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AGENDA ITEM: 4

HEALTH SCRUTINY PANEL
17 JULY 2006

DRAFT
FINAL REPORT INTO OUT OF HOURS SERVICES

Purpose of the Report

1. To present the DRAFT findings of the Health Scrutiny Panel, following its review into the Out of Hours services.

Recommendations

2. That the Panel considers the DRAFT Final Report into the Out of Hours Service and makes any amendments felt necessary.

3. That the Panel, following consideration of the evidence contained with the DRAFT Final Report, considers its conclusions and any recommendations it would like to make.

Background

3. As a result of significant NHS changes since 1997, General Practitioners (GPs) now work under a new contract of employment, negotiated between the British Medical Association (BMA) and Department of Health.

4. A significant element of the new GP contract relates to the provision of Out of Hours services and the responsibility for such service provision. Out of Hours is essentially everything outside 8am to 6pm Monday to Friday, including bank holidays.

5. Traditionally, local GP practices were responsible for the provision of Out of Hours services. As a result of the responsibility sitting at such a level, services across any given area were fragmented, with some GPs providing the service and other GP practices choosing to commission other parties to provide the service in their given area.

6. Under the new GP contract, Primary Care Trusts (PCTs) now have the responsibility to provide Out of Hours services to their population they serve.

7. Middlesbrough PCT, together with the other Tees Valley PCTs, jointly commissioned an out of hours service from an independent sector organisation called Primecare. The contract to provide the Out of Hours service began on 1 April 2004 and runs until summer 2007.

8. With this backdrop in mind, the Health Scrutiny Panel thought it would be a good juncture to conduct a review into the effectiveness of the service.

Introduction

9. In its investigation of the topic at hand, the Health Scrutiny Panel's work was directed by the following terms of reference.

9.1 To investigate the effectiveness of the current out of hours service.

Specifically

9.2 To investigate how the service is provided and managed.

9.3 To investigate how the service is performance managed and lessons learnt implemented.

9.4 To establish how the service is performing against local or national targets and/or standards.

9.5 To investigate the views of stakeholders in relation to the service

9.6 To investigate whether there are any improvements that can be made to the service.

Membership of the Panel

10. Councillor E Dryden (Chair), Councillor H Pearson OBE (Vice Chair), Councillors S Biswas, E Lancaster, T Mawston, R Regan (until 17 May 2006), K Walker (until 17 May 2006) Cllr Rooney (from 17 May 2006) & J Harris (from 17 May 2006).

Methods of Investigation

11. The Health Scrutiny Panel met between February and May 2006 to consider evidence in relation to the scrutiny review. A detailed record of the meeting proceedings is accessible through the 'Commis' system. The Panel received evidence from a wide range of sources, which is detailed in the body of the report.

Evidence from Middlesbrough PCT and Primecare

12. At its meeting on 6 March 2006 the Panel took evidence from Middlesbrough PCT and Primecare, the independent sector organisation contracted to provide the Out of Hours service.

13. The evidence started with a brief history of the Out of Hours service in Middlesbrough and the definition of what Out of Hours means in the modern day NHS.

14. The Panel heard that Out of Hours services are defined as primary medical care & services, which are provided outside normal office hours. That is, from 6pm until 8am on weekends and bank holidays. It was confirmed to the Panel that the provision of Out of Hours services is now the PCTs statutory responsibility.

15. The Panel heard that from 1945, the provision of Out of Hours services was the responsibility of General Practitioners. In 1990 a new GP contract came into force, which in turn brought about the Out of Hours service being provided by Commercial Deputising Services, which in many respects was a forerunner to the modern Primecare organisation. It was clarified to the Panel at this stage however, that such Commercial Deputising Services contracted with General Practice as opposed to the Primary Care organisation, as the obligation to provide Out of Hours services was General Practices to meet.

16. In 2000 the Carson report[1] was published. The Panel heard that the Carson report was the first in depth consideration of Out of Hours for a substantial amount of time and proposed hugely significant developments to Out of Hours services. The report called those proposals "a flexible, national model of integrated out-of-hours provision, which will deliver consistent standards of high quality care to patients across the country"[2].

17. The Carson report did not, however, claim to suggest revolutionary changes 'across the board'. Rather it identified (then) current best practice and encouraged its introduction across the country. The Panel heard that it was the Carson report which really moved thinking on Out of Hours forward and towards a position whereby how Out of Hours looked and felt for the patient became a critical consideration.

