Out-of-hours services
A commissioning handbook

August 2012
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1. Introduction

This document is about commissioning out-of-hours services but it will also touch on the interface between GP out-of-hours services and the wider health and urgent care systems.

It is for clinical commissioning group (CCG) staff commissioning out-of-hours services for the first time.

PCC has drawn on Department of Health guidance and good commissioning practice. Other references have been included, where relevant.

2. Background

2.1 The link between commissioning out-of-hours services and primary medical services:

GP services are currently commissioned by primary care trusts (PCTs) through three basic types of contract:

- General Medical Services (GMS)
- Personal Medical Services (PMS)
- Alternative Provider Medical Services (APMS).

The content of these contracts is largely driven by government legislation although there is flexibility, particularly in PMS and APMS contracts, to make local variations to terms, service specification and price.

All three contract types start on the basic premise that the contractor will provide primary medical services 24 hours a day, seven days a week over the full year but provide a mechanism for contractors to opt out of responsibility for service provision during a defined out-of-hours period.

GMS, PMS and most APMS contracts define core hours as between 8am and 6.30pm Monday to Friday, excluding bank holidays, and out of hours as any period outside core hours.

The decision to opt out of out of hours is completely at the discretion of the contractor, which has led to a varied national landscape of out-of-hours care.

Where practices have decided to opt out, their contract value has been reduced and responsibility for commissioning a suitable service to provide primary medical services during the out-of-hours period has transferred to the relevant PCT. Under the Health and Social Care Act 2012, responsibility for commissioning out-of-hours services will transfer to CCGs from April 2013.

Practices that retained responsibility for providing out-of-hours services do not have to provide the services themselves. Most subcontract provision to a specialist out-of-hours provider.

2.2 Out-of-hours services defined

The GMS contract defines the out-of-hours period as:
The period beginning at 6.30pm on any day from Monday to Thursday and ending at 8am on the following day
The period between 6.30pm on Friday and 8am on the following Monday
Good Friday, Christmas Day and bank holidays.

It defines ‘out-of-hours services’ as services to be provided during the out-of-hours period, which are essential or additional services if provided by the contractor to its registered patients in core hours.

The contract goes on to specify that the contractor only has to provide such services during the out-of-hours period if they think the patient’s medical condition makes it unreasonable to expect them to wait for the services during core hours.

2.3 What is not meant by out of hours?

The definition makes it clear that any practice that closes during core hours is not out of hours. The contractor must always make suitable arrangements for its patients. Out-of-hours providers often also provide services to general practices in hours, for example triaging calls during an afternoon when the practice is closed, so commissioners must take care to ensure that their contract payments are not subsidising charges made for such in-hours services.

2.4 Who is responsible for commissioning out-of-hours services

CCGs will be responsible for commissioning out-of-hours services where local GPs have ‘opted out’. However, the NHS Commissioning Board will still be responsible for commissioning out-of-hours services where practices remain opted in, either directly from the practice or indirectly through the practice’s designated subcontractor.

In many areas, responsibility for out of hours is clear – either all practices remain opted in or have chosen to opt out. However in some PCT areas the situation is less clear, with a mixture of practices having chosen to opt in and opt out. In such circumstances CCGs will need to carefully consider how they work with the NHS Commissioning Board and/or the local opted-in practices themselves, to ensure a coherent strategy for out-of-hours services.

Opted-in practices often use the same out-of-hours provider as is commissioned locally to provide services for opted-out contractors, so commissioners must ensure that their contract payments are not subsidising charges made by the out-of-hours provider for opted-in practices.

2.5 Why is commissioning of out of hours important?

Out-of-hours services are important because they form an integral part of urgent care services provided to patients.

Good out-of-hours provision can lead to better health outcomes for patients and reduced acute hospital emergency costs, both in terms of A&E attendances and A&E admissions.
3. Commissioning out-of-hours services

3.1 Who are the providers of out-of-hours services?

Before April 2004 there was no contractual opportunity for GPs to opt out of out of hours. All GPs had 24 hours a day, seven days a week responsibility for their patients. To cope, most practices formed co-operatives with other local practices to provide services when their own surgeries were closed. Co-operatives generally required both a subscription and a working commitment from their members. Private companies were also established to meet this need.

Since April 2004 these co-operatives have evolved into a range of different organisation types, some are still partnerships, but others have developed into organisations such limited liability partnerships, limited companies and social enterprise organisations.

Any organisation may hold a contract to provide out-of-hours services subject to restrictions set out by the Department of Health.

