The Regulation and Quality Improvement Authority

Review of GP Out-of-Hours Services in Northern Ireland

April 2021

Glossary

Belfast Trust	Belfast Health and Social Care Trust
BMA	British Medical Association
DoH	Department of Health
ED	Emergency Department
EWTD	European Working Time Directive
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
GPIP	General Practice Intelligence Platform
HMRC	Her Majesty's Revenue and Customs
HSC	Health and Social Care
HSS	Health and Social Services
IT	Information Technology
KIS	Key Information Summary
KPI	Key Performance Indicator
MDO	Medical Defence Organisation
NHS	National Health Service
LES	Local Enhanced Scheme
NIAS	Northern Ireland Ambulance Service
NIECR	Northern Ireland Electronic Care Record
NIHSCIS	Northern Ireland Health and Social Care Interpreting Service
NIMDTA	Northern Ireland Medical and Dental Training Agency
NMC	Nursing and Midwifery Council
Northern Trust	Northern Health and Social Care Trust
PCC	Patient Client Council
PDSA	Plan, Do, Study, Act
PMPL	Primary Medical Performer’s List
PPI	Personal and Public Involvement
QED	Quotient of Effectiveness in Dalriada
QI	Quality Improvement
RAIL	Regional Adverse Incident Learning System
RESWS	Regional Emergency Social Work Service
RCGP	Royal College of General Practitioners
RQIA	Regulation and Quality Improvement Authority

SOSCARE	Social Services Client Administration and Retrieval Environment
South Eastern Trust	South Eastern Health and Social Care Trust
Southern Trust	Southern Health and Social Care Trust
UK	United Kingdom
Western Trust	Western Health and Social Care Trust

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care services in Northern Ireland. RQIA's reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Reviews are supported by a core team of staff and by independent assessors, who are either experienced practitioners or experts by experience. RQIA reports are submitted to the Department of Health (DoH) and are available on the RQIA website at www.rqia.org.uk.

Acknowledgements

RQIA wishes to thank all those who facilitated this Review through participating in discussions, meetings, surveys and providing relevant information.

Membership of the Expert Review Team

Mr Richard Dixon	Complaints Services Manager, Patient and Client Council, Northern Ireland
Dr Lourda Geoghegan	Ex-Director of Improvement and Medical Director, RQIA
Mr Hall Graham	Retired Assistant Director, Improvement Directorate, RQIA
Dr Nigel Hart	General Practitioner, Associate Director for Primary Care, Queen's University Belfast, Associate Director (Quality Improvement) General Practice Training, Northern Ireland Medical and Dental Training Agency
Dr John O'Malley	Retired Medical Director of Out-of-Hours Provider, Mastercall Healthcare, North West England
Dr Sian Tucker	Clinical Director, Lothian Unscheduled Care Service, NHS Lothian, Scotland
Mr Steve Wilson	Senior Programme Manager, Healthcare Improvement, Scotland

Membership of the Reference Group

Dr David Johnston	Royal College of General Practitioners, Northern Ireland
Dr Paul Molloy	Royal College of General Practitioners, Northern Ireland
Dr Claire Loughrey	Northern Ireland Medical and Dental Training Agency
Dr Margaret O'Brien	Health and Social Care Board
Dr Frances O'Hagan	Northern Ireland General Practitioners Committee, British Medical Association
Dr David Ross	Northern Ireland General Practitioners Committee, British Medical Association

Membership of the Project Team

Mrs Helen Hamilton	Support Project Manager, RQIA
Mr Jim McIlroy	Project Manager, RQIA
Ms Anne McKibben	Project Administrator, RQIA
Mrs Jacqui Murphy	Review Programme Manager, RQIA
Mrs Rachel Stewart	Head of Information, RQIA

Contents

Executive Summary

RQIA first reviewed the GP Out-of-Hours Service in 2010[1]. As part of our 2015-2018 Review Programme, we agreed to revisit the service to examine progress made since the 2010 Review and also following the 2016 DoH Review of GP-Led Primary Care Services in Northern Ireland[2].

This Review examined the operational systems in place within GP Out-of-Hours Services and assessed the governance arrangements that assure the provision of a safe, person-centred, quality service, including the effectiveness of the leadership arrangements.

It commenced in April 2017 with the formation of an Expert Review Team, comprising members with experience in clinical and corporate governance in commissioning and medical education and members with experience in general practice and out-of-hours service provision. A mixed methodology approach was utilised and the Review concluded in March 2018.

Previous Local/ National Reviews and Reports

We considered the opportunities for modernising and improving services identified by other United Kingdom (UK) reviews of GP Out-of-Hours Services (outlined in Section 1.2 of this report), in the context of best practice and in relation to suitability for Northern Ireland.

Particular attention was paid to the progress made with respect to the implementation of the recommendations from two previous local reviews namely:

- RQIA Review of GP Out-of-Hours Service (2010)
- DoH Review of GP-Led Primary Care Services in Northern Ireland (2016)

We found that the majority of the recommendations from both of these reviews had either not been implemented, or had been partially implemented.

We have made applicable recommendations throughout this report which we consider should now be taken forward as a priority, in order to support a safe, more effective and sustainable service model.

Key Findings

Throughout this report we have identified areas of good practice and have made recommendations (Section 7.2) that, if implemented, we believe would support the establishment of a more sustainable service model with a clear

[1] Review of GP Out-of-Hours Services. Regulation and Quality Improvement Authority (September 2010). Available from https://www.rqia.org.uk/RQIA/files/09/09b5172a-1630-4df8-9cff-b77d3183b827.pdf (Cited: May 2020)

[2] Review of GP-led Primary Care Services in Northern Ireland: Recommendations of Working Group. Department of Health (March 2016). Available from https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/review-gp-led-primary-care-services.pdf (Cited: May 2020)

strategic direction, whilst strengthening the governance arrangements within GP Out-of-Hours Service throughout Northern Ireland.

Current Model and Sustainability of the GP Out-of-Hours Service

During the course of this Review, the Expert Review Team identified a number of challenges with the present GP Out-of-Hours Service model and considered that this model may not be sustainable into the future. We found that increasingly fewer GPs were contributing to the GP Out-of-Hours Service, a consequence of: increasing pressures facing daytime GP Services; increasing pressures in the out-of-hours service; limited flexible working arrangements; and financial implications associated with working in the out-of-hours service such as static pay and changes to pension arrangements. If no action is taken, the result is likely to be fewer locations able to provide GP Out-of-Hours Services, as well as increasing gaps in rotas and services in those locations that remain, with consequent delays and longer waiting times for patients.

However, we were also encouraged that many providers were trying to improve the skill mix within their workforces and utilise the skills of a variety of healthcare professionals. We also welcomed the fact that some providers were making better use of technology to facilitate provision of home working to provide remote triage, advice and treatment to patients. The Expert Review Team welcomed these developments which are essential; not for only improving patient care and supporting services but also for ensuring that the service is a suitably attractive employer for staff.

Overall, the Expert Review Team determined that a new operating model for GP Out-of-Hours Services should be urgently developed to support wider transformation across Health and Social Care. However, there was also an urgent need to immediately stabilise services.

Governance and Oversight

During this review we found significant weaknesses in governance and leadership arrangements. The existing arrangements for oversight by the HSC Board were not effectively addressing the real-time challenges facing the service.

We did not find a clear vision for a future model for GP Out-of-Hours Services in Northern Ireland to inform effective service planning or to ensure appropriate service improvements were being taken forward.

The Expert Review Team identified that oversight and management of the service was heavily reliant on meeting Key Performance Indicators (KPIs) in relation to response times. New KPIs are required that are linked to patient outcomes, experience and quality of care in order to provide robust assurances.

We found that the operational arrangements for oversight and management of staff varied according to staff group and also between employed versus

sessional staff. As a result, providers could not easily provide comprehensive assurance across the entire service.

There was a significant demand on the time of Clinical Leads. Most of their time was spent on ensuring continuity of service provision and which impacted significantly upon their ability to fully commit to their responsibilities around governance, risk management, performance audits and quality improvement.

Risk Management

The Expert Review Team was encouraged to find that providers demonstrated a clear understanding of the risks associated with their services and had processes in place for the management of risk. We identified, however, that these processes were not being robustly implemented and that risks were not always reflected in risk registers.

The Expert Review Team considered risk management was an area which would benefit from regional co-operation. This work could involve defining a set of common core risks affecting all providers with a common approach as to how they are managed at a regional level.

Medicines Management

In relation to medicines management, we were not assured that the arrangements for oversight of the supply, storage and physical carrying of controlled drugs and access to controlled drugs for palliative care were sufficiently robust.

We found limited evidence of a regular audit programme relating to medication and prescribing which had contributed to limited assurance. The Expert Review Team acknowledged that Clinical Lead capacity influenced the time available to commit to audits of this service area.

Safeguarding

Robust policies, procedures and training arrangements for safeguarding are essential for ensuring that safeguarding issues are recognised and actioned appropriately within these services. While providers had developed appropriate policies and procedures, the Expert Review Team was concerned to find that they could not confirm the number of staff who had completed safeguarding training. This appeared to have been a particular issue with respect to GPs.

We were also concerned that the Adastra system did not have triggers to flag when children were on the Child Protection Register and that GPs relied mainly on clinical experience to recognise potential child protection issues.

Shared Learning

We found that there was no sharing of outcomes beyond that of reporting to the HSC Board and that shared learning occurred mainly within providers rather than between providers. We again identified Clinical Lead capacity as a significant constraint in respect of disseminating such learning.

The Expert Review Team considered that formalised sharing of information between providers would strengthen the governance and assurance arrangements of GP Out-of-Hours Services and support improvements in patient care and outcomes. This would include learning from incidents, accidents and complaints

Patient Expectations

The results from our online and postal surveys indicated a high level of patient satisfaction among those using the GP Out-of-Hours Service. We found that expectation of a face to face care contact was high and that patients who received a home visit or consultation were more satisfied than patients who received telephone advice.

The Expert Review Team was concerned to find that many patients perceived the GP Out-of-Hours Service as a continuation of daytime GP services rather than an urgent care service. This perception was important in relation to the service's ability to respond to demand. We found variable mechanisms in place across providers for obtaining patient feedback. As a consequence, this information was not always meaningful or able to be analysed sufficiently well to drive improvements across the GP Out-of-Hours Services.

Section 1: Background and Context

1.1 Introduction

In October 2006, the Department of Health in England published The Direction of Travel for Urgent Care, which outlined the definition of urgent care as:

"the range of responses that health and care services provide to people who require – or perceive the need for – urgent advice, care, treatment or diagnosis[3]."

The GP Out-of-Hours Service enables people to directly access a GP service out-of-hours without a referral and within the community setting. GP Out-of-Hours Services in Northern Ireland, as in the rest of the United Kingdom (UK), are one of a number of urgent care services provided to those seeking medical care when normal GP services are closed.

Routine GP services are usually provided Monday to Friday, 8:00 am to 6:30 pm, excluding weekends and public/bank holidays. Outside of these times, patients seeking a GP for urgent issues which they feel cannot wait until their own practice opens, can access GP Out-of-Hours Services.

The care delivered through GP Out-of-Hours Services is intended to differ from the type of care delivered within a GP practice during normal working hours. The care provided is not intended to be a continuation of the normal GP service, but rather, is intended to assess and treat only the most urgent problems which cannot wait until the normal GP service is available.

While not all Primary Care Services are available 24 hours a day, seven days a week, the King's Fund reported that there is an expectation from the public that some core services should be[4]. In October 2000, the Carson Report, Raising Standards for Patients New Partnerships in Out-of-Hours Care, an independent Review of GP Out-of-Hours Services in England, set out a fundamental principle that:

"The purpose of GP Out-of-Hours Services in primary care should meet those urgent patient needs that cannot safely be deferred until the patient's own GP practice is next open[5]."

In Northern Ireland the out-of-hours period that is intended to be covered by GP Out-of-Hours Services is defined within The Health and Personal Social

---

[3] The Direction of Travel for Urgent Care. Department of Health (2006). Available from http://www.stemlyns.org.uk/download.php?dtType=library&fileID=28 (Cited: May 2020)

[4] Understanding Pressures in General Practice. The Kings Fund (May 2016). Available from https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf (Cited: May 2020)

[5] Raising Standards for Patients New Partnerships in Out-of-Hours Care - October 2000. Available from http://www.stemlyns.org.uk/download.php?dtType=library&fileID=10 (Cited: May 2020)

Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004, to be:

a) the period beginning at 6:30 pm on any day from, and including, Monday to Thursday and ending at 8:00 am on the following day;
b) the period between 6:30 pm on, and including, Friday to 8:00 am on the following Monday; and
c) any public holiday or local holiday agreed with the Health and Social Care (HSC) Board[6].

Under the regulations, care must be provided during the stipulated times and any deviation or additional times undertaken only with the agreement of the commissioner. In 2004, an agreement between GPs in Northern Ireland and the legacy Health and Social Services (HSS) Boards allowed for the provision of additional cover, with GP Out-of-Hours Services starting at 6:00 pm each evening. This arrangement was still in place at the time of this Review.

In considering the context of this Review we considered how the current model for GP Out-of-Hours Services in Northern Ireland has evolved and sought to understand key, unique differences to models elsewhere in the UK.

For example, GPs in England can opt to provide 24-hour care for their patients (opted-in services), or to transfer responsibility for out-of-hours services to NHS England (opted-out services), which is responsible for providing a high-quality service for the local population. In Northern Ireland, GPs can also choose to provide their own arrangements for out-of-hours cover; however no GPs currently offer this.

In Northern Ireland during the out-of-hours period the options for seeking urgent medical care are limited to GP Out-of-Hours Services, Minor Injury Units (MIUs) (usually available until 9:00 pm) or HSC Trust Emergency Departments (ED).

In contrast, elsewhere in the UK there are a variety of alternative options for the provision of out-of-hours care[7]. Those patients who urgently need medical help or advice, but do not have a life-threatening situation, are advised to consider calling NHS 111. NHS 111 will direct the patient to the NHS service they need.

In some areas patients can visit an urgent care service such as an NHS Walk-in Centre, Urgent Care Centre or MIU. These services can provide treatment for minor injuries or illnesses such as cuts, bruises and rashes and they have proved to be a successful complementary service alongside traditional GP and accident and emergency services. Any member of the public can simply present to the service for assessment regardless of which GP practice they are registered.

---

[6] The Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004. Available from https://www.legislation.gov.uk/nisr/2004/140/contents/made (Cited: May 2020)

[7] Using the NHS: NHS Out-of-Hours Services. Available from https://www.nhs.uk/using-the-nhs/nhs-services/urgent-and-emergency-care/nhs-out-of-hours-services/ (Cited: May 2020)

In Northern Ireland the 2004 General Medical Services (GMS) Contract included a clause which enabled GPs to opt out of providing 24-hour cover for their patients[8]. The majority of GP practices subsequently opted out of providing out-of-hours care for their patients from 1 January 2005, with the responsibility transferring to the then four Health and Social Services Boards (now the regional Health and Social Care Board (HSC Board) as commissioners of GP Out-of-Hours Services. In 2005, the HSS Boards commissioned seven provider organisations to deliver GP Out-of-Hours Services.

In 2009, the Review of Public Administration amalgamated the then 19 HSS Trusts into the current six HSC Trusts, under the Health and Social Care (Reform) Act 2009[9]. GP Out-of-Hours Service Providers then reduced in number from seven to five provider organisations. There has been no change to the number of providers of GP Out-of-Hours Services since 2009.

The current provider organisations are:

- Belfast Health and Social Care Trust (Belfast Trust);
- South Eastern Health and Social Care Trust (South Eastern Trust);
- Southern Health and Social Care Trust (Southern Trust);
- Dalriada Urgent Care (mutual organisation) in the Northern Health and Social Care Trust (Northern Trust) area; and
- Western Urgent Care (mutual organisation) in the Western Health and Social Care Trust (Western Trust) area.

1.2 Previous Local and National Reviews and Reports

RQIA first reviewed the GP Out-of-Hours Service in 2010[10]. As part of this current Review, the Expert Review Team examined progress since the 2010 Review and also since the 2016 DoH Review of GP-Led Primary Care Services in Northern Ireland[11].

A table which summarises the Expert Review Team's assessment of progress against the recommendations from both of these local reviews has been included at Appendix A.

[8] The National Health Service (General Medical Services Contracts) Regulations 2004. Available from http://www.legislation.gov.uk/uksi/2004/291/contents/made (Cited: May 2020)
[9] The Health and Social Care (Reform) Act (Northern Ireland) 2009. Available from https://www.legislation.gov.uk/nia/2009/1/contents (Cited: May 2020)
[10] Review of GP Out-of-Hours Services. Regulation and Quality Improvement Authority. (September 2010). Available from https://www.rqia.org.uk/RQIA/files/09/09b5172a-1630-4df8-9cff-b77d3183b827.pdf (Cited: May 2020)
[11] Review of GP-led Primary Care Services in Northern Ireland: Recommendations of Working Group. Department of Health (March 2016). Available from https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/review-gp-led-primary-care-services.pdf (Cited: May 2020)

Since the 2010 RQIA Review, several reports in relation to GP Out-of-Hours Services have been published throughout the UK, which contained recommendations for modernising or improving these services. We examined these reviews to identify the key themes and issues, which would inform this current Review.

New Approach to the Inspection of National Health Service (NHS) GP Out-of-Hours Services: Findings from the First Comprehensive Inspections: Care Quality Commission (October 2014)[12]

This report detailed the findings from the first comprehensive inspection programme of NHS GP Out-of-Hours Services in England, by the healthcare regulator, the Care Quality Commission (CQC). Thirty NHS GP Out-of-Hours Services, run by 24 registered providers, were inspected between January and March 2014. These providers had responsibility for the care of approximately 36% of the population in England.

Overall, CQC found that the majority of services provided were safe, effective, caring, responsive and well-led. Some of the positive findings included:

- good monitoring of the quality of care provided through audit and investigation of incidents;
- sharing of learning within and across providers;
- fewer locum GPs covering shifts;
- awareness raising about the service in the local communities; and
- development of innovative and responsive care as a result of feedback from patients.

The CQC review also found some variation in the quality and safety of care across the services and identified areas where improvements could be made. These included:

- the management and storage of controlled drugs;
- systems for checking and monitoring equipment, including oxygen and emergency medicines;
- recruitment processes; and
- information on how to make complaints about the service.

In response to the findings, CQC issued compliance actions to some services; however, no serious concerns requiring enforcement were identified at the time.

[12] Our New Approach to the Inspection of NHS GP Out-of-Hours Services: Findings from the First Comprehensive Inspections. Care Quality Commission (October 2014). Available from https://www.cqc.org.uk/sites/default/files/20140924_gp_out_of_hours_final.pdf (Cited: May 2020)

The Future of GP Out-of-Hours Care: Royal College of General Practitioners (2015)[13]

In 2015, the Royal College of General Practitioners (RCGP) undertook a Review of GP Out-of-Hours Services in England. The review focused on the current arrangements for delivering services and any potential changes which would be needed for any future model, in order to ensure it would be sustainable.