18. The Panel heard that in 2004, a new GP contract came into force, which gave PCTs the responsibility to provide Out of Hours services. Locally, it was agreed by the five Tees Valley PCTs (Darlington, Langbaurgh, Middlesbrough, Hartlepool & Stockton) that the Out of Hours services would be contracted and provided on a cross PCT basis. The Panel heard that each GP in the areas affected were asked whether they would like to provide their

[1] Can be found at www.out-of-hours.info/downloads/oohreview.pdf

[2] Please see Page 2

own Out of Hours services and no GPs in the Middlesbrough area responded in the positive.

19. The Panel heard that the PCTs aim in assuming the responsibility for the Out of Hours service was “to improve the appropriateness, consistency and quality of care and enhance capacity and skills so as to manage the increasing demand in a clinical safe and effective manner”.

20. The Panel was talked through the Commissioning process undergone to secure a service provider for Out of Hours services. The five Tees Valley PCTs established an Out of Hours Board, which set out in detail the specification of services, which had four facets with standard conditions, for which tenders were invited.

21. Following a tendering process, a contract lasting from 1 April 2004 to 31 March 2007 was awarded to Primecare Cleveland.

22. The Panel heard that the Model of Care provided by the current Out of Hours arrangements had four facets. These were Telephony, Triage, Treatment & Transport. Performance in these four elements is monitored monthly and fed back to the PCTs joint arrangements, through contract management processes.

23. The performance of the Out of Hours service is also monitored through clinical governance arrangements, monitoring of complaints, audit of the service and practice feedback.

24. The Panel enquired as to what an organisation such as Primecare can offer the service that GPs cannot. The Panel heard that despite a large proportion of patients feeling that the service from the GP is the ‘gold standard’, it is often not the best service that patients could get in a variety of settings.

25. The PCT gave the example of a out of hours home visit by a GP, that could be conducted under a 40W light, with a dog barking and other domestic disturbances which may be occurring in the house or in the immediate area at that time.

26. Given this example, the Panel could see how a case could be made to suggest that a doctor trying to diagnose a patient, with such distractions nearby would not be in the best interests of the patient. Accordingly, the Panel could see the logic behind an argument which would suggest that the patient would be better examined in a specifically designed setting, such as the Out of Hours centre provided for this purpose on the JCUH site. The Panel accepted that the offer of transport to this facility, if such a visit was deemed medically necessary was a substantial plus point in the current Out of Hours service. Consequently, if someone feels it necessary to call the Out of Hours service, they would be asked a series of questions in relation to their symptoms (triage) and then passed onto a clinical professional who will recommend a course of treatment or arrange a visit to a medical facility. Transport will also be arranged if necessary.

27. Following consideration of evidence from a number of sources, the Panel felt that it would be prudent to speak with Middlesbrough PCT again, so it could explore issues which had arisen since the first discussion with the PCT and seek points of clarification on a number of matters.

28. As a result of that, the PCT attended a meeting of the Panel on 23 May 2006 to continue this discussion and address the additional points, which the Panel wanted to consider.

29. Firstly, as a result of information which the Panel has received, the Panel wanted to enquire as to how Out of Hours services are provided for people with chronic long term conditions, and whether they are treated any differently to 'ordinary' calls to the Out of Hours service.

30. The Panel heard that at present, patients with chronic long term conditions are treated in the same way as all others, i.e. the call will be made to Out of Hours services and it will be triaged. Self-management of such conditions is encouraged and supported, although the Panel heard that there are governance issues when clinical action is involved, to protect both patient and professional. The Panel was told, however, that it was not to say things cannot be moved on where such action would be in the interests of patients. The Panel was told that there was potential for such patients' details to be added to the Primecare database, in a similar fashion as those of palliative patients were. Patients receiving palliative care have their records with Primecare, with an enhanced level of clinical information available. This can aid and facilitate clinical decision-making.

31. The Panel heard, however, that in the view of the PCT there are still improvements to be made with reference to chronic condition patient's experience of the Out of Hours system. To some extent, patients are still dealt with at the convenience of the system, as opposed to a system that operates for the convenience of patients.