3.2 Why is tendering for out-of-hours services Important?

It is essential that commissioners follow proper procurement process when appointing an out-of-hours provider to avoid potential legal challenge and to secure a service that is best value for money.

To determine the correct procurement approach, commissioners should review their local standing financial instructions and follow local procurement policy. The Department of Health has also published a helpful guide: Procurement Guide for Commissioning of NHS-funded Services (July 2010).

It is unlikely that any qualified provider (AQP) will be appropriate for the commissioning of out of hours because the commissioner will probably want to appoint a single, or very limited number of providers for the role, which will closely integrate with other urgent care providers in the area.

Because of their value, out-of-hours contracts will need to go out to tender to comply with Department of Health requirements to demonstrate public sector procurement and EU procurement law and EU requirements for Part B services – those of transparency, proportionality, non-discrimination and equality of treatment.

Procurement requires careful planning and scrupulous compliance with rules and procedures. It is therefore essential that commissioners have determined the service specification, undertaken the necessary consultation and established the contractual and financial framework before embarking on a tender. These matters will be described in more detail below.

3.3 Avoiding conflict of interest in the tendering process

Most areas for potential conflict of interest arise where GPs involved in making key decisions associated with the procurement or who are directly involved in the process itself, have some form of association with a bidder or potential bidder, for example, they are shareholders or hold a key post. Even GPs working shifts for a bidder could be considered to have a conflict of interest if the procurement could put
that work at risk. For these reasons it is often preferable to ask neutral GPs outside the area to provide medical advice and clinical evaluation in the procurement process.

Commissioners should also carefully consider officer staff that are involved in the procurement, and ensure they have no external interests in bidder organisations or have anything to gain eg a future job from bidder organisations.

3.4 Defining the services specification

It is essential to define the service specification for the out-of-hours service before the formal procurement procedure begins to ensure the right provider is selected.

The services specification must clearly describe:

- The service required and how it fits into the local urgent care pathway(s)
- How the service is expected to integrate into other local services eg local general practices
- Expected outcomes and performance standards
- Integrated governance requirements that ensure safety of patients, security of data and quality of service
- The legacy of other previous providers
- The demographics of the population being served.

Commissioners should ensure that they include:

- The national out-of-hours quality requirements – annex 1
- The recommendations of the Care Quality Commission – annex 3
- The summary of recommendations for PCT and out-of-hours providers – annex 4
- The relevant standards for better health – annex 5.

3.5 Key performance measures

Commissioners should establish a suite of out-of-hours key performance indicators (KPIs) that assure people the service is being delivered to the required standard.

It is good practice to identify 10 to 15 KPIs for a contract that are easily measurable and are reported by the provider to the CCG at a reasonable frequency, such as monthly or quarterly.

As a minimum, the commissioner should include KPIs that ensure provider compliance with the national out-of-hours requirements set out in annex 1 (eg no more than 0.1% of calls to the OOH provider are engaged) and interpret whether such compliance has been achieved using the guidance in annex 2.

Commissioners should ensure that the performance management process and contractual remedial actions are properly documented in the contract. They should make sure reasonable sanctions are defined for KPI failure and that contract termination is an option for significant or repeated failure or non-compliance.
3.6 Tendering review process

Invitations for expressions of interest must be posted on the Supply2Health website including:

- A memorandum of information, that draws key information from the service specification
- An idea of the financial envelope within which bids will be expected
- Details of the contract duration.

This information will help potential bidders to decide whether to express interest and prevent commissioners’ and providers’ time being wasted.

Providers that have expressed interest are usually invited by the commissioner to complete a pre-qualification questionnaire (PQQ). This is to ensure that potential bidders are eligible to provide the service and acts as filter to ensure that a manageable number of organisations are invited to tender.

Finally, those providers that are selected on the strength of their PQQ are invited to submit a tender. Tenders generally consist of three components:

- Volume one – setting out the tender process, expectations and rules
- Volume two – specific questions requiring bidder response
- Volume three – the proposed contract.

From the start of the procurement process all bidders and potential bidders must be treated equitably. This includes access to information and compliance with deadlines, as well as how bids are evaluated.

The evaluation of both PQQs and tender bids must be fair and robust. Scoring systems should be determined before the documents are published to bidders, and as far as possible evaluators determined their model answers before they start evaluating bids. In particular evaluators must ensure they only score based on the content of the tender. They must not draw upon any personal knowledge of the bidder. This is particularly important for evaluators considering local bids.

Once a decision is made to appoint a provider the commissioner must make the appointment on the basis of the submitted bid. To subsequently establish a contract at a higher financial value, or to significantly change service specification would be considered bad practice and could lead to successful challenge from unsuccessful bidders.

