

**Primecare response to the Care Quality
Commission Investigation in to the out-
of-hours services provided by
Take Care Now**

Summary July 2010

Introduction

The Care Quality Commission (CQC) carried out an investigation into the out-of-hours services provided by the organisation Take Care Now (TCN) and published their full report in July 2010.

Primecare have previously produced responses to both the initial investigation and the Department of Health Report Dr David Colin-Thomé and Professor Steve Field, *General Practice Out-of-Hours Services: Project to consider and assess current arrangements*, January 2010. Both reports are appended to this final response.

Summary recommendations

CQC, in their final report, focussed on recommendations in those areas that were not part of the recent review by the Department of Health¹ * or the coroner's recommendations.

This document sets out Primecare's response to the CQC summary document recommendations published in July 2010

Primecare are a large commercial provider of out of hour's services and we are consistently reviewing and learning from the latest developments in the field of urgent care. Over the past three years we have invested significantly in our clinical governance systems and processes to assure ourselves, our patients and our commissioning organisations of the quality and safety of all our health care services.

During 2009 and early 2010 there has been significant coverage in the media about the safety of out of hours services following an incident in an out of hours service run by another provider in Cambridgeshire. Following this incident the Care Quality Commission issued an interim report urging Primary Care Trusts to robustly monitor their contracts with out of hour's providers. Primecare have issued an initial report in October 2009 (attached as appendix one) and in April 2010, our own statement to this report (attached as appendix two) which is published on our website, www.primecare.uk.net. We have also written to all our commissioners following a thorough internal review to provide assurance of the actions that are in place to mitigate the risk of such untoward incidents occurring in Primecare services.

We launched our Quality Accounts programme in the spring of 2010 that includes a quarterly report to commissioners on our performance against national and locally agreed quality indicators. These reports are well received by commissioners and demonstrate again our commitment to providing quality patient services and supporting commissioners in their contracting responsibilities. We plan to publish the Quality Accounts for our service users to view later this year to ensure transparency of our services.

In addition, Primecare set up a specific work group in February 2010 to review the recommendations from the OOH review and this document sets out our response to those recommendations. Whilst many of the recommendations are for PCT commissioners, we believe that providers must play an important role in driving up

¹ * Dr David Colin-Thomé and Professor Steve Field, *General Practice Out-of-Hours Services: Project to consider and assess current arrangements*, January 2010
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quality standards and enabling commissioners to properly monitor and quality assure our services.

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 that there are sufficient suitably trained and experienced clinical staff, particularly doctors, engaged in planning and delivering these services.

Primecare have a high regard for clinical leadership within the organisation to ensure that sufficient suitably trained and experienced clinical staff, particularly doctors are engaged in planning and delivering these services. This is evidenced by our clinical governance structures, our national leadership by the Group Medical Director and Head of Medicines Management and our Local Medical Directors, Advisors and clinical managers. In addition we have an external medical advisor and a number of Clinical Advisory Groups where we ensure that local GPs and healthcare leaders can assist us in the design and delivery of 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. Primary care trusts 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. We 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. PCTs must ensure that 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.

Primecare accept these recommendations and will work proactively with PCTs to ensure that all recommendations are met in full.

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.

Primecare's response:

- GP coverage

Primecare have a high focus on recruiting and retaining local doctors and we measure each month via our traffic light dashboard metrics to the senior management and quarterly in our Quality Accounts, our percentage of local doctors (which is defined in agreement with each contact area and PCT) and our percentage of agency doctors used. Our targets are 95% local doctors and less than 5% agency doctors used; this is measured as a percentage of the total hours on the rota. Our target for the fulfilment of sessions on the rota is 100% and the performance in this area is reported in our Quality Accounts. All rotas' are stored centrally for transparent visibility and are set by forecast and measured post service. Rota forecasting takes into account previously held data plus any breach information to ensure that we learn from call arrival patterns.

Primecare's average shift deficit in a month is 99.8% representing minimal hours lost due to sickness or last minute change. Primecare share our rota's with many of our commissioning PCT's and are happy to work in partnership to reassure PCT's of our commitment in this area.

- Interview and induction

In regard to the detection and monitoring of any sub optimal performance of our doctors, Primecare has a robust Selection, Recruitment and Induction process for clinical staff which has been further strengthened in 2010. Every doctor who works for Primecare (including those from agencies) undergoes an interview and pre assessment prior to commencement of their first session and their induction is conducted by a senior clinician. Following their first session with Primecare, the Local Medical Advisor or the Clinical Services Manager undertakes a full assessment of their work. This information is also given to the doctor to form part of their yearly appraisal with their PCT. Regular refresher seminars are also standard and part of clinician's Continuing Professional Development.

Primecare do not have any doctors flying in at short notice to fill shifts. Primecare use a preferred provider agency, usually our own internal Primecare Locums Service, to ensure consistency and high standards. All the agencies that are used by Primecare have been provided with a copy of our minimum standards.

There are rare occasions when Primecare uses doctors from outside the UK, but in all occasions these are doctors who work with us regularly for an agreed length of time i.e. one week every month and have provided evidence of practice within the UK plus undertaken a language review and competency assessment at interview.

Following reviewing the recommendations from CQC, Primecare have reviewed the recruitment and induction of agency doctors' policy, and ensured that evidence of

proficiency in English is included as mandatory. All relevant employees have been instructed that they must follow the policy and best practice in the recruitment and induction of agency doctors and this is audited by the quality team.

Prior to a new or agency doctors commencing with Primecare, they must provide evidence of our minimum requirements:

Current Doctors:

GMC Licence to practice
Appropriate Professional Indemnity
Performers List
CRB within 3 years

New Doctors including Agency:

Child Protection within 3 years
Basic life support
Evidence of practice in the UK

Primecare's Performers List, our clinician database, is updated with all of the minimum requirements information and is routinely audited by the Central Clinical Governance Team to ensure compliance.

It is the responsibility of the Clinical Governance Committee to advise on minimum standards. These standards are continually reviewed in order to drive up the quality of the service.

Primecare's interview and induction processes are developed differently depending on the skills and knowledge of the individual. We have different programmes in place for people who already have good knowledge and experience of out of hour's services, a programme for people whose first language is not English, and a detailed programme for people with less out of hours experience or local knowledge.

Primecare's Generic Induction Manual for doctors' is modular based and contains clear information on medicines management and controlled drugs as well as other modules such as the role of the coroner, child protection and telephone triage.

- Not working excessive hours

Primecare have a number of different ways of monitoring doctors' hours to ensure that they work within safe and appropriate limits. Firstly at interview and within our consultancy agreements, we ensure that all hours worked for all organisations are declared to us so that we can take a view as to whether this is appropriate. Secondly, we share our rotas with the commissioning PCT so that they can take a view as to whether they feel the hours are appropriate as they may hold additional information. Thirdly, we write to each and every doctor and nurse explaining our position statement on excessive hours and that they are accountable for declaring to us any additional hours, plus for their own work life balance and ability to judge their physical and emotional state when applying for work. Fourth, we remind staff via our clinical newsletters and finally we take action as a company to track high payments and take action where we see a number of high hours being worked.

In addition we have maximum shifts of 9 hours triage and 11 hours in face to face consultations and do not allow doctors to back to back shifts as our rota co-ordinators are briefed to ensure this does not happen.

- Training

Primecare has a statutory and mandatory training policy which is monitored via our own Primecare Performers List which is an extensive database which tracks each clinician's data including audit and training.

Child Protection Training, Infection Control and BLS/ALS are our top three training areas and our standard is 100%. Our policy outlines the details of the training and its monitoring process.

Primecare also have an interactive Learning Zone where all staff can access e learning in addition to face to face CPD sessions.

In addition to mandatory training, Primecare provide a range of other training and CPD opportunities. These include, triage training and update sessions on effective communication, defensible documentation, Palliative care and many others. We work closely with the Deanery to provide a range of opportunities.

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

Primecare's response:

Primecare have regular meetings with our commissioning PCTs and provide a range of information such as NQR reports, Quality Accounts and data on rota's, complaints and incidents. Primecare have an open relationship with our commissioners and pride ourselves on the integrity of the data provided. Primecare can evidence where we have changed practice when services have not met expectations or where issues have been raised.

Primecare have a dedicated Business Analysis Team who report on activity against the National Quality Requirements (NQR's). There is a transparency of information which is shared with the commissioning PCT on a monthly basis. It is locally interrogated and each breach to the NQR's is investigated and reported upon. There is no local ability to modify call outcomes and there is a written process for this which is overseen by senior staff. Patients are counted once only and this can be evidenced within the system.