32. Further to that, the Panel heard that in relation to chronic conditions patients, whilst they are not treated hugely differently to 'ordinary' callers to the Out of Hours service, one could make quite a strong argument to suggest that they should be. It was acknowledged that this area was rather underdeveloped and was in need of development to fully meet with the needs of this distinct patient grouping. Indeed, the point was made that if that patient group were not treated according to their rather unique needs, frustration of patients may lead to their short-circuiting of the system and over reliance on the acute sector. In turn, this may place unnecessary strain on the acute sector.

33. On a note of caution, however, it was stated that such a system where a group of patients were given more control over there care could potentially be open to abuse and would need to be monitored to ensure its proper use.

34. The Panel was interested to hear the PCT's perspective on whether the Out of Hours service change has caused an upturn in the number of people

engaging Accident & Emergency services to have their non-emergency complaints addressed. The Panel heard that, at present, the data is inconclusive. The PCT has noted an increase in A&E activity, although it is not clear as to what such increases are attributable to. The Panel heard that whilst it was confirmed that more people were accessing A&E from the Out of Hours service, there are more Out of Hours 'hours' and the proportions referred to A&E are stable.

35. The Panel did hear that in the view of the PCT, there may be at times, too many 'handoffs' between someone calling with a medical complaint and clinical action being agreed. It was confirmed to the Panel that a consultation might involve separate telephone conversations with a nurse and doctor. The Panel agreed with the concept that if such 'handoffs' become the norm or people became frustrated with the amount of time taken to arrive at a form of clinical action, people may act independently and engage with A&E. This would create extra demand on those services, the nature of which may well be inappropriate for those services to deal with. The Panel judged this to be an undesirable outcome and would hope that the triage system could be refined to such an extent, that the temptation for people to short-circuit the system is eliminated as much as possible. In addition, and arguably more importantly, there may also be a risk that such delays result in a worsening of someone's condition. The Panel heard that a key element of ensuring that people accessed the most appropriate service at the proper time was educating people about their conditions, in addition to publicising better what services were available where and for what purpose they were designed. The Panel felt this was something that could be improved significantly.

36. It was confirmed that the Out of Hours service has a treatment and assessment facility, which is based at the James Cook University Hospital, very close to the Accident & Emergency facility.

37. The Panel heard that as a result of the government 'payment by results' system being rolled out, there may actually be a disincentive for staff in the A&E unit to refer people through to the Out of Hours facility that may be more suited to it. To clarify, if people present at A&E and are better suited to being dealt with by the Out of Hours facility, the acute trust would be, in effect, denying itself of income, which may result in a situation whereby income generation would prevail over what was most desirable clinically. The Panel felt that this was an area of concern, which should be considered in an attempt to avoid such an eventuality. Further, the Panel acknowledged that such an attitude from trusts was perhaps understandable and predictable, given the nature and ethos of 'payment by results'. On this point, however, the Panel also acknowledges the logic of placing the Out of Hours facility at the James Cook University Hospital. Nonetheless, the Panel wishes to emphasise its concern that given the 'payment by results' ethos, such an eventuality as outlined above is possible and would be disappointing if it occurred.

38. Following a recent report from the House of Commons Public Accounts Committee, which highlighted the higher than expected costs of the Out of Hours arrangements, the Panel were particularly interested in hearing about

the cost of the Out of Hours arrangements in the Tees Valley. The Panel heard that the cost of the Out of Hours was in line with PCT projections, albeit in excess of the Government's £6000 per GP. The Panel heard that from available assessments, the cost of Out of Hours services in the Tees Valley is around the national median. It was noted by the Panel that Primecare was not the cheapest tender for the Out of Hours contract, although it was felt to have been the best suited to the required task and was consequently why it was awarded to Primecare. It was confirmed that the contract between the PCT and Primecare was signed on 28 March 2006.

39. The Panel heard that in excess of 90% of those patients defined as an urgent case were assessed within the 20 minutes allowed. Further to that, it was confirmed that all emergency calls were assessed within the 3 minutes allowed. The Panel noted that the service provider, Primecare, actually defines what is meant by 'urgent' and 'emergency' in the context of the Out of Hours services. It was noted that, theoretically, there could be a danger in the service provider defining what is 'emergency' and what is 'urgent'. This is due to the fact that calls could be identified as 'urgent' to allow the service provider longer to deal with the matter. This is something that the Panel feels should be monitored to ensure it does not happen.