The RCGP Review identified that the following key changes were required:

- developing more integrated services to facilitate the sharing of patient information;
- reducing obstacles for GPs to deliver Out-of-Hours care;
- increasing funding to adequately resource GP Out-of-Hours Services;
- ensure further transparency in the commissioning processes for GP Out-of-Hours Services;
- implementing new training programmes for GPs;
- improving assessment for GP Out-of-Hours competencies; and
- undertaking long-term workforce planning.

Review of GP-Led Primary Care Services in Northern Ireland: Department of Health (2016)[14]

In 2016, DoH published the findings of its Review of GP-Led Primary Care Services in Northern Ireland. While the Review focused on Primary Care GP Services, the GP Out-of-Hours Service was also included.

The Review aimed to identify ways to develop a more sustainable GP Out-of-Hours Service through:

- encouraging the recruitment of more GPs into the service;
- increasing the skill-mix of the service;
- introducing more flexible ways of working, such as remote triage; implementing new training programmes for staff;
- undertaking a review of key performance indicators; and
- a media campaign to highlight the appropriate use of the service.

The Review made 11 recommendations for improvement relating to GP Out-of-Hours Services (outlined in Appendix C).

[13] The Future of GP Out-of-Hours Care. Royal College of General Practitioners (2015). Available from http://www.rcgp.org.uk/policy/rcgp-policy-areas/out-of-hours.aspx (Cited: May 2020)

[14] Review of GP-led Primary Care Services in Northern Ireland: Recommendations of Working Group. Department of Health (March 2016). Available from https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/review-gp-led-primary-care-services.pdf (Cited: May 2020)

Pulling Together: Transforming Urgent Care for the People of Scotland – The Report of the Independent Review of Primary Care Out-of-Hours Services: Scottish Government (November 2018)[15]

This review was undertaken to evaluate the effectiveness of the delivery of Primary Care Out-of-Hours Services in Scotland. It assessed the current model and made recommendations for a future model that would be more sustainable and could deliver high quality, safe and effective care.

The Review was multidisciplinary and involved representatives from health, voluntary and community sectors, in addition to the public. Working groups were established to examine areas such as workforce and training, quality and safety, and data and technology. The aim was to identify and develop the most suitable models of care.

The Review made 28 recommendations to transform the model for GP Out-of-Hours Services in Scotland. The key themes to be taken forward included:

- the development of a new model of care with future involvement from more stakeholders;
- person-centred care and addressing of health inequalities;
- public awareness of the service;
- effective workforce planning and better use of resources; and
- more effective use of data and technology.

Throughout this Review, we examined GP Out-of-Hours Services within the context of best practice outlined in these national reports. However, we payed particular attention to the recommendations from the aforementioned local reviews, and outlined the progress made against the recommendations contained in those reports.

[15] Pulling Together: Transforming Urgent Care for the People of Scotland - The Report of the Independent Review of Primary Care Out of Hours Services. Scottish Government. (November 2018). Available from http://www.gov.scot/Resource/0048/00489938.pdf (Cited: May 2020)

1.3 Terms of Reference

The terms of reference for this RQIA Review were:

1. To examine the current systems in place for GP Out-of-Hours Services in Northern Ireland, taking cognisance of the intended function and scope of the service;

2. To examine progress following:

    - the RQIA Review of GP Out-of-Hours Services (2010);
    - the DoH Review of GP-Led Primary Care Services in Northern Ireland (2016);
    - other local reports on GP Out-of-Hours Services; and
    - national reports in relation to GP Out-of-Hours Services.

3. To assess the governance arrangements that assures the safety, effectiveness and leadership of the GP Out-of-Hours Service.

4. To gather the views and experiences of patients and other stakeholders in relation to the GP Out-of-Hours Service.

5. To report on the findings, identify areas of good practice and, where appropriate, make recommendations for improvement.

1.4 Review Methodology

The Review used a range of methodologies, as outlined in Figure 1, each designed to obtain information and intelligence to inform our assessment.

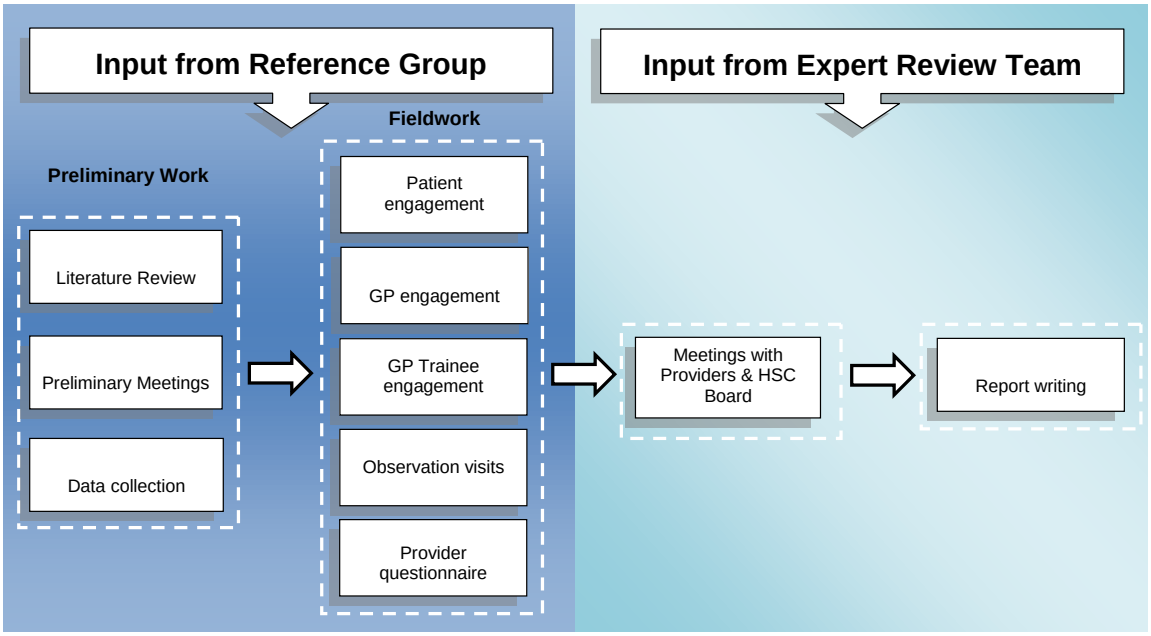


Figure 1: Methodology for the Review

- RQIA engaged an independent Expert Review Team, comprising expert reviewers from England, Scotland and Northern Ireland, with knowledge and experience of delivering GP Out-of-Hours Services.
- A local Reference Group was established to provide independent input and expert advice to inform this Review.
- A literature review was undertaken and several reports and reviews from other parts of the UK were considered, in order to identify key themes and issues that may be relevant to GP Out-of-Hours Services in Northern Ireland.
- Preliminary meetings took place with Policy Leads for GP Out-of-Hours Services at the DoH.
- Preliminary meetings were held with representatives from the British Medical Association (BMA) and with out-of-hours staff to discuss arrangements for delivering GP Out-of-Hours Services
- Data obtained from the HSC Board and the providers were analysed to profile GP Out-of-Hours Services.
- Engagement with patients was carried out to obtain their views and experiences of using GP Out-of-Hours Services using the following:

    - an online survey promoted by both RQIA and the out-of-hours providers. This patient survey is included as Appendix D;
    - a paper survey circulated to a sample of 5% of patients who contacted the GP Out-of-Hours Service during a two-week period;
    - the Patient and Client Council (PCC) invited calls from patients to share their experiences of using GP Out-of-Hours Services; and
    - the PCC also signposted patients to the online survey.

- Engagement with GPs, using an online survey, to obtain their views and experiences of GP Out-of-Hours Services. This GP survey is included as Appendix E.
- Focus groups with GP trainees to obtain their views and experiences of both the GP Out-of-Hours Service including their training placements.
- Site visits to five GP Out-of-Hours facilities, including one from each provider.
- Completion of a pre-review questionnaire by the five providers and the HSC Board. The questionnaires allowed the providers to detail their current arrangements for delivering GP Out-of-Hours Services and their vision for the future model of the service.
- Meetings with the HSC Board and the GP Out-of-Hours Providers focusing on the governance arrangements associated with delivering the services, how services could be improved and possible future models.

1.5 Exclusions

Out-of-hours services, such as dental, pharmacy and the Regional Emergency Social Work Service (RESWS) were excluded from this Review but interfaces with these services have been referenced, where relevant.

The Expert Review Team identified several recommendations contained within the 2010 RQIA Review of GP Out-of-Hours Services which were deemed not to fall within the scope of the 2018 Review and these are highlighted in Appendix B. The progress against these specific recommendations was therefore not examined in this Review.

Section 2: GP Out-of-Hours Services in Northern Ireland

At the time of Review, Northern Ireland had a population of approximately 1.87 million[16] people, who, at some time, might require access to primary care medical services. In a standard week:

- GP practices in Northern Ireland provided daytime services during approximately 33% (55 hours out of 168 hours) of the week (Monday to Friday 8:00 am to 6:30 pm); and
- GP Out-of-Hours Services provided cover for the remaining 67% of the week (as defined in the GMS Contract).

In weeks with public holidays:

- In a week with one public holiday, the cover provided by GP Out-of-Hours Services increased to 76%; and
- In a week with two public holidays, the cover provided by GP Out-of-Hours Services increased to 82%.

While there is an imbalance of cover between daytime GP services and Out-of-Hours Services, this must be set in the context of the actual number of contacts with each service.

During 2014, a review of GP practices led by the then Department for Health, Social Services and Public Safety[17], found that during 2013/14, there were an estimated 12.7 million consultations in daytime GP practices. The consultations included those with GPs, practice nurses and treatment room nurses. In comparison, the number of contacts with the GP Out-of-Hours Service during 2013/14 was 572,135 (indicating that approximately only 1 in 23 contacts with GPs were within Out-of-Hours services).

2.1 The Current GP Out-of-Hours Model

In three areas (Southern, South Eastern and Belfast), GP Out-of-Hours Services were provided by HSC Trusts, with services in the Northern and Western areas being provided by Dalriada Urgent Care and Western Urgent Care respectively which were mutual not for profit organisations. GP Out-of-Hours Services were delivered mainly by GPs, with in some cases input from other healthcare professionals including nurses, nurse practitioners and pharmacists.

At the time of this Review, five providers served the populations within their respective HSC Trust area. The number of Primary Care Centres operated by

[16] Mid-year Population Estimates for Northern Ireland. Northern Ireland Statistics and Research Agency. (2017). Available from https://www.nisra.gov.uk/sites/nisra.gov.uk/files/publications/MYE17-Bulletin.pdf (Cited: May 2020)

[17] Estimating the Volume and Growth in Consultation Rates in General Practice in Northern Ireland, 2003/04 to 2013/14: Analysis of Survey Returns from General Practices. Department for Health, Social Services and Public Safety. (January 2015).

each provider varied, but was generally based on the size of the geographical areas they covered (Graph 1).

Graph 1: Geographical Areas

GP Out-of-Hours Services in Northern Ireland did not function in isolation, but were interlinked with other unscheduled care services[18], such as EDs, MIUs or the RESWS. While the model for the overall delivery of the service was the same, the operational arrangements varied between providers.

The key difference between the providers was the skill mix of the healthcare professionals delivering the care. Table 1 outlines the arrangements in place at the time of this Review.

Table 1: Summary of GP Out-of-hours Service Model by Provider (October 2017)

[18] Unscheduled care is the care which cannot reasonably be foreseen or planned in advance of contact with the relevant healthcare professional.

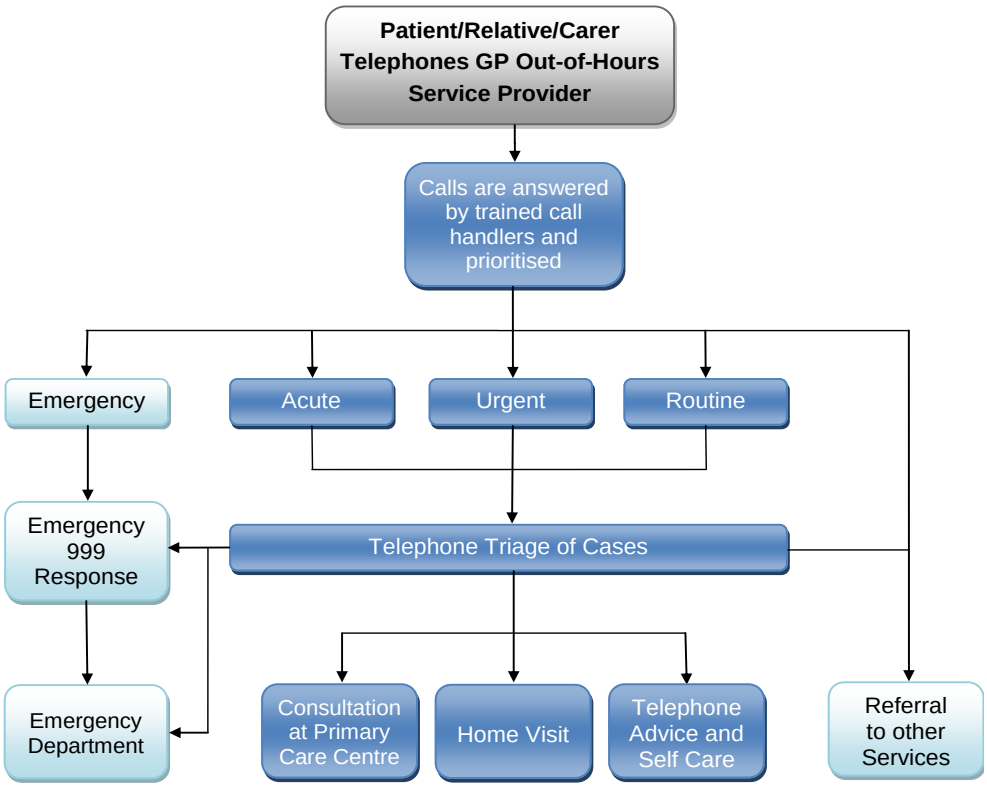
Provider	Belfast Trust	Dalriada Urgent Care	South Eastern Trust	Southern Trust	Western Urgent Care
Population in Trust Area	354,706	473,076	356,693	377,231	300,431
Provider Type	HSC Trust	Mutual	HSC Trust	HSC Trust	Mutual
Number of Primary Care Centres	2	4	3	5	5
Location of Primary Care Centres	North and West Belfast South and East Belfast	Ballymena Coleraine Moneymore Whiteabbey	Downpatrick Lisburn Newtownards	Armagh Craigavon Kilkeel Newry South Tyrone	Altnagelvin Enniskillen Limavady Omagh Strabane
Contracted GPs[19]	47	0	36	76[20]	13
Sessional GPs[21]	100	180	124	67	72
Telephone Numbers	Two	One	Two	One	One
Triage Type	Telephone Base	Telephone Base	Telephone Base Home	Telephone Base Home	Telephone Base
Triage provided by	GPs	GPs Nurses Pharmacists	GPs Nurse Practitioners[22]	GPs Nurses Nurse Practitioners Pharmacists	GPs Nurses
Triage Outcomes	Onward referral Telephone Advice Consultation Home visit	Onward referral Telephone Advice Consultation Home visit	Onward referral Telephone Advice Consultation Home visit	Onward referral Telephone Advice Consultation[23] Home visit	Onward referral Telephone Advice Consultation Home visit
Consultation provided by	GPs	GPs	GPs Nurse Practitioners	GPs Nurse Practitioners	GPs Nurse Advisors Nurse Practitioners[24]

Source: Information supplied by GP Out-of-Hours Service Providers (October 2017)

[19] Contracted GPs are those practitioners who are employed by the Provider to work a specified number of hours.
[20] 27 salaried GPs and 49 GPs who are on zero hour contracts
[21] Sessional GPs are those practitioners who are employed by the Provider to work on an occasional basis for an unspecified number of hours.
[22] Only at peak times (Saturday and Sunday mornings between 9.00 am and 1.00 pm)
[23] Also consultation service based at Castleblayney Health Centre
[24] Only on some sites

Across Northern Ireland, all providers delivered GP Out-of-Hours Services using the same operational model, as outlined in Figure 2 below. This model of provision of GP Out-of-Hours Services in Northern Ireland had not changed since being established in 2004, other than the reduction from seven to five provider organisations in 2009.

Figure 2: GP Out-of-Hours Operational Model



Call Handling

When contact was made with a GP Out-of-Hours Service, a call handler recorded the patient's details and their symptoms on the electronic system, Adastra[25]. Based on the patient's symptoms, an initial triage was undertaken by a call handler and each patient was then categorised as emergency, acute, urgent or routine.

The Standards for GP Out-of-Hours Services state that:

- emergency calls are immediately re-routed for an emergency 999 response;
- acute calls are sent for immediate triage;
- urgent calls are to be triaged within 20 minutes; and
- routine calls are expected to be triaged within one hour[26].

[25] Adastra is the clinical patient management system that is used by all GP Out-of-Hours Service Providers in Northern Ireland

[26] GP Out-of-Hours Service Standards for Northern Ireland. Available from http://www.gpoutofhours.hscni.net/service-standards-for-gp-out-of-hours/ (Cited at 28/05/20)

Callers may also be referred to other services, such as the RESWS, Mental Health Teams, or daytime GPs, as appropriate.

The following recommendation was made within the 2010 RQIA Review of GP Out-of-hours Services in Northern Ireland:

The Regional Out-of-Hours Project should establish an agreed timescale for the introduction of a single telephone number for out-of-hours services in Northern Ireland. [Appendix B: Recommendation 15]

We were informed that this recommendation had been considered but had not been implemented, as the telephony infrastructure was not in place to facilitate a single regional telephone number. The HSC Board informed us they were scoping the telephony capability for a single number to be used in the future.

Therefore:

- Dalriada Urgent Care, the Southern Trust, and Western Urgent Care each had a single telephone number;
- The Belfast Trust had two telephone numbers; call handlers could answer calls received to either of the two telephone numbers; and
- The South Eastern Trust had two telephone numbers; call handlers could answer calls received to either of the two telephone numbers.

The following recommendation was made within the 2016 Review of GP-Led Primary Care Services in Northern Ireland:

By March 2017, consider trialling the Ask My GP in out-of-hours following the outcome of the in-hours pilot [Appendix C: Recommendation 4.9]

This model utilised a web-based application which patients completed with details of their health problem. This information was then forwarded to the GP for review before telephone triage was undertaken.