3.7 Contractual matters

A commissioner can use whatever form of contract that he or she considers appropriate, provided that the provider can legally enter into that agreement, and that the contract is suitable for out-of-hours services. Commissioners should be aware that certain contract forms and provider organisation types might have an impact on that provider’s ability to offer NHS pensions to its staff. This could be important if the commissioner appoints a new provider and the old provider was offering NHS pensions to its staff and such rights are transferred to the new provider under TUPE.
4. Succeeding to existing contractual arrangements

4.1 Contract legacy

Many CCG will inherit a contract that has already been established by the PCT, however they’ll still be able to lever change. Staff should carefully scrutinise the current agreement and establish its remaining duration.

Opportunities should be taken to vary contracts to comply with legislation and CCG commissioners try to use all the existing terms of the agreement to maximise performance and compliance with the national out-of-hours requirements.

4.2 Negotiating changes

In most cases, changes to contracts may only be implemented through mutual agreement of the parties. This is relatively easy if a change is accompanied with investment of new funds but much more difficult if the contract value is proposed to be reduced or if the provider is expected to do more for the same contract value. The following represent levers that GP commissioners may employ in the right circumstances:

- Extension of the contract duration. This may be offered subject to local procurement rules in exchange for financial or service quality concessions
- Reduction in unnecessary contract administration
- Service reconfigurations that reduce provider costs without compromising on quality
- Rational arguments to implement changes, reduce costs in a phased way to make the provider more competitive, and therefore more likely to win a future tender
- Benchmarking against other providers
- Peer pressure for change, especially in relation to service quality and safety
- Involvement of external agencies (eg CQC), other local stakeholders to apply pressure for change.

There are many strategies that could be adopted but it’s good practice to conduct them in a professional, open and transparent manner and that negotiations are nearly always more fruitful where good relationships exist between the two parties.

5. Contract performance management

The monitoring and performance management of any contract is essential to ensure that the provider delivers the required services to an appropriate standard.

Commissioners are advised to set out a clear performance management protocol, which is shared with the contractor, setting out the escalation procedure that will be followed in the event of a breach of contract terms or failure of KPI.

Setting out such protocols will help CCG staff and establish a professional and transparent relationship with providers.

Typically such an escalation procedure will involve four stages:
- Stage one: Information resolution
- Stage two: Formal recognition of issue and senior staff involvement
- Stage three: Contractual breach/remedial notice
- Stage four: Contractual sanctions/termination.

Commissioners will need to judge, based on the seriousness of the contractor’s failure, at which stage they enter the escalation process.

They will also need to consider the relationship with other important organisations or processes such as local clinical performance management protocols, General Medical Council and the Care Quality Commission.

Furthermore, they will need to establish the appeals process and its links to the contract dispute resolution process.

5.1 Monitoring out-of-hours contracts

Monitoring is the collection, processing and presentation of data required by the commissioner to ensure the provider is delivering the contracted services to the required standard.

Commissioners should carefully define the data to be monitored and the frequency that it is to be collected. It is particularly important to establish this at the outset of a contract as the provider will need to establish appropriate systems that deliver and harvest the data. For example, clinicians may need to be instructed to code an aspect of their consultation in a particular way on the provider’s clinical system. If that instruction isn’t provided at the outset then the data may be able to be recovered in future.

Commissioners must also be assured during any procurement process that the bidders will have systems that are capable of producing the data necessary for monitoring the service. For out of hours, this means data that will allow the monitoring of the requirements set out in annex 1, that is, appropriate telephone and IT systems.
5.2 Contractual remedial actions, breaches, sanctions and termination

The commissioner should ensure that for new contracts, specific provisions for contract remedial actions, breach of terms, sanctions and termination are set out clearly in the contract documentation.

Where a contractor fails to deliver all or part of the contract to the required standard, or to comply with contract terms, the commissioner may consider formal contractual action. Under normal circumstances the commissioners would have tried to work informally with the provider to resolve the issues first but the problems may be persistent or very serious in nature.

To take formal contractual action the commissioner must first establish that there has been a breach of contract terms. This may involve an investigation by a CCG officer or neutral third party. Then commissioners should follow the process specified within the contract.

In general the following options will be available.

**Remedial notice**

This is served on the contractor where there is a breach of contract, which is capable of remedy. It sets out the contract term(s) breached, the remedial actions required within a specified timescale and the actions that will be taken by the commissioner if the provider fails to comply with the remedial actions within the specified timescale. These will generally either be sanctions or termination.

