Government Response to the House of Commons Health Committee Report on GP Out-of-Hours Services. Fifth Report of Session 2003-4

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
October 2004

Cm 6352

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This Command Paper sets out the Government's response to the Health Committee Report on GP Out-of-Hours Services.

Conclusions and Recommendations

1. Our evidence suggests that while PCTs across the country are in varying states of readiness for taking on responsibility for providing GP out-of-hours services, forward planning is taking place and support systems are available. However, we were concerned at reports that this critical transition was in some circumstances being managed at too junior a level within PCTs, and also that some PCTs were failing to think about more integrated approaches within their wider local health economies. We urge the Department to consider these concerns raised in our evidence in their support and management of PCTs, and also to encourage, where possible, a greater degree of public consultation and involvement around the redesigning of GP out-of-hours services, as our evidence suggests that this has so far been largely lacking. (Paragraph 21)

The Department is responsible for setting the strategic direction for the development of unscheduled care services, based on the recommendations of the *Independent Review of GP Out-of-Hours Services in England* in 2000.[1] The implementation of this and related strategies, is a matter for the local health economy, led by the commissioning PCTs. Since April 2004, Primary Care Trusts (PCTs), at dates agreed with their GP practices, have been assuming responsibility for the delivery of out-of-hours services to their population.

PCTs are approaching their new commissioning responsibilities in a number of ways: direct provision by the PCT itself, as a PCTMS service (Primary Care Trust Medical Services); commissioning provider organisations such as GP co-operatives or commercial companies, to provide out-of-hours services through an APMS contract (Alternative Provider of Medical Services), and establishing partnerships with emergency care providers such as ambulance trusts, to lay the foundations for an integrated network of unscheduled care.

1 *Raising Standards for Patients. New Partnerships in Out-of-Hours Care. An Independent Review of GP Out-of-Hours Services in England* (Department of Health, October, 2000) - www.out-of-hours.info/downloads/oohreview.pdf

Developing new arrangements for out-of-hours services is a challenge for PCTs, but one which is being tackled through engagement at all levels of the PCT and local health economy with the commissioning process, and strong operational management, both at PCT and Strategic Health Authority (SHA) level. Chief Executives and Directors are fully engaged and have made successful implementation of the new arrangements of out-of-hours a priority.

There is a strong performance management line to ensure out-of-hours services are delivered effectively. PCTs are monitoring the performance of providers in meeting their contracts. The National Out-of-Hours Quality Standards[2] (and from 1 January, the Quality Requirements),[3] provide a benchmark of quality for this. SHAs performance manage their PCTs in their planning and delivery of services. SHAs will report appropriately to the Department on delivery, and exceptional issues will be referred to the Department's Recovery and Support Unit.

The Department continues to provide support and advice to PCTs and SHAs, and facilitative support on the ground will be provided by the Department's out-of-hours co-ordinators and the National Primary and Care Trust Development Team.

PCTs have a legal duty, under Section 11 of the Health and Social Care Act 2001, to ensure that the views of patients and the public inform the planning and development of services. PCTs have ensured that patients have been consulted on the changes to out-of-hours services, and involved in the commissioning of services through a range of patient and public involvement groups and in some cases local authority Overview and Scrutiny Committees.

A new mutual society model of out-of-hours provider allows community participation in the running of the service. As with foundation trusts, members of the public can be members of the society and sit on the board, as can all local unscheduled care providers and key stakeholders, strengthening the community focus, and facilitating integration.

PCTs are commissioning models of care based on patient need, which, in meeting the quality standards, attain a high level of quality, but must also ensure that commissioning arrangements have the flexibility to support the longer-term development of models of integrated provision.

In some areas development of the wider integrated unscheduled care networks is taking longer owing to local variations in the pattern of delivery. Some health communities are concentrating on securing a new high quality service in place that meets traditional out-of-hours needs, others are planning to develop the wider network further in the new year.