Primecare welcome any additional quality monitoring and are proactive in the production of our Quality Accounts for this purpose. Primecare's Business Analysis are proficient at providing additional information requested by our commissioners. Primecare invite PCTs to meet with us and to scrutinise and audit the data we provide.

11. Providers of out-of-hours services 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.

Primecare's response:

Primecare have a clear clinical governance (CG) structure with CG being centrally led in terms of policy, standards and compliance but locally delivered in each contract. The reporting of incidents is visible across both aspects and is collated locally and centrally. When an issue arises the local team will document it on their local CG template and it will be discussed at their monthly meeting or immediately if of a serious nature. This may also transfer across to a regional CG meeting where relevant. All monthly CG minutes are collated by the central team and issues taken onto either the relevant forum such as Clinical Risk, Audit and Clinical Effectiveness, Education and Service Development or the Clinical Management Forum, also encompassing Pharmacy, or onto the National Clinical Governance Committee (CGC) with the senior management team. Minutes are centrally collated and distributed as required providing an audit trail of issues arising and actions taken. Senior clinicians are visible on the forums and in the CGC meetings, as is the Head of Medicines management.

12. Providers of out-of-hours services 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.

Primecare's response:

- Serious Incidents

Primecare are able to evidence this requirement including informing the PCT of any serious incident and the learning we derive from them.

All our staff have received training, and have access to, the National Patient Safety Agency's 'Incident Decision Tree' and RCA to ensure that the root cause of each incident is identified and reported on correctly.

- Learning

Primecare are a learning organisation and our learning policy and process is appended in appendix three. Primecare have a robust system of monitoring its complaints and ACIs to incorporate learning, not just locally, but for national dissemination and sharing of best practice. Primecare can demonstrate where both learning from internal and external complaints and incidents has changed practice within the organisation.

Any learning and follow up is written up in an anonymous way in local Clinical Newsletters and also passed to the quarterly Clinical Management Forum in order that learning points are incorporated into updated policy and nationally cascaded.

- Trend analysis

Where any trends are identified, via our Codel report building software, we have a process of action and learning which would preclude any lack of action being taken. This includes raising the issues on our local, regional and national risk registers which are clinically reviewed each month.

13. Providers of out-of-hours services 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.

Primecare's response:

- **Clinical Audit**

Primecare have a robust audit strategy and our system of audit has been in place for over 10 years for nurses and extended to doctors 5 years ago. Therefore we can evidence a culture embedded within the organisation of audit, feedback and improvement action plans. Our staff receive written and face to face feedback and we can evidence improvement in performance through robust audit process. Our audit strategy also embraces targeted clinical outcome audit as well as quality audits for the individuals. Thus we can target audits to meet local needs such as A&E avoidance initiatives and reduction in 999 trends. We audit a minimum of 1% of contacts.

We will look to include a clinical audit programme for each of our contracted out of hours services that we will agree with local commissioners including targeted audits to support local initiatives, multi agency audits and audits of high impact conditions. We welcome the opportunity for PCTs to further support audit within the Out of Hours services

- Sharing information

Our audit feedback forms and discussion templates with doctors ensure that at the end of each meeting a defined action plan is agreed together with an agreed list of persons to share the outcome with which may include the PCT or performers list where significant concerns are recognised.

This might include referral to our Clinician Alert Register which precludes the doctor working in any Primecare site or referral to the others such as the GMC. We do not undertake this lightly and always consult with the doctor and the PCT Performers List as well as the PCT Commissioner.

14. Providers of out-of-hours services must have adequate advice and input from a pharmacist to ensure robust policies and procedures for the management of medicines, including controlled drugs.

Primecare's response:

Primecare's Head of Medicines Management is Ms Davan Eustace- (insert Qualifications)

Primecare have robust medicines management systems in place; these are led by our Medical Director and our Head of Medicines Management. Our policies on medicines management have been reviewed in 2010 following the CQC report and also our document on Medicines Management for doctors which is clearly visible and must be signed as read in our Induction manuals.

Following our review of the CQC recommendations, we confirmed that Primecare does not store 100mg ampoules of Diamorphine at any of our sites. A comprehensive risk assessment was completed on the risk of inappropriate access to controlled drugs, which demonstrated that Primecare is at minimum risk. Controlled drugs are accessed in one of two ways, either by a local CD cupboard (Primecare have a home office licence in place) or by a documented and agreed local pathway such as a community pharmacy.

The Controlled Drugs Standards of Performance has been reviewed and cascaded to the responsible person on each Primecare site with additional training as required.

In the month of September 2009 Primecare commenced the introduction of a new electronic medicines management and prescribing system. This system has key advantages: the first advantage is that our staff can now actively manage the drug stock. The system is able to provide real time information on what amount of drugs we currently have in stock and the current usage by our clinical staff. This allows Primecare to complete a comprehensive audit on clinician prescribing and dispensing ensuring that they are compliant with the formulary.

The second key advantage is that it improves the decision making process for our clinicians. The system provides clinicians with in depth information about each drug, and warns them if a particular drug is not suitable for a patient. Also the system allows clinicians to print prescriptions, which reduces the risk of the incorrect drugs being given to the patient.

Primecare have a medicines management audit which is completed internally by the Head of Medicines Management and her team. We are also subject to MHRA inspections. Primecare would support any further audits by the PCT.

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.

Primecare's response:

Primecare audit all call handlers on a 1% of calls received basis and a minimum of 10 calls per call handler per quarter. A minimum pass rate of 85% is monitored on our internal dashboard and mirrored within our Quality Accounts. Call handlers have a monthly one-to-one meeting with their line manager where feedback is given and development areas are discussed and additional coaching arranged where required.

Further actions may be taken from these as appropriate, for example, additional training. This is also used as an opportunity to gain suggestions from the call handler on how they believe the service can be improved. The appropriate use of the decision support templates is monitored through the call handler audits and the patient pathway audits.

Clinician's audits – please refer to response to recommendation 13.

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.

Primecare's response:

Primecare pride ourselves in encouraging an open culture and listening to all employee suggestions and concerns. We promote the reporting untoward incidents from serious to minor issues on our ACI forms. Our central clinical governance team facilitate service improvement forums; we have a company suggestion scheme, employment satisfaction survey and patient safety representatives across the business. As part of our ongoing patient safety campaign, senior members of the management team visit different sites to speak to all employees and contracted clinicians. All concerns, ideas and suggestions are reviewed and appropriate actions are taken. Individuals receive a personal response in all cases

Recommendations for SHAs

17. SHAs should ensure that their strategic frameworks, and their systems of performance management and support, reflect the pivotal role of out-of-hours services in the entire urgent care service in a local area, including ensuring learning from incidents in these services.

Primecare's response:

Primecare have a visit planned by one of our SHA's to visit our contact centre and become more involved in understanding the challenges and the service. We would like to replicate this across all of our contracts.

Additional information

In order to answer a number of different comments within the report we have added the following additional information.

1. TCN failed to recognise the importance of learning lessons from complaints and incidents. It was not sufficiently focused on clinical risk and did not adequately report or investigate serious incidents. In particular, it failed to act quickly enough on the concerns that emerged from the two overdoses of Diamorphine in 2007, or on the National Patient Safety Agency alert in 2006.

Primecare's response:

Primecare are a learning organisation and our learning policy and process is appended in appendix three. Primecare have a robust system of monitoring its complaints and ACIs to incorporate learning, not just locally, but for national dissemination and sharing

of best practice. Primecare can demonstrate where both learning from internal and external complaints and incidents has changed practice within the organisation.

- Alerts

Primecare have a robust alerts process in place. Primecare are registered with all relevant organisations to receive alerts from the MHRA pharmaceutical alerts, to staff alerts from the GMC, NMC and Performers lists and others. As alerts arrive, they are, in real time, fielded out to a team of people within the organisation such as the Medical Director, clinical leads from service lines such as OOH, Dental, Secure, Police plus an external medical advisor and our Head of Medicines Management. A view is taken as to whether the alert is relevant to the services lines and a log of all received alerts is kept. Relevant alerts are sent out to branches in the timescale advised and the branches ensure that each remote site receives them. They are logged and archived locally and a read receipt kept from staff. They are also made visible on our Local Information System electronically and updated regularly.

2. TCN's systems for medicines management were inadequate, leading among other things to controlled drugs being stored and administered inappropriately. Recently medicines management had improved and the system for accessing controlled drugs was more robust and easily monitored.