**Breach notice**

This is served on the contractor where there is a breach of contract but no remedy is possible. It sets out the contract term(s) breached, any relevant sanctions, and the actions to be taken by the commissioner if the provider repeats the breach.

The mechanism for invoking sanctions should be set out within the contact and should be followed closely by the commissioner. They will usually take the form of a deduction from the contract value commensurate with breach or the decommissioning of a relevant part of the service.

Sanctions should not be regarded as a penalty and should be quantified as either

- The cost of service re-provision during the period of breach
- The cost of that element of the contract to which that breach relates.

Plus the cost to the commissioner of handling the breach/remedial process

As a last resort, where there is a serious or repeated breach of contract, or the contractor has failed to comply with a remedial notice, the commissioner may seek to terminate the contract.

Where the commissioner follows this route it should carefully follow the relevant clauses of the contract and take appropriate legal advice. In particular the commissioner should ensure that termination is the right and proportional response to the breach.
6. **Commissioning integrated out-of-hours services**

6.1 **Links with GP walk-in services**

Many CCG areas have walk-in services located within their area, either commissioned as part of the GP-led health centre programme or that were established as part other local or national strategic initiatives.

Often these offer services for unregistered patients outside core hours but are not integrated in any way with out-of-hours services.

Patients in need of physical examination during the out-of-hours period could be directed by the out-of-hours service provider to walk-in centres during the periods they are open, rather than receiving visits or having to attend the out-of-hours provider’s base.

Commissioners would need to look at the comparative costs of using the OOH providers against the additional costs of using the walk-in centre. Walk-in centres may not be cheaper!

The best option would be to tender the two services in tandem or as a single integrated service. In this way the contract(s) can be structured to ensure that the services are integrated and represent best value for money.

6.2 **Community nursing services**

There are significant benefits for integrating community nursing services with out of hours. Community nurses that are properly supported by OOH GPs will be able to manage patients more effectively in patients’ own homes during the out-of-hours period and effective collaboration should result in a reduction of emergency admissions. OOH GPs could effectively support the community nurse team with more specialised clinical advice, while the nursing team could provide further support to patients identified by the OOH provider GPs as needing a more comprehensive support package than the OOH provider can provide.

6.3 **Community pharmacy services**

Out-of-hours services should effectively integrate with late opening pharmacies, both to ensure that patients can collect prescribed medication and to receive patients signposted from the pharmacy.

Across the country many late-opening pharmacies operate an effective low-cost service that complements the local urgent care services. Commissioners should seek to exploit the opportunities this presents and where such services don’t exist consider commissioning them as part of their urgent care strategy.

Many areas have also established specific arrangements with local community pharmacists to supply palliative care or pain control drugs prescribed by OOH GPs or community nurses during the out-of-hours period. Such arrangements can be a cost-effective mechanism of reducing A&E admissions.
6.4 Dental and ophthalmic services

Commissioners need to carefully consider how they will provide for urgent dental or eye care needed within the out-of-hours period. Such patients may present in the first instance at the OOH provider. Good integration with local community dental providers and optometrists during the out-of-hours period may reduce unnecessary A&E attendances or hospital admissions.

6.5 Links to other urgent care services

Commissioners will need to consider carefully how the OOH service integrates with local A&E and hospital-based urgent care services so, where appropriate, patients can be diverted rapidly to services they need.

Equally commissioners could explore ways in which the OOH service provides support to the A&E department to reduce waiting times and reclaim patients that should be treated by primary care.

Other important considerations should be links with out-of-hours social care and psychiatric care.

6.6 Integration with 111

Under recent government proposals some patients will be directed to the OOH provider through the local, 111 telephone triage and signposting service. It is therefore critical that the OOH provider has strong relationships with the 111 service provider and that patient flow from the 111 service to OOH service is carefully defined within suitable care pathways and contractual arrangements. This should ensure that patients are properly streamed to the OOH provider to avoid necessary A&E attendance or hospital admissions, assuring the safety and best outcomes for patients.
7. Summary

GP out-of-hours provision is an important part of the local urgent care services network. When drafting, good service specifications need to comply with national requirements, meet specific local needs and integrate well with the services provided by other local urgent care service providers.

Commissioners should take all reasonable steps to ensure that they engage the OOH provider that represents the best value for money. This will not always be the cheapest, as a higher cost provider might provide a higher quality service that reduces costs elsewhere in the urgent care system. The normal process to appoint a provider will be through an open and transparent tendering process.

Having appointed a suitable provider the commissioner will need to ensure it is bound to deliver services through a robust contract that will assure the delivery of services to the required standard through appropriate contract terms and key performance indicators.