2 *National Quality Standards in the Delivery of Out-of-Hours Services* (June 2002) – www.out-of-hours.info/downloads/quality_standards.doc

3 *National Quality Requirements in the Delivery of Out-of-Hours Services* (October 2004) – www.out-of-hours.info/downloads/quality_requirements.doc

2. We are impressed with the potential of some models of GP out-of-hours service provision, including integration with ambulance services and creative use of skill mix. However, some of the models we have seen seem to be predicated on well developed collaborative working relationships with successful existing local out-of-hours service providers, and we urge the Department to encourage such collaborative working wherever possible. (Paragraph 32)

Collaboration between PCTs and providers is vital to the development of out-of-hours services which are both effective, and sustainable. The guidance issued to PCTs in October 2003, *Key First Steps to Delivering a Sustainable, Integrated and High Quality Service*[4] and subsequent communications have emphasised the need to involve existing accredited out-of-hours providers in developing service requirements. Department of Health workshops with SHA out-of-hours leads and PCTs, and the work of the Department's regional out-of-hours co-ordinators, have encouraged effective collaborative working between commissioners and providers.

PCTs have recognised the value of building on existing expertise and experience – particularly that of the former GP co-operatives – and many have chosen to take a preferred provider approach to commissioning, inviting existing organisations to submit proposals in response to service specifications.

A balanced approach, coupled with collaborative working between a range of providers (such as commercial providers and GP co-operatives), can support the sustainability of out-of-hours services, permitting the development of a network of provision, in which different providers interact. This enables greater flexibility and resilience than could be achieved if a PCT was reliant upon a single organisation. The successful implementation of a model of integrated unscheduled care will depend on the effectiveness of local networks of relevant providers.

The mutual organisation model of an out-of-hours provider, a model towards which some providers are moving, is based on a community-wide collaborative approach to meeting the needs of the local health economy. Membership of the mutual provider is open not simply to employees, and patients, but also to representatives of all local providers and commissioners of unscheduled and emergency care, "giving people ownership of the organisation and a legitimate and real say in the provision of a service to them or the community in which they live."[5]

We will continue to emphasise the importance of collaborative working between PCTs and providers, and between PCTs where they commission independently, to ensure that their plans are mutually beneficial and do not undermine the local health economy. SHAs have a pivotal role to play here in taking an overview of the local network of provision, and we will continue to support SHAs through the out-of-hours co-ordinators, in undertaking this role.

4 *Implementing the nGMS Contact: Out of Hours. Key First Steps to Delivering a Sustainable, Integrated and High Quality Service* (Department of Health, October 2003), www.out-of-hours.info/downloads/031015_ooh_paper_final_.doc

5 Peter Hunt and Cliff Mills, *Care on call: a mutual approach to out of hours primary care services* (Mutuo, NatPaCT, NAGPC, January 2004), p. 16 - www.out-of-hours.info/downloads/care_on_call2.pdf

The independent national evaluation of the "exemplar" sites, will be published shortly. One of the purposes of the evaluation was to gain experience of developing integrated services. Participants in the evaluation, strongly emphasized the importance of good communications (both written and verbal), of establishing good working relationships and trust between key individuals working together at a senior level, and of investing time to enable partner organizations to understand each other and the different ways in which they work.

3. We look forward to the publication of the guide for PCTs and providers to be issued in Summer 2004, and recommend that it makes mandatory scope for the provision of medication, where necessary, at the same time and place as out-of-hours consultation. (Paragraph 40)

Detailed guidance on the supply of medicines out-of-hours will be published in November 2004. It will explore how PCTs might most usefully tackle the *Review* recommendations. The guide includes a new national formulary, which identifies those medicines which should be available to meet patients' urgent medical needs during the out-of-hours period. It specifically recommends that PCTs review and improve their out-of-hours arrangements for palliative care medicines.

Directions and amendments to regulations are currently being drafted to enable PCTs to use their primary medical services powers to arrange for out-of-hours providers to supply medicines directly to patients, where pharmaceutical services are not available out-of-hours. Separately, opening hours is one of the issues being explored in the NHS Confederation / Department of Health / Pharmaceutical Services Negotiating Committee discussions on the new community pharmacy contract.

A national conference early in 2005 will introduce PCTs and out-of-hours providers to the issues around medicine supply, and provide guidance on how to take forward the *Review* recommendations. Where necessary, this will be followed up with workshops to explore particular local challenges.