Primecare's Response:

Primecare have robust medicines management systems in place which are led by our Group Medical Director and our Head of Medicines Management. Our policies on medicines management have been reviewed in 2010 and also our document on Medicines Management for doctors which is clearly visible and must be signed as read in our Induction manuals. Controlled drugs are accessed in one of two ways, either by a local CD cupboard (Primecare have a home office licence in place) or by a documented and agreed local pathway such as a community pharmacy.

3. TCN reported activity in a way that was confusing and potentially misleading, and did not act to resolve this. The performance that TCN reported to the PCTs on the national quality requirements did not accurately reflect the actual performance of the organisation, and could potentially have concealed poor performance.

Primecare's response:

Primecare have a dedicated Business Analysis Team who report on activity against the National Quality Requirements (NQR's). There is a transparency of information which is shared with the commissioning PCT on a monthly basis. It is locally interrogated and each breach to the NQR's is investigated and reported upon. There is no local ability to modify call outcomes and there is a written process for this which is overseen by senior staff. Patients are counted once only and this can be evidenced within the system.

4. TCN grew too rapidly and the focus on expansion and business priorities was at the expense of governance and clinical services. Although clinical governance was well articulated by TCN, there was insufficient capacity to deliver it. It was not rooted in frontline patient services, nor demonstrated by clear accountability or local clinical leadership.

Primecare's response:

Primecare have a dedicated Business Development team which focuses on both the expansion of business and its implementation. This is supported by an implementation

team led by a senior director and project management support. The central clinical governance team also support in both aspects and are fully involved in any service changes. Primecare's clinical governance structure is appended in appendix four. Local clinical governance is led by a Local Medical Director or advisor who is prominent in the local healthcare community. Usually a local GP Principal and often an LMC or PEC chair, they are ably supported by a team including clinical service managers and clinical auditors. Often a local clinical advisory group also takes account of the views of other local GPs and leaders of urgent care. There are defined lines of clinical accountability from the local teams via the central clinical governance compliance team led by the Head of Safety and Quality and reporting on a traffic light dashboard monthly to the Managing Director and Group Medical Director.

5. TCN failed to recognise problems in its own systems that might have helped prevent the death of Mr Gray. It was reluctant to admit its shortcomings and provided information to the PCTs and to us that was often inaccurate or incomplete.

Primecare's response:

Primecare have regular meetings with our commissioning PCTs and provide a range of information such as NQR reports, Quality Accounts and data on rota's, complaints and incidents. Primecare have an open relationship with our commissioners and pride ourselves on the integrity of the data provided. Primecare can evidence where we have changed practice when services have not met expectations or where issues have been raised.

6. Call Streaming to Primary Care Centres.

Primecare's response:

Primecare only use call streaming in our West Midlands contracts as the majority are based on a 100% triage contract. Where we do call stream, we have specific decision support guidelines electronically built into the system so that call handlers are supported to make the correct decisions. All patients who are streamed are asked if they would like to proceed straight to a Primary Care Centre (PCC) or whether they would like to speak to a clinician. If they choose a PCC they will only be booked with the NQRs i.e. within one hour.

The electronic decision support templates are part of the adastra system and are audited as part of the patient pathways. Any concerns raised, either by the audit or from clinical and non clinical staff are investigated and immediately reported to the Adastra Clinical Advisory Board for review. Primecare's Head of Safety and Quality is also part of this review panel.

7. Failure to follow the Stroke Pathway

Primecare's response:

Primecare call handlers all have immediate access to an electronic inbuilt stroke decision support template to ensure that patients with symptoms of stroke are transferred without delay to the 999 service.

When the change in NICE guidelines was introduced, all our call handlers were immediately advised of the change in protocol. Any changes to protocol are communicated electronically via our Local Information System and a hard copy is placed into each employee communication folder.

Call handlers are trained on the importance of identifying such conditions and prioritising these cases, ensuring a 999 call is executed. FAST guidelines are incorporated into this training. Call Handlers are trained on the National Quality Requirements and have a full awareness that ILT conditions must be passed through to the ambulance service within the designated 3 minutes.

8. Seeking the views of local GPs on the service.

Primecare's response:

Primecare have not directly sought the views of local GPs formally but would support this measure. Primecare do informally via the LMA and clinical managers seek the views of local GPs on the service and they are invited to any open days and Patient Forums held.

Conclusion

Primecare have thoroughly reviewed the CQC report and the report from Dr David Colin Thome and Professor Steve Field on arrangements for out of hour's services. Primecare already had in place many systems that meet the recommendations for providers. Where we felt the recommendations further strengthened our processes in assuring quality and safety we have been pleased to adopt them. Additionally we have established procedures that will support health care commissioners in fulfilling their responsibilities of commissioning and performance management, management of performer's lists and in gaining assurance of selection, induction and training processes.

We have also reviewed the report's profile of what makes a good out of hour's service in terms of commissioning and provision, especially for the patient. Our assessment of where we are against these aspects of provision is included at appendix four.

Appendix One



October Review

Report summarising the findings of a review following the inquiry into Take Care Now and out-of-out services following the death of David Gray

1. Introduction

As an organisation that is committed to continuous improvement, Primecare takes responsibility to learn not only from internal events but those which affect other healthcare organisations. This report has been produced for Primecare to distribute learning across the organisation and also for commissioners so that they can be assured of the safety of our services.

This report outlines all recommendations from the Care Quality Commission's review into the incident of the death of a patient as a result of receiving 10 times the recommended dose of Diamorphine.

Whilst many points of learning within the document do not affect Primecare directly due to current controls already in existence, Primecare has noted those aspects, which are generic learning points as detailed below.

2. Background

This report seeks to learn and provide assurance regarding Primecare's practices and governance from the findings of a Serious Untoward Incident (SUI) investigation into the death of David Gray, a 70-year-old Cambridgeshire man on 16th February 2008. His death came as a result of receiving 10 times the recommended dose of Diamorphine, a controlled painkiller. Mr Gray was seen by a locum doctor, arranged through a locum agency by the out of hour's provider in that area. The incident has received significant attention in the local and national media.

The doctor had visited Mr. Gray the day after having flown in from Germany. The doctor received induction and assessment and had three hours sleep before beginning his session. It was the first time the doctor had worked in an out-of-hours service and he claimed to be confused and said that the containers of the controlled drugs all looked similar. The doctor is now barred by the GMC from practising in the UK.

Court proceedings in Germany relating to the incident were concluded on 15 April 2009. The doctor was given a nine-month suspended sentence for causing death by negligence in the UK. There will be an inquest in Cambridgeshire later this year or early in 2010.

3. Recommendations from the Care Quality Commission's review – for Commissioners.

- 3.1. The PCTs need to improve their routine monitoring of out-of-hours services. This means more detailed scrutiny of what is being provided, particularly the quality of the service that their patients receive.

They should look in detail at the services that they commission, including the efficiency of call handling and triage, the number of unfilled shifts, the proportion of shifts covered by non-local doctors, the induction and training those doctors receive, and the quality of the decisions made by clinical staff.

Primecare actions:

Primecare have reviewed and strengthened our Clinical Governance procedures regarding reporting to our commissioners. A clinical governance dashboard is collated on a monthly basis to monitor the clinical quality of the service through a combination of local branch and central reporting. This is consistent with the Care Quality Commission review of Out of Hours services at Take Care Now and Primecare will continue to develop Quality Accounts reporting that reflects more direct interrogation of the quality of clinical service delivery. The Quality Accounts will incorporate rota fulfilment assessments as well as other quality metrics in line with Standards for Better Health and the new Health and Social Care Act 2008 which comes into effect 01st April 2010.

In addition to this Primecare have undertaken a complete internal audit of clinical rota management across the business and 'LEAN' principles are being applied in recommendations from this audit.

4. Primecare's response to the other recommendations.

4.1. Controlled Drugs.

Report - 'Withdrawn 100mg ampoules of Diamorphine and have taken steps to ensure that schedule 2 controlled drugs are stored and dispensed more securely'.

'TCN needs to complete its work on its policy for managing medicines, as it includes some information that is currently too generic or not appropriate for out of hours. It should be tailored to the actual out-of-hours services that the organisation provides'.

Primecare's response:

Primecare do not store 100mg ampoules of Diamorphine at any of our sites. Following our review of the CQC recommendations, we have confirmed that they are not held and a comprehensive risk assessment was completed on the risk of inappropriate access to controlled drugs, which demonstrated that Primecare is at minimum risk.