40. As part of its wider research, the Panel had learned that the NHS Confederation said that 80% of patients were satisfied with the service they had received from the NHS[3]. The Panel was interested to learn as to whether this was reflected in local satisfaction with the Out of Hours services. The Panel was told by the PCT that results from surveys conducted by Primecare indicated that 94-97% of Tees Valley patients are satisfied with the service provided by the Out of Hours service.

41. Further on this matter, the Panel heard that the neighbouring Langbaurgh PCT (equal partners in commissioning the Primecare service) had carried out a survey on Out of Hours, which indicated that 61% of service users were 'happy' with the service and 30% were 'partially happy' with the service. The Panel felt that this result could be read one of two ways. Firstly, it could be said that 91% of those asked seemed to be satisfied enough with the service to not criticise it or complain about it, which could be seen as a major positive. Alternatively, it could be viewed, as only those who classify themselves as 'happy' are actually happy with the service provided and 'partially happy' are by definition, not 'happy' with the service. It therefore follows that 61% of service users asked being happy with service, which the Panel felt, painted a rather different picture.

42. In terms of what the PCT had learned so far, the Panel was interested to enquire how the PCT's experiences would inform its future plans for the provision of the Out of Hours service.

43. The Panel heard that the PCT is more able to manage the market than it was when it took on the responsibility for Out of Hours. The PCT explained to the

[3] Please see http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/4969462.stm

Panel that both it and the market were more mature and it may be that different elements of the service will be delivered by different organisations in the future. The Panel heard that greater emphasis needed to be placed on patient education and self-reliance in the near future. Too many calls are presently being made to the Out of Hours service, which could be dealt with "in hours", NHS Direct or other means. Further, the Panel heard that more work needs to be done to develop the workforce and skills within it; the PCT also informed the Panel that it felt, at present, it had not done enough to exploit the newer skills of nurses, nurse practitioners or emergency care practitioners.

44. To expand on this, the Panel also heard that it was felt there could be improvements in the triage process, to ensure that the level of expertise needed in handling a call is ascertained more swiftly. That is, whether or not every call specifically requires doctor level expertise. The PCT informed the Panel that the Tees Valley PCTs need to hasten work on this area.

45. The Panel enquired as to where the PCT thinks that the current Out of Hours service could be improved. The PCT told the Panel that as with all services the Out of Hours services need to be improved (and not just changed) to be more patient centred and more responsive to the needs of patients and their carers. At times, the Panel heard, patients are still seen at the convenience of the system rather than the other way around. The Panel heard that this would inevitably need better working across organisations and across those agencies providing unscheduled care for the aims to be delivered.

46. The Panel welcomed the PCT's candour and its determination to improve how services look and feel to the patient and their carer(s). Nonetheless, in the past the Panel has heard a significant amount of evidence from local NHS organisations, outlining the fact that services need to become more service responsive.

47. Specifically in relation to the Out of Hours service, the Panel would like to see demonstrable changes or a planned programme of changes which illustrates how services are being more responsive to patient needs. Such a schedule of activity could form part of the thinking when the renewal of the Out of Hours contract is considered in 2007. Further to this point, the Panel would like to see areas of activity, which are aimed specifically on improving the patient journey. That is, the supply of information and inter working between different agencies as the patient moves through the different aspects of the health service. The Panel has received evidence to indicate that when people are in a specific service area, the services provided are, on the whole, of a very high quality. There is an increased likelihood of problems arising when it is required for different facets of the NHS to 'pass people on' and provide information with reference to their condition. It is this aspect of the Out of Hours service, that the Panel would like to see work specifically done to improve the mechanisms of care, specifically in relation to people with long term chronic conditions.

48. In conclusion to the meeting, the Panel was interested to hear from the PCT as to what, in its view, were the biggest impacts of the new Out of Hours services on primary care services.

49. In response, the Panel was told that there is an improved level of patient access and the fact that doctor's surgeries are now able to "switch off" at a definite time each day. The Panel accepted the importance of this point, as exhausted clinicians are clearly not in the interests of any local community. There is however a caveat in relation to the increased patient access, which indicates that there has not been, as yet, any noticeable increase in the quality of primary care services as a result of the changes to Out of Hours.

Evidence from Middlesbrough Primary Care Trust Patient & Public Involvement Forum

50. In an investigation of any particular service, to gain a full perspective of how the service is performing and perceived it is necessary to research the views of its customer base, or in this case the patients it serves.