4. In our view, existing GPs, including those who work in co-operatives, will continue to form the backbone of future provision of out-of-hours services. They are also the NHS's main source of expertise in this complex area, and yet the availability of the GP workforce for out-of-hours cover still remains uncertain. It is therefore vital that they do not become disengaged from the process of redesigning GP out-of-hours services during this critical transition phase, and their expertise and local knowledge lost. We recommend that the Government should take all reasonable steps to encourage PCTs to work collaboratively with GPs, including those in co-operatives, and to encourage PCTs to provide the flexibility and support, as well as the financial incentives, necessary to retain a motivated GP workforce. (Paragraph 53)

We value greatly the contribution that GPs make and the high quality service they provide. Even where GPs transfer their out-of-hours responsibility, many will continue to be engaged in shaping and providing high quality services to patients in the future, through Professional Executive Committees (PECs), GP co-operatives or their successors.

By enabling GPs to transfer their traditional responsibility for out-of-hours care, the new contracts will have a positive impact on the working lives of GPs, and by encouraging recruitment and retention, will increase capacity within the primary care workforce. The new opportunities for developing a responsive, integrated approach to unscheduled care will in turn provide a more interesting and rewarding working environment for GPs and other health professionals.

Whilst most GPs are choosing to transfer the *responsibility*, many are continuing to participate in the *provision* of out-of-hours care, working for provider organisations, such as GP co-operatives, mutual and commercial providers, or on PCT rotas. We are committed to ensuring that the new arrangements for out-of-hours care are supported by a significant GP workforce. It is essential, to meet the full range of patient need, that every out-of-hours service includes a GP workforce sufficient to enable patients to have face-to-face access to a GP when clinically appropriate, including, where necessary, a home visit from a GP. This is a new Quality Requirement that all out-of-hours providers will need to meet as a contractual obligation from 1st January 2005.

Implementation of the recommended model of integrated unscheduled care will provide new opportunities for GPs to work with and provide clinical leadership to, multi-professional teams and participate directly in the redesign of services, opportunities for professional development which should prove attractive to many GPs. This needs to be supported by the provision of appropriate terms and conditions including the remuneration package – which can be linked to the extent of a GP commitment to a rota to support sustainability (e.g. paying more for a longer-term commitment), and effective clinical management structures. We continue to emphasise to providers and commissioners the importance of the recruitment, retention and professional development of GPs, as with all professions who make up the out-of-hours workforce, through providing the right terms and conditions of service.

An additional incentive, for all who work for NHS or not-for-profit providers of out-of-hours care will be the eligibility to participate in the NHS pension scheme for their out-of-hours work. The appropriate legislation will be amended and finalised by the start of the new year, and applications may be backdated to April 2004, or the time when the new contracts for primary care were introduced. Further guidance will be issued shortly setting out this process.

5. **We strongly support the better use of skill mix to deliver out-of-hours care, not only for its potential to relieve pressure on GPs and deliver cost savings, but also, more importantly, for its potential to deliver a better quality of service to patients. However, out-of-hours care is a complex service to provide, and health professionals other than doctors will need appropriate training if they are to deliver it to a high standard. Our evidence suggests that those working in the NHS are well aware of the difficulties attendant upon recruiting and training this new workforce, and we urge the Government to ensure that PCT forward planning allows sufficient time for this to take place, and takes account of the view that triage by the most experienced clinician available, who may or may not be a doctor, is the most effective use of resources. (Paragraph 62)**

The effective development of a multi-professional workforce making best use of the skills and competencies of staff – in particular nursing staff – was a cornerstone of the model of integrated out-of-hours care recommended by the *Independent Review of GP Out-of-Hours Services* in 2000. The most effective out-of-hours care is that which permits patients to receive the advice or treatment they need from the professional with the right skills to deliver it. The effective use of skill-mix and team working is well established in in-hours primary and secondary care.

Developing staff competencies and establishing clinical teams is a long-term option, requiring commitment from each staff group, and cannot be done quickly, or without adequate supervision and leadership. PCTs are already laying the foundations in developing training opportunities for staff and broadening their vocational experiences, so that they can bring their skills and experience to bear in the future. Workforce planning is increasingly taking place across the emergency care network.