If it's an inherited OOH contract, the commissioner should review the contract arrangements to ensure, as a minimum, that the provider is required to comply with national requirements and where they are deficient seek to vary the contract so that compliance is mandatory.
Annex 1: National quality requirements

Source:
National Quality Requirements in the Delivery of Out-of-hours Services
Department of Health
July 2006
Gateway no. 6893

1. Reporting compliance

Providers must report regularly to PCTs on their compliance with the quality requirements.

2. Communication with general practices

Providers must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8am the next working day. Where more than one organisation is involved in the provision of OOH services, there must be clearly agreed responsibilities regarding the transmission of patient data.

3. Exchange of information

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).

4. Audit of patient contacts

4.1 Providers must regularly audit a random sample of patient contacts and appropriate action will be taken on their results. Regular reports of these audits will be made available to the contracting PCT.

4.2 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.

4.3 This audit must be clinician-led with suitable experience in providing OOH care and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service.

4.4 Providers must co-operate fully with PCTs in ensuring that these audits include clinical consultations for those patients whose episode of care involved more than one provider organisation.
5. **Sample of patient experiences**

5.1 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.

5.2 Regular reports of these audits must be made available to the contracting PCT.

5.3 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.

6. **Complaints procedure**

6.1 Providers must operate a complaints procedure that is consistent with the principles of the NHS complaints process.

6.2 They will report anonymised details of each complaint and the manner in which it has been dealt with, to the contracting PCT.

6.3 All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.

7. **Meeting predictable fluctuations in demand**

7.1 Providers must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as Saturday and Sunday mornings, and the third day of a bank holiday weekend.

7.2 They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand.

8. **Initial telephone call handling**

**Engaged and abandoned calls**

8.1 No more than 0.1% of calls engaged.

8.2 No more than 5% calls abandoned.

**Time taken for the call to be answered by a person**

8.3 All calls must be answered within 60 seconds of the end of the introductory message, which should normally be no more than 30 seconds long.

8.4 Where there is no introductory message, all calls must be answered within 30 seconds.
9. **Telephone clinical assessment**

**Identification of immediate life-threatening conditions**

9.1 Providers must have a robust system for identifying all immediate life threatening conditions.

9.2 Once identified, those calls must be passed to the ambulance service within three minutes.

**Definitive clinical assessment**

Providers that can demonstrate they have a clinically safe and effective system for prioritising calls, must meet the following standards:

9.3 Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person.

9.4 Start definitive clinical assessment for all other calls within 60 minutes of the call being answered by a person.

9.5 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**

9.6 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.

10. **Face-to-face clinical assessment**

**Identification of immediate life-threatening conditions**

10.1 Providers must have a robust system for identifying all immediate life threatening conditions.

10.2 Once identified, those patients must be passed to the most appropriate acute response (including the ambulance service) within three minutes.

**Definitive clinical assessment**

Providers that can demonstrate they have a clinically safe and effective system for prioritising patients must meet the following standards:

10.3 Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre.

10.4 Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre.

10.5 Providers that do not have such a system must start definitive clinical assessment for all patients within 20 minutes of the patients arriving in the centre.
Outcome

10.6 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.

11. Clinical consultations

11.1 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) and in the most appropriate location.

11.2 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 home.

12. Face-to-face consultations

Face-to-face consultations (whether in a centre or in the patient's home) must be started within the following timescales, after the definitive clinical assessment has been completed:

12.1 Emergency: within one hour.

12.2 Urgent: within two hours.

12.3 Less urgent: within six hours.

13. Patients with communication difficulties

13.1 Patients unable to communicate effectively in English will be provided with an interpretation service within 15 minutes of initial contact.

13.2 Providers must also make appropriate provision for patients with impaired hearing or impaired sight.
Annex 2: Compliance with quality requirements

Source:
National Quality Requirements in the Delivery of Out-of-hours Services
Department of Health
July 2006
Gateway no. 6893

In a number of areas, providers have to demonstrate 100% compliance. In many circumstances, achieving compliance at all times would require a disproportionate provision of resources and, for that reason, compliance with these standards is defined as follows:

1. Full compliance

Normally, a provider would be deemed to be fully compliant where average performance was within 5% of the requirement. So, where the requirement is 100%, average performance of 95% and above would be considered fully compliant.

2. Partial compliance

Where average performance was between 5% and 10% below the requirement, a provider would be considered partially compliant and the commissioner would explore the situation with the provider and identify ways of improving performance. So, where the requirement is 100%, average performance of between 90% and 94.9% would be deemed to be partially compliant.