The Controlled Drugs Standards of Performance has been reviewed and cascaded to the responsible person on each Primecare site.

In the month of September Primecare commenced the introduction of a new electronic medicines management and prescribing system. This system has key advantages: the first advantage is that our staff can now actively manage the drug stock. The system is able to provide real time information on what amount of drugs we currently have in

stock and the current usage by our clinical staff. This allows Primecare to complete a comprehensive audit on clinician prescribing and dispensing ensuring that they are compliant with the formulary.

The second key advantage is that it improves the decision making process for our clinicians. The system provides clinicians with in depth information about each drug, and warns them if a particular drug is not suitable for a patient. Also the system allows clinicians to print prescriptions, which reduces the risk of the incorrect drugs being given to the patient.

4.2. Patients presenting with symptoms of stroke.

Report - 'TCN to ensure that patients with symptoms of stroke are transferred without delay to the 999 service'.

Primecare's response:

Primecare call handlers all have immediate access to a stroke decision support template to ensure that patients with symptoms of stroke are transferred without delay to the 999 service.

Call handlers are trained on the importance of identifying such conditions and prioritising these cases, ensuring a 999 call is executed. FAST guidelines are incorporated into this training. Call Handlers are trained on the National Quality Requirements and have a full awareness that ILT conditions must be passed through to the ambulance service within the designated 3 minutes.

In line with the Royal College of GPs toolkit, 1% of patient pathways are audited with a link with the training lead and audit lead to mitigate risk in relation to poorly performing call handlers or clinicians

4.3. Agency and new doctors.

Report – 'Overseas doctors, including those from the European Economic Area, need to provide evidence of proficiency in English'.

Primecare's response:

Following reviewing the recommendations from CQC, Primecare have reviewed the recruitment and induction of agency doctor's policy, and ensured that evidence of proficiency in English is included as mandatory. All relevant employees have been instructed that they must follow the policy and best practice in the recruitment and induction of agency doctors.

All doctors (including those from agencies) undergo an interview and pre assessment prior to commencement of their session. Following their first session with Primecare the Local Medical Advisor or the Clinical Services Manager undertakes a full assessment of their work. This information is also given to the doctor to form part of their yearly appraisal with their PCT.

The number of new and agency doctors used by Primecare are closely monitored. Primecare standards are that the proportion of new doctors started in a month is less

than 20% of the total hours and the number of hours of agency doctor used as a proportion of total hours is less than 5%.

There are rare occasions when Primecare uses doctors from outside the UK, but in all occasions these are doctors who work with us regularly for an agreed length of time i.e. one week every month and have provided evidence of practice within the UK.

Prior to a new or agency doctors commencing with Primecare, they must provide evidence of our minimum requirements:

Current Doctors:

GMC Licence to practice
Appropriate Professional Indemnity
Performers List

New Doctors including Agency:

CRB within 3 years
Child Protection within 3 years
Basic life support
Evidence of practice in the UK

Primecare's Performers List database is updated with all of the minimum requirements information and is routinely audited by the Central Clinical Governance Team to ensure compliance.

It is the responsibility of the Clinical Governance Committee to advise on minimum standards. These standards are continually reviewed for appropriate requirements in driving up the quality of the service.

Primecare hope that you have found this report useful and that it has provided you with assurance regarding the safety of our service. If you have any further queries, please do contact you Primecare Contract Manager.

4 February 2010

News Statement

FAO: News editors / health reporters
For immediate release

Statement following the inquest concerning the death of Mr. David Gray

Primecare, which runs out of hours urgent care services across the country, has responded to the inquest into the tragic death of Cambridgeshire man that concluded on 4 February 2010. Mr Gray received a fatal dose of Diamorphine from an agency doctor who was doing a shift for a different out of hour's provider, Take Care Now.

As a result of this incident, and the interim findings by the Care Quality Commission, Primecare have produced a full report for commissioners to provide assurance of the quality and safety of their out of hours services.

Primecare services are mostly staffed by local clinicians. Locum doctors and agencies are only used occasionally. Primecare has set their own standards so that every month no more than 5% of doctor hours are covered by agency doctors or new starters.

Primecare are able to assure Primary Care Trusts and Local Health Boards who commission their services of the robust process that is carried out before a new doctor starts work for Primecare. This includes registration, CRB and training checks as well as a thorough induction.

All of Primecare's out of hour's service are staffed by doctors and nurses so that safe, high quality services are provided to the local population that meet the National Quality Requirements and local performance levels. In some areas, Primary Care Trusts mandate the staffing levels required for a population.

Primecare have introduced a Quality Account reporting system for commissioners that clearly explains on a quarterly basis Primecare's performance against national and locally agreed quality indicators. This Quality Account covers many of the recommendations in the Department of Health's project report on GP out of hour's services that has been subsequently published.

ENDS

Notes to editors

- 1 For more information contact Ruth Wilkin, Head of Communications and Marketing on ruth.wilkin@primcare.uk.net, 0121 214 3763.
- 2 A full copy of Primecare's report responding to the death of Mr Gray is available on Primecare's website at www.primcare.uk.net/news

Appendix Three

A Learning Organisation

The learning that individuals and organisations derive from serious incidents is critical to the delivery of excellence in healthcare standards and is the cornerstone of Clinical Governance.

²The great majority of healthcare is of a very high clinical standard, and serious failures are uncommon in relation to the high volume of care provided every day. Yet where serious failures in care do occur they can have devastating consequences for individual patients and their families, cause distress to the usually very committed health care staff involved and undermine public confidence in the services provided. Many could be avoided if only the lessons of experience were properly learned.

When things go wrong, whether in health care or in another environment, the response has often been an attempt to identify an individual or individuals who must carry the blame. The focus of incident analysis has tended to be on the events immediately surrounding an adverse event, and in particular on the human acts or omissions immediately preceding the event itself.

It is of course right, in health care as in any other field, that individuals must sometimes be held to account for their actions - in particular if there is evidence of gross negligence or recklessness, or of criminal behavior. Yet in the great majority of cases, the causes of serious failures stretch far beyond the actions of the individuals immediately involved. In a complex field such as health care, a huge number of factors are at work at any one time which influences the likelihood of failure. These factors are a combination of:

- **active failures:** 'unsafe acts' committed by those working at the sharp end of a system, which are usually short-lived and often unpredictable; and
- **latent conditions:** that can develop over time and lie dormant before combining with other factors or active failures to breach a system's safety defenses. They are long-lived and, unlike many active failures, can be identified and removed before they cause an adverse event.

Human error may sometimes be the factor that immediately precipitates a serious failure, but there are usually deeper, systemic factors at work which if addressed would have prevented the error or acted as a safety-net to mitigate its consequences.

Activity to learn from and prevent failures therefore needs to address their wider causes. It also needs to stretch beyond simply diagnosing and publicising the lessons from incidents, to ensure that these lessons are embedded in practice. The distinction between passive learning (where lessons are identified but not put into practice) and active learning (where those lessons are embedded into an organizations' culture and practices) is crucial in understanding why truly effective learning so often fails to take place.

² An Organisation With a Memory 2000

It is possible to identify a number of barriers that can prevent active learning from taking place, but there are two areas in particular where healthcare can draw valuable lessons from the experience of other sectors.

- **Organisational culture** is central to every stage of the learning process - from ensuring that incidents are identified and reported through to embedding the necessary changes deeply into practice. There is evidence that 'safety cultures', where open reporting and balanced analysis are encouraged in principle and by example, can have a positive and quantifiable impact on the performance of organizations'. 'Blame cultures' on the other hand can encourage people to cover up errors for fear of retribution and act against the identification of the true causes of failure, because they focus heavily on individual actions and largely ignore the role of underlying systems.
- **Reporting systems** are vital in providing a core of sound, representative information on which to base analysis and recommendations. Experience in other sectors demonstrates the value of systematic approaches to recording and reporting adverse events and the merits of quarrying information on 'near misses' as well as events which actually result in harm.

Too often lessons are identified but true 'active' learning does not take place because the necessary changes are not properly embedded in practice.

The Way Forward

In summary, a learning organisation needs to develop:

- unified mechanisms for reporting and analysis when things go wrong;
- a more open culture, in which errors or service failures can be reported and discussed;
- mechanisms for ensuring that, where lessons are identified, the necessary changes are put into practice;
- a much wider appreciation of the value of the system approach in preventing, analysing and learning from errors.