PCTs need to plan for services that are provided by a number of networked and integrated providers with multidisciplinary teams, making more use of telephony and a wider range of professional skills, including nurses and paramedics.

Local initiatives, which take account of the particular needs of a health economy, are key to this process. For example, Medway on Call Care in Chatham, Kent, has developed their own local minor injuries training course, accredited by University of Kent at Canterbury, to train nurses working in multi-professional teams with GPs at their Same Day treatment centre. The mutual provider model has encouraged a number of providers to use the community benefit structure to incentivise and develop staff.

The Quality Requirements continue to emphasise the importance of regular and rigorous clinical audit of the services that are provided, drawing particular attention to constructing that audit in such a way that the clinical performance of everyone who works for the service is assessed. This is especially important in a period of important changes in the range of health professionals who provide the service.

6. We accept the value of a single telephone access point for patients for all out-of-hours services. However, NHS Direct will have substantially to increase its capacity in order to cope with this burden. We remain concerned that full integration of NHS Direct and GP out-of-hours services could introduce unnecessary delay and increase referrals to other parts of the NHS. We recommend that alongside their work to develop capacity, NHS Direct should work collaboratively with others, including GPs, involved in delivering nurse telephone triage services for out-of-hours care to develop and refine their referral protocols to ensure this does not happen. (Paragraph 78)

The independent evaluation of the "exemplar programme" has shown that NHS Direct and out-of-hours services can be effectively and safely clinically integrated. The evaluation also describes how the Exemplar Programme has demonstrated the feasibility of providing out-of-hours care to standards described in the *Independent Review of GP Out-of-Hours Services*. The report will be published shortly by the University of Southampton, and details of how to access it will be made available at www.out-of-hours.info

The *Independent Review* recommended that patients should access integrated out-of-hours services through a single call, routed in the first place through NHS Direct and passed where necessary to the appropriate provider in that area. The Department of Health Technical Links programme will ensure that by the end of 2004 all patients who call NHS Direct in the out-of-hours period can have their demographic and clinical details passed to the appropriate out-of-hours provider where necessary without the patient having to make a further call: a single point of access.

Work will continue to ensure that those patients who initiate out-of-hours access via routes other than NHS Direct will also benefit from single-number access. This will be achieved by using a dedicated number for a single health community or by having calls made by a patient to their GP practice during the out-of-hours period automatically diverted to an appropriate local provider.

The Department of Health and NHS Direct recognise the challenges in expanding capacity within NHS Direct to meet the demand for clinical integration with out-of-hours services. As well as new investment in the service this is being addressed in a number of ways:

- NHS Direct has been working to improve capacity for some time, including setting targets to improve the productivity and efficiency of the service. This work will continue to have a high profile within the service.
- Plans are on track over the next 18 months to use technology to unlock the significant economies of scale available to NHS Direct as a national provider.
- Pilots are currently underway to stream calls more effectively. Where patients have a clear need for a face-to-face consultation, using a robust protocol, call handlers will be able to refer the patient directly to the appropriate provider.

We support these initiatives and will work closely with NHS Direct to help make the best use of their capacity and monitor progress. However we are aware that as NHS Direct will not be able to provide the capacity to provide a fully integrated national service until December 2006 PCTs managing the new GMS changes now are likely to commission other providers to undertake this work in some areas. We are therefore preparing guidance that will be available over the autumn to support those taking on telephone clinical assessment to ensure they can effectively meet the National Quality Requirements.

Between now and the end of March 2005 under the Department's programme of fast track clinical integration, NHS Direct is working with PCTs and out-of-hours providers to extend the coverage of some level of clinical integration to approximately a third of the population of England.

It is essential NHS Direct adds value to the patient's experience and we will encourage NHS Direct to continue working with other service providers and GPs on validated benchmarks and NHS Direct referral protocols to ensure clinical performance which is acceptable to the medical and nursing professions.