3. Non-compliance

Where the average performance was more than 10% below the Requirement, the provider would be deemed to be non-compliant and the commissioner would specify the timescale within which the provider would be required to achieve compliance. Thus, where the Requirement is 100%, average performance of 89.9% and below would be deemed to be non-compliant.

4. Considerations when evaluating average performance

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 commissioners 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 considered partially or non-compliant. For example:

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

4.3 Where a provider is commissioned to deliver services for a number of different PCTs, it is important that its compliance data is disaggregated by PCT area. Data averaged across the PCTs could conceal wide variations in the quality of service provided in each locality, and it is only by reporting performance for each separate PCT population that commissioners will be able to assess the quality of the service that is being provided to their patients.

5. Other considerations when provider is not in full compliance

Wherever a provider is not in full compliance with a particular requirement, the commissioner will want to be clear that performance has not reached a plateau from which no further improvement is taking place. So, the commissioner would look for evidence of continual improvement over time and, in the absence of such evidence, downgrade its assessment of compliance accordingly.
Annex 3: Care Quality Commission recommendations

Source:
Investigation into the out-of-hours services provided by Take Care Now
Care Quality Commission
July 2010

Overall recommendation

1. Out-of-hours services present a high risk to both patients and staff. All parties involved in the provision and purchase of out-of-hours services need to ensure there are sufficient suitably trained and experienced clinical staff, particularly doctors, engaged in planning and delivering these services.

Recommendations for those who commission out-of-hours services

2. Primary care trusts must consider out-of-hours services as a vital component of both primary care and of urgent care and ensure they are procured and developed strategically, linking with other providers of these services.

3. PCTs need to be aware of the risks in out-of-hours services and actively commission services to reduce these risks. In particular, they need to ensure adequate staffing by GPs.

4. The authors reiterate the recommendation from the interim statement that all PCTs should scrutinise out-of-hours services more closely and that staff responsible for monitoring out-of-hours contracts should be sufficiently senior and understand the information being reported by providers. There needs to be clarity on how and what activity is recorded.

5. PCTs should ensure that all serious incidents occurring in out-of-hours services are reported, thoroughly investigated and learning disseminated. Audits should be considered to identify under reporting.

6. PCTs need to seek and act on feedback from key stakeholders about out-of-hours services and have clear governance structures in place for escalation of concerns.

7. They must ensure there is adequate support, including clinical support, for those administering the performers’ list so that only appropriately qualified, trained, experienced staff, with good English and knowledge of the NHS, can join and stay on the list.

8. PCTs must ensure an effective and timely two-way flow of relevant information with out-of-hours services about poorly performing doctors, and appropriate action.
Recommendations for those who provide out-of-hours services

9. Above all, providers of out-of-hours services need to have enough properly qualified, trained and experienced staff on duty, who have adequate support, can communicate effectively and are not working excessive hours. In particular, there should be adequate GP coverage.

10. Providers of these services need to have effective systems to record activity accurately and analyse data and performance.

11. Providers should have a robust governance system in place, including a clear hierarchy of committees and a high standard of minute taking, so that decisions and accountability are clearly recorded.

12. They must report all serious incidents, including those arising from complaints, and ensure these are thoroughly investigated, with analysis of underlying causes, high quality reports, and changes made at operational level.

13. Providers need to ensure that clinical audit is used to identify the quality of clinical performance, that feedback is timely, that poor performance is identified and dealt with, and that information is shared appropriately with the relevant PCT(s) and/or other authorities in a timely fashion.

14. Providers must have adequate advice and input from a pharmacist to ensure robust policies and procedures for managing medicines, including controlled drugs.

15. Providers should audit their handling of calls in a routine and systematic way. Providers should conduct audits both of call handlers and clinicians using voice recordings as well as documented notes.

16. Providers of out-of-hours services need to have effective means to communicate with their frontline staff, particularly about clinical matters, and to listen to the views and concerns of staff.
Annex 4: General practice out-of-hours project: summary of recommendations

Source:
General practice out-of-hours services
Project to consider and assess current arrangements
Professor David Colin-Thomé and Professor Steve Field
January 2010

Commissioning and performance management

1. PCTs should review the performance management arrangements in place for their out-of-hours services and ensure they are robust and fit for purpose. This includes the frequency of the contractual review meetings with providers and the seniority of staff attending these meetings (including clinicians). There should be a quality review meeting separate to the contractual review attended by senior clinicians from both organisations and other appropriate senior clinicians. In particular, the authors want PCTs to involve local GPs in the process. This can be achieved by working with their local medical committees, RCGP groups, faculties, clinical executive groups, local and with practice-based commissioning consortia. Nonetheless, providers need to be clear that they are accountable for delivering services. Clarity of accountability is particularly important where provision is split between two or more providers.