51. Accordingly, at its meeting on 27 March 2006, the Panel took evidence from the Chair of the Patient & Public Involvement Forum (PPIF) attached to Middlesbrough PCT, in relation to the PPIF's views on the effectiveness of the Out of Hours service.

52. The Panel heard that the PPIF was designed to be the voice of patients contributing to the day to day running of the PCT. It often took part in unscheduled visits to primary care facilities and makes recommendations for change where necessary.

53. The Panel heard that the PPIF had previously commissioned a survey, whereby patients views were sought on a range of primary care services, including the Out of Hours service.

54. It was said that according to that particular survey, there were no adverse comments worthy of note regarding Out of Hours and that satisfaction with the response times and the service provided were very high.

55. Further to that, it was said that healthcare professionals within primary care facilities (such as Carter Bequest) were also impressed with the Out of Hours service, drawing favourable comparisons with the previous system.

56. Whilst the Panel noted the results of the survey in relation to Out of Hours, it was noted that the survey was on a wide range of matters, of which Out of Hours was one area. The Panel felt that it would be a useful exercise to access available survey type data, which majored on Out of Hours and could provide more detailed information about how the service was perceived to be performing.

57. The Panel heard that, in the view of the PPIF, that a potential problem was the delay perceived to be present through the triage process when someone

first calls the Out of Hours service. As a result of this and the additional process that Out of Hours callers have to go through, it was felt that there was a danger some people may become frustrated and seek to 'short-circuit' the system. People could do this by calling upon the services of ambulances or 'turning up' at Emergency Departments directly. The Panel noted that this potential delay due to triage was also cited by Middlesbrough PCT as a potential problem area in the effective operation of Out of Hours.

58. This scenario was identified as concerning for the Panel and one to make every effort to avoid.

59. Reference was also made to the fact that the Out of Hours service provision contract was out for renewal in 2007. The Panel heard that the PPIF would be interested in being involved in the PCT's setting of the tendering specifications for the new contract. This was something, which in principle, the Panel was in support of.

Evidence from the Cleveland Local Medical Committee

60. At its meeting on 19 April 2006, the Panel took evidence from the Cleveland Local Medical Committee, which is a statutory body established to represent General Practitioners (GPs) in a given area.

61. The Panel heard that the reason arrangements with respect to Out of Hours services had recently changed was as a result of the new GP contracts, which were negotiated between the British Medical Association (BMA) and the Department of Health.

62. Before the new contract took effect, Out of Hours services were provided in the Middlesbrough area through a partnership between General Practice and the forerunner organisation to Primecare (which now provides the Out of Hours service exclusively).

63. The Panel heard that fairly recently before the new contract came into force, Out of Hours' demands were growing too great for General Practitioners to cover, due to the demands of their 'in hours' positions. On this point, the Panel was advised that historically, Out of Hours commitments were largely restricted to emergency work, whereas in present times people call upon medical assistance when conditions (in the majority of cases) could not be classified as emergencies.

64. It was highlighted to the Panel that 90% of new General Practice recruits are women who are, on average, less likely to work full time than men. Further to that, it is safe to assume that a sizeable proportion of those new recruits will also wish to have families and want to arrange their working lives around that.

65. All of the above, contributed to the Out of Hours commitments becoming increasingly difficult to service. Indeed, the Panel heard that such commitments in relation to Out of Hours also had an impact on recruitment,

with the majority of recently qualified physicians electing to pursue a career in hospital based medicine.

66. The Panel heard that, with the PCT now having statutory responsibility for the provision of Out of Hours services, it has created an environment where the service is properly structured and monitored and operates on a more consistent basis, when compared to its predecessor. It was confirmed to the Panel that Primecare provides the service across the Tees Valley on behalf of the Tees Valley PCTs, so that service consistency extends beyond the boundaries of Middlesbrough Council or Middlesbrough PCT.

67. The Panel heard from the Cleveland Local Medical Committee that overall, local GPs were pleased with the new service and understandably, are relieved that they no longer have the responsibility to provide the service. As a result of this, the Panel heard that GPs are now able to concentrate fully on their 'day job', knowing they will not have to work overnight. Consequently, GPs are now providing much more proactive and preventative services.

68. The Panel also heard that as an extension of the improvements to the working lives of GPs that the Out of Hours services have made, is that it is likely that more medical graduates will be attracted to General Practice. This is due to the fact that the hours and time commitment is much more transparent to those interested in such a career.