7. GP out-of-hours services provide only one of many routes for people needing urgent care. Out-of-hours services are part of a larger network of 'unscheduled' care providers, which can include emergency ambulances and A&E departments, as well as GP emergency clinics run during the day. If one of these services is withdrawn or changed, or access becomes more difficult, demand for urgent care will simply increase in other parts of the system. It is not surprising, therefore, that A&E departments are anxious that changes in the provision of GP out-of-hours services may impact on already rising attendance rates. (Paragraph 86)

The independent evaluation of the Exemplar sites found that where NHS Direct and out-of-hours services have been integrated there was no attributable impact on overall demand for immediate care services.

We have more recently found no evidence that changes in primary care provision have contributed to the recorded step change in demand for A&E services in the twelve months from April 2003. In particular, we have not been able to establish any link between changes in out-of-hours provision and the national rise in A&E attendances since April 2004. The timing of the increase in demand for A&E does not correspond with changes to the nature of out-of-hours provision.

Where new arrangements for out-of-hours services have been introduced, NHS Direct data does show some evidence of an increase in demand for its services on a Saturday morning, but the number of calls which are triaged has not significantly increased, suggesting that in the majority of cases the increase in demand can be met by providing information only.

However, we will continue to monitor demand for A&E and NHS Direct over the coming months, as the majority of PCTs introduce their new arrangements for out-of-hours services. We are considering how best to carry out a more detailed analysis of the dependencies between the various elements of the unscheduled care system, which will enable us to understand the impact of changing demand within the system, and how to tailor the local development of services accordingly.

8. We deplore the loss of GP Saturday morning surgeries which will limit access to their GP for many working people, and we recommend that PCTs should provide such clinics in primary care centres or co-located emergency departments. (Paragraph 87)

Traditionally, patients have not been guaranteed access to a GP on a Saturday morning. Under the old GMS Contract, a full-time GP was required to be available to patients for 26 hours a week, spread reasonably over 5 days, for at least 42 weeks a year. The NHS has therefore never required GPs to open on Saturdays. Many have done so in response to patient needs and expectations but this has varied across the country. Many GPs chose to offer Saturday morning surgeries (usually, but not always, for emergencies) even though there was no contractual obligation to do so.

Under the terms of the new contracts, Saturday morning is now defined as part of the out-of-hours period. PCTs will assume responsibility for the provision of services to patients during this time, and will be required to commission services which meet the National Quality Standards, and from 1 January, the Quality Requirements, including ensuring "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."

As a result, all patients will, for the first time, be guaranteed high-quality urgent care across the country on Saturday mornings, and in many places, access for patients with urgent clinical problems will be improved. NHS Direct has developed its capacity plans to take account of the potential increase in demand for advice on Saturday mornings.

In addition, the new contracts took account of this change in service delivery and routine appointments on Saturday mornings can be provided to patients. However, it is for PCTs to determine the needs of their local health economy, and commission services accordingly. PCTs can commission Saturday morning GP surgeries as a Locally Enhanced Service, the cost of which is negotiated locally with the practice, and funding for which is included within the new GMS Enhanced Services Floor.

Furthermore, the Department of Health is also considering a number of options for enhancing patient access to NHS services, such as commuter NHS walk-in centres.

9. Accessing healthcare outside normal working hours can currently involve negotiating a maze of different services and telephone numbers. We agree that in the long term, services should be designed around patients, taking account of where local patients are most likely to access healthcare. We are encouraged to see this already happening in certain places, through, for example, the co-location of primary care centres and A&E departments. However, we also believe that there is a place for patient information campaigns in order better to equip patients to play an active role in their own healthcare. Clear information should be available to everyone who needs it, setting out what local NHS services are available where, in order to help patients make informed choices on how to access out-of-hours healthcare. We recommend that the Government takes steps to ensure PCTs proactively provide information on NHS services to their local populations on a regular basis, paying particular attention to the need to keep people informed of any changes that may occur as a result of the handover of responsibility for out-of-hours care. (Paragraph 88)

PCTs are required to issue a guide to the services they provide to their population, which includes information on unscheduled care services, including how to access out-of-hours services. A similar requirement is placed on all GP practices to make available to their patients a practice leaflet which includes information on the arrangements for services in the out-of-hours period, whether or not provided by the practice, and how the patient may contact such services.

Locally, PCTs have been working to ensure that information on out-of-hours services is prominent in the local press, and ensure that publicity material is widely circulated.