The Building Blocks

Before a Learning Organisations can be implemented, a solid foundation can be made by taking into account the following:

Awareness
Environment
Leadership
Empowerment
Learning

Awareness

Organisations must be aware that learning is necessary before they can develop into a Learning Organisation. Learning must take place at all levels; not just the Management level. Once the company has accepted the need for change, it is then responsible for creating the appropriate environment for this change to occur in.

Environment

Centralised, mechanistic structures do not create a good environment. Individuals do not have a comprehensive picture of the whole organisation and its goals. This causes political and parochial systems to be set up which stifle the learning process. Therefore a more flexible, organic structure must be formed which encourages innovations and promotes passing of information between workers and so creating a more informed work force.

It is necessary for management to take on a new philosophy; to encourage openness, reflectivity and accept error and uncertainty. Members need to be able to question decisions without the fear of reprimand. This questioning can often highlight problems at an early stage and reduce time consuming errors. One way of over-coming this fear is to introduce anonymity so that questions can be asked or suggestions made but the source is not necessarily known.

Leadership

Leaders should foster and encourage learning to help both the individual and organisation. It is the leader's responsibility to help restructure the individual views of team members. Management must provide commitment for long-term learning in the form of resources. The amount of resources available (money, personnel and time) determines the quantity and quality of learning. This means that the organisation must be prepared to support this.

Empowerment

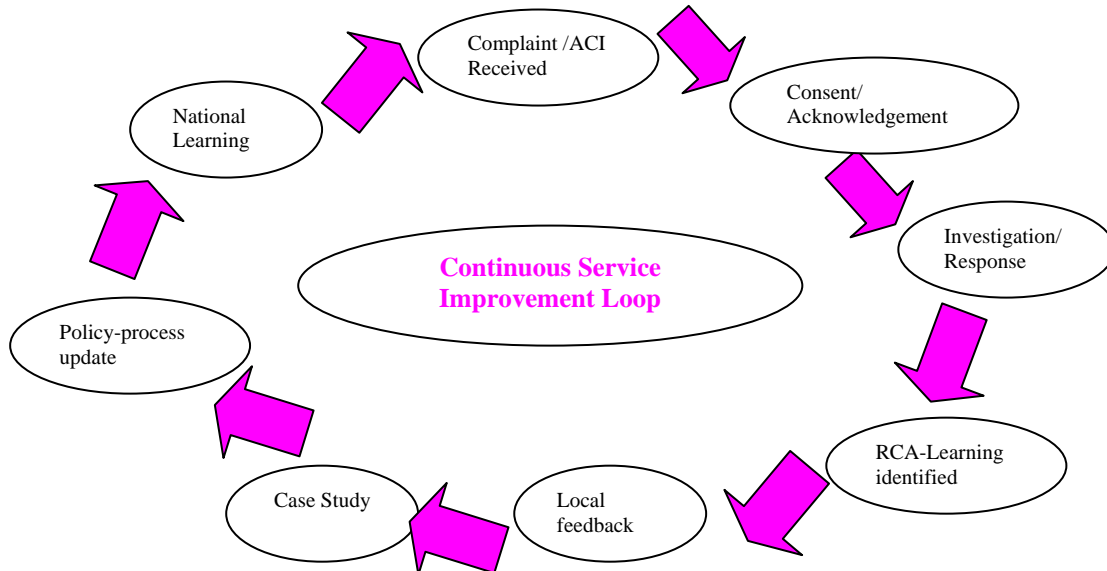
The focus of control shifts from managers to workers. This is where the term Empowerment is introduced. The workers become responsible for their actions; but the managers do not lose their involvement. They still need to encourage, enthuse and co-ordinate the workers. Equal participation must be allowed at all levels so that members can learn from each other simultaneously.

Learning

Managers are responsible for setting up an open, flexible atmosphere in their organisations to encourage their workers to follow their learning example and can also encourage different sites to communicate and share knowledge, thus making a company truly a Learning Organisation.

Primecare have developed a service improvement loop to demonstrate how the lessons learned from effective complaints handling can feed into the continuous improvement of the organisation and can play a significant part in improving service delivery.

The attached diagram shows the loop in action.



The Primecare Process of Cascading Learning across the Organisation

Primecare gathers learning from a number of differing sources which includes but is not restricted to:

- Complaints
- Serious Untoward Incidents
- Adverse Clinical Incidents
- Near Misses
- Sentinel events- including external events which may impact on the service
- Compliments
- Patient ,commissioner and staff feedback
- Benchmarking
- Suggestions
- Issues log and reports
- Pilots
- Alerts
- Inquests(Secure services)

The way in which learning is gathered is via Primecare’s Code1 Complaints database which encourages staff to enter learning outcomes for each complaint and ACI. The compliance measure for learning is measured monthly via Primecare’s Dashboard (which reports to the Senior Management Team) and Quality Accounts (which report to commissioners and the public). This shows the percentage of learning against a 100% standard. A range of reporting including trend analysis is also produced, plus type and severity.

Local Learning is the responsibility of the Clinical Manager in each contract and this is disseminated to the individual involved via a verbal or written format. Learning is further collated into a quarterly Local Clinical Newsletter which is published to all staff and commissioners. Patients' newsletters are also produced.

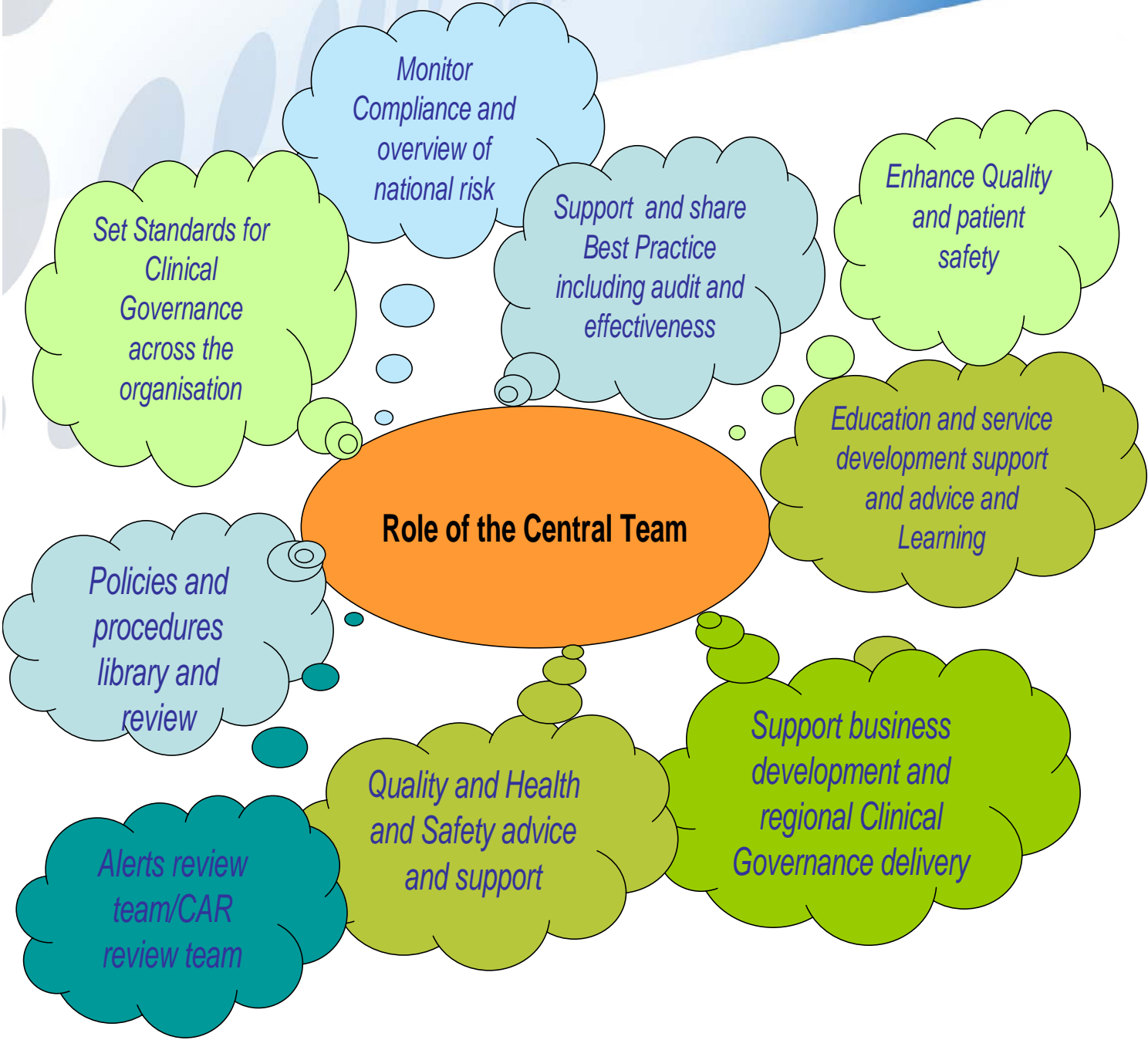
Learning may be in the form of memos to staff or can often be more usefully applied in a case study in an anonymous format.