2. PCTs should supplement the core national quality requirements (NQRs) with a suite of locally developed quality indicators, which include requirements to monitor clinical outcomes trends, patient reported outcomes and undertake more intensive patient and stakeholder feedback surveys. Consideration should be given to quality incentive payments linked to these local KPIs.

3. In line with national quality requirement five, PCTs and providers should review the current arrangements in place for receiving patient experience reports. PCTs should also consider how other feedback received on the service (whether formally through complaints, or informally using the PALS service and so on) could be incorporated into performance management arrangements. They should also ensure they are regularly sourcing feedback from other stakeholders such as local GPs, A&Es and ambulance services, and examining trends in incidents reported. If feedback indicates any trends, PCTs should ensure they follow these up immediately.

4. PCTs should support out-of-hours providers to become a valued and integral part of the local health economy, ensuring that they have a place on any local urgent care boards or networks. This would include ensuring the provider is able to develop integrated care pathways with other parts of the system including A&E and ambulance services to ensure delivery of an integrated, efficient service.

5. PCTs and out-of-hours providers should benchmark their services in ensuring the validity of their performance data. For instance, this could include participation in the primary care foundation benchmarking exercise. Benchmarking will enable PCTs to consider whether the resources allocated to the service are sufficient to ensure delivery of productive and high quality services.
6. Out-of-hours providers should consider the recruitment and selection processes in place for clinical staff to ensure they are robust and that they are following best practice in this area. This includes evidence of a detailed knowledge and skills outline for staff which sets out the generic qualifications and appropriate experience, skills (including telephone assessment) and knowledge required to work in the out-of-hours service and should be applied to all locums as well as staff who regularly work for the provider.

7. Out-of-hours providers should consider the contents of their induction process to ensure it is comprehensive and completed before any staff work a first shift for the service. This induction process should be tailored according to the needs of the individual staff member, and would be more detailed for staff who have not previously worked in the local area or in the out-of-hours service. Special consideration should be given to induction requirements for staff who do not usually work in the UK. The induction process should be followed up by appropriate shadowing and mentoring arrangements, particularly for less experienced staff.

8. PCTs should review whether recruitment, induction and mentoring requirements for the out-of-hours provider are set out adequately in their contract with the provider, and satisfy themselves that these are passed through to any sub-contractor or agency that the provider engages.

9. Providers should co-operate with other local and regional providers (both in and out-of-hours) to share any concerns over staff working excessive hours for their respective services. PCTs and providers alike should also encourage clinical staff to share information about their working arrangements with all organisations that they work for, and providers should ideally put this requirement in their clinicians’ contracts.

10. Out-of-hours providers should consider the adequacy of their clinical governance arrangements (including those for clinical audit) and should consider undertaking trend analysis of clinical performance for common and/or high impact conditions as part of these audits. These could be used to form part of an internal or external benchmark of clinical performance to help raise standards. PCTs should also ensure they consider the cost of the provider undertaking these audits as part of recommendation five.

11. PCTs should regularly check that all the locum and sessional staff on their medical performers’ list have appropriate access to appraisal and continuing professional development (CPD).

12. Out-of-hours providers should consider the benefit of signing agreements with locum agencies for preferred provider status to ensure consistency in the quality of any locums required.
Annex 5: Standards for better health

Source:
Standards for Better Health
Department of Health

Safety

Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

1. Healthcare organisations protect patients through systems that:
   - 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
   - Ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.

2. Healthcare organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.

3. They protect patients by following guidance from NICE interventional procedures.

4. Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that:
   - The risk of healthcare-acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA
   - All risks associated with the acquisition and use of medical devices are minimised
   - All reusable medical devices are properly decontaminated before use and that the risks associated with decontamination facilities and processes are well managed
   - Medicines are handled safely and securely
   - 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.

5. Healthcare organisations continuously and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from the care of one organisation to another.
Clinical and cost effectiveness

Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.

6. Healthcare organisations ensure that:

- They conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care
- Clinical care and treatment are carried out under supervision and leadership
- Clinicians continuously update skills and techniques relevant to their clinical work
- Clinicians participate in regular clinical audit and reviews of clinical services.

7. Healthcare organisations co-operate with each other and social care organisations to ensure that patients’ individual needs are properly managed and met.

8. Patients receive effective treatment and care that:

- Conform to nationally agreed best practice, particularly as defined in national service frameworks, NICE guidance, national plans and agreed national guidance on service delivery
- Take into account their individual requirements and meet their physical, cultural, spiritual and psychological needs and preferences
- Are well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations
- Are delivered by healthcare professionals who make clinical decisions based on evidence-based practice.