The Department has been working with NHS communication leads, patient organisations and other key stakeholders, to ensure that patients are fully apprised of the new arrangements in their locality, including providing guidance on practice and PCT leaflets, and on materials for communicating to local populations.

Important as high quality patient information is, however, it is also clear that in spite of every attempt to direct patients towards particular services, there are many circumstances in which patient behaviour has proved difficult to change. In inner city areas, for example, many patients see their local Accident and Emergency Department as their first port of call when they have urgent, unplanned needs. It was for this reason that the *Reforming Emergency Care* Strategy published in 2001 put a particular emphasis on moving away from attempts to change 'inappropriate' patient behaviour, by focusing instead on the importance of providing robust, consistent clinical assessment wherever patients chose to present themselves. Thus whether they call their out-of-hours service, go to their local pharmacy, or go to the Accident and Emergency Department, they should encounter the same consistent assessment, which will determine whether their needs can in fact be met with advice or, where they do need a consultation with a heath professional, direct them to the service best placed to meet their particular needs.

10. Although providing services to community hospitals is a separate issue from GP out-of-hours services, it certainly seems possible from the evidence that we have heard that the handover of responsibility for GP out-of-hours services from GPs to PCTs will prompt some GPs to re-evaluate and perhaps to withdraw the services they currently provide to community hospitals, as part of their on-call duties. In our view it is regrettable that this vital subset of GPs' work has not been addressed more swiftly, and we urge the Government to ensure that this is resolved as a matter of urgency to ensure that the extremely valuable service provided by community hospitals is not jeopardised. (Paragraph 94)

We have already commissioned the NHS Confederation to look into the situation, as part of the work they have been taking forwards to scope out issues for modernising the medical non-consultant career grades. We have asked for a report with their recommendation by October 2004. We will not be in a position to agree any new arrangements until the NHS Confederation has reported.

The NHS Confederation will be looking at arrangements for the employment of medical staff in community hospitals as a whole and it will be in a position to look at the issue strategically. Community hospitals vary in nature and we need to consider not only the role of general practitioners, but also the expanding roles of other staff in intermediate care.

For example, in some cases patient care in community hospitals is nurse led, and we need to consider the appropriateness of contractual arrangements for general practitioner involvement in these units in the context of modernising the NHS. This is why we are asking the NHS Confederation to scope out this issue, and look for a solution which is sustainable in the long-term, rather than rushing headlong into a short-term solution.

While we accept that there may be potential localised problems with the staffing of community hospitals, we have no evidence that there is a potential problem with these arrangements on a national scale. PCTs have a range of freedoms to employ and contract staff in different ways and it will be for them to manage any local staffing issues that emerge.

11. While we do not feel that we are in an appropriate position to make recommendations on the necessary funding levels for GP out-of-hours services and how this should sit with PCTs' other spending priorities, it is clear from our evidence that there is anxiety in many quarters about securing adequate funding for GP out-of-hours services. Furthermore, with the true cost of GP out-of-hours services having been largely disguised until now by GPs' previous practice, this is essentially a 'new' cost for the NHS, and one for which there are few precedents for commissioning or providing. In the light of this, we recommend that the Department monitor closely the financial arrangements for funding GP out-of-hours services. We will continue to investigate this in future years as part of our annual Public Expenditure Inquiry. (Paragraph 107)

In recognition of the costs of providing out-of-hours services previously partly borne by the GP, the investment in out-of-hours, as in other elements of primary medical services, has been greatly increased from 2004/05.

Where GMS providers transfer responsibility for out-of-hours services their contract price is reduced by 6% of the global sum. Where PMS providers do the same, their salary is reduced by £3.31 per patient, equivalent to £6,085 per average GP list of 1838 patients. If every practice in the country transferred responsibility, £180 million would be made available to PCTs to fund out-of-hours services.

The Development Fund, supporting the development of out-of-hours services and infrastructure has been doubled to £92 million from this year and we will continue to monitor the use of this budget and regularly review its use.

Of £28 million available to support PCTs facing the biggest challenges in developing out-of-hours services in extremely rural or urban areas, £14 million has been allocated in this financial year. The use of this funding will be reviewed, and feedback on the allocation methodology invited from PCTs, to inform the allocation of the remaining £14 million in 2005/06.