69. The Panel heard that, in the view of the Cleveland Local Medical Committee, the new Out of Hours regime was safer than the previous Out of Hours arrangements. That is not to suggest that the previous system was unsafe, although the Panel was told that there was more potential for it to be unsafe, due to the haphazard way it was staffed, monitored and due to potential tiredness of GPs. In this sense, the new system was safer, as there are more safeguards, more intelligence gathering and a separate and distinct roll call of Out of Hour doctors, who are not also relied upon to provide day surgeries.

70. It was stated to the Health Scrutiny Panel that there has not been a significant rise in Out of Hours contacts from immediately before the contract with Primecare came into effect (1 April 2004) to the present day. It was noted, however, that under the Primecare arrangements it would appear that more people are receiving medical advice Out of Hours and more people are being seen on the Primecare Out of Hours facility, based at James Cook University Hospital.

71. In the view of the Cleveland Local Medical Committee, the fact that more people are being assessed in the specifically designed Out of Hours facility at James Cook University Hospital is to be welcomed. The Panel heard that such facilities are better for patients and are significantly better for clinicians attempting to assess someone's condition, due to improved lighting, floor space and suchlike.

72. Further to the clinical quality argument advanced by the Cleveland Local Medical Committee above, there is also an efficiency argument to support the

increased use of such facilities. In the time it would take a clinician to travel to and from a consultation and carry out the consultation, the same clinician could carry out three or four consultations in the Out of Hours facility.

73. The Cleveland Local Medical Committee advised that this arrangements seemed to have found favour with patients, as together with the use of the facility based at James Cook University Hospital, was the offer of transport for people to attend.

74. The Panel enquired as to the level of access the Out of Hours service would have to patient records, which would be housed at their local surgery. It was confirmed to the Panel that the Out of Hours service would only have access to patients records that are created through previous contacts with the service, that is they would not have access to the records held by the patient's General Practitioner.

75. The Panel understands that in one sense, this is a positive safeguard to protect patient's sensitive and potentially immaterial personal information. Alternatively, it may mean that Out of Hours services are operating in the dark to some extent when attempting to treat people, without knowing their full medical profile. On the point of Out of Hours services being able to access personal information electronically, the Panel was told that present technology is someway from being able to provide such a solution, leaving aside the ethical and data protection matters to consider. On this point, the Panel heard that in a large proportion of acute emergency care episodes, General Practitioner's records are not hugely important. It was, nonetheless, accepted that in some cases Out of Hours services might be working without the full facts.

76. Further to this debate, the Panel was informed that after every episode involving Out of Hours, the patient's GP receives a full and comprehensive written account of the contact, including information on symptoms, the medical complaint and any action that was taken. Such accounts arrive at the practice the next working day.

77. The Panel enquired as to how people with chronic conditions, often requiring hospital intervention, are treated and dealt with under the Out of Hours arrangements.

78. The Panel heard that such cohorts of people 'short-circuiting' the system, by not contacting Out of Hours was not necessarily a good thing for the efficiency of the acute sector, nor were hospital based services the most appropriate all of the time for treatment of such conditions.

79. Further to that, the Panel heard that those in General Practice are often told of the need to reduce the amount of hospital admissions and episodes requiring hospital based input.

80. The point was made; however, that there is no need for someone to be seen by a clinician, if enough is known of his or her prevailing condition through

triage and patient history to indicate that they require a certain course of action.

81. The Panel heard that the crux of the matter was designing a system, which allowed people with chronic diseases some capacity for self-diagnosis and swift access to the necessary support (whether in hospital or the community). The same system also needed the necessary processes in place whereby people could receive appropriate levels of advice and assistance without treating hospitals as the first port of call. The Panel heard that further work was needed to deliver on this entirely.

82. The Panel heard from the witness that it seemed that fewer people were directly accessing hospital than have done historically. The Panel heard that the reasons for this were unknown, although the emerging NHS funding framework and particularly 'payment by results' could play a significant part in the rates of people directly accessing hospital.

83. The Panel heard that following a discharge, patients are often told to contact their GP should there be a recurrence of the problem and not to contact the ward directly.

84. The Panel was told that this may be due to the fact that if the patient were to be readmitted via the GP, it would count as a separate health episode and would therefore generate a separate stream of funding. Without the GP's involvement, it would probably count as the same episode and not generate any more income.

