National Quality Requirements in the Delivery of Out-of-Hours Services

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Introduction

Since November 2002, all organised providers of out-of-hours (OOH) services have had to comply with national OOH Quality Standards. With the introduction of the new Standards for Better Health\(^1\) (published in July 2004), these Quality Standards have been replaced by National Quality Requirements in the delivery of OOH services which will come into effect on 1\(^{st}\) January 2005.

Under the new primary medical care contracts introduced in April 2004, all those who provide OOH services (including GP practices that do not transfer their responsibility for OOH services) will have to meet the new national OOH Quality Requirements.

In addition PCTs will need to ensure that the services they provide or commission comply with Standards for Better Health. A number of these new national Standards set out requirements which were defined in the original OOH Quality Standards – examples of the new Standards and the original OOH Quality Standards they have replaced are set out in Annex One.

OOH services will be delivered under one of four contractual frameworks:

**Organised Providers of OOH Services - APMS**

PCTs will only commission OOH services from providers that are able to meet the OOH Quality Requirements. Meeting the Quality Requirements will be a contractual requirement and providers will report regularly to PCTs on their compliance with them.

**PCTs providing their own OOH Service - PCTMS**

Where the PCT chooses to provide the service itself, the obligations laid on providers by the Requirements will apply to that part of the PCT that is delivering the service; it will report regularly on its compliance with the Requirements to that (different) part of the PCT that takes responsibility for the quality of OOH services in its area.

**GP Practices providing their own OOH Services – GMS and PMS**

From 1\(^{st}\) January 2005, those GP practices that choose not to transfer the responsibility for the provision of OOH services, will have to comply with the national OOH Quality Requirements in the service that they provide to their patients. Detailed reporting on their compliance with some of the Requirements (especially in the area of patients’ initial access to their service), could place disproportionate demands on the practice. It is important therefore, that the PCT and the practice reach a shared understanding of the manner in which the practice will demonstrate its compliance with the Requirements, and the way in

\(^1\) These Standards are set out in *National Standards, Local Action. Health and Social Care Standards and Planning Framework*, Department of Health, 2004, which is available from the OOH website [http://www.out-of-hours.info](http://www.out-of-hours.info)
which the service will be monitored. In reaching agreement about the most appropriate way of doing this, PCTs must ensure that they do not impose any undue burden on the practice.

**GMS and PMS Practices sub-contracting to another provider**

GP practices that subcontract their OOH services to another provider will continue to be bound by the contractual requirement to ensure that the services delivered to their patients meet the Quality Requirements. If a GMS contractor that has not transferred responsibility wishes to sub-contract its out-of-hours services, it will need to secure the agreement of the PCT first; in determining whether or not to agree, the PCT will want to be confident that the provider can meet the Quality Requirements. The PCT, the practice and the provider will also need to agree on the most effective way in which compliance with the Quality Requirements can be regularly reported to the PCT. PMS contractors will need to inform the PCT if they sub-contract their OOH services.

**Meeting periods of peak demand**

One of the most distinctive features of OOH services is the manner in which patient demand varies from day-to-day. In practice, however, almost all of those variations are predictable – every week, demand rises substantially on Saturday and Sunday mornings, and the third day of every Bank Holiday weekend is invariably even busier. Not least because these fluctuations are predictable, providers can plan the staffing of their service to ensure that, especially at these periods of peak demand, patients will have access to the clinician best equipped to meeting their particular needs. Practices may of course choose to run routine surgeries during these periods under a locally enhanced service contract with the PCT, but wherever this is not the case, PCTs will want to ensure that the OOH service it has commissioned is properly staffed and equipped to meet these peaks in demand.

**Routine services provided in the OOH period**

The OOH Quality Requirements apply to services that are designed to meet the urgent needs of patients that cannot safely be deferred until the patient’s own GP practice is next open, and do not apply to surgeries and similar services that are primarily intended to offer primary medical services of a general nature. Thus, for example, where a practice provides a routine Saturday morning surgery as part of a Local Enhanced Service, the Standards set out here would not apply to that service.
The National Quality Requirements

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

2. Providers must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8.00 a.m. the next working day. Where more than one organisation is involved in the provision of OOH services, there must be clearly agreed responsibilities in respect of the transmission of patient data.

3. Providers must have systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness).

4. Providers must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the contracting PCT. The sample must be defined in such a way that it will provide sufficient data to review the clinical performance of each individual working within the service. This audit must be led by a clinician with suitable experience in providing OOH care and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service.

Providers must cooperate fully with PCTs in ensuring that these audits include clinical consultations for those patients whose episode of care involved more than one provider organisation.

5. Providers must regularly audit a random sample of patients' experiences of the service (for example 1% per quarter) and appropriate action must be taken on the results of those audits. Regular reports of these audits must be made available to the contracting PCT.

Providers must cooperate fully with PCTs in ensuring that these audits include the experiences of patients whose episode of care involved more than one provider organisation.

6. Providers must operate a complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report anonymised details of each complaint, and the manner in which it has been dealt with, to the contracting PCT. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.

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

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2 A provider is any organisation providing OOH services under GMS, PMS, APMS or PCTMS
8. **Initial Telephone Call:**

*Engaged and abandoned calls:*
- No more than 0.1% of calls engaged
- No more than 5% calls abandoned.

*Time taken for the call to be answered by a person:*
- All calls must be answered within 60 seconds of the end of the introductory message which should normally be no more than 30 seconds long.
- Where there is no introductory message, all calls must be answered within 30 seconds.

9. **Telephone Clinical Assessment**

*Identification of immediate life threatening conditions*
Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those calls must be passed to the ambulance service within 3 minutes.

*Definitive Clinical Assessment*
Providers that can demonstrate that they have a clinically safe and effective system for prioritising calls, must meet the following standards:
- Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person
- Start definitive clinical assessment for all other calls within 60 minutes of the call being answered by a person

Providers that do not have such a system, must start definitive clinical assessment for all calls within 20 minutes of the call being answered by a person.

*Outcome*
At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

10. **Face to Face Clinical Assessment**

*Identification of immediate life threatening conditions*
Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those patients must be passed to the most appropriate acute response (including the ambulance service) within 3 minutes.

*Definitive Clinical Assessment*
Providers that can demonstrate that they have a clinically safe and effective system for prioritising patients, must meet the following standards:
- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre
- Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre

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

*Outcome*
At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.
11. Providers must ensure that patients are treated by the clinician best equipped to meet their needs, (especially at periods of peak demand such as Saturday mornings), in the most appropriate location. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP, including where necessary, at the patient's place of residence.

12. **Face-to-face consultations** (whether in a centre or in the patient’s place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:
   - Emergency: Within 1 hour.
   - Urgent: Within 2 hours.
   - Less urgent: Within 6 hours.

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

Standards for Better Health and the original OOH Quality Standards

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

Core Standard 1
Health care organisations protect patients through systems that:

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

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

Core Standard 4
Health care organisations keep patients, staff and visitors safe by having systems to ensure that:

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

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

Core Standard 7
Health care organisations:

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

Includes the requirements of the original OOH Quality Standard in relation to corporate governance and transport.
Core Standard 9
Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

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

Core Standard 10
Health care organisations:

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

Core Standard 11
Health care organisations ensure that staff concerned with all aspects of the provision of health care:

a) are appropriately recruited, trained and qualified for the work they undertake;
b) participate in mandatory training programmes; and

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

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

Core Standard 20
Health care services are provided in environments which promote effective care and optimise health outcomes by being:

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

Core Standard 21
Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

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