Where local learning may have a national impact, the Codel system supports a cascade of the learning item to the Head of Safety and Quality who nationally collates learning for dissemination to the business.

Both local and national learning is discussed and documented monthly in local Clinical Governance Meetings and the information is collated quarterly to the Clinical Governance Committee where policy changes may be made in light of the information. In addition learning points may be referred to the Education Forum, The Audit and Clinical Effectiveness Forum, The Clinical Risk Forum or The Clinical Management Forum where a review team will discuss and take relevant actions.

A National newsletter updating staff of new and updated learning is published bi annually plus learning is updated into a number of different Advisory Documents, such as the Advisory Document for Triage, and staff induction Manuals. In this way both new and existing staff are kept apprised of learning in an open and honest culture.

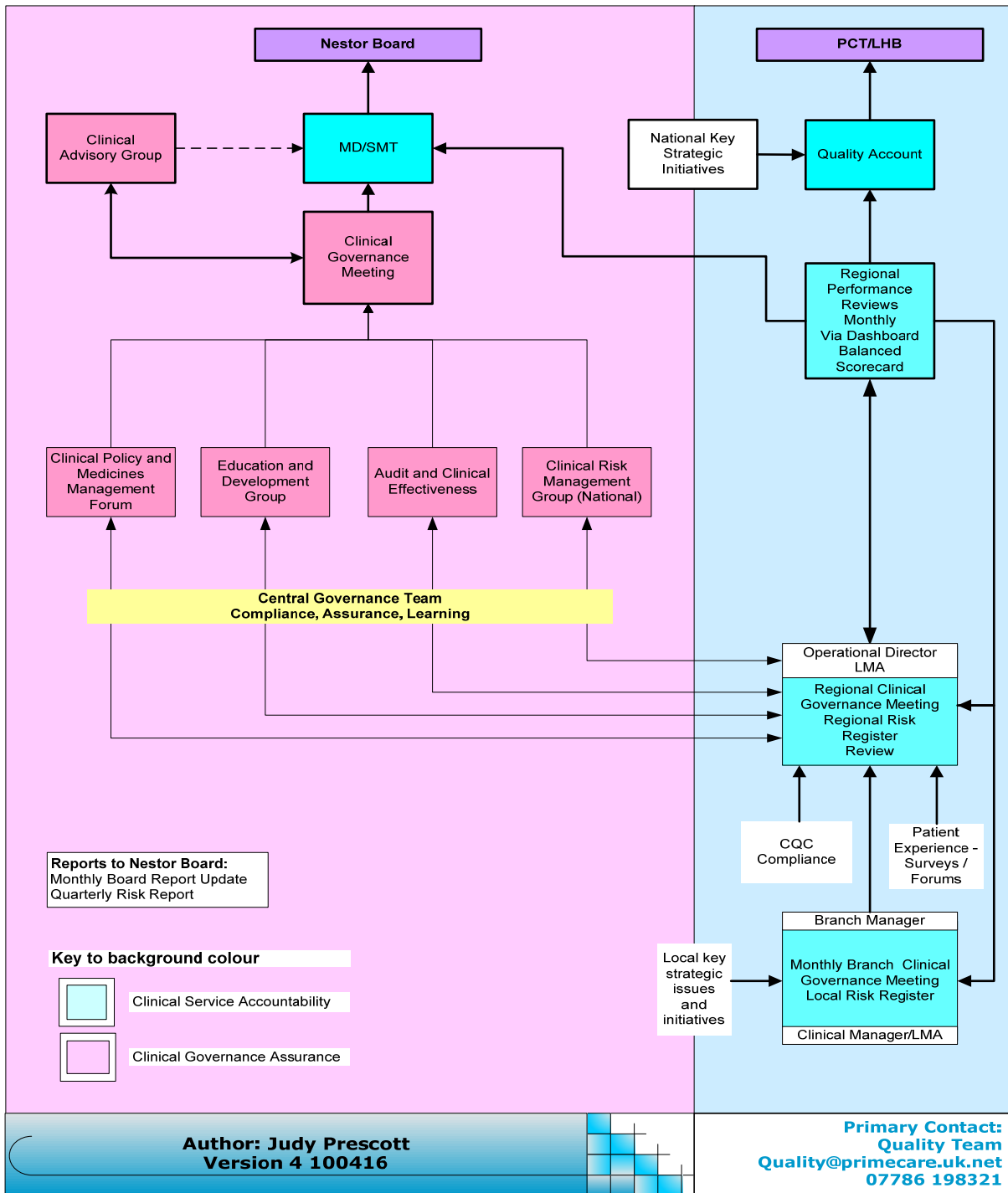
A collation of learning from Inquests across the years has been written for the benefit of staff working in secure services so that learning is shared across sites. Although this is specific to Secure, there are often issues which may cross fertilise into other areas of the business. The Head of Quality and Safety and the Central Clinical Governance Team are responsible for the standard setting and compliance of standards within the organisation including learning from incidents



Further Reading:

Advisory Document for Triage
Learning from Serious Incidents
Primecare Complaints Policy

Clinical Governance Framework



Appendix Five

Leading quality out of hour's provision:

Response to “General Practice Out of Hours Services -
‘Project to consider and assess current arrangements’”

April 2010

Foreword

This document sets out Primecare's response to the document published in February 2010 by Dr David Colin-Thome and Professor Steven Field addressing out of hours arrangements.

Primecare are a large commercial provider of out of hour's services and we are consistently reviewing and learning from the latest developments in the field of urgent care. Over the past three years we have invested significantly in our clinical governance systems and processes to assure ourselves, our patients and our commissioning organisations of the quality and safety of all our health care services.

During 2009 and early 2010 there has been significant coverage in the media about the safety of out of hours services following an incident in an out of hours service run by another provider in Cambridgeshire. Following this incident the Care Quality Commission issued an interim report urging Primary Care Trusts to robustly monitor their contracts with out of hour's providers. Primecare have issued our own statement to this report which is published on our website. We have also written to all our commissioners following a thorough internal review to provide assurance of the actions that are in place to mitigate the risk of such untoward incidents occurring in Primecare services.

We have recently launched our Quality Accounts programme that includes a quarterly report to commissioners on our performance against national and locally agreed quality indicators. These reports are well received by commissioners and demonstrate again our commitment to providing quality patient services and supporting commissioners in their contracting responsibilities.

In addition Primecare set up a specific work group in February 2010 to review the recommendations from the OOH review and this document sets out our response to those recommendations. Whilst many of the recommendations are for PCT commissioners, we believe that providers can play an important role in driving up quality standards and enabling commissioners to properly monitor and quality assure our services.

Dr Bruce Websdale
Medical Director, April 2010

Primecare response to recommendations

Section 1:

Commissioning and Performance Management

1. PCT's to review their performance management arrangements:
 - a. Frequency and seniority
 - b. Quality review meetings separate to contractual review
 - c. Attended by senior clinicians, local GP's, LMC
 - d. Clear accountability where more than 1 provider involved

We welcome the recommendation to ensure regular and appropriate performance management with a separate quality review meeting. In partnership with local commissioners we are already adopting this approach in some areas.

2. PCT's should supplement the core NQR's with a suite of locally designed quality indicators to which consideration should be made for quality incentive payments
 - a. Clinical outcome trends
 - b. Patient reported outcomes
 - c. Patient and stakeholder feedback

Primecare already audit both individually and jointly across our services to ensure appropriate clinical outcomes and provide a range of outcome information in our reports to commissioners. This includes our reducing trend on referral to Accident and Emergency departments.

Primecare have scored highly in a number of benchmarking reviews, notably the high number of PCTs who use Primecare as their out of hours providers being rated in the "better" or "best" performing cohorts.