The HSC Board did consider this model and determined that asking patients to complete a web-based form could potentially delay access to urgent care. Therefore, it was not trialled in the out-of-hours setting, at that time.

Clinical Triage of Calls

After the initial call handling triage, clinical triage of calls was undertaken by practitioners based in Primary Care Centres.

The Southern Trust had fully introduced the option of remote triage, which allowed practitioners to log on to the telephony and computer systems from remote locations, mostly at home, and triage cases online.

The South Eastern Trust was developing arrangements for operating remote triage. The Trust advised that issues in relation to system log-in, call recording and governance of prescriptions were delaying implementation.

The Expert Review Team considered that it may be beneficial for the South Eastern Trust to discuss this with Southern Trust colleagues, to review their learning and identify the solutions which the Southern Trust had utilised to address these issues.

There had been a number of developments with respect to increasing the skill-mix of healthcare professionals involved at the clinical triage stage, including:

- within Dalriada Urgent Care, the Southern and South Eastern Trusts: triage was undertaken by GPs, nurse practitioners, and pharmacists;
- within Western Urgent Care, triage was undertaken by GPs and nurses; the provider was considering introducing pharmacists to this role; and
- within the Belfast Trust, triage was undertaken only by GPs. However, the Trust acknowledged this was an area they would review in the future.

There were three possible outcomes for patients following the triage stage; these are:

- telephone advice, reassurance and advice on self-care, or referral to another service;
- face-to-face consultation with a practitioner at a Primary Care Centre; and
- face-to-face consultation with a practitioner at the patient's residence (also referred to as a home visit).

2.2 GP Out-of-Hours Activity

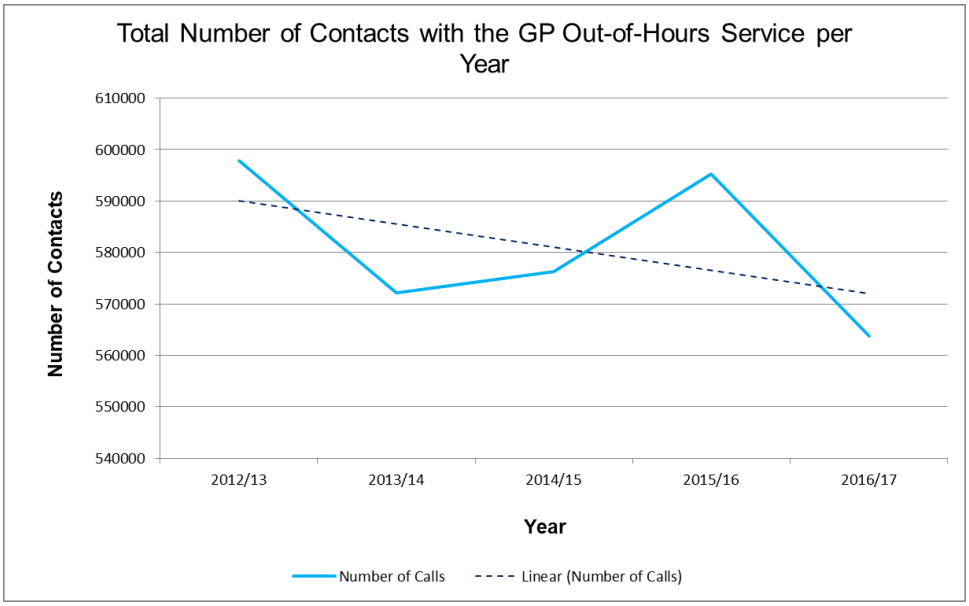
We received data from both the providers and the HSC Board, relating to the number of contacts with the service. It should be noted that some of the figures provided, covering the same time period, varied slightly due to data cleansing undertaken after the specified time period.

Contact with GP Out-of-Hours Services

We analysed the activity expressed as the total number of contacts per year for the period from 2012/13 to 2016/17. During this period, the yearly volume of contacts with GP Out-of-Hours Services had fluctuated.

Figure 3 illustrates that the average trend, in terms of overall number of contacts with the GP Out-of-Hours Service, had fallen by 5.7% (34,184) between 2012/13 and 2016/17.

Figure 3: Annual number of Contacts with GP Out-of-Hours Services across Northern Ireland between 2012/13 and 2016/17

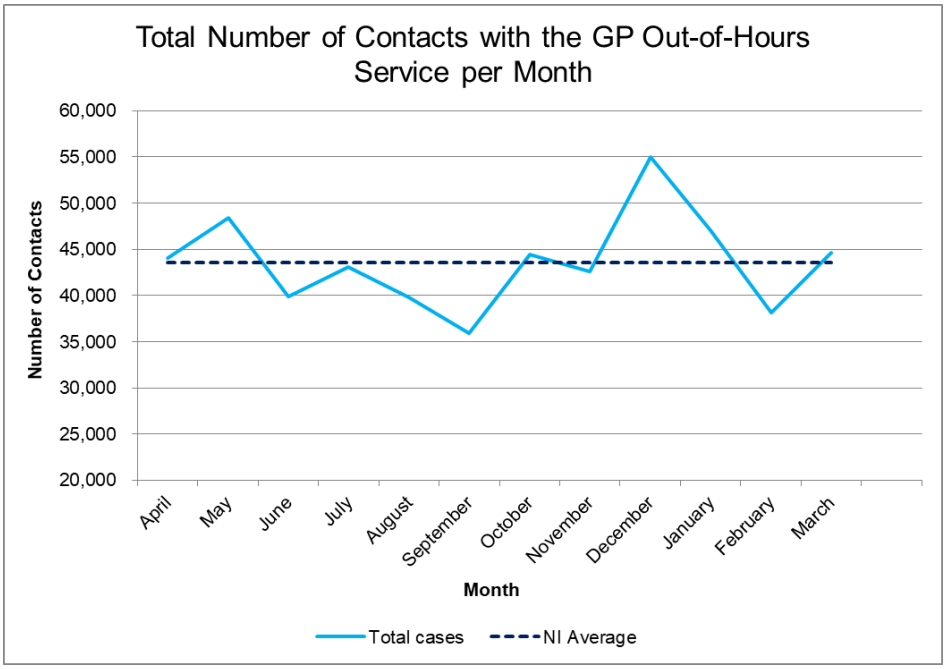


Source: HSC Board Performance Monitoring Returns (August 2017)

The pattern of use of GP Out-of-Hours Services varied between calendar months. Contacts with the GP Out-of-Hours Service increased in those months which included public holidays when daytime GP Services were closed.

Figure 4 shows higher numbers of contacts in April, May, July and December correlating with months that included public holidays.

Figure 4: Number of Contacts with GP Out-of-Hours Services per Month in 2016/17



Source: HSC Board Performance Monitoring Returns (August 2017)

Contact with GP Out-of-Hours Services by Provider

During 2016/17, GP Out-of-Hours Services received 563,679 contacts from patients; the proportion of contacts varied between providers. Table 2 summarises the number of contacts with GP Out-of-Hours Service Providers per 1,000 resident population.

The highest rate, 360 contacts per 1,000 resident population occurred in Western Urgent Care, and the lowest rate occurred in the Southern Trust, with 225 contacts per 1,000 resident population.

Table 2: Number of Contacts per 1,000 Resident Population with GP Out-of-Hours Service Providers during 2016/17

Provider	Number of Contacts	Mid-Year Population Estimate 2016	Rate of Contacts per 1,000 Resident Population
Belfast Trust	110,893	354,706	313
Dalriada Urgent Care	156,169	473,076	330
South Eastern Trust	103,487	356,693	290
Southern Trust	84,962	377,231	225
Western Urgent Care	108,168	300,431	360
Total	**563,679**	**1,862,137**	**303**

Source: HSC Board Performance Monitoring Returns and Northern Ireland Statistics and Research Agency (August 2017)

Contact with GP Out-of-Hours Services by Gender and Age Band

Providers submitted information about contacts with GP Out-of-Hours Service Providers by gender and age band of Patients during 2016/17. From data provided, we determined that:

- in 2016/17, 42% (234,900) of contacts made with the GP Out-of-Hours Service (expressed as gender of patient) were male, and 58% (329,191) were female; and
- calls in relation to children (under 10 years of age) and older people (over 60 years of age) were the most frequent to the service[27]; accounting for 53% of all contacts.

Contact with GP Out-of-Hours Services by Time Profile

All providers reported that the patterns of contact with their Service were consistent and predictable with the busiest times between 6:00 pm and 10:00 pm on week-days and between 9:00 am and 2:00 pm at the weekends. Data supplied by Dalriada Urgent Care in relation to daily call volume during December 2017 confirmed this pattern of contacts with the service (Appendix F).

[27] Based on figures provided from four Providers, using RQIA specified age bands (excludes figures for South Eastern Trust).

The following recommendation was made within the 2016 Review of GP-Led Primary Care Services in Northern Ireland:

By June 2017, develop and commence a trial of an interface service delivery model (times to be considered but potentially between the hours of 4pm to 9pm), with a view to rolling it out across the region. [Appendix C: Recommendation 4.10

At the time of this Review, the implementation of an interface service delivery model had not been progressed in Northern Ireland.

In discussions with providers, the Expert Review Team highlighted that this initiative had been trialled in Scotland; however, the outcome from this trial was that this type of initiative did not reduce the number of contacts with GP Out-of-Hours Services.

2.3 Impact on Unscheduled Care Services

GP Out-of-Hours Services did not function in isolation; they were inextricably linked to other services across the health sector, including daytime GP services and unscheduled care provided by EDs. Therefore, what happened in other parts of the health sector impacted on GP Out-of-Hours Services and vice-versa.

GP Out-of-Hours Services did not provide open access to Primary Care Centres and, unlike other parts of the UK, walk-in primary care health facilities did not exist in Northern Ireland. At the time of this Review, EDs were the only walk-in facilities available to patients.

In 2008, the College of Emergency Medicine undertook a review of unscheduled care in Northern Ireland and identified that ED attendances were between 20-30% higher than in the rest of the UK[28]. A similar finding was outlined in a House of Commons Briefing Paper in 2017, which stated that, relative to population size, Northern Ireland has the highest rate of attendance at major ED departments of all UK countries[29].

During 2016/17, of the 797,666 total attendances at EDs in Northern Ireland:

- 733,491 (92.0%) were new attendances;
- 37,028 (4.6%) were unplanned review attendances; and
- 27,147 (3.4%) were planned review attendances[30].

[28] The Way Ahead 2008-2012, Strategy and guidance for Emergency Medicine in the United Kingdom and the Republic of Ireland. College of Emergency Medicine (December 2008)
[29] Accident and Emergency Statistics: Demand, Performance and Pressure – (Number 6964, 21 February 2017). House of Commons Briefing Paper. Available from http://researchbriefings.files.parliament.uk/documents/SN06964/SN06964.pdf (Cited: May 2020)
[30] Hospital Statistics: Emergency Care 2016/17. Department of Health Information Analysis Directorate. Available from https://www.nisra.gov.uk/statistics/health-and-social-care/health-and-social-care-statistics (Cited: May 2020)

In the same period, GP Out-of-Hours Services received 563,679 contacts.

Statistics in relation to ED waiting times emphasised the increasing number of attendances and longer waiting times at EDs [31]. This suggested the unscheduled care system may not have the ability to appropriately deal with any significant increases in ED attendances of a non-critical nature. Therefore, GP Out-of-Hours Services had a critical role in supporting this element of the unscheduled care system in the future.

2.4 Call Handling and Outcomes

Telephone Advice

Telephone advice was provided when the clinical triage practitioner considered the patient's condition required advice rather than a face-to-face consultation. This may have included information on alternative sources of help for non-urgent conditions, reassurance, or advice on self-care relevant to the patient's symptoms.

Provision of telephone advice was the most frequent outcome following contact with GP Out-of-Hours Services. During 2016/17, approximately 56% of triage outcomes resulted in telephone advice (Figure 5).

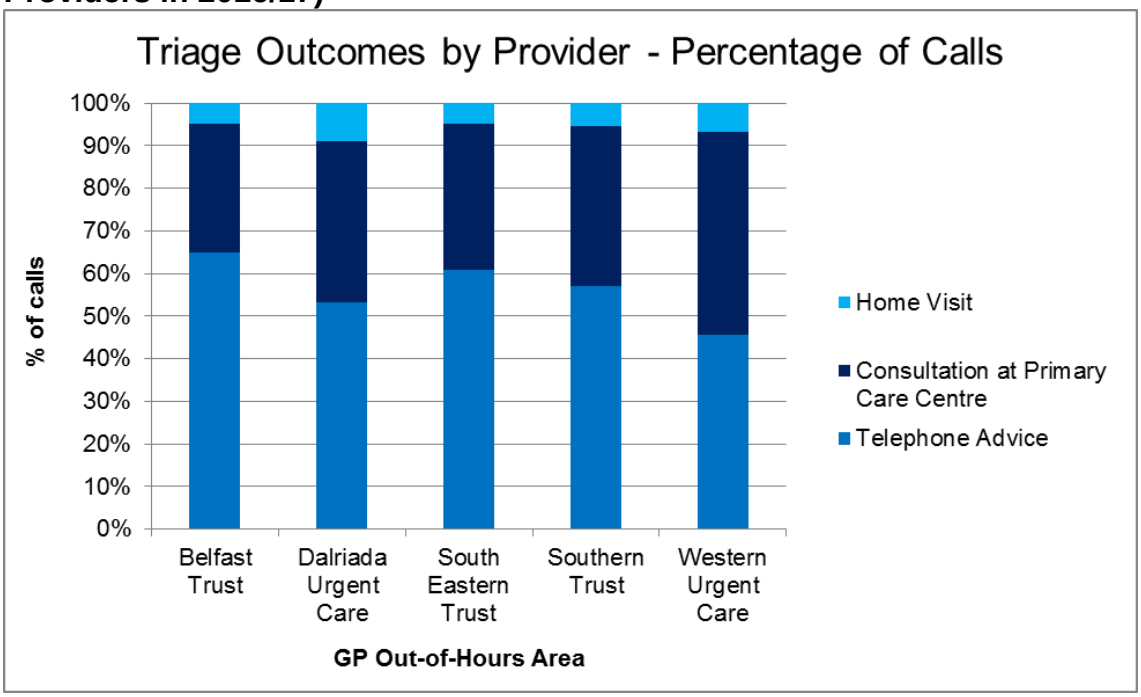
Figure 5: Percentage of Triage Outcomes Provided by GP Out-of-Hours Services in 2016/17

Source: HSC Board Performance Monitoring Returns (August 2017)

An exception was noted in Western Urgent Care where consultation at a Primary Care Centre was the most frequent triage outcome, as shown in Figure 6.

[31] Accident and Emergency Statistics: Demand, Performance and Pressure – (Number 6964, 21 February 2017). House of Commons Briefing Paper. Available from: http://researchbriefings.files.parliament.uk/documents/SN06964/SN06964.pdf (Cited: May 2020)

Figure 6: Triage Outcomes (Provided by GP Out-of-Hours Service Providers in 2016/17)



Source: HSC Board Performance Monitoring Returns (August 2017)

Referral to Other Services

Telephone advice may have included, redirection to emergency care or referral to another more appropriate service, such as:

- the Northern Ireland Ambulance Service (NIAS);
- the ED or MIU;
- mental health services;
- community nursing;
- social services;
- daytime GP services;
- dental services; and
- community pharmacy.

Analysis of the data supplied by the HSC Board identified that during 2016/17, approximately a quarter (25%) of all contacts with GP Out-of-Hours Services had resulted in a referral to other services:

- 84,815 referrals (15%) to emergency care[32]; and
- 56,109 referrals (10%) to other primary cares services[33].

There were variations between Providers in the proportions of onward referrals, as outlined in Figure 7. Western Urgent Care referred 43% of

[32] Referral to Emergency Care is considered as: (i) Emergency 999; (ii) Emergency Departments, Minor Injury Unit/ Urgent Care Treatment Centre; (iii) Ambulance via GP Urgent

[33] Referral to other services is considered as: (i) Mental Health Services; (ii) Community Nursing Services; (iii) Social Services; (iv) Daytime GP Services; (v) Dental Services

contacts to other services, while the other four providers referred between 19%-26% of contacts to other services.

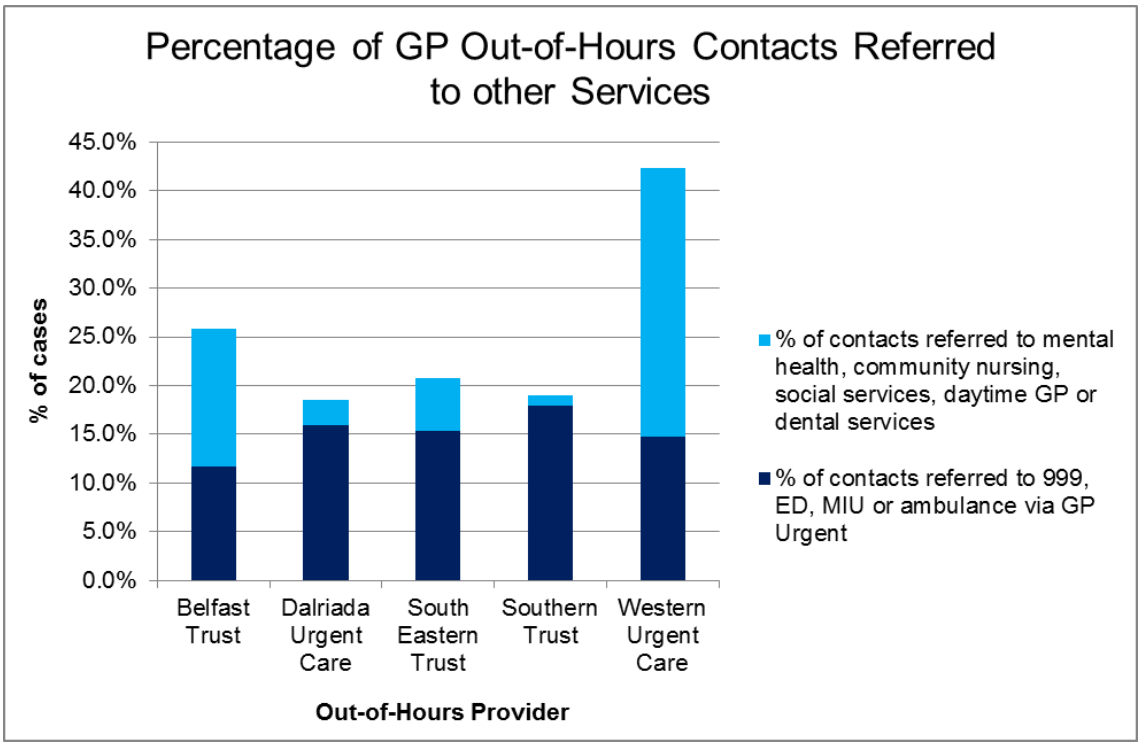
Between providers, the proportions of contacts requiring onward referral to emergency care were similar, with only a 6% variation. The proportion referred to emergency care/ ED was fairly consistent with the lowest (12%) in the Belfast Trust and the highest (18%) in the Southern Trust.