Regular and timely assessment of the recurrent and non-recurrent investment needed for out-of-hours services will include exploring the potential for unifying all unscheduled care allocations, as a single unscheduled care budget, to support the integrated model of unscheduled care recommended by the review of out-of-hours services.

As with the management of chronic disease in the community, the effective provision of unscheduled and emergency care upstream, has the potential to substantially relieve pressures downstream in primary and secondary care. PCTs are increasingly recognising this pivotal role of out-of-hours services within the health economy, and deploying their unified budgets accordingly.

12. We support the introduction of quality standards for all providers of GP out-of-hours services, and we hope that these will be rigorously audited. Providers should also be encouraged, through incentives, to exceed quality standards and work towards continuous improvement. We are concerned by reports that financial pressures may adversely affect the quality of services some providers are able to offer, and we recommend that a broad-brush assessment against current quality standards is conducted prior to the handover of responsibility to PCTs, in order to provide a baseline against which performance under the new system can be measured. (Paragraph 111)

Until 1 January 2005, when the new Quality Requirements for out-of-hours services come into force, existing out-of-hours provision should continue to meet the existing Quality Standards and PCTs will continue the existing system of accreditation.

The accreditation process assesses providers against the benchmark of the existing Quality Standards; from 1 January 2005, accreditation will end: quality will be assured through PCTs performance managing providers in their delivery of services, using the new Quality Requirements as the new benchmark.

PCTs must ensure that they commission a service which meets the Quality Requirements, and SHAs will rigorously performance manage PCTs in their delivery. Where out-of-hours provider performance falls below acceptable levels, this is a performance management issue for the commissioning PCT. The out-of-hours provider must put in place an immediate action plan to address the issues. Failure to do so will place them in breach of their contractual duties.

The new Quality Requirements have been refined and updated. They now include a specific requirement that where there is a clinical need, patients in the out-of-hours period will have a home visit from a GP; or be able to see a GP and other health care staff in a primary care centre, local surgery or a NHS walk-in centre, depending on the local service configuration of emergency services. They also strengthen the requirements in respect of the audit of clinical practice and the patient experience of services. The requirements require providers to audit the quality of the care they provide and to take prompt and appropriate action to remedy identified shortcomings. Thus, not only do providers have a responsibility to address systemic or organisational weaknesses in their services, they are also required to work with individuals to address weakness in their clinical performance.

In terms of the requirement regularly to monitor the patient experience of the service, the Department is working with the authors of the two patient questionnaires that are used in daytime general practice to develop comparable questionnaires for use in out-of-hours services. Once those questionnaires start to be used, we will encourage PCTs and providers to see them as the springboard for more active public and patient involvement in the planning and development of out-of-hours services, once again following a model that has been successfully pioneered in day time general practice.

PCTs, in drawing up their service specifications for the arrangements under the new primary care contracts, have taken the existing standards as their benchmark of quality and designed their requirements accordingly. Prior to the implementation of new arrangements, PCTs have been encouraged to assess their proposed provision against a range of criteria suggested by the Department, to assess the robustness, sustainability and quality of their plans and their state of readiness to assume responsibility.

The capital incentive scheme has incentivised such assessments, with PCTs being eligible for capital payments when they are able to satisfy their SHAs that they have robust plans in place, and, in the second phase, which will run until the end of the 2004/05 financial year, when they are able to demonstrate that they have been delivering a quality out-of-hours service, over a reasonable length of time.

We will continue to support PCTs and SHAs in their development of new approaches to performance management of their out-of-hours services at a time of ongoing change.

Conclusion

The implementation of the new arrangements for out-of-hours care is not an end in itself, but represents an important step towards the achievement of a fully integrated model of unscheduled care, which is both safe and responsive to the unplanned needs of patients, and is effective in its delivery of a wide range of different services across the community.

The new primary care contracts provide an opportunity for PCTs to begin putting this model into operation; the evolution of unscheduled care services will see the gradual removal of existing distinctions between different parts of the service, and the emergence of a unified system, its elements differing only in so much as they provide patient care to meet different clinical needs.

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