In 2010, Primecare launched our Quality Accounts programme. Primecare now produce a Quality Account for each of our contracted out of hours services, and we are developing Quality Accounts in all of our other service lines. The Quality Account includes our performance against the core NQRs as well as a set of national and locally agreed quality and safety indicators. The local indicators are agreed on discussion with the relevant commissioner.

A Quality Overview is included in each quality account that sets out measurable performance against our indicators at a glance. Our patient experience section includes the following measures:

- Complaint rate
- Percentage of complaints acknowledged within three working days
- Percentage of final responses completed within 20 working days
- Percentage of complaints with learning outcomes
- Patient satisfaction surveys carried out on 1% of all contacts
- Percentage of CFEP patient experience surveys carried out that quarter
- Primecare performance in CFEP surveys against national benchmark for telephone advice, home visits and appointments at primary care centres
- Compliance with evidenced quarterly meetings with patients, urgent care networks and local stakeholders

3. PCT's to review inclusion of NQR 5, patient experience reports and wider stakeholder feedback including GP's, A&E, Ambulance service with trend analysis

Primecare currently run or plan to run the CFEP patient experience surveys in all our out of hours services. Results of these surveys are reported to our commissioners. We welcome the expansion of surveys to include feedback from the local health economy. In a number of our existing contracts we already contribute to urgent care networks.

4. PCT's should ensure OOH providers become integral part of local health economy and have a place on Urgent Care Boards

The out of hour's service is an integral part of the local health economy. We always participate in urgent care networks, even taking the initiative by establishing and leading these in some parts of the UK. We believe that performance is enhanced and services improved through true integrated and partnership working, regardless of provider. Primecare have participated in a number of successful pilots to reduce avoidable admissions and referrals to Accident and Emergency departments.

5. PCT's and Providers should benchmark their services e.g. Primary Care Foundation (PCF) work; this will enable PCT consideration of sufficient resource allocation to ensure quality service delivery
6. Ensure the recommendations from work carried out by PCF benchmarking are implemented

Primecare has established a benchmarking working party who are currently reviewing all benchmarking information and ensuring that action plans are in place for each of our contracted out of hours services. We will ensure that commissioners have the opportunity to review our benchmarked performance and can monitor our improvement plans.

7. Board level reporting on quality of OOH to Provider, PCT and SHA level

We welcome reporting of out of hour's performance at the highest levels and would recommend that our Quality Accounts are reported to the relevant commissioning Board on a quarterly basis.

8. DH to provide improvement programme for PCT OOH contract management

We welcome this recommendation to support commissioners in managing the out of hour's contract and confirm our commitment in assisting the Department of Health on developing this programme.

Section 2:

Selection, Induction, Training and use of out of hour's clinicians (including use of locums)

9. PCT's and Providers to continue to work with post graduate deaneries to ensure GP Registrar training

Primecare already has close links with the relevant post graduate deaneries and we have a policy in place to ensure that in every contract we offer a range of GP Registrar training opportunities within our out of hours services.

10. RCGP to review guidance concerning GP Registrar training

We welcome this recommendation and would like to work alongside the RCGP in review the guidance for GP Registrar training. We are also establishing consistent guidance across Primecare services for GP Registrar training offering every opportunity for high quality training under RCGP guidance.

11. OOH Providers should consider the recruitment and selection process for clinical staff (and be applied to locums)

- a. Knowledge and skills outline for staff setting out generic qualifications and appropriate experience
- b. Telephone assessment skills
- c. OOH knowledge

Primecare has reviewed its recruitment policy in light of the recommendations and strengthened the clarity of knowledge and skills requirements for all our clinicians including agency and locum clinical staff. We regularly review our selection procedures to account for telephone assessment skills and experience of working in an out of hour's environment.

We have in place job descriptions and competency outlines for all staff and these are robustly assessed at interview. Telephone assessment is a discrete skill which we provide full training for. We also robustly audit this skill.

Primecare has both organisation-wide and local induction manuals which cover a range of relevant subjects. New starters are supported by an experienced local mentor ensuring a tailored approach to suit any selected candidates.

12. OOH Providers to consider content of their induction process which should be completed before first shift
 - a. Tailored to needs of individual
 - b. Local knowledge
 - c. Special consideration for non UK staff
 - d. Followed by appropriate shadowing and mentoring arrangements

Every doctor that works for Primecare (including those from agencies) undergoes an interview and pre assessment prior to commencement of their first session. Following their first session with Primecare, the Local Medical Advisor or the Clinical Services Manager undertakes a full assessment of their work. This information is also given to the doctor to form part of their yearly appraisal with their PCT. Regular refresher seminars are also standard and part of clinician's Continuing Professional Development.

Primecare's interview and induction processes are developed differently depending on the skills and knowledge of the individual. We have different programmes in place for people who already have good knowledge and experience of out of hour's services, a programme for people first language is not English and a detailed programme for people with less out of hours experience or local knowledge.

Primecare's policy sets out a minimum shadowing and mentorship period which is tailored to the needs of the individual doctor under the leadership of the Local Medical Advisor.

13. PCT's to review whether induction, shadowing, mentoring are set in contract

We welcome this recommendation and we can already provide evidence of our induction, shadowing and mentoring processes which has been adopted as an internal policy even where not contractually explicit.

14. Provider cooperation with PCT's on concerns regarding staff working excessive hours

We have invited our PCTs to establish a local process to track working arrangements. In Wales we have been working for some time with the Deanery to form an All Wales GP Passport to track doctor's work across providers. Primecare were the first out of hour's provider to pilot this in partnership with the NHS Wales Business Service Centre.

15. OOH Providers to consider clinical governance arrangements and include

- a. Clinical audit
- b. Trend analysis of clinical performance for common/high impact conditions
- c. PCT should consider the cost of providers undertaking these audits (see 5 above)

Primecare has in place a robust clinical governance structure at both national and local levels. We already undertake clinical audit in line with our comprehensive audit strategy. We will look to include a clinical audit programme for each of our contracted out of hours services that we will agree with local commissioners including targeted audits to support local initiatives, multi agency audits and audits of high impact conditions. We welcome the opportunity for PCTs to further support audit within the Out of Hours services

16. PCT's should ensure all locum and sessional staff on their Performers List have access to appraisals and CPD

We welcome this recommendation and are considering including evidence of appraisal as one of our minimum standard requirements for all doctors working in Primecare services. Additionally we are exploring the PCT appraisal system at a local level to encourage OOH performance to be part of out of hour's doctor's appraisal

17. OOH Providers should consider the benefit of signing preferred provider agreements with locum agencies

Primecare has its own locum business, Primecare Locums, which provides clinicians for Primecare services and to other providers. Primecare Locums follows the same process of assurance that is carried out on all new and agency doctors in Primecare services.

As a minimum, all new and agency doctors must provide evidence of:

- Up to date GMC Registration with Licence to practice
- Appropriate valid Professional Indemnity CRB check (within the last three years)
- Evidence of recent completion of Child Protection Training (within the last three years)
- Basic life support training
- Evidence that they practice in the UK and are registered on a local PCT Performer's List

Any selected doctor from any agency background is required to fit our criteria of knowledge and skill and to undergo local assessment by the LMA and a robust and suitably tailored induction process. All new doctors are provided with shadowing and mentoring during their first sessions

Primecare only rarely uses external locum agencies. However all recruitment and induction policies apply, and we continue to work across our organisation to establish preferred provider locum agencies as appropriate.

18. DH/CQC to ensure future requirement for provider organisations to source workers fit to practice including locum agencies

Primecare already has robust criteria for the selection of out of hour's clinicians and will work quickly to ensure that all clinicians working within Primecare services comply with any future Care Quality Commission requirements.

Section 3:

Management and Operation of Performers Lists

19. DH working with GMC to consider the extent PCT's can rely on GMC registration process.

We await the outcome of this recommendation however we believe that our due diligence processes should provide assurance in the interim.

20. DH to urgently issue guidance to PCT's re making decisions about necessary knowledge of English in order to be admitted to Performers List

All doctors from overseas are now mandated to provide us with evidence on proficiency in English before they can start work and additionally are assessed at interview on a set criterion to ensure safe and effective communication skills.

21. DH guidance on when PCT's need to informally invite applicants for discussion of their applications

We have noted this recommendation.

22. Performers List review – appropriateness for GP Registrars

We will review the outcome of this recommendation and the impact on use of GP registrars in our out of hour's service.

23. PCTs should ensure all doctors who have not provided Primary Care services in the NHS should be required to complete an individually tailored induction prior to commencing

We have noted this recommendation and have tailored our interview and induction processes as described above.