However, a significant variation was identified in the proportion of patients requiring onward referral to primary care services. This was lowest (1%) in the Southern Trust and the highest (28%) in the Western Trust.

Although there were differences in referral rates, this sometimes reflected the coding habits of doctors. While some GPs felt that no further action was required, others often advised the patient to contact their own GP if they felt they weren't improving which was then coded as an onward referral.

An understanding of these triage outcomes is important for those planning services. They will wish to consider the level to which GP Out-of-Hours services connect patients to other services and the potential for other means of providing information about access to these services. This may reduce the burden on Out-of-Hours Services.

Figure 7: Percentage of GP Out-of-Hours Contacts by Provider Referred to other Services in 2016/17



Source: HSC Board Performance Monitoring Returns (August 2017)

Consultation at a Primary Care Centre

When a patient was assessed as requiring a face-to-face assessment, they were offered a consultation at a Primary Care Centre or a home visit. The

timing of the consultation depended on the urgency of the patient's condition. During discussions with GPs and GP trainees, both groups indicated that they were more inclined to offer children a consultation at a Primary Care Centre. The reason given was that this group was more difficult to accurately assess by telephone.

During 2016/17, approximately 37.4% of all triaged calls resulted in a consultation at a Primary Care Centre (Figure 5); the percentage of consultations at Primary Care Centres varied between providers (Figure 6).

All providers operated a timed appointments system for patients who required a Primary Care Centre consultation. The scheduling of appointments was dictated by the workload and availability of practitioners . Prioritisation of appointments was primarily dictated by the urgency of the patient's condition.

Patients that required a consultation were usually offered an appointment at a Primary Care Centre located nearest to their home or place of residence. However, during busy periods, providers may have offered patients appointments at an alternative Primary Care Centre, which was less busy. Around provider catchment boundary areas, it was common for patients resident in or registered with a GP in one area to contact a provider in another area. The decision on which provider appointment to attend would be agreed with the patient.

The Adastra system had the capability to permit a provider to view the overall activity of all other providers. However, detailed appointment information for Primary Care Centres of other providers was not readily available. Some providers, GPs and GP trainees highlighted cases where patients had been advised to attend a Primary Care Centre of another provider, only to find it was fully booked or no practitioners were available to deliver consultations. We could not find any data that accurately recorded the number of instances where this happens.

The Expert Review Team considered that providers should review the instances when patients were referred to other providers and consider the optimal pathways for patients to access the services they require.

The Southern Trust described an initiative to improve access to consultations for patients residing in areas bordering the Republic of Ireland, whereby the Trust had established a consultation service at Castleblayney Health Centre in the Republic of Ireland. This service enabled patients who contacted the GP Out-of-Hours Service and who required a consultation to be offered an appointment to see a GP in Castleblayney Health Centre. For many patients this was a more conveniently located facility, with a shorter journey time.

The Expert Review Team identified this initiative as an example of effective cross-border working which other providers could consider for their services (as applicable).

Home Visits

Home visits are face-to-face consultations in the patient's own home or place of residence, such as a nursing home or residential care home. The triage practitioner offered home visits using certain criteria, for example:

- the patient's condition was assessed to be more appropriate for face-to-face consultation, but it was clinically or functionally inappropriate to ask the patient to attend a Primary Care Centre; or
- the visit was for the confirmation of a death, or
- to assist with assessment of acute mentally unwell patients and detentions[34] under the Mental Health (Northern Ireland) Order 1986[35].

During 2016/17, approximately 6.5% of total triage outcomes resulted in a home visit (Figure 5); the percentage of consultations at the patient's residence varied between providers (Figure 6).

The timing of home visits was primarily dictated by the urgency of the condition of the patient; however, workload and the availability of practitioners to carry out home visits was also a consideration.

Nursing Homes

During this Review, some providers and a number of GPs working in GP Out-of-Hours Services told us that they were receiving an increasing number of calls from nursing homes and residential care homes. However, there was no substantial data to confirm the actual volume of these contacts.

Western Urgent Care informed us that responding to referrals from nursing homes and residential care homes previously was a large proportion of their workload. As a result, the Western Trust implemented a programme of training for nursing home and residential care home staff, to enable them to carry out tasks, such as managing intravenous infusions and catheters themselves, rather than contacting GP Out-of-Hours Services. Western Urgent Care reported that, following the training, the number of referrals from nursing homes and residential care homes decreased.

The Belfast Trust reported that, when they identified an increase in referrals from a particular nursing home or residential care home, Trust staff would engage with the home's manager, to try to identify and resolve any issues that had contributed to increased referrals.

The Southern Trust informed us that their Acute Care at Home Team[36] provided anticipatory care for patients in their own homes or in nursing or

---

[34] This is when the patient's GP is required to sign the detention form to facilitate admission of further assessment in hospital. During the out-of-hours period the patient's own GP is usually unavailable and this assessment therefore is completed by the GP Out-of-Hours Service.

[35] Mental Health (Northern Ireland) Order 1986. Available from: https://www.legislation.gov.uk/nisi/1986/595 (Cited: May 2020)

[36] The Acute Care at Home Team is a dedicated Consultant Geriatrician-led multidisciplinary team with a primary focus on maintaining older people at home in the event of an acute illness or unexpected deterioration in health. The service provides triage, assessment,

residential care homes where appropriate; however, this was only available for patients who were already on their caseload. This was a short term intervention service. GPs from the Out-of-Hours Services, District Nursing, and Marie Curie provided the majority of palliative and end of life care for patients in Nursing and Residential homes.

The Expert Review Team commended the proactive approach taken by providers by engaging with nursing and residential care homes to manage their patients' needs effectively with the consequent impact on reduced referrals to GP Out-of-Hours. To encourage further development of such initiatives across the region, the Expert Review Team considered that providers should:

- collect data relating to referrals from nursing homes and residential care homes to identify areas of high activity for follow-up; and
- formally document any positive initiatives and associated outcomes, and share learning with the other providers.

The Expert Review Team acknowledged that providers should fully appreciate the specific needs of patients within nursing and residential care homes and balance this against the capacity of the GP Out-of-Hours Service. They would then be able to take effective steps to improve the service offered while perhaps lessening the demand on the Out-of-Hours Service.

diagnosis and treatment as an alternative to in-patient care specifically to those at risk of or potentially requiring admission to hospital.

Section 3: The GP Out-of-Hours Service and Model

3.1 Service Challenges

GP Staffing Levels

Through our discussions with GPs and providers, we learned that the biggest challenge facing GP Out-of-Hours Services was the limited number of GPs available to work in these services. Despite skill-mix initiatives involving other healthcare professionals, the services remained primarily dependent upon GPs and could not function with insufficient GP numbers.

Despite a 20% increase in the number of GPs in Northern Ireland between 2004 (1,078) and 2017 (1,297), providers described difficulties with encouraging GPs to work in GP Out-of-Hours Services.

Although the overall number of GPs in Northern Ireland had been increasing, it was the decreasing number of GPs contributing to GP Out-of-Hours Services that was impacting most upon the sustainability of these services (Table 3).

Table 3: Comparison of the number of GPs working for GP Out-of-Hours Service Providers between 2010 and 2017

	2010	2017
Provider	**Number of GPs**	**Number of GPs**
Belfast Trust	153	147
Dalriada Urgent Care	175	180
South Eastern Trust	154	160
Southern Trust	140	94
Western Urgent Care	180	85
Total	**802**	**666**

Source: Information supplied by HSC Board, HSC Board Performance Monitoring Returns (August 2017), and Report of the RQIA Review of GP Out-of-Hours Services, 2010

Between 2010 and 2017, the number of GPs working in GP Out-of-Hours Services fell by approximately 16.9%.

This problem is further highlighted in Table 4, which shows, between April 2017 and December 2017; approximately 5.5% of GPs withdrew from working in GP Out-of-Hours Services. All providers except the South Eastern Trust experienced a reduction in their contributing GP numbers during this period.

Table 4: Number of GPs working for GP Out-of-Hours Service Providers between April 2017 and December 2017*

	Belfast Trust		Dalriada Urgent Care		South Eastern Trust		Southern Trust		Western Urgent Care	
GP type	**Apr '17**	**Dec '17**	**Apr '17**	**Dec '17**	**Apr '17**	**Dec '17**	**Apr '17**	**Dec '17**	**Apr '17**	**Dec '17**
Sessional GPs[37]	120	100	194	180	89	124	82	67	82	72
Salaried GPs[38]	56	47	1	0	44	36	25	27	12	13
Total	176	147	195	180	133	160	107	94	94	85

Source: Information supplied by HSC Board (March 2018). *This was the most recent information available to the Expert Review Team at the time of the review.

Sustaining the Service

During this Review, all providers highlighted the reduction in the numbers of GPs working in the GP Out-of-Hours Services, indicating this had affected their ability to meet service demands and advised that this was making it difficult to sustain delivery of the service into the future.

Managers and administrative staff reported that a considerable amount of their working day was spent finding GPs to fill unallocated sessions. On any day, it was not uncommon for staff to be contacting GPs to fill vacant sessions for that same evening/night.

We were told, by the Clinical Leads, that demand for services was predictable and so they had taken actions such as the introduction of fixed rotas while trying to increase the number of staff available during public holidays and peak times. Despite this, Clinical Leads stated that, if the trend of decreasing numbers of contributing GPs continued, it was unlikely that all sessions could be filled in future. During 2016/17, providers were able to fill only 86.1% of planned GP sessions within GP Out-of-Hours Services across Northern Ireland (Table 5).

Table 5: Number of planned and filled GP hours for GP Out-of-Hours Service Providers during 2016/17 (Including Public Holidays)

Provider	Number of GP Hours Planned	Number of GP Hours Filled	% of GP Hours Filled
Belfast Trust	34,156	32,858	96%
Dalriada Urgent Care	38,778	38,837	100%
South Eastern Trust	51,141	32,630	64%
Southern Trust	34,834	25,319	73%
Western Urgent Care	36,639	31,711	87%
Total	**195,548**	**168,355**	**86%**

Source: Information supplied by HSC Board (March 2018)

[37] Sessional GPs are those practitioners who are employed by the Provider to work on an occasional basis for an unspecified number of hours.
[38] Salaried GPs are those practitioners who are employed by an organisation and who receive a salary.

The Expert Review Team concluded that, as fewer GPs contribute to the service, these practitioners will be required to work more frequent sessions to keep the service operational during the out-of-hours period. This was considered to be unsustainable and ultimately would require significant reform which may include a reduction in the available operating hours or a reduction in the total number of Primary Care Centres providing GP Out-of-Hours Services

Of the 403 GPs that responded to the online survey, 211 (52%) advised that they had worked sessions for the GP Out-of-Hours Service within the previous 12 months. Of those 211, 186 (88%) had worked at least one session per week and 80 (43%) had worked at least one session per month.

GPs provided a number of reasons why they considered fewer GPs were contributing to GP Out-of-Hours Services. The pressure of work in daytime GP services was cited as a major influencing factor. Of the 211 GPs who told us that they worked in GP Out-of-Hours Services, 46% stated that the workload in daytime practice was a prohibiting factor to working additional shifts. Of the GPs that responded to the survey who do not work in GP Out-of-Hours Services, 31% stated that the high workload in daytime practice was the deciding factor for them choosing not to work in GP Out-of-Hours Services.

The Expert Review Team noted that despite the changing skill-mix in GP Out-of-Hours Services it will always be a GP-led Service requiring a commitment from GPs. Providers told us that if all GPs committed to providing just a few sessions per month, the pressures on GP Out-of-Hours Services could be alleviated.

The Expert Review Team agreed that service pressures could be resolved by all GPs committing to working in the service. However, in reality, to be sustainable, GP sessional commitments to the service must be balanced against their daytime workload and other work and personal commitments. Currently there is no contractual obligation for GPs to participate in GP Out-of-Hours Services and the Expert Review Team considered that this is unlikely to change in the future. This means that incentives and enablers for GPs to participate in the Out-of-Hours Service remain critically important.

It had been widely documented that daytime GP services were under severe pressure to deliver against the rising demand for these services.

Three particular sources were considered:

(i) Estimating the Volume and Growth in Consultation Rates in General Practice in Northern Ireland, 2003/04 to 2013/14: Analysis of Survey Returns from General Practices reported by the then Department for Health, Social Services and Public Safety, in January 2015[39];

[39] Estimating the Volume and Growth Strategic Framework for GP Out-of-Hours, HSC Board (June 2012). Available from

(ii) General practice in Northern Ireland: The case for change reported by the BMA in Northern Ireland in February 2015[40]; and
(iii) Understanding Pressures in General Practice[41] reported by the King's Fund in May 2016, all highlight that general practice is under pressure in respect of increased demand.

These three studies highlighted the key challenges in general practice to be:

- a rising number of consultations on an annual basis;
- the ageing population and the increasing numbers of people with increasingly complex needs;
- increasing patient expectations; and
- difficulty recruiting sufficient numbers of GPs.

The Expert Review Team considered that if the challenges within daytime GP services were addressed, this could increase the number of GPs willing to contribute to GP Out-of-Hours Services. In particular, the recommendations from the 2016 Review of GP-Led Primary Care Services in Northern Ireland aimed at addressing the challenges facing daytime GP services should be taken forward and implemented.

Workload in GP Out-of-Hours Services

Since the 2010 RQIA Review of GP Out-of-Hours Services, the number of GPs working in the service and the number of contacts with the service have changed considerably, in the intervening years up to 2017, as outlined in Table 6.

Table 6: Comparison of the number of GPs and contacts with the GP Out-of-Hours Service Providers between 2010 and 2017

	2010		2017	
Provider	**Number of GPs**	**Number of Contacts**	**Number of GPs**	**Number of Contacts**
Belfast Trust	153	94,685	147	110,893
Dalriada Urgent Care	175	130,710	180	156,169
South Eastern Trust	154	84,412	160	103,487
Southern Trust	140	112,036	94	84,962
Western Urgent Care	180	102,222	85	108,168
Total	802	524,065	666	563,679

Source: Information supplied by HSC Board, HSC Board Performance Monitoring Returns (August 2017) and Report of the RQIA Review of GP Out-of-Hours Services, 2010

---

http://www.hscbusiness.hscni.net/pdf/Strategic_Framework_GP_Out_of_Hours.pdf (Cited: May 2020)

[40] General practice in Northern Ireland: The Case for Change. British Medical Association, Northern Ireland General Practitioners Committee (February 2015).
[41] Understanding Pressures in General Practice. The King's Fund. (May 2016) Available from https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf (Cited: May 2020)

Between 2010 and 2017, the number of GPs working in GP Out-of-Hours Services decreased by 16.9%, and the number of contacts with the service increased by 7.5%.

While total contacts increased between 2010 and 2017, in the last five years there has been a steady reduction in contacts which have decreased by 5.7% since 2012. The Expert Review Team considered that the reducing numbers of GPs working in the GP Out-of-Hours Service, combined with an increase in the number of patients with mental illness and complex conditions requiring additional time for consultation, were contributing factors that had offset any potential easement attributable to a reduction in the number of contacts since 2012.

Of the 211 GPs that responded to the online survey who had worked in the Out-of-Hours Service, 21% referred to increasing work pressures in GP Out-of-Hours Services. These included patient demands and expectations, time pressures and a lack of staff. During focus groups many GP trainees, although they had different working responsibilities to the GPs, referenced similar work pressures. These work pressures were described as a prohibitive factor for many GPs who were not working additional sessions or not undertaking any Out-of-Hours sessions at all.

The Expert Review Team considered that the workload within GP Out-of-Hours Services needs to be addressed to reduce the number of GPs from withdrawing their support for the service. Realistically, a reduction in the workload is only likely to be achieved by either increasing the number of GPs or reducing the number of contacts with the service. Currently, as providers have little control over patient contact with the service, new solutions to increase the number of GPs working in GP Out-of-Hours Services are of vital importance.

Inappropriate Use of out-of-hours services

The availability of appointments in daytime GP services varied between practices, but this availability was highlighted by providers, GPs, GP trainees and patients, as a reason for patients deciding to contact GP Out-of-Hours Services. When patients experienced a lack of availability of appointments or long waiting times within daytime general practice it was expected that patients would seek care elsewhere.

This Review found some evidence of patients using GP Out-of-Hours Services as an alternative to their daytime GP Service, however, the actual scale of this practice could not be determined.

Of the patients who responded to our survey, 9% (31) openly stated the reason for their contact with GP Out-of-Hours Services, was being unable to get a suitable appointment with their own GP, or that it suited them to attend GP Out-of-Hours Services because of work commitments.

For GP Out-of-Hours Services, the declining number of GPs available to provide Out-of-Hours cover had implications for both the service and patients. The principle effects were the reduced availability of appointments and increased waiting times for patients.

With ED being generally the only alternative source of care during the Out-of-Hours period, when access to GP Out-of-Hours was difficult patients would potentially attend EDs.

Financial Impact on GPs Working in GP Out-of-Hours Services

GPs who worked in GP Out-of-Hours Services informed us that they were being financially impacted by a static pay rate, increasing indemnity costs and changes introduced by Her Majesty's Revenue and Customs (HMRC). The effect was a reduced financial incentive for many GPs to work in GP Out-of-Hours Services. Consequently, GPs were withdrawing their support for the service.

Static Pay Rate for GPs: We were informed from a number of sources that there had been no pay increase for GPs working in GP Out-of-Hours Services since 2009/10.

In 2005, an indicative regional pay rate for GPs working in GP Out-of-Hours Services was set. The pay rate was nominally linked to the mid-point on the NHS Consultant scale and it was intended that any uplift in pay would be linked to awards in relation to consultant pay, as recommended by the Review Body on Doctors' and Dentists' Remuneration[42]:

- of the 211 GPs who responded to the survey who worked in GP Out-of-Hours Services, 14% stated that the payment rate was a prohibiting factor for them working further shifts;
- of the 192 GPs who responded to the survey who do not work in GP Out-of-Hours Services, 6% stated that the payment rate was a contributory factor in their decision; and
- during focus groups, many GP trainees told us that the rate of pay was a factor in their decision as to whether to work in GP Out-of-Hours Services in the future.

The ability to recruit sufficient GPs to cover the less popular shifts, such as the "red eye shift" (12:00 am to 8:00 am) and at public holiday periods, had always been a challenge for providers.

All providers operated within a defined budget, although they had some flexibility to vary rates to ensure an adequate supply of GPs across the seven-day week, particularly to fill less popular slots on rotas. The level of flexibility to vary rates occasionally created some divergence in rates of pay among the providers which sometimes created competition for staff.