Governance

Managerial and clinical leadership and accountability, as well as the organisation’s culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the healthcare organisation.

9. Healthcare organisations:

- Apply the principles of sound clinical and corporate governance
- Actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources
- Undertake systematic risk assessment and risk management
• Ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources
• Challenge discrimination, promote equality and respect human rights.

10. Healthcare organisations support their staff through:

• Having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services
• Organisational and personal development programmes, which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.

11. Healthcare 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.

12. Healthcare organisations:

a) Undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies

b) Require that all employed professionals abide by relevant published codes of professional practice.

13. Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare:

a) Are appropriately recruited, trained and qualified for the work they undertake

b) Participate in mandatory training programmes

c) Take part in further professional and occupational development commensurate with their work throughout their working lives.

14. Health care organisations that either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.

15. Integrated governance arrangements representing best practice are in place in all such organisations and across all health communities and clinical networks.

16. Healthcare organisations work together to:

a) Ensure that the principles of clinical governance are underpinning the work of every clinical team and every clinical service
17. Healthcare organisations work together and with social care organisations to meet the changing health needs of their population by having an appropriately constituted workforce and skill mix across the community and ensuring the continuous improvement of services through better ways of working.

18. Healthcare organisations use effective and integrated information technology and information systems, which support and enhance the quality and safety of patient care, choice and service planning.

19. Healthcare organisations work to enhance patient care by adopting best practice in human resources management and continuously improving staff satisfaction.

**Patient focus**

Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.

20. Healthcare organisations have systems in place to ensure that:

- Staff treat patients, their relatives and carers with dignity and respect
- Appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information
- Staff treat patient information confidentially, except where authorised by legislation to the contrary.

21. Healthcare organisations have systems in place to ensure that patients, their relatives and carers

- Have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services
- Are not discriminated against when complaints are made
- Are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

22. Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.
23. Healthcare organisations continuously improve the patient experience, based on the feedback of patients, carers and relatives.

24. Patients, service users and, where appropriate, carers receive timely and suitable information, when they need and want it, on treatment, care, services, prevention and health promotion and are encouraged to express their preferences; and supported to make choices and shared decisions about their own health care.

25. Patients and service users, particularly those with long-term conditions, are helped to contribute to planning of their care and are provided with opportunities and resources to develop competence in self-care.

**Accessible and responsive care**

Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

26. The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

27. Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

28. They ensure that patients with emergency health needs are able to access care promptly, within nationally agreed timescales and national expectations on access to services.

29. Healthcare organisations plan and deliver health care, which:

   - Reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice
   - Maximises patient choice
   - Ensures access (including equality of access) to services through a range of providers and routes
   - Uses locally agreed guidance, guidelines or protocols for admission, referral and discharge that accord with the latest national expectations on access to services.

**Care environment and amenities**

Care is provided in environments that promote patient and staff well-being, respect patients’ needs and preferences, and optimise health outcomes. So they should be designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, and be well maintained and cleaned.

30. Healthcare services are provided in environments that promote effective care and optimise health outcomes by being safe and secure; protecting patients, staff,
visitors and their property, and the physical assets of the organisation. They should also support patient privacy and confidentiality.

31. Healthcare services are provided in environments that 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.

32. Healthcare is provided in well-designed environments that:

- Promote patient and staff well-being and meet patients’ needs and preferences, and staff concerns
- Are appropriate for the effective and safe delivery of treatment, care or a specific function, including the effective control of healthcare-associated infections.

Public health

Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

33. Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:

- Co-operating with each other and with local authorities and other organisations
- Ensuring that the local director of public health’s annual report informs their policies and practices
- Making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships.

34. Healthcare organisations have systematic and managed disease prevention and health promotion programmes that meet the requirements of the national service frameworks. They have national plans on reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

35. Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.

36. Healthcare organisations:

- Identify and act upon significant public health problems and health inequality issues, with primary care trusts taking the leading role
• Implement effective programmes to improve health and reduce health inequalities, conforming to nationally agreed best practice, particularly as defined in NICE guidance and agreed national guidance on public health

• Protect their populations from identified current and new hazards to health

• Take fully into account current and emerging policies and knowledge on public health issues in developing their public health programmes, health promotion and prevention services for the public, and commissioning and providing services.
Primary Care Commissioning

Primary Care Commissioning (PCC) is a not-for-profit social business with roots in the NHS and three principal activities:

- Commissioner support
- Provider support
- Training and development

Find out more by visiting our website: www.pcc.nhs.uk