24. DH to review exchange of information between PCT's and GMC

We have noted this recommendation.

Conclusion

Primecare have thoroughly reviewed the report from Dr David Colin Thome and Professor Steve Field on arrangements for out of hour's services. Primecare already had in place many systems that meet the recommendations for providers. Where we felt the recommendations further strengthened our processes in assuring quality and safety we have been pleased to adopt them. Additionally we have established procedures that will support health care commissioners in fulfilling their responsibilities of commissioning and performance management, management of performer's lists and in gaining assurance of selection, induction and training processes.

We have also reviewed the report's profile of what makes a good out of hour's service in terms of commissioning and provision, especially for the patient. Our assessment of where we are against these aspects of provision is included at appendix 1.

Appendix 1

Primecare – delivering good out of hours services

Section 1: Commissioning and Performance Management

Relationships and Integration

1. OOH service commissioned for local need and integrated into local urgent care health economy

Primecare reports our integration with the local health economy on our monthly performance dashboard and at regular PCT meetings through sharing Quality Accounts.

2. Commissioners to ensure OOH Providers integrate with urgent care boards etc and foster partnership working

Primecare will report these to PCTs on our performance dashboard and through our Quality Accounts.

3. Good relationship between Commissioners, Provider and local GP groups to support necessary discussions around patient care

Primecare works in partnership with local health economies supported by local senior GPs acting as Local Medical Advisors.

4. Local GP's and PBC consortia are involved with the assessment of OOH services and includes involvement with LMCs

Primecare work closely with local GPs, PBC consortia and LMCs particularly through the role of the LMA.

5. Good relationships between PCTs Providers and Deaneries to ensure Registrar training

Primecare has good working relationships with deaneries to support Registrar training within the out of hour's environment.

Performance Management

1. Regular meetings at least quarterly with Commissioner

Primecare to continue systematic compliance of regular meetings reported by Dashboard/QA

2. Providers to submit regular reports on compliance of NQR and other appropriate metrics to include trend analysis and benchmarking

Primecare already reports through regular NQR reports and Quality Accounts

3. Good contract may also contain requirement for reporting appropriateness of referrals and treatments, % patients receiving call backs, % dealt with by self care advice and results of 'mystery shopper' surveys

Primecare is committed to developing our current appropriateness assessments

4. PCT's are urged to escalate issues and incidents to the PCT Board

Primecare are aware of the implications of escalation of incident reporting.

Quality

1. Good providers will have robust policies and procedures in place regarding clinical governance and where more than one provider involved will have shared CG process with the providers meeting regularly

Primecare have in place robust clinical governance arrangements and will strengthen our processes for shared services.

2. Quality will be an agenda item at contract reviews but ideally there should be separate quality board meetings attended by senior clinicians and managers as well as GP's and PBC consortia

Primecare will continue to ensure internal and external reporting on quality

3. Discussions at these meetings will focus on ensuring lessons are learnt and that systems are in place to record such items and to analyse trends

Primecare will continue to report lessons learned through our dashboard and Quality Accounts and will build upon our current trend analysis work.

4. Commissioners should be aware of clinical audit that should extend beyond RCGP toolkit including trend analysis of clinical performance for common and/or high impact conditions

Primecare will review clinical condition coding and develop further focussed audit including trend analysis

Patient perspective

1. Patients are aware of how to contact services and can access information through an appropriate website

Primecare will work with PCTs to test effectiveness of out of hour's information

2. The OOH service is able to access the patient record or a summary record

Primecare will continue to be involved in the Adastra working party on this agenda.

3. The clinician conducting the clinical assessment is appropriate for the patient condition – appropriateness could be measured in local patient surveys

Primecare provides GP-led out of hours services. We carry out local patient surveys.

4. After assessment appropriate outcome is communicated and delivered to identified time scales

Primecare will continue to report promptly and to the NQR standard on appropriateness and timeliness of outcomes

5. The assessing clinician has good local knowledge or has access to such information

Primecare will continue our development of high quality Local Information Systems (LIS) and check effectiveness

6. The patient presenting by the phone is dealt with by 1 call and if not is made aware of timescales for call back and includes information for what to do if condition deteriorates

Primecare will continue to audit performance

7. If there are delays to call backs then a comfort call should be made, all this activity frequency being audited

Primecare will review standardisation of comfort call usage and audit this.

8. If PCC offered the patient is given clear instructions on how to reach it

Primecare believes it provides clear information tom patients but will review how such information delivered and explore new methods.

9. Medications on HV's are provided from carried stock

Our Adastra medicines management system demonstrates appropriate dispensing from Primecare medicines stock

10. Medications from PCC ideally given by on site pharmacy

Primecare will review how on site medicines are provided or close working with local accessible pharmacies

11. Patient experiences seamless pathway despite number of providers

Primecare will discuss with our PCTs the opportunities to test the pathway

12. Patient is offered the opportunity to feedback either in real time or as a retrospective survey or telephone questionnaire

We will continue to ensure systematic patient satisfaction/feedback occurs and look for 'real time' opportunities

13. Data is transferred to patients GP by 8am the next working day

Primecare will continue Transfer of Responsibility recording and audit this

Selection, Induction, training and Use of out-of-hours Clinicians (including use of locum GPs)

Selection/Training

1. Commissioners need to:
 - a. Assure themselves that providers recruit appropriately qualified and trained staff
 - i. On English Performers List preferably local
 - ii. Have UK in hours experience preferably locally
 - iii. Good command of English
 - b. Ensure it is contractual requirement for providers to work with post graduate deanery ref GP Registrar training

- c. Consider value of stipulating experienced local in-hours clinicians should work OOH

Primecare have noted these opportunities for supporting service improvement.

2. Providers should:

- d. Ensure they comply with legislation and contracts when recruiting, selecting and training staff (including GP Registrars)

Primecare currently checks against legislation and contract for compliance.

- e. Have a robust selection process governed by a 'knowledge and skills' framework for staff
 - i. Qualifications and eligibility
 - ii. Sight of references
 - iii. Interview process covering 'knowledge and skills' and clinical skills review

Primecare has adopted current recommendations into minimum entry requirements and enshrined the principles in its clinician management policy

Induction

- 1. Commissioners to mandate robust induction process from providers, particularly those unfamiliar with local OOH provision

Primecare has updated its induction guidance to follow suggested recommendations

- 2. Providers to ensure induction process includes assessment of command of English and local procedure knowledge

Primecare's policy supports robust interrogation of language ability and local knowledge (or adequate LIS support)

- 3. Provider induction to include thorough demonstration of and training in clinical system, prescribing process, local formulary and use of controlled drugs; a more tailored induction process will be used for GP first shift if unfamiliar with NHS OOH services and lacks local geographical understanding

Primecare has updated our Clinician Management policy and guidance

- 4. There are robust shadowing arrangements for an appropriate number of shifts and mentoring support is available when required; initial audit will take place within first few sessions

Primecare has a Clinician Management Policy in place that includes shadowing, monitoring and audit.

Use of locums

1. The use of locums is the exception and not the norm, only being required to fill unexpected sickness leave

Primecare uses locums rarely. We track all locum usage and report this on our performance dashboard

2. If use of agency unavoidable, providers try to use preferred provider with whom they have well-established working relationship

Primecare Locums is Primecare's preferred provider and we will seek alternative preferred providers across the organisation for the rare situations when an external agency is required.

3. Providers have signed agreement in place with agency

Primecare has its own agency Primecare Locums and arrangements with others for times when external agency usage is required.

4. Any recruitment requirements of the provider (or PCT) are passed through to the agency

Primecare has clear written minimum requirements for all clinicians including those provided by agencies.

5. The provider understands what checks the agency undergo and sees evidence of these

Primecare has a full understanding of the checks carried out by agencies including the limitations of such checks and its role as provider to review evidence.

6. The providers 'knowledge and skills' outline applies also to the agency

Primecare will ensure the 'knowledge and skills' outline is agreed with agencies

7. Locums go through at least the same induction, shadowing and mentoring process as regular staff

Primecare adopts equal if not more onerous process for locums.

Management and Operation of Performers Lists

1. Good Providers
 - a. Follow good employment practices when recruiting and appointing doctors
 - b. Alert the PCT when taking disciplinary action OR if a doctor leaves their employment without performance issues being resolved first

- c. Are responsible for ensuring that the people they employ have the required knowledge and skills including language competency for posts for which they are applying

Primecare applies all the above, without exception in best practice management of its clinicians through compliance with its policy and guidelines.