[42] Review Body on Doctors' and Dentists' Remuneration. Available from https://www.gov.uk/government/organisations/review-body-on-doctors-and-dentists-remuneration (Cited: May 2020)

In the absence of any pay uplift, the HSC Board introduced a number of Local Enhanced Schemes (LES) to support the payment of enhanced rates to GPs working during less popular shifts, incentivising GPs to work additional shifts and to recruit new GPs into GP Out-of-Hours Services. The concept behind the LES was valuable, particularly as these schemes provided some assistance in averting service failure.

Although these schemes have been running for a number of years, the Expert Review Team considered that these could potentially be divisive, creating again a scenario where GPs working on the same shift were being paid at different rates and that this method of enhancing GP Out-of-Hours Services was potentially not sustainable.

This was acknowledged by the HSC Board which, in August 2016, submitted a business case to DoH in relation to a review of the remuneration within GP Out-of-Hours Services. At the time of this Review, the HSC Board reported that the business case had not yet been approved; consequently, the HSC Board acknowledged that the business case now needs to be updated to reflect the potential implications from changes being introduced by HMRC.

Indemnity Costs: Rising indemnity costs associated with working in GP Out-of-Hours Services was also reported as a financial challenge for GPs and a potential stumbling block to encouraging more GPs to work in GP Out-of-Hours Services.

In July 2014, the Health Care and Associated Professions (Indemnity Arrangements) Order 2014 was introduced; this stipulated that all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice[43].

While doctors working for NHS organisations providing services to NHS patients were indemnified by the NHS Crown Indemnity scheme, GPs were not indemnified by the scheme and required separate personal medical indemnity. Therefore, GPs working in GP Out-of-Hours Services required indemnity which is additional to any arrangements in place for their daytime work.

From April 2018, following a ruling from HMRC, Crown Indemnity could be extended to the GPs working for the three Trust providers; however, GPs working for Dalriada Urgent Care and Western Urgent Care (Mutual providers) were still required to provide their own medical indemnity cover for any out-of-hours work.

To offset any disadvantage for GPs working for the Mutual providers, the HSC Board had allocated funding through a Localised Additional Costs Scheme to Dalriada Urgent Care and Western Urgent Care. At the time of this Review,

[43] The Health Care and Associated Professions (Indemnity Arrangements) Order 2014. Available from https://www.legislation.gov.uk/ukdsi/2014/9780111114483 (Cited: May 2020)

no decision had been made in relation to whether this funding would be recurrent.

Medical Defence Organisations (MDO) provide medical indemnity cover; the subscription rate paid by GPs varied depending upon the type of work undertaken and the number of sessions worked per week. Due to historically perceived risks associated with out-of-hours work, higher subscription rates applied to GPs undertaking sessions in GP Out-of-Hours Services.

One of the MDOs, the Medical Defence Union, had experienced a steady annual rise in the number of claims from primary care medical patients. This had contributed to an increase in claims of approximately 10% per year and had resulted in increased indemnity subscriptions for GPs[44].

The issue of increasing medical indemnity costs was described by all providers as a prohibitive factor for many GPs:

- of the 211 GPs who responded to the online survey, who worked in GP Out-of-Hours Services, 25% stated that the cost of medical indemnity was a prohibiting factor for them working further shifts;
- of the 192 GPs who responded to the survey, who did not work in GP Out-of-Hours Services, 9% stated that the cost of medical indemnity was a deciding factor; and
- during focus groups, many GP trainees reported that the cost of medical indemnity was a factor in their decision whether to participate in GP Out-of-Hours Services in the future.

During the latter stages of fieldwork for this Review, the HSC Board told us that health departments across the UK were jointly discussing the issues associated with GP indemnity.

The Expert Review Team considered that the issue of indemnity should be addressed to encourage more GPs to be recruited into GP Out-of-Hours Service. However, as rising indemnity costs were being considered at a governmental level, we have not made any specific recommendations concerning this issue.

Impact of HMRC Changes: From 6 April 2017, the legislation relating to off-payroll working through an intermediary (IR35) changed[45]. At the time of this Review, all providers were preparing to make changes to their arrangements for employing GPs.

[44] Medical Indemnity Guidance for GPs. British Medical Association (February 2018).
[45] Off-payroll working through an intermediary (IR35) is anti-avoidance tax legislation brought in by then-chancellor Gordon Brown in 2000. Its purpose is to prevent 'disguised employment', in which a worker receives payment from a client through an intermediary, but whose relationship with the client is such that had they been paid directly then they would be employees of the client. Available from https://www.gov.uk/guidance/ir35-find-out-if-it-applies (Cited: May 2020)

HMRC concluded that sessional GPs working in GP Out-of-Hours Services should be treated in the same way as salaried GPs. Consequently, GPs working in GP Out-of-Hours Services would become employees. The effect of GPs being classed as employees was that they would become subject to income tax, National Insurance contributions and superannuation on any payments they received for their out-of-hours work.

These costs potentially impacted on salaries and benefits arising from daytime GP work, and in particular, upon contributions and lifetime allowances associated with pensions. The HSC Board and providers had been working to determine how the changes would affect GPs working in GP Out-of-Hours Services. The perception among GPs was that these changes would have a negative impact.

Providers informed us that salaried GPs were paid a reduced hourly rate, in comparison to sessional GPs, to take account of annual leave, sick leave, and other entitlements. Sessional GPs transitioning to this new employee status may have experienced a reduction in their pay, and therefore the providers considered there was the potential for some sessional GPs to withdraw from working in GP Out-of-Hours Services.

An additional financial pressure for providers arising from the HMRC decision, would be the employer requirement to pay annually recurring National Insurance contributions for all GPs working in GP Out-of-Hours Services.

In an attempt to mitigate the risk associated with HMRC changes, providers were preparing to employ GPs on generic zero-hours contracts, to minimise any potential loss in earnings. It was not known whether all GPs would accept the transition to employee status, and the full impact of the changes may not be known for some time.

Additionally, the Government had agreed to review pension arrangements for higher paid NHS staff, including consultants in England and Wales; the outcomes from this were not available at the time of this Review.

Gender Profile of GPs

The Expert Review Team observed that between 2014 and 2017, in Northern Ireland, there had been a significant change in gender balance of doctors within the GP workforce. (Table 7).

Table 7: Number of GPs Registered to Practice in Northern Ireland by Gender from 2004 to 2017

Year	Male GPs	% Male GPs	Female GPs	% Female GPs	Total
2004	**697**	**65%**	**381**	**35%**	**1,078**
2010	682	59%	478	41%	1,160
2017	**631**	**49%**	**666**	**51%**	**1,297**

Source: Business Services Organisation Information & Registration Unit (February 2018)

In 2004, there were approximately 30% more male GPs than female GPs; by 2017 there were 2% more female GPs than male GPs.

Providers indicated that the change in gender balance within the GP workforce had brought:

- more instances of maternity leave;
- an increase in part-time working as a result of child care requirements; and
- an increase in the number of requests for flexible working to help with work-life balance.

Dalriada Urgent Care informed us that the change in gender profile had provided both challenges and benefits for their service; they reported that more female GPs, who worked part-time in daytime GP services, were supplementing their hours by working shifts in the GP Out-of-Hours Service.

Providers estimated that this trend will continue and eventually there would be a greater number of female GPs than male GPs across Northern Ireland.

Increased Demand for Work/Life Balance

Providers told us that there had been a growing desire among GPs for better work life balance and this especially related to younger male and female GPs.

It was highlighted during the Review that many male GPs were choosing to opt for part-time working, to allow them to develop a portfolio career in which they also undertook other work, such as shifts in ED or teaching roles. During focus groups, some GP trainees told us they were interested in pursuing this type of career.

3.2 Initiatives Undertaken by Providers

Skill-Mix Developments

Acknowledging that the number of GPs available to work in Out-of-Hours Services was not going to increase immediately, previous reviews have highlighted that providers should explore opportunities to develop the skill-mix within their Services.

The following recommendation was made by the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

Services should explore ways in which the expertise and knowledge of both trust and community pharmacists may be used to improve prescribing and the management of medicines within the out-of-hours service. [Appendix B: Recommendation 26].

The following recommendation was made within the 2016 DoH Review of GP-Led Primary Care Services in Northern Ireland:

During 2016/17, service providers should explore opportunities to build the skills mix in out-of-hours services, including through the use of nurse triage services and pharmacist prescribers. Providers should also consider the scope for partnership working with other services, such as community pharmacies, to ensure that patients are directed to the most appropriate health professional. [Appendix C: Recommendation 4.1].

At the time of this Review, four providers had introduced either nurses or pharmacists into their workforce. However, the increase in skill-mix had not in itself provided a solution to the low number of GPs, as there was also a shortage of available nurses and pharmacists. At the time of this review, it was noted that the Belfast Trust had not introduced either nurses or pharmacists into its out-of-hours service.

Providers, that employed nursing staff, reported that this had been beneficial to their service; we were told that nurses were flexible and able to assist with some of the non-clinical responsibilities within the service such as assisting with triage and consultations.

During 2016/17, between the three providers (Dalriada Urgent Care, the Southern Trust and Western Urgent Care) utilising nurses within their GP Out-of-Hours Service, 90% of planned nurse hours were filled (Table 8). Of these, the Southern Trust filled the lowest proportion of planned nursing hours (53.9%).

Table 8: Number of planned and filled Nurse Hours for each GP Out-of-Hours Service Provider during 2016/17 (Including Public Holidays)

Provider	Number of Nurse Hours Planned	Number of Nurse Hours Filled	% of Nurse Hours Filled
Belfast Trust	0	0	0.0%
Dalriada Urgent Care	19,588	19,502	99.6%
South Eastern Trust*	0	0	0.0%
Southern Trust	7,870	4,246	53.9%
Western Urgent Care	19,839	18,886	95.2%
Total	**47,297**	**42,634**	**90.0%**

Source: Information supplied by HSC Board (March 2018)
**During 2016/17, the South Eastern Trust utilised nurses within the service for a short period of only three months. Due to the short period, the figures are not used.*

Nurse practitioners were considered by providers to be very valuable resource because of the greater range of care they could provide. Providers however highlighted a shortage of available nurse practitioners. They reported that nurses found it difficult to access nurse practitioner training, as many could not be released from their primary jobs to undertake training. Additionally, they reported there was often limited funding in their Trusts or through their GP Practices to enable nurses to undertake nurse practitioner training.

The South Eastern Trust reported it had also met with NIAS for initial exploratory discussions about introducing paramedics into the skill-mix for its out-of-hours service.

Remote Triage

The following recommendation was made by the 2016 DoH Review of GP-Led Primary Care Services in Northern Ireland:

By December 2016, introduce a remote triage service across the out-of-hours service to meet periods of high demand. [Appendix C: Recommendation 4.6]**.**

At the time of this Review, it was apparent that this recommendation had not been implemented across the entire region:

- the Southern Trust had implemented home triage and advised that it was working well;
- the South Eastern Trust was in the process of implementing home triage; however, they reported challenges in relation to recording of conversations with patients, and remote log-on to the Adastra system; and
- none of the remaining providers had progressed the implementation of home triage.

Shift Sessions

Providers reported that they had reorganised shift patterns and introduced more flexibility in relation to the length of shifts in the Out-of-Hours Service to try and make the working conditions more attractive for GPs. GPs could either start later or finish earlier in the evenings or at weekends. Rather than work a full session, GPs could choose to work for only a couple of hours to accommodate other work or family commitments.

During the various review meetings both providers and GPs welcomed these changes.

3.3 The Future of GP Out-of-Hours Services

Having reviewed the current model for Out-of-Hours provision, the Expert Review Team agreed that managers, practitioners and staff should be commended for maintaining these out-of-hours services in the face of significant challenges.

The Expert Review Team agreed that the current model for GP Out-of-Hours Services is unsustainable in their current format and considered that GP Out-of-Hours Services should form a key work stream within the transformation of Northern Ireland's unscheduled care system. The findings of this Review should inform the design of a future sustainable model for GP Out-of-Hours Services. In the interim, the Review Team did however, agree that urgent action was required to incentivise GPs to work in the service, to improve the availability of appointments and reduce the waiting times for appointments or treatment.

As some patients were not using the service as an urgent care service, the Expert Review Team agreed that the purpose of the service should be clearly defined to be explicit on what falls within its scope. Providers should be supported to ensure the service works within its defined scope and if needed, patients presenting with non-urgent conditions should be redirected to other more appropriate services. Operating within this model may create challenges in relation to patients with unrealistic expectations and those that have developed customary behaviours in relation to how they use Out-of-Hours Services. Without clear communication and engagement these changes may initially result in lower overall patient satisfaction levels or an increased number of complaints.

The Expert Review Team considered that a new operating model for GP Out-of-Hours Services must be developed to address the immediate challenges and to stabilise Services. This would require:

- establishing a regionally agreed definition of the GP Out-of-Hours Service and clearly defined specification of what falls within its scope;
- ensuring urgent recognition of GP Out-of-Hours Services within the overall unscheduled care setting;
- encouraging more GPs to work in GP Out-of-Hours Services;
- addressing the remuneration and financial challenges facing GPs working in GP Out-of-Hours Services;
- reviewing options for more flexible working arrangements; and
- increasing the skill-mix of practitioners delivering care and treatment.

The Expert Review Team considered that DoH should establish a Working Group with the necessary authority to design and implement a new model for the delivery of GP Out-of-Hours Services which should also include development and implementation of a regional quality improvement programme for GP Out-of-Hours Services.

Development of a new operating model for GP Out-of-Hours Services cannot be addressed in isolation and in particular, although beyond the scope of this review, action must also be taken to address the challenges facing daytime GP Services. The working group must also take into consideration the wider transformation agenda in relation to the provision of Unscheduled Care. Longer term action is then required to ensure that GP Out-of-Hours Services are sustainable into the future.

Recommendation 1	**Priority 1**
The Department of Health should establish a Working Group with the necessary authority to design a new model for GP Out-of-Hours Services within the programme of the wider Transformation Agenda. The Working Group should: a) Define a new model, with an agreed definition, describing the purpose of the Service and specifying its scope; b) Ensure the new model is embedded within the wider unscheduled care infrastructure and ensure that it is complementary to other options such as walk-in centres, minor injury units and internet/telephone advice; c) Examine options for modernisation of triage, remote working and leveraging technology; d) Determine the sustainable number of locations, required staffing resources and preferable skill-mix to provide a sustainable service; e) Develop a comprehensive communication and engagement strategy to promote the renewed model; f) Agree interim measures to stabilise the current GP Out-of-Hours Services in the interim; and g) Actively progress the implementation of recommendations from this Review and the 2016 DoH Review.	

Section 4: Governance and Oversight

Ensuring that the elements of leadership, management and governance are functioning correctly enables providers to ensure they deliver high quality services.

We found that providers had a strong commitment to delivering high quality, safe and effective care; however, their ability to do so was impacted by a reduction in the number of GPs working in GP Out-of-Hours Services and limited support being provided for these services by the HSC Trusts.

4.1 Governance Arrangements

A well-led service should have in place robust governance arrangements which include clear mechanisms for reporting and monitoring of a service's safety, effectiveness and overall performance. We found that the effectiveness of these governance arrangements varied across providers depending upon the type of organisation.

Organisational Structures

The three providers that are part of HSC Trusts had established governance arrangements in line with the existing organisational structures of their Trusts.

- The Belfast and South Eastern Trust providers were integrated within their respective Trust organisational structures, positioned within the Unscheduled Care Directorates. These providers benefited from direct reporting arrangements through their respective Directorates and Trust Executive Management Teams through to their respective Trust Boards.
- In the Southern Trust, the provider was positioned within the Enhanced Services Directorate. This provider also had direct reporting arrangements through its Trust structures through to the Trust Board.

The two independent Mutual providers were Dalriada Urgent Care and Western Urgent Care; they were independent and not part of any HSC Trust. We found that these providers had developed their own specific governance arrangements. They were self-managing and reported to their respective Steering Council and Steering Group, which included representatives from the Northern and Western Trusts. The Steering Council and Steering Group acted in a role equivalent to the Trust Board, providing scrutiny, challenge and decision-making.

Trust providers reported activity, performance and governance compliance through their respective Directorates to their Executive Team and Trust Board. Performance of their GP Out-of-Hours Service was also discussed at Chief Executive Accountability meetings.

The Mutual providers reported activity, performance and governance compliance to their respective committees; the Clinical Governance Sub-Committee in Dalriada Urgent Care and the Governance and Performance

Committee in Western Urgent Care, then to their respective Steering Council and Steering Group.

Despite these reporting arrangements the Expert Review Team found little evidence of constructive scrutiny or recognition of GP Out-of-Hours Services by the management structures within the HSC Trusts.

Commissioning Oversight

The 2017/18 HSC Board Service Specification for the provision of Urgent Primary Care Out-of-Hours in Northern Ireland detailed the service requirements and standards to which GP Out-of-Hours Services must adhere. Providers send monthly performance returns to the HSC Board, providing details of performance and achievement against these KPIs.

These KPIs are discussed in more detail in Section 4.5 Performance of the Service.

The HSC Board held quarterly Performance and Governance meetings with individual providers to review performance against KPIs and review governance issues, such as incidents, complaints and risk management. The Expert Review Team considered that the increasing pressures and challenges faced by GP Out-of-Hours Services required greater leadership, scrutiny and oversight by the HSC Board.

Strategic Direction and Service Planning

A number of previous Reviews, as outlined in Section 1.2, made recommendations designed to shape the future model of GP Out-of-Hours Services. However, we did not find there was a clear vision for the future model for GP Out-of-Hours Services in Northern Ireland which was informing service planning or shaping any service improvement being taken forward.

- During the 2010 RQIA Review of the GP Out-of-Hours Service, providers informed the Review Team that they were awaiting a decision on the long-term strategic direction for the service.
- The 2010 RQIA Review of the GP Out-of-Hours Service made a recommendation to clarify the future strategic direction for GP Out-of-Hours Services (Appendix B: Recommendation 1).
- In 2012, the HSC Board released the Strategic Framework for GP Out-of-Hours[46], which outlines several recommendations to take the service forward.
- A financial review of the service was undertaken in 2013, with a report published in September 2013, which outlines financial recommendations for the service.
- In 2014, the HSC Board released another Strategic Framework for GP Out-of-Hours[47]; the Expert Review Team considered the 2014 framework

[46] Strategic Framework for GP Out-of-Hours. HSC Board (June 2012). Available from http://www.hscbusiness.hscni.net/pdf/Strategic_Framework_GP_Out_of_Hours.pdf (Cited: May 2020)
[47] Strategic Framework for GP Out-of-Hours. HSC Board (January 2014).

is a duplication of the 2012 framework, with revised dates for implementation of the 2012 recommendations.
- In 2016, the DoH published its report of the Review of GP-Led Primary Care Services in Northern Ireland, which included recommendations for GP Out-of-Hours Services.

