PCTs struggled to commission out-of-hours care. **Rick Stern** explains how GPs can do better

SURVIVALGUIDE

Commissioning out-of-hours care

The basics

Learn the lessons from recent history
Traditionally, PCTs spent little time on out-of-hours services. In the last two years – since the death of David Gray – this has changed dramatically. Under GP commissioning, the lessons of the recent investigations must be learned. The key points are:

- Commissioning and performance management are vital functions that need time and attention. Particular attention needs to be paid to tackling inappropriate variation between areas and providers as highlighted by national benchmarking.[1]
- Selection, induction, training and use of out-of-hours clinicians (including the use of locums) must be monitored to ensure providers have staff who are fit for purpose.
- Management and operation of medical performers lists is a commissioning responsibility – until there is a national process for this you will need to ensure that your provider is not using GPs who were rejected elsewhere in the country.

Examine National Quality Requirements
Out-of-hours services have been subject to National Quality Requirements (NQRs) since 2004. These cover a number of areas including responsiveness, audit, patient perception and a requirement to link with other organisations to provide anticipatory care plans. It may be because they provide a more rounded picture that requires interpretation that they have not attracted the same attention as national targets. You will need to understand the requirements and how your local provider is performing against them. NQR 9 – which requires definitive clinical assessment for urgent calls to be started within 20 minutes of the call being answered, and for definitive clinical assessment for all other calls to start within 60 minutes of the call being answered – has been widely misunderstood and misinterpreted. Some providers have used the term 'definitive' to apply when using nurses for the first stage, but others have interpreted 'definitive' to mean seeing a doctor. The benchmark by the Primary Care Foundation has improved reporting and understanding of this requirement.

Getting started

Assess out-of-hours in context of other services
Out-of-hours has always been part of 24/7 urgent care and also needs to link closely with the patient's practice. The more you can do to ensure practices manage urgent care as well as possible, the easier it will be for the out-of-hours service to be effective. This may involve ensuring people can get through on the phone, making sure you have enough consultation to meet demand and reviewing home visits.

Effective commissioners will need the out-of-hours service to work alongside in-hours general practice, community services, NHS Direct, ambulance services, urgent care centres and A&E as well as becoming an integral part of the response to 111 calls at least overnight at weekends and possibly during the day too.

Analyse benchmarked data
Understand all the information and resources available, many of which are described on the Department of Health *Urgent and emergency care* web page. You will also want to look at recent national benchmark reports on your local service.[2] Most PCTs bought into this national service run by the Primary Care Foundation, offering like-for-like comparisons for most services across the country. It is a useful way of identifying areas for improvement.

Hold regular meetings with providers
Develop regular meetings to review performance against agreed standards. You will also want to discuss how providers understand and manage their wider impact on the system. Are they effective at completing calls or visits or do they pass on a high level of patients to A&E and the local hospital? We know there is a strong link between how quickly patients are seen and what patients think of the quality of service – so are they good at managing a rapid response? How good are they at managing variation in demand? Do they have good governance, including clinical governance and support of GPs and nurses, as well as an effective structure for governing the organisation, such as external scrutiny from non-executive directors?

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Getting results

Challenge existing configuration of services
Ensure you develop a coherent local vision for urgent and emergency care and make sure that it is understood by providers as well as more widely. Various forums, such as an urgent and emergency care network, will be useful in developing and spreading this vision. Developing the vision will involve challenge – some of the services that were set up over the past 10 years may have extended patient choice and offered new points of access, but do they make sense in delivering a coherent local service in a testing financial environment?

Importantly, the different services need to perform well individually if they are to work well together. If as commissioners you want a provider to deliver more than one service, then you should expect them to meet the standards for both services, not to settle for the lowest common denominator.

Address variation
Encourage your provider to build on the benchmarking information, offering clear comparisons across providers and to look in greater detail at the clinical variation between individual doctors and nurses. The cost and effectiveness of the service is driven by the host of individual decisions made by clinicians, so understanding and reducing variation is crucial to delivering a consistent service. The clinical lead should not only be looking at the outliers, but also consistently feeding information back to individuals and comparing them with their peers so that they can identify specific things that they might do differently for the benefit of patients and the service.

The NHS Alliance, supported by other national bodies, is currently running a pilot with 12 out-of-hours providers across England to encourage both anonymous reporting by clinicians and sharing learning across organisations when things go wrong. Think about using your influence as a commissioner not just to provide requirements and guidance, but to develop a more open culture where people and organisations can learn from mistakes.

Consider longer contracts
Recognise that there is a cost attached to tendering, and that improving a service requires investment. Look to let contracts for longer periods and demand that providers invest in software, training, equipment and facilities and work with them during the contract to improve the service and value for money. If the service does not improve you will be able to end the contract – but you are much more likely to secure a safe and consistently improving service over a 10-year contract than by letting three contracts over the same period.

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References
1 Improving out-of-hours care: what lessons can be learned from a national benchmark of services? January 2010. Henry Clay, Primary Care Foundation.
2 The Department of Health *Guidance for the NHS in delivering out-of-hours GP services*. www.dh.gov.uk/en/Healthcare/Urgentand emergencycare/DH_113752
3 Primary Care Foundation. www.primarycarefoundation.co.uk

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