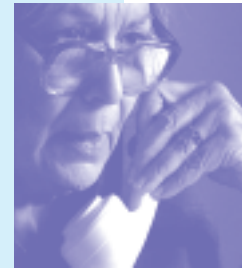
In many settings, the only patients who will access the OOH centre will have completed a definitive clinical assessment on the telephone as a result of which they will have either been given an appointment, or have been told to come to the centre within a specified period of time. While the terms of this Requirement will not apply in these circumstances (and there is certainly no intention that every patient entering the centre should have a second definitive clinical assessment), it is important that the staff who receive the patient are in a position to re-evaluate the patient's condition and, where appropriate, upgrade their level of urgency.

While this will always be good practice, as the patient's condition may have worsened between the time of the telephone assessment and their arrival in the centre, it is particularly important that this re-evaluation takes place where the patient misses their appointment or fails to attend within the time that was specified by the clinician who completed the definitive clinical assessment.

QUALITY REQUIREMENT 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.



COMMENTARY:

In planning the out-of-hours workforce, providers should ensure that patients can always have access to the health professional best suited to meet their needs. An effective service is likely to make use of a multi-professional approach, which includes GPs and other health professionals. Providers should ensure that they have capacity to meet this requirement at times of peak demand, such as Saturday mornings and Bank Holidays.

GPs have particular skills and experience in managing the range of conditions which patients present in a primary care setting. Providers must ensure patients have the opportunity for a telephone consultation or a face-to-face consultation with a GP, and where clinically appropriate, a home visit.

The usual model for patients who are not seen at their place of residence will be to be seen in a primary care centre, local surgery or a NHS WiC, depending on the local service configuration of emergency services.

QUALITY REQUIREMENT 12

Face-to-face consultations (whether in a centre or in the patient's place of residence) will be completed 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.

COMMENTARY:

This Requirement applies to all face-to-face consultations, whether they take place in a centre or in the patient's place of residence. Definitions of emergency, urgent or non-urgent will be made by the clinician who completes the definitive clinical assessment of the patient's needs, and the record system will need a means of capturing and auditing this information. The time standards apply to the period after the definitive clinical assessment has been completed, not the time at which it started as defined in Quality Requirements 9 and 10 above.

Although the proportion of patients needing a home visit has fallen steadily in recent years, there are a small but significant minority of patients whose needs can only be effectively met by a home visit, and every provider must therefore be resourced in such a way as to enable these patients to be seen in their own homes. Making judgements about which patients need to be seen in this way is never easy, however, and it is therefore very important that the PCT(s) and the provider reach a clear, unambiguous and explicit agreement about the criteria that will be used to make this judgement. A number of well-established guidelines already exist (for example the Staffordshire LMC Guidelines or NHSD protocols), but whether or not these are followed, what matters is that there is an agreed method of reaching these decisions, approach, and that this is communicated to patients as well as to staff.



QUALITY REQUIREMENT 13

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

COMMENTARY:

While NHS Direct is singularly well-equipped to meet this particular Requirement, there is no reason why providers who are not integrated with NHS Direct should not be able to meet it as well. Any organisation can access the service provided by Language Line and details of its interpreting services can be found at: http://www.languageline.co.uk/our_services/interpreting/

A variety of different technologies are available to meet the needs of patients with impaired hearing or impaired sight, and these include Type Talk.

ANNEX 2

Standards for Better Health and the original Quality Standards

A number of the Core Standards set out in Standards for Better Health define requirements which were described in the original OOH Quality Standards.

CORE STANDARD 1

Health care organisations protect patients through systems that:

- a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents; and
- b) ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.

Includes the requirements of the original OOH Quality Standard in relation to significant events.

CORE STANDARD 4

Health care organisations keep patients, staff and visitors safe by having systems to ensure that:

- a) the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA;
- b) all risks associated with the acquisition and use of medical devices are minimised;
- c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed;
- d) medicines are handled safely and securely; and
- e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

Includes the requirements of the original OOH Quality Standard in relation to medicines.

CORE STANDARD 7

Health care organisations:

- a) apply the principles of sound clinical and corporate governance;
- b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources;
- c) undertake systematic risk assessment and risk management (including compliance with the controls assurance standards);
- d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources;
- e) challenge discrimination, promote equality and respect human rights; and
- f) meet the existing performance requirements set out in Appendix 1.

Includes the requirements of the original OOH Quality Standard in relation to corporate governance and transport.



CORE STANDARD 9

Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

Includes the requirements of the original OOH Quality Standard in relation to clinical records.

CORE STANDARD 10

Health care organisations:

- a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and
- b) require that all employed professionals abide by relevant published codes of professional practice.

CORE STANDARD 11

Health care organisations ensure that staff concerned with all aspects of the provision of health care:

- a) are appropriately recruited, trained and qualified for the work they undertake;
- b) participate in mandatory training programmes; and
- c) participate in further professional and occupational development commensurate with their work throughout their working lives.

These two Standards include the requirements of the original OOH Quality Standards in relation to staff working in OOH services.

CORE STANDARD 20

Health care services are provided in environments which promote effective care and optimise health outcomes by being:

- a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and
- b) supportive of patient privacy and confidentiality.



CORE STANDARD 21

Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

These two Standards include the requirements of the original OOH Quality Standard in relation to premises.