At the time of this Review, limited progress had been made in relation to implementation of these Strategic Frameworks or recommendations of Reviews previously undertaken.

Despite the publication of a Strategic Framework in 2014, the HSC Board informed us there was no overarching strategy for GP Out-of-Hours Services. However, the HSC Board also explained that it had been undertaking preparatory work in relation to implementing recommendations from the 2016 Review of GP-Led Primary Care Services in Northern Ireland.

We found that the arrangements for monitoring by the HSC Board were not effectively addressing the various challenges facing the service. The Expert Review Team considered that real change, in the form of a clear strategy and renewed model for GP Out-of-Hours Services, as well as implementing the recommendations from previous reviews, was crucial to the future sustainability of these Services. This is discussed in Section 3, with a resulting recommendation.

Escalation of System Pressures

We found that there was an escalation process in place for GP Out-of-Hours Services to inform senior managers, the HSC Board and the DoH of potential pressures within the system. All providers produced a weekly report containing information about demand and identifying significant issues such as reduced clinical cover or consolidation of Primary Care Centres. In addition to the HSC Board and the DoH, the information was shared with HSC Trust EDs and NIAS, so any potential impact on their service could be anticipated and planned for.

The South Eastern Trust, Southern Trust and Western Urgent Care advised of regularly using the escalation process. The HSC Board confirmed that escalations were received and filed; however, the Expert Review Team was not assured that there was any effective follow up or immediate action to support the providers and mitigate risks associated with the escalation.

Providers told us that issues concerning service pressures were also escalated locally to the on-call manager and subsequently to the on-call Directors within the Trust and HSC Board.

The Expert Review Team considered that these mechanisms were not working as effectively as they potentially should. Providers reported that, despite repeated escalations, often little or no action was subsequently taken. We were not assured that providers had been provided with effective support or been informed of potential arrangements, in the event of service continuity issues arising.

The Expert Review Team concluded that the Health and Social Care Board and HSC Trusts, in collaboration with providers should review arrangements for both escalating and subsequently addressing issues during the Out-of-Hours period and develop formal arrangements for managing service pressures.

Recommendation 2	**Priority 1**
The Health and Social Care Board and HSC Trusts, in collaboration with providers, should: a) review the current GP Out-of-Hours Escalation Plan and Escalation Status Report arrangements for escalating and addressing issues during the Out-of-Hours period; and b) develop arrangements which clearly define the range of possible options and actions to be taken to address identified risks, particularly those relating to service continuity.	

4.2 Clinical Leadership

Clinical leadership arrangements varied across providers:

- within the Belfast Trust it was provided through one medical manager and one deputy medical manager;
- within the Dalriada Urgent Care it was provided through two Clinical Directors;
- the South Eastern Trust had one Clinical Lead and two medical managers. At the time of this Review, one further medical manager's position was vacant;
- the Southern Trust had one Clinical Lead and two medical managers; and
- Western Urgent Care had one Clinical Director and three medical managers.

Capacity of the Clinical Leads

The Clinical Leads/Clinical Directors for GP Out-of-Hours Services had overall responsibility for all aspects of the service within which they work. This included:

- provision of safe and effective clinical care;
- providing clinical leadership and support to doctors and nurses;
- education and training;
- performance management; and
- handling of complaints.

These roles were normally undertaken by Lead GPs who worked a set number of sessions per week in GP Out-of-Hours Services, while spending the remaining time in their own GP practices.

We found that the HSC Board Service specification did not detail a minimum number of sessions, based on organisation size, which should be undertaken in order to fulfil a Clinical Lead role.

The Clinical Leads reported that they attended steering, governance and performance meetings both within their own service, as well as regional meetings with the HSC Board. The Expert Review Team having considered the extensive remit of the Clinical Leads was concerned this could not be undertaken effectively given the limited number of sessions available to them.

We were told that the Southern Trust had increased the number of sessions allocated to their Clinical Leads in recognition of the breadth of this role to allow more time for managing its service.

During our discussions with Clinical Leads it was apparent that, despite their clear commitment to the service and despite their best efforts some aspects of governance, performance management and service improvement had not been undertaken. The Expert Review Team considered that the Clinical Leads were unable to dedicate sufficient time to areas such as risk management, performance audits and developing quality improvement initiatives for the service. The Expert Review Team also considered that clinical leads had not received sufficient support from their respective Trusts and the GP Out-of-Hours Service in general was not given sufficient priority by any of the trusts.

During meetings with the management teams of each of the providers, the Expert Review Team observed members of the clinical teams having to use significant periods of time to try to obtain doctors to work sessions even on that particular evening. We were told that the amount of time spent by Clinical Leads trying to find cover for unfilled shifts had negatively impacted on their ability to execute all the various responsibilities around governance, performance and improvement of the service.

The Expert Review Team considered that providers should ensure that Clinical Leads have sufficient capacity to fulfil their management and governance responsibilities. The providers should engage with Clinical Leads, to identify potential solutions and consideration could be given to either increasing the number of sessions undertaken by the Clinical Leads, or to increasing the number of support staff available to assist with the requirements in relation to governance, performance management, and service improvement.

Recommendation 3	**Priority 1**
The Out-of-Hours Providers should ensure Clinical Leads have sufficient capacity to effectively undertake their management and governance responsibilities to ensure safe and effective oversight of their Service.	

4.3 Management of the Workforce

The workforce within each provider consisted of several key staff groups:

- General Practitioners (GPs)
- Nurses
- Nurse Practitioners
- Pharmacists
- Call Handlers
- Drivers
- Service Managers

The number of staff in each group varied between providers and was dependent upon how the service is delivered operationally.

Recruitment Policies and Procedures

We examined the recruitment and selection procedures in place in all providers and found that overall these were satisfactory.

- Dalriada Urgent Care and Western Urgent Care had developed their own recruitment and selection processes, and managed these internally.
- Belfast, Southern and South Eastern Trusts utilised their respective Trust recruitment and selection processes. The respective Human Resources departments and the regional Recruitment and Selection Shared Service had oversight of all employment arrangements. All providers had adequate procedures to check that new appointments have the appropriate qualifications, skills and knowledge to undertake the job.

Recruitment of GPs

In relation to the recruitment of GPs to the Out-of-Hours Service, the recruitment and selection process included a number of additional pre-employment checks to ensure any potential employees are on the Primary Medical Performers List (PMPL), submit a copy of their General Medical Council (GMC) Licence to Practise, a copy of their professional indemnity and two references.

Providers confirmed that checks were completed annually to ensure GPs had completed their annual appraisal with NIMDTA, had current GMC registration, and had up-to-date medical indemnity. AccessNI Criminal record checks[48] for GPs were undertaken by the HSC Board as part of the requirements for being on the PMPL.

The Expert Review Team noted that all providers relied on the PMPL as a key assurance that the GPs working within the services had the required capabilities and competencies. While this Review did not assess the

[48] AccessNI is a branch in the Department of Justice. Its role is to process applications from members of the public or organisations who require a criminal record check for employment purposes. Available from https://www.nidirect.gov.uk/campaigns/accessni-criminal-record-checks (Cited: May 2020)

robustness of the PMPL directly, the HSC Board and some providers assured us that meeting the requirements to remain on the PMPL is a robust and rigorous process and provided good assurance.

Recruitment of Nursing Staff

We examined the processes for the recruitment of nurses within these services and found a similar process which included checks to ensure registration with the Nursing and Midwifery Council (NMC), submission of references and a formal interview. Additional annual checks were carried out to ensure current NMC registration.

Recruitment of Other Staff

We found that the recruitment of other staff was in line with expected recruitment and selection procedures. All staff were subject to AccessNI Criminal record checks, prior to being offered a position.

We were advised that within Dalriada Urgent Care, the selection process for nurses and non-clinical staff included an additional step of psychometric testing, to assess whether potential employees are capable of working in a high-paced environment. When asked why GPs do not undergo psychometric testing, the provider told us that it was assumed that they had the prerequisite skills for working in such an environment.

Induction of New Staff

We found that all providers had delivered some induction training to new staff prior to them starting work in the GP Out-of-Hours Service. This included orientation with the facilities and familiarisation with computer systems, mentorship programmes and supervised practice, familiarisation with policies and procedures, as well as mandatory and on the job training. Staff were subject to a probationary period of work, during which they were monitored to ensure capability and competency. Staff unable to demonstrate the necessary competencies during their probationary period were not usually retained within the service.

Contracted Hours

All providers identified that they had a small number of GPs contracted to them; this group was supplemented by a larger pool of sessional GPs. We heard that the majority of GPs worked in local GP practices in the same area covered by the provider and are familiar with local HSC services. Locum GPs were not used to fill shifts within GP Out-of-Hours Services.

The workforce delivering out-of-hours services were, in the main, comprised of medical practitioners who had another primary GP position. This arrangement could present challenges when providers sought to assure themselves they are adhering to the European Working Time Directive (EWTD)[49]. This directive set limits on the number of hours that an employee

[49] The European Working Time Directive (EWTD) is an EU initiative designed to prevent employers requiring their workforce to work excessively long hours, with implications for health and safety. The Directive reduces the working week to an average of 48 hours and there are further regulations relating to break periods and holiday allowance, such as: 11

should work within a week, although there are arrangements to allow individuals to opt out. While the five providers, the HSC Board and the BMA had signed up to a collective agreement to ensure safe working hours in GP Out-of-Hours Services, they all reported this was difficult to implement, particularly as GPs who are self-employed can opt out of the EWTD.

The following recommendation was made by the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

Out-of-hours providers should consider methods of providing assurance that doctors are not working excessive hours by working shifts for different providers. [Appendix B: Recommendation 3].

Providers reported that all staff were advised, by their respective employers, of their professional responsibility to ensure that appropriate rest periods are taken. In an attempt to comply with the EWTD, providers regularly reminded staff about the requirements of the Directive and all providers had rules relating to rest periods built into the shift booking systems.

Monitoring was undertaken annually by staff completing a declaration of secondary employment or an appropriate opt-out form. While providers reported they were able to manage compliance with the EWTD for contracted staff, they had no mechanism for managing the compliance of sessional GPs against the EWTD.

The Expert Review Team considered that, although there were some good arrangements in place in respect of the management of staff, there were also weaknesses in ensuring compliance with the EWTD. Providers should continue to monitor compliance under the current arrangements to obtain assurance that doctors are not working excessive hours.

Operational Arrangements for Oversight of Staff

The arrangements for oversight and management of staff were similar across the providers; however, the operational systems varied considerably depending upon the staff group. The Expert Review Team identified that the management arrangements for operational staff such as nurses, administrators, call handlers, etc. were more comprehensive than the arrangements for the sessional staff, such as GPs.

General Practitioners (GPs)

Across all providers, GPs were subject to performance management audits which focused on:

- the time and outcomes relating to their triaging of calls;
- their number of base consultations;
- their number of home visits; and
- how they generally perform on their shifts.

---

hours rest a day and a right to a day off each week; a right to a rest break if the working day is longer than six hours; 5.6 weeks paid leave each year.

This was usually based on data extracted from the Adastra computer system.

We found evidence that, in practice, active assessment of the performance of GPs was limited in some of the providers. We were told that mechanisms for supportive and effective performance management had been extensively discussed on a regional basis, but there was no agreed process for this.

Providers informed us that there was no consistency in reporting or reviewing performance and that the efforts to manage pressures within the service and encourage GPs to undertake shifts took precedence. Providers also indicated that they believed active performance management had the potential to discourage some GPs from working for GP Out-of-Hours Services.

The Expert Review Team considered there were likely to be benefits in the strengthening of performance management systems and that a regional approach should be taken to ensure that arrangements are consistent, supportive, fair and proportionate across all providers.

In the absence of a regional approach to performance management of GPs in Out-of-Hours Services, Dalriada Urgent Care and the Southern Trust had developed their own specific arrangements.

Dalriada Urgent Care: Had developed, and was piloting, a system known as QED (Quotient of Effectiveness in Dalriada). Based upon RCGP standards, the system provided a quantitative analysis of GP performance, relating to a number of patients triaged and consultations undertaken during each shift and over a longer period. The results were provided to the individual GPs, who could compare these to anonymised data, to gauge performance in comparison to their peers. The system also allowed Clinical Leads to identify GPs who were not performing well, or were experiencing difficulties.

Southern Trust: GP performance was actively monitored on an ongoing basis and reviewed by Clinical Leads. Outcomes were provided to the individual GP for his/her ongoing learning in relation to clinical assessment. If inconsistencies were identified, the medical management team would follow up with the GP involved and, if required, provide support to assist improvement. The Southern Trust advised that anonymised results of GP performance had been shared with the other providers for benchmarking purposes.

Other Providers: The Adastra system was used to review the performance of GPs in terms of workload and activity; any outliers/exceptions were followed up. Providers advised that they undertook audits of GP triage outcomes to ensure a consistent approach. Regular audits of practice were not routine, but generally undertaken in response to an issue or a complaint. Providers told us that they used the data from complaints as part of their management of GP performance; however, as the number of complaints was small, the value of this information was limited.

The Expert Review Team considered that the weakness in the comprehensive assessment of the performance of GPs was associated with the limited capacity of Clinical Leads to undertake this work.

Recommendation 4	**Priority 3**
The GP Out-of-Hours Providers, with advice from the HSC Board, should develop an effective system, with agreed metrics, to assess the performance of GPs within GP Out-of-Hours Services (See also Recommendation 6). The learning from initiatives undertaken by Dalriada Urgent Care and the Southern Trust should be considered.	

Non-Medical Staff

Providers identified that the preferred method of assessing the performance of operational staff, such as call handlers, administrators and nurses was audit. This was supplemented by regular supervision and appraisal.

They reported that feedback was provided to staff and used to identify any training, mentoring, or performance improvement needs. Though we agreed that audits were useful in principle, we were not convinced that providers could assess the performance of staff through the limited number of audits undertaken. The exception was Dalriada Urgent Care, which undertook considerably more audits and demonstrated a better understanding of the processes for assessing the performance of staff.

More frequent audits may provide some information about the performance of individual staff. However, it was acknowledged that the providers did not have the capacity to undertake a programme of regular performance audits, while at the same time addressing the daily challenges in ensuring service continuity.

We noted the different approaches, across staff groups to performance management through audit, staff appraisal and active monitoring. We acknowledged that different staff groups required different approaches to assessment of performance and management; however, for all staff groups this should be based upon information relating to patient outcomes, patient experience and quality of care.

Management of Workload

The management of workload was raised in both the GP online survey and in focus groups with GP trainees. Both GPs and GP trainees noted that some shift co-ordinators, at times, checked on their progress or reminded them about the number of patients they had triaged or provided a consultation for. This sometimes created some tension between staff.

GPs told us that in their daytime practice they considered themselves to be highly skilled professionals who managed their own daily workload. However, when GPs work in GP Out-of-Hours Services, they are essentially employees with limited control over the management of their workload.

Shift co-ordinators and Clinical Leads were jointly responsible for managing the workload in GP Out-of-Hours Services, and were held accountable for delivering against the expected KPIs. Shift co-ordinators were required to liaise with GPs for updates on the progress of their caseload. . GPs as highly autonomous practitioners and, in many cases, managers of their services may not have been accustomed to this level of oversight in their daytime practice.

GPs also carried a significant proportion of the clinical risk associated with the GP Out-of-Hours Services. As such, we identified the potential for differences in understanding between GPs and shift co-ordinators in respect of what constituted reasonable levels of monitoring and oversight. We concluded that effective communication to address these differing perceptions would support staff to focus collaboratively on delivering a quality service.

Recommendation 5	**Priority 3**
Providers should ensure a shared understanding of respective roles GPs and the other staff groups within their GP Out-of-Hours Service.	

Providers informed us that, when issues were identified in relation to performance, behaviour or capability of operational staff or GPs, their respective line manager would address these directly with the staff involved. Individual action plans were agreed and monitored to help achieve the required improvement.

Supervision and Appraisal

Across providers there were similar arrangements in place for supervision and appraisal of staff; however, the arrangements for nurses, administrators, call handlers, etc. differed compared to the arrangements for GPs.

Supervision and appraisal were provided for operational staff such as managers, nurses, pharmacists, and administrators. Line managers scheduled supervision sessions in line with agreed timeframes and also carried out annual appraisals. If issues with performance were identified, the supervision and appraisal processes allowed managers to develop plans to address any issues.

GP appraisal was managed and facilitated by NIMDTA and so providers did not undertake supervision or appraisal for GPs working in GP Out-of-Hours Services. GPs must complete annual appraisals and five yearly revalidation to remain on the Primary Medical Performers List (PMPL)[50]. The Clinical Leads supported the GP appraisal process by signing off any relevant

[50] The Northern Ireland Primary Medical Performers List is a list of GPs and medical practitioners that have been assessed before they can perform primary medical services. The list is held by the HSC Board and is subject to The Health and Personal Social Services (Primary Medical Services Performers Lists) Regulations (Northern Ireland) 2004, which provides a framework to ensure patients are protected from unsuitable or inefficient practitioners.

documentation, such as the CP2a Form[51] and GMC revalidation was also supported by medical managers.

GP Trainees

The sustainability of the GP Out-of-Hours Service will depend on current GP trainees electing to work in the service in the future. A positive or negative experience as a GP trainee could influence whether or not they choose to engage with the service in the future. During focus groups, the majority of GP trainees told us they were likely to work in GP Out-of-Hours Services in future as a GP, but that they would consider the working conditions and pressures on the service at that time.

During this Review, the Expert Review Team shared with providers, an initiative developed by the Out-of-Hours system in Scotland. It allowed GP trainees to work in GP Out-of-Hours Services, under supervision, in their last two months of training. During this period, the GP trainees were counted within the GP numbers, and were not supernumerary, which helped to alleviate staffing pressures over the summer months. This solution could assist in stabilising the service, and we would encourage providers to consider it.

We concluded that in order to ensure continued interest among current GPs and GP trainees in contributing to GP Out-of-Hours Services, providers and other stakeholders must work together to address the various challenges facing the services. Additionally, supervisors and mentors could actively encourage and motivate GP trainees to work in the service.

The following recommendations were made by the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

The out-of-hours service should continue to work with Northern Ireland Medical and Dental Training Agency (NIMDTA) on the role of trainees in the out-of-hours service. [Appendix B: Recommendation 6].

NIMDTA and providers should agree on arrangements which should be in place for out-of-hours services to provide feedback on GP trainees' performance and for out-of-hours services to receive feedback on trainee experience of these placements. [Appendix B: Recommendation 7].

We found that providers facilitated the training requirements of GP trainees within GP Out-of-Hours Services. GP trainees reported positive experiences of working in the services and were also positive about other aspects of the service.

[51] The CP2a Form should be completed annually for all roles not including daytime GMS. The CP2a Form enables information from other posts/ roles where a licence to practice is required to be discussed at appraisal. The Form also informs the appraiser of outstanding complaints or performance concerns currently under investigation.