85. The Panel was also told that this process is not assisted by historically poor communication between the primary sector (i.e. GPs) and the acute sector.

86. Whilst the Panel acknowledged the difficulties of communication between different health sectors, it found it frustrating that communication could not be improved more quickly.

87. Further to that, the Panel was alarmed at the hypothetical prospect of delays in patient care, with (the potentially unnecessary) involvement of the GP, to ensure that a separate stream of funding is secured for the treatment of a patient. The Panel feels such a scenario is unfortunate, although feels that it is a result of the funding regime the NHS is now required to work under.

88. The Panel heard that whilst the witness accepted it could be something of "rigmarole", we live in a society where processes are increasingly important, which potentially poses a bigger question than the swiftness of which medical matters are dealt with.

89. In conclusion, with reference to the evidence from the Cleveland Local Medical Committee, the following points are worth noting.

90. The new system of Out of Hours creates a safer and more sustainable service, which in time will attract more medical graduates into General

Practice, due to the prospect of a more clearly defined working commitment. The Out of Hours service will also contribute to a better provision of services within primary care, as 'in hours' GPs are able to concentrate more fully on those 'in hours' services.

91. The evidence received from the Cleveland LMC would indicate that the offer of transport is popular and the triage employed by the Out of Hours process is also a very positive development, which can lead to a blue light response, advice or a home visit. The fact that people can always call back if a condition worsens is also something, which is to be welcomed.

92. Problem areas centre on the continuity of patient records and the transfer of information between different elements of the NHS. As touched upon earlier in this report, it is an area constricted by data protection and patient privacy rules. Further to that, at present the technology to provide continuous patient record is not sufficiently obtainable for it to be put into practice, which leaves that ambition as very much longer term.

93. The Cleveland Local Medical Committee acknowledges that the Out of Hours service configuration will attract more recruits into General Practice. There is, however, a need to attract a significant amount of future GPs, as at present a large proportion of GPs are over 50 year old and are not a huge distance from retirement age.

94. The Panel heard that there is a need to intensify recruitment efforts into General Practice. The fact that since 1997 there has been a 70% rise in consultant numbers and a 15% rise in GP numbers hints at an inequity requiring correction.

95. The Panel also heard from the Local Medical Committee that there may be an opportunity to develop how patients with chronic disease are treated and how they may access necessary services out of hours without having to access the Out of Hours system as the 'man in the street' would.

Results of Quantitative Study

96. In addition to the information received in meetings through questions, answers and further discussion the Panel has also received copies of performance reports into the Out of Hours service.

97. The National Quality Requirements Overview Performance Report (from March 2006) judges the service according to sixteen sections. They are scored according to a Traffic Light System, in which 'green' is good to adequate performance, 'amber' is fair to inadequate performance and 'red' is poor performance.

98. In all standards except two, the Panel notes that performance is judged to be 'green' that is good to adequate performance, which is an encouraging feedback. The Panel did note, however, that the two standards rated as 'amber' are 'telephony' and 'clinical assessment'. Whilst all the standards

addressed in the assessment are important, the Panel takes the view that in the Out of Hours service configuration currently provided in Middlesbrough, the standard of telephony on offer is paramount. The Panel therefore reads with some concern that it is judged at 'amber', that is fair to inadequate performance. The Panel would hope that such a situation will be rectified quickly.

99. Secondly, the Panel again reads with some concern that the standard in relation to clinical assessment is presently at amber. The Panel would hope to see that rectified as a matter of priority, for the same reasons as outlined above.

Conclusions

To be inserted following the Health Scrutiny Panel's deliberations.

Recommendations

To be inserted following the Health Scrutiny Panel's deliberations

BACKGROUND PAPERS

(a) www.out-of-hours.info

(b) http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/4969462.stm

(c) Primecare Cleveland Patient Experience Survey October 2005

(d) Primecare Cleveland Patient Experience Survey January to May 2005

(e) Middlesbrough Primary Care Trust, Out of Hours Service Update, Paper to the Professional Executive Committee, December 2005

(f) Middlesbrough Primary Care Trust, Raising Standards for Patients: New Partnerships in Out of Hours Care, 20 October 2003.

(g) Letter to Health Scrutiny Panel from Cleveland Local Medical Committee, 18 April 2006

(h) The National Quality Requirements Overview Performance Report, March 2006.

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