At the time of this review, the documentation used to monitor the performance of a GP trainee's placement in GP Out-of-Hours Services was provided; this was an integral part of the assurance and validation processes for GP trainees working in GP Out-of-Hours Services.

We also identified that the role of the GP trainee sometimes varied between providers in relation to the roles and tasks assigned to them. This was due to the differing approaches of various GP trainers rather than the expectations of the provider. In view of this, it was considered that NIMDTA could review the variation of approaches from GP trainers, with the aim of providing a more consistent approach irrespective of provider.

4.4 Support for Staff

In order to provide support for staff working in GP Out-of-Hours Services, providers should ensure that suitable facilities and adequate resources and equipment are available. Policies and procedures, such as lone working and zero tolerance of abuse against staff, were available in all providers.

Providers did not report any historical security incidents at their Primary Care Centres. During our observation visits, we confirmed that security measures were in place for the safety of staff working in Primary Care Centres; these included external and internal security for the building(s). Intercoms and closed circuit television cameras were also in operation and access to the centres could be restricted, when required.

We were informed that for each provider, a shift co-ordinator was on duty during the out-of-hours period and was accessible to all staff to provide support or resolve any issues that arose. A manager was always on-call to support the shift co-ordinator. Any queries or issues that arose, which required immediate attention or escalation, were forwarded to the Clinical Leads.

Those who participated in the GP online survey and in the GP trainee focus groups raised some concerns relating to lone working and a lack of interaction with other staff on duty, in relation to support during the out-of-hours period.

Lone working was specifically raised as an issue for providers within several Primary Care Centres (Dalriada Urgent Care, the Southern Trust and Western Urgent Care) where sometimes staff needed to be redeployed across a provider's Primary Care Centres to meet demand. This was an issue for a number of GPs and increasingly a consequence of the limited number of GPs working in the service. While GPs did not refuse to work in locations on their own, they advised that they were conscious about their safety and security. The Expert Review Team considered the issues associated with lone working had the potential to discourage GPs from undertaking certain shifts.

Some providers reported that they had considered reconfiguring their GP Out-of-Hours Service by reducing the number of out-of-hours sites in order to utilise a limited resource more efficiently.

The following recommendation was made by the 2016 DoH Review of GP Led Primary Care Services in Northern Ireland:

By June 2017, review the number of out-of-hours bases. [*Appendix C: Recommendation 4.11*]

At the time of this Review, this recommendation had not been progressed. The Expert Review Team considered that this action should be progressed by the DoH working group when developing a new operating model for GP Out-of-Hours Services (Recommendation 1).

A number of GPs and GP trainees reported limited interaction with other staff on duty during shifts in the out-of-hours period; particularly those GPs that completed a whole shift in a consultation room. The Expert Review Team acknowledged that such scenarios do occur and suggested that providers may wish to consider other ways of supporting team working such as:

- team meetings at the start of shifts;
- occasional breaks or catch-up meetings; or
- undertaking a mix of duties during a shift, such as triage and consultation.

AREA OF GOOD PRACTICE

In the Southern Trust, a staff forum had been established which is comprised of GP Out-of-Hours staff who undertake various operational roles in a variety of locations. The aim of the staff forum was to facilitate collaboration between GP Out-of-Hours staff and management in order to improve working practices and conditions.

Other Providers could consider this type of model as a mechanism for actively engaging with their staff.

Keeping Staff Informed

All providers informed us that updates to policies and procedures or changes within the service were primarily communicated to staff by email. Information was also updated on Trust intranet sites or provided at staff meetings. Dalriada Urgent Care and the Southern Trust both used their internal newsletters to communicate information to staff.

4.5 Performance of the Service

Across all providers, oversight and management of their service focused mainly on the Key Performance Indicators (KPIs) that are outlined in the GP Out-of-Hours Service Specification and Standards (summary attached at Appendix G).

In 2008, an Out-of-Hours Steering Group lead by the Directorate of Integrated Care in the HSC Board created the initial Service Specification and Standards, which have been revised and updated to reflect changes in the service. However, the KPIs continued to focus on meeting targets in relation to time taken for triage and for consultations.

Providers advised they collected key performance data and reported it to the HSC Board on a monthly basis; this was collated into monthly reports and was shared with DoH. The HSC Board monitored the performance of the providers against the KPIs and provided daily reports, used for benchmarking services against each other. Quarterly performance and governance meetings were held between the HSC Board and providers to discuss performance against the KPIs.

All providers advised of difficulties meeting the KPIs. In particular, they reported that the decreasing number of GPs working in the service was the biggest factor associated with not being able to meet these KPIs. Providers highlighted that while KPIs existed for GP Out-of-Hours Services, no corresponding KPIs existed for daytime GP services. .

The Review Team agreed that the KPIs appeared to be process measures and were not indicators of service quality or patient outcomes. It appeared that individual clinicians were being measured on their ability to respond to a patient within a particular timescale, rather than the quality of care they provided to that patient.

Providers were asked to outline what KPIs they felt would be more appropriate. They were however unclear as to the most appropriate KPIs and offered a number of different views about what they should be. The Expert Review Team highlighted that services in England, Scotland and Wales were moving toward increasing their use of outcome-based metrics, with a focus on improving the patient's experience of care, including quality and satisfaction.

The following recommendation was made within the 2016 Review of GP-Led Primary Care Services in Northern Ireland:

By November 2016, review the current out-of-hours key performance indicators to assess whether they remain appropriate for the effective and efficient provision of out-of-hours services. [Appendix C: Recommendation 4.5]

At the time of this Review, we were not provided with evidence that this recommendation had been implemented. We considered that the implementation of this recommendation should be taken forward as a key priority.

Providers must ensure they have robust systems to provide assurance in relation to the quality of care delivered. A core dataset should be defined for the GP Out-of-Hours Service. This information could be used to inform staff appraisal and performance management. It would also underpin clinical audit

and quality assurance requirements for reporting, through each organisation's accountability structure and to the commissioners of the service.

The Expert Review Team considered that providers should be able to influence the development and modernisation of GP Out-of-Hours Services through agreeing appropriate KPIs that can better reflect the quality of the work they do. In Section 3 we discussed the establishment of a DoH Working Group in relation to the future model of GP Out-of-Hours Services and we consider that the following recommendation should be informed by local and national benchmarking data and co-ordinated and progressed by this newly established Working Group.

Recommendation 6	**Priority 1**
The DoH Working Group established in Recommendation 1 should: a) develop and implement a suite of new Key Performance Indicators (KPIs) for GP Out-of-Hours Services which reflect patient outcomes, patient experience and quality of care; and b) develop a system to ensure the data collected is used to inform clinical audit and quality assurance requirements, relating to triage, assessment and treatment and is used to inform staff appraisal.	

Use of Data

The following recommendation was made within the 2016 Review of GP-Led Primary Care Services in Northern Ireland:

From June 2016, all service providers must use the Adastra patient management system to routinely analyse management information and ensure that resources are deployed as effectively as possible to meet predicted service demand. [*Appendix C: Recommendation 4.3*]

Submitted evidence demonstrated that this recommendation had been implemented; all providers were using Adastra to manage their GP Out-of-Hours Services. When providers identified issues, such as increased waiting times or call volumes, they used data from Adastra to help determine the cause of the issues and to ascertain what solutions could be found.

We were told that, while most of the challenges with Adastra related to retrieving information, difficulties with recording information on the system also existed. One example related to the recording of a patient's presenting clinical condition(s). This challenge was especially highlighted by GP trainees during focus groups, who informed us that Adastra did not have sufficient variety of condition codes to accurately describe patient presentation. GP trainees reported that they either recorded conditions in a very generic manner, or did not give the condition a classification at all. Both GPs and nurses described encountering similar problems.

This challenge was confirmed when the providers submitted to the Expert Review Team a report of the top ten conditions presenting each month in the Out-of-Hours service. According to this data, the number one classification of patient conditions was described as '*other'*.

The Expert Review Team acknowledged the challenges associated with coding conditions, and considered that it affected the providers' ability to appropriately use data to inform their service. This should be addressed so that services have better quality of information to support effective service development.

Recommendation 7	**Priority 2**
Providers should work collectively with support from HSC Board, GPs and other staff to develop regional guidance for accurately coding and recording patients' clinical conditions on Adastra.	

Clinical Audit of Triage and Consultations

The Regional Service Specification for GP Out-of-Hours Services required providers to report to the HSC Board the outcomes of triage and consultations. Provider audits primarily focused on reporting the volumes of patient contacts and response times in relation to these contacts. Providers were able to supply data in relation to the numbers of patients that had been triaged and subsequently had received advice, a consultation at a Primary Care Centre or a home visit.

We found that clinical audit of triage outcomes varied between providers and overall audit activity was limited. We noted that nurses who carried out triage were subject to more frequent audits than GPs who undertook this role. We noted for example, the Southern Trust and Dalriada Urgent Care had used data from Odyssey[52] to develop audits of nurse triage outcomes. However were not told of any of these audits being carried out for GPs.

Overall, in the GP Out-of-Hours Service, meaningful audits which assessed the quality of triage, consultations and advice provided were limited. Data which would assure the quality of clinical practice or patient outcomes following triage, advice or consultation were not provided.

Comparison of performance and quality across services can be a useful driver for improvement and a mechanism to share learning. We noted that audits were being undertaken by each provider but found no evidence that this information was being used collectively to enable providers to compare their clinical services or share good practice.

[52] Odyssey TeleAssess is clinical decision support software used by GP Out-of-Hours Services to efficiently manage demand. It supports nurse telephone triage and the provision of up to date advice.

The following recommendation was made within the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

A programme of agreed regional clinical audits should be carried out across all out-of-hours providers to enable them to compare their clinical services. [Appendix B: Recommendation 11].

During meetings with the Belfast Trust, the provider highlighted there was no regional agreement about which outcomes should be audited, despite there being many suggestions for potential measures and indicators.

Providers reported that there was no ongoing programme of audit of outcomes from advice provided by or consultations undertaken by GPs. Providers informed us that audits of GP triage outcomes were usually undertaken on an ad-hoc basis or in response to a complaint. Data gathered in relation to the effectiveness of GP triage were limited to the percentage of calls resolved at triage and the percentage of patients referred for a consultation at a Primary Care Centre or at a home visit.

The Belfast Trust told us that they did not have the resources to undertake regular audit of GP triage outcomes and the Southern Trust reported that an audit of GP triage outcomes was previously attempted, but it was found to be time-consuming and yielded no useful findings or recommendations.

Western Urgent Care also reported that the service did not have the resources to carry out regular audit of outcomes arising from GP advice and consultations.

AREA OF GOOD PRACTICE

The Southern Trust informed us that it had undertaken an audit of clinical notes using criteria recommended by the RCGP.

The results highlighted the need to improve the documentation of all activity and in particular, the need to always record the safety netting advice provided to patients, should their condition change post-assessment.

The outcome of the audit had been shared with all clinicians within the Southern Trust GP Out-of-Hours Service.

We concluded that providers made limited use of the data which the Adastra system could provide. Adastra stores information that could help providers better understand their Service; however, providers indicated that they did not have the resource, in terms of time or expertise to extract and analyse the required clinical audit data.

The Expert Review Team considered that there was insufficient evidence of clinical audit within the GP Out-of-Hours Service and insufficient data available to drive improvements across and within these services. We emphasised that using data to understand why patients are using the service in the way they are and addressing any issues in relation to quality and outcomes, was more effective than recording data in respect of response times to demonstrate achievement of targets and KPIs.

We therefore concluded that the recommendation from the 2010 RQIA Review of GP Out-of-Hours Services, relating to regional clinical audit has been only partially implemented.

Recommendation 8	**Priority 3**
The HSC Board should collaborate with providers to design a regional programme of clinical audits, therefore ensuring more effective use of the data and information captured by the Adastra system.	

4.6 Risk Management

Risk management is important for all organisations in enabling them to predict challenges or risks to services and plan proactively to take actions to mitigate these risks.

The following recommendation was made by the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

Out-of-hours providers should have specific risk registers which are kept under regular review. [*Appendix B: Recommendation 2*].

During discussions with the Expert Review Team, providers demonstrated a clear understanding of the risks associated with their services. All providers submitted copies of risk registers for their GP Out-of-Hours Service. We could see that risks were regularly reported to the HSC Board and were discussed at quarterly Performance and Governance meetings as part of monitoring arrangements.

The Expert Review Team considered the quality of the risk registers in capturing all known risks varied between providers and a number of risks highlighted in discussions had not been listed on all risk registers.

Some risk registers did not clearly identify who was responsible for the risks and some did not set out any actions to mitigate against the risks contained in the registers. We considered that amongst the providers, the Southern Trust and Dalriada Urgent Care had the most comprehensive risk registers.

We also considered the quality of the completed risk registers was likely to be influenced by the lack available time for Clinical Leads.

For providers that were part of a HSC Trust, risks could be escalated to the Corporate Risk Register dependent on the severity and impact of the risk. The Corporate Risk Register for the Southern Trust was the only one that included a risk relating to the GP Out-of-Hours Service; however, the Expert Review Team considered that the risk listed did not fully represent the actual risks facing the service. This was of particular significance in view of GP Out-of-Hours Services being an integral part of urgent and unscheduled care provision.

We considered that providers must have a robust understanding of the risks facing their service, both clinical and operational, which are common and individual to each provider. As the core risks are common to each service, providers should take the opportunity to collectively identify ways to mitigate against them. Providers should ensure that risks are reflected on the appropriate risk registers within the service and within their respective Trusts. We concluded that the recommendation from the 2010 RQIA Review of GP Out-of-Hours Services, relating to the management of risk had been only partially implemented.

Recommendation 9	**Priority 1**
Providers should ensure they have robust risk management systems and processes which accurately describe the entire key the risks facing GP Out-of-Hours Services. These must include: a) systems which ensure staff identify all risks including common core risks across providers (both operational and clinical), b) identification of effective actions to mitigate and manage the identified risks on a regional basis where necessary and c) risk registers which document in detail identified risks and effective actions to mitigate them.	

Incidents and Accidents

The following recommendation was made by the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

All out-of-hours providers should review their arrangements to ensure that all staff understand the importance of reporting incidents and near misses to maximise opportunities for learning and to reduce the risk of recurrence. [*Appendix B: Recommendation 10*].

We found that providers had established arrangements for the management of incidents and accidents, which were supported by policies and procedures. The Trust providers reported they adhered to their respective Trust's policies and procedures, while the Mutual providers had developed their own.

The following recommendation was made by the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

The development of a regional system for the collation of learning from incidents occurring in out-of-hours services should be considered during the development of the new Regional Adverse Incident Learning System (RAIL) for health and social care in Northern Ireland. [*Appendix B: Recommendation 9*]

The Regional Adverse Incident Learning (RAIL) System was to be a model which intended to:

- maximise the reporting of adverse incidents and near misses;
- ensure that learning from all incidents and near misses is identified;
- provide a mechanism to share learning from adverse incidents in a meaningful way; and
- ensure that learning from adverse incidents is put into practice in a timely manner.

We found that the RAIL system had not been developed or implemented, so the development of a regional system for the collation of learning from incidents occurring in GP Out-of-Hours Services had consequently not been taken forward.

At the time of this Review, arrangements for sharing regional learning existed for serious adverse incidents (SAIs). SAIs were reported through the regional Procedure for the Reporting and Follow up of Serious Adverse Incidents[53]. Providers advised that the number of incidents and accidents was low, but it was not clear what regional or national comparisons were being used to inform this judgement. Through our discussions with providers and with Clinical Leads it was evident that there were no formal arrangements for sharing information and learning arising from incidents, adverse incidents, and accidents between providers.

We have made a related recommendation in Section 5.7, Innovation and Quality Improvement: Shared Learning.

4.7 Complaints Management

Management of complaints is an important aspect of clinical governance, both for identifying issues with the safety and effectiveness of services but also to provide intelligence that can drive quality improvement and promote a better patient experience.

Providers informed us of their arrangements for the management of complaints, which were supported by associated operational policies and procedures. Trust providers indicated they followed their respective Trust policies and procedures, while the Mutual providers had developed their own

[53] Procedure for the Reporting and Follow up of Serious Adverse Incidents. HSC Board (November 2016). Available from: http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf (Cited: May 2020)

policies and procedures. During our discussions with staff they demonstrated good knowledge and awareness of their respective complaints processes.

We asked providers for data relating to their complaints; the information provided is listed in Table 9 below. The information summarises the number of complaints for each of the three years from 2015 to 2018.

More detailed information would need to be reviewed in order to analyse trends by complaint type or area of care and to determine their correlation with particular aspects of the service.

Table 9: Number of Complaints Received by GP Out-of-Hours Providers from April 2015 to March 2018

Provider	2015/16	2016/17	2017/18
Belfast Trust	21	19	14
Dalriada Urgent Care	10	9	21
South Eastern Trust	13	12	17
Southern Trust	10	13	10
Western Urgent Care	4	4	30**
Total	**58**	**57**	**92**

Source: Information supplied by HSC Board – March 2018
** A number of the complaints received by Western Urgent Care during 2017/18 related to contact with the service prior to 2017 due to delays in patients submitting complaints.

Providers reported that they informed the HSC Board of all complaints at quarterly HSC Board Regional Governance meetings. Anonymised information is then passed to the Regional Complaints Office within the HSC Board for consideration for inclusion in communications developed to disseminate learning; for example in the joint HSC Board/Public Health Agency (PHA) Learning Matters[54] newsletter. This newsletter, issued on a bi-annual basis, included learning from complaints and learning arising from other areas such as SAIs, safety and quality issues and medicines alerts. While statistics in relation to the types of complaints in the Out-of-Hours Service were provided, details about how the complaints had been addressed and their outcomes had not.

The Expert Review Team considered that although the Learning Matters newsletter was useful, it covered the entire HSC system and as a result it may not sufficiently reflect issues relevant to GP Out-of-Hours Services. The newsletter alone did not provide relevant information that could empower providers to enact change and the frequency of distribution did not allow providers the opportunity to act in a timely and responsive way.

We concluded that there would be significant benefit to providers in collating and distributing specific information about complaints within GP Out-of-Hours Services; this should be included in any new arrangements for sharing of learning across the service.

[54] HSC Board/ Public Health Agency newsletter – 'Learning Matters'. Available from http://www.publichealth.hscni.net/publications/learning-matters-newsletters (Cited: May 2020)

In view of the pressures and high volume of activity service (563,679 patient contacts during 2016/17), we noted that the volume of complaints appeared to be low.

Providers told us that the low number of complaints may have been an indicator of the high quality of GP Out-of-Hours Services. However, this should not be assumed, as during observation visits, we found that information about how to complain was not readily available in all of the Primary Care Centres. The Expert Review Team thought that this could have contributed to the low number of complaints.

The following recommendation was made by the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

The out-of-hours service should ensure that patients are aware of the mechanism for making a complaint. [Appendix B: Recommendation 27]

The Expert Review Team could not find evidence that this recommendation had been fully implemented. Based on the Expert Review Team's experience, for GP Out-of-Hours Services of these sizes, the number of complaints appeared small.

Of the 211 GPs who responded to the online survey, who had worked shifts in GP Out-of-Hours Services in the previous 12 months, 25 (12%) made reference to complaints. These references are categorised into two distinct areas: perception of being at high risk of being complained about and inadequate support from managers in relation to complaints.

GP trainees told us that it is "sometimes easier just to treat a patient, rather than try and get them to understand that they should not have been using this service". Although none of the GP trainees had been named in a complaint, they told us they were worried about receiving a complaint in the future.

GPs reported receiving limited support from managers within GP Out-of-Hours Services in relation to complaints. They reported feeling unsupported in cases where they had been challenged by patients, who they sometimes felt had unrealistic expectations.

We concluded that providers should strengthen the existing arrangements for making and responding to complaints. This would require stronger promotion of the complaints process with patients and would also include appropriate support for both complainants and GPs.

Recommendation 10	**Priority 2**
All providers should strengthen the arrangements for raising and managing complaints, which include: a) active promotion of the complaints procedure to all patients, b) developing arrangements that ensure GPs are appropriately involved in the assessment and management of complaints, c) ensuring appropriate support arrangements are in place for both complainants and GPs, and mechanisms to collect and; d) disseminate regionally and locally any learning arising in a timely way.	

Section 5: Quality and Safety

The provision of a high quality and safe service requires that patients are protected against avoidable harm and abuse. The key areas we examined with respect to patient safety were risk management, including call handling, availability of equipment, infection control, arrangements in place for safe medicines management and the safeguarding of vulnerable people. We also reviewed service performance and quality improvement developments.

5.1 Operational Arrangements

Call Handling

All providers reported a similar system for handling calls. When contact was made with GP Out-of-Hours Services, call handlers recorded patient details, symptoms and performed an initial categorisation of the case. Call handlers used a variety of guidance to categorise calls based on the level of urgency. Calls were categorised as either emergency, acute, urgent or routine.

The Expert Review Team considered that the initial triage and categorisation by call handlers was an important stage in the care of patients. Incorrectly categorising a patient had the potential to impact on the timeliness of their care and could also result in a negative outcome for the patient. Providers minimised the potential for incorrect categorisation by providing call handlers with guidance and training. Providers told us about their arrangements for this training.

- The Belfast Trust reported that it ensured that all call handlers received customer care training and 'Enhance your Telephone Answering' training. Bespoke training for call prioritisation which used examples of emergency and urgent calls was also provided.
- Dalriada Urgent Care reported it provided training for call handlers prior to commencing their first shifts, and they were subsequently kept under review for a further six months. Additional training was provided periodically, which included information about the detailed steps required when taking a call, collecting information, and feedback from audits of practice.
- The South Eastern Trust reported it provided training for call handlers along with Prioritisation Guidelines, which highlighted a range of urgent conditions which may present at initial contact. Prioritisation Guidelines were regularly reviewed and updated. The Trust also reported it was planning a revised update for call handlers and was considering using the Adastra Case Prioritisation Protocol software which was used in Western Urgent Care.
- The Southern Trust reported it provided an induction and training programme for call handlers, which included both theoretical and practical elements. The training included supervised 'on the job' observation, one to one mentoring and feedback regarding their communication with patients, effective prompting, call classification and safety netting. Service Call Prioritisation Guidance, which had been developed over time by the Clinical Lead and Out-of-hours Manager, was also available to call

handlers. The guidance provided specific prompts for call handlers to establish information about a patient's condition in order to determine the correct categorisation.

- In Western Urgent Care, all call handlers underwent a period of induction and training before commencing work. Call handlers had access to the Adastra Case Prioritisation Protocol software to assist with symptom identification and prioritisation.

The following recommendation was made within the 2016 DoH Review of GP Led Primary Care Services in Northern Ireland:

By February 2017, develop a regional training programme for out-of-hours staff, initially concentrating on call handlers to enable better call categorisation, through improved communication and negotiation skills. [*Appendix C: Recommendation 4.7*].

At the time of this Review, this recommendation had not been progressed.

The Expert Review Team acknowledged that the role of the call handler was an important point in the triage process, and a wrong decision at this early stage had the potential to contribute to poorer outcomes for the patient. In view of this we considered that call handlers should be fully supported and receive adequate training for the role and that the previous recommendation in relation to a regional training programme, initially focused on call handlers, should be taken forward as soon as possible by the HSC Board.

Call Handling Audits

All providers advised that they actively managed the performance of call handlers through ongoing audit and provided examples of the audit proforma they use.

The South Eastern Trust used the audit checklist from the RCGP Urgent and Emergency Care Clinical Audit Toolkit[55] (RCGP Audit Toolkit), while the other providers used checklists modified from the RCGP Audit Toolkit.

Providers confirmed they completed weekly, monthly or quarterly call handling audits, with the results reported to the HSC Board for discussion at quarterly HSC Board governance meetings. Audits focused on:

- the competencies of the call handlers in relation to customer care and interaction with patients;
- appropriate prompting to gather all required and relevant information;
- correct case prioritisation; and
- safety netting.

[55] Urgent and Emergency Care Clinical Audit Toolkit. Royal College of General Practitioners. Available from http://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/urgent-and-emergency-care.aspx (Cited: May 2020)

Recordings of telephone discussions between call handlers and patients were used to inform the audits and call handlers received feedback on the audit outcomes.

One key indicator in the call handling audit was the number of cases re-categorised following categorisation by the call handler. Providers advised that due to the experience call handlers, the number of re-categorised cases was low. One provider, the Southern Trust, informed us they no longer reported on the re-categorisation of calls from urgent to routine as their audits found no cases.

The Expert Review Team recognised the low number of issues associated with re-categorisation; however they would encourage providers to continue to report against this standard to ensure ongoing good practice, provide assurance against poor practice and also to provide evidence of good performance.

AREA OF GOOD PRACTICE

The South Eastern Trust used its 'Safety Quality and Experience' Quality Improvement Programme to support a project, named 'Keeping our eyes on KPIs'. The aim of this project was to raise awareness and initiate action if a call, categorised as an urgent case was waiting for longer than 20 minutes to be triaged by a practitioner, thus breaching the KPI. The project also assessed the number of patients not attending for their appointment and not answering a call back from the GP and the subsequent impact on the service.

Within the service specification for GP Out-of-Hours Services, providers were required to audit at least 1% of patient calls each year. Based on the number of contacts with the service, as outlined previously (Table 2), the Expert Review Team's expectation was that an average of approximately 22 patient calls should be audited per week by each provider. The actual requirement would vary between providers, in line with the number of calls received.

The HSC Board supplied information identifying that most providers were not auditing the required number of calls on a regular basis. Although Dalriada Urgent Care exceeded the required threshold, for auditing patient calls, the other four providers did not meet the required threshold.

The Expert Review Team, concerned by the low level of call handling audits, concluded that providers should ensure that regular audits are undertaken. These should meet the agreed requirement for auditing 1% of patient calls each year to ensure an effective mechanism for assuring the quality of the service.

5.2 Environment

During observation visits to identified Primary Care Centres, RQIA staff noted that consulting rooms were of an appropriate size and provided an adequate level of confidentiality. There was sufficient and appropriate storage for supplies and consumables. The standard of cleanliness was generally high; all consulting rooms were found to be in good condition with adequate handwashing facilities and sharps containers.

Equipment

We examined the availability of equipment within GP Out-of-Hours Services to ensure this was appropriate for the provision of safe care. We acknowledged that the equipment supplied in Primary Care Centres was primarily for assessment of urgent care cases and is less than what would be required during normal daytime practice.

All providers expected GPs to bring their own medical diagnostic equipment, e.g. stethoscopes, with them when working in GP Out-of-Hours Services. During focus groups, many GP trainees indicated they supplied their own equipment, including disposable items, as they could not be sure what would be available. Other equipment and resources, such as medications, temperature sleeves, tongue depressors and nebulisers, were stocked in Primary Care Centres and in cars.

Of the 211 GPs that responded to the survey only 40 (19%) GPs referred specifically to the provision of equipment. Of these 40 GPs, almost a quarter (24%) considered Primary Care Centres to be well equipped while almost half (44%) reported that provision was poor. The key area of concern in relation to poor equipment provision focused on IT equipment rather than clinical equipment.

Providers told us that equipment and resources were checked on a regular basis. We were told that equipment provided within the cars used for home visits was checked on a daily basis, usually prior to dispatch. Equipment was securely stored in consultation rooms, with staff required to sign-out/sign-in any equipment needed in another location.

Overall, in the majority of cases, clinical staff reported they had access to the equipment they need while working during the out-of-hours period. All non-clinical staff and nurses were provided with adequate equipment and resources to fulfil their roles. We concluded that providers should continue to ensure that access to all necessary equipment is available during all of the out-of-hours period and that stock levels are efficiently maintained and monitored.

Infection Prevention and Control

Providers reported that they followed their respective Trust's policies and procedures in relation to infection prevention and control.

Some of the clinical areas used by Dalriada Urgent Care and Western Urgent Care are located within Northern and Western Trust premises and staff reported that they adhered to the respective Northern and Western Trust policies and procedures in relation to infection prevention and control. Dalriada Urgent Care had also developed its own specific infection prevention and control policies and procedures for the Primary Care Centre(s) not on HSC Trust premises.

All providers reported that staff could access sufficient resources associated with infection prevention and control, such as the Regional Infection Prevention Control Manual, posters, education, training and personal protective equipment.

5.3 Medicines Management

In reviewing medicines management we considered whether patients were protected from the risks associated with the unsafe use and management of medicines.

The Northern Ireland GP Out-of-Hours stock list, provided by the HSC Board, identified a core list of medications that should be available in out-of-hours settings. Providers told us that the quantities of medications stored varied between different Primary Care Centres based upon expected activity at the centres.

During our observation visits, we found good systems in place for the secure storage of medicines either in a safe, or a locked drugs cabinet. Small quantities of medication were also stored securely in the cars for use during home visits. A medicine stock list and log books were used to monitor and control the use of medications. Usage was also recorded on the Adastra system as part of the patient's care record.

In the Belfast, Southern and South Eastern Trusts, the respective HSC Trust Pharmacy departments were responsible for the management of medicines, including supplying and replenishing stock. Pharmacy technicians were responsible for checking that all drugs, including those stored in cars, were present and within their expiry dates. Dalriada Urgent Care and Western Urgent Care held direct responsibility for this area.

We found that the medicines stored within these premises were used primarily for patients requiring immediate treatment following assessment at the Primary Care Centre. At times, when Community Pharmacies were closed and there was an urgent medical need, providers would supply limited amounts of medication to patients. Providers reported that the quantities are restricted to that which would cover the period of time until the patient is able to contact their own GP.

Repeat Prescriptions

In the past, it had been possible for patients to contact pharmacies directly for repeat prescriptions. However, more scrutiny of pharmacies by the HSC

Board meant this practice had been stopped. This subsequently resulted in more patients contacting out-of-hours services to obtain prescriptions. It was noted that the only on-call pharmacies covering during the out-of-hours period, outside of commercial shopping times, were located in the Belfast area.

Providers had arrangements in place for accessing these on-call pharmacies; however, access to timely medication through this service was a challenge for some of the providers, particularly the Southern Trust, Dalriada Urgent Care and Western Urgent Care.

Providers advised that requests for repeat prescriptions placed pressure on the service and that considerable time was expended prioritising prescription requests. Providers were asked if there were data to support this experience but this could not be provided at the time of our Review.

The following recommendation was made within the 2016 DoH Review of GP-Led Primary Care Services in Northern Ireland:

During 2016/17, to reduce demand on GP out-of-hours, run an emergency supply pilot to allow pharmacists to provide an emergency supply of medication to patients free of charge, without the need for a repeat prescription. [*Appendix C: Recommendation 4.2*].

We were informed that an Emergency Supply Pilot Service was undertaken in Community Pharmacies in the Northern LCG area from 14 March 2016 to 18 December 2017. The Service was designed to:

- ensure patients could access an urgent supply of their regular prescription medicines where they are unable to obtain a prescription, before they need to take their next dose;
- ensure equity of access to medicines irrespective of the patients' ability to pay; and
- relieve pressure on Out-of-Hours medical services and emergency care services at times of high demand.

The HSC Board evaluation recommended roll out of the service from all eligible community pharmacies across Northern Ireland; the pilot concluded on 18 December 2017 as the HSC Board was unable to extend it while the implementation of a Northern Ireland wide service was taken forward.

The following recommendation was made within the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

Services should explore ways in which the expertise and knowledge of both trust and community pharmacists may be used to improve prescribing and the management of medicines within the out-of-hours service. [*Appendix B: Recommendation 26*]

The level of requests for repeat prescriptions in out-of-hours services may be reduced by measures to improve access to repeat prescriptions during daytime hours.

We concluded that more efficient solutions for providing urgent repeat prescriptions during the out-of-hours period would be required either within GP Out-of-Hours Services or through alternatives. Some possible solutions for improving the management of prescription requests during the out-of-hours period were discussed. These included:

The introduction of pharmacists into the workforce delivering care: this measure, in line with the recommendation above, would support the triage of prescription requests and other medication issues. Depending upon the volume of calls associated with prescription requests, a regional approach could be considered, where calls could be redirected to other providers, where a pharmacist was available to provide cover across more than one geographical area.

The Southern Trust and Dalriada Urgent Care reported they had introduced this model at weekends. Dalriada Urgent Care advised that approximately 5-7% of calls to the service had been requests for repeat medication or medication queries. This equated to approximately 50-60 calls directed to pharmacists each day (Saturday, Sunday and bank holidays), which saved up to 7.5 hours of GP triage time.

Both providers reported this arrangement had improved the efficiency of their GP Out-of-Hours Service. At the time of this Review, the South Eastern Trust and Western Urgent Care informed us they were also considering introducing pharmacists into their service.

Reintroduction of the scheme that enabled community pharmacies to dispense repeat medications without a prescription: as some community pharmacies have longer opening hours than GP practices this could be an alternative to contacting GP Out-of-Hours Services at particular times of the day. These schemes had been implemented by both NHS England[56] and NHS Scotland[57], and were available in various areas across the UK.

Within Northern Ireland, community pharmacies were not able to dispense repeat prescriptions without a prescription as it was not in line with the regulations laid out within Northern Ireland the Human Medicines Regulations 2012[58]. Any change in practice could only follow change in these regulations.

---

[56] Urgent Repeat Medication Requests Guide for NHS 111 Services - How to refer directly to pharmacy and optimise use of GP Out-of-Hours Services. NHS England (October 2015). Available from: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/80-repeat-med-guide-nhs111.pdf (Cited: May 2020)

[57] National Patient Group Direction for Urgent Provision of Repeat Medicines, Appliances and ACBS Products. NHS Scotland. (October 2016). Available from: http://apps.cps.scot/media/112756-Unscheduled-Care-Pharmacy-Guide-PGD-v21-sect-11-word-final.pdf (Cited: May 2020)

[58] Northern Ireland the Human Medicines Regulations 2012

No provision of repeat prescriptions within GP Out-of-Hours Services: in this approach GP Out-of-Hours Services would refuse to fulfil repeat prescriptions. We noted that some Out-of-Hours Providers[59] across the UK had decided not to provide a repeat prescription service, however we considered that there were significant risks in this approach, particularly where an urgent medical need exists. This approach may also re-direct work to an HSC Trust ED that could otherwise have been addressed by the GP Out-of-Hours Service.

The Expert Review Team noted that the arrangements in Northern Ireland, in respect of community pharmacists being unable to fulfil repeat prescriptions, may affect referrals to GP Out-of-Hours Services. We advised that providers should seek to fully understand the impact of repeat prescriptions on their service and identify solutions that enable patients to access urgent medications in the most efficient way this may include employing pharmacists in the out-of-hours workforce during periods where demand for this service is highest.

Providers, in conjunction with the DoH and HSC Board, should develop a regional approach to improve the ease of access to repeat prescriptions during normal working hours and the out-of-hours period. This work could be informed by learning from the pilots of using pharmacists within Dalriada Urgent Care and the Southern Trust GP Out-of-Hours Services.

Controlled Drugs

Controlled drugs are identified prescription medicines controlled under the Misuse of Drugs Regulations (Northern Ireland) 2002[60]. Examples include drugs such as diamorphine, morphine, pethidine and midazolam.

It is important that controlled drugs are handled correctly due to their potential for misuse. The HSC Board had included guidance on the management of controlled drugs in out-of-hours services in the Regional GP Out-of-Hours Guidance manual.

All providers, with the exception of the South Eastern Trust, stocked limited quantities of controlled drugs; the range and volumes varied between Primary Care Centres. Dalriada Urgent Care and Western Urgent Care informed us that the storage of controlled drugs at their Primary Care Centres was becoming more complicated due to the interpretation of medicines regulations. Both providers were in contact with Pharmacy Advisors in the DoH and the HSC Board, to try and resolve this issue. The Pharmacy Advisers have been working with the Providers to encourage and support them in applying for a controlled drugs licence.

Providers told us that controlled drugs were usually only administered to those patients receiving palliative care. The Expert Review Team was informed that

[59] Shropdoc Out-of-Hours Provider. Available from: https://shropdoc.org.uk/ (Cited: May 2020)
[60] The Misuse of Drugs Regulations (Northern Ireland) 2002. Available from http://www.legislation.gov.uk/nisr/2002/1/contents/made (Cited: May 2020)

many GP practices were good at ensuring anticipatory care for palliative patients and consequently the demand to provide it during the out-of-hours period was low.

In the Northern Trust area, the Marie Curie Service supported many palliative patients and Dalriada Urgent Care worked closely with them, when required. Western Urgent Care worked closely with district nurses to manage palliative patients during the out-of-hours period. In the Southern Trust, the GP Out-of-Hours Service, District Nurses, and Marie Curie Service delivered the majority of palliative care in the out-of-hours period. The Acute Care at Home Team provided palliative care for a limited number of patients on their caseload, when appropriate, with the support of the other services.

GPs had access to specialist palliative medication advice from the various hospices, if required. During part of the out-of-hours period, a Palliative Care Supply Service[61] was available in eight community pharmacies, this aimed to facilitate on-call access to palliative care medicines for patients.

However, when Community Pharmacies were closed, there was no access to required palliative care medicines. All providers reported that when GPs were faced with the scenario of not having access to palliative care medicines, or the time to get such medicines being excessive, they suggested that patients were referred to hospital. The Expert Review Team noted the impact this had on both secondary care services and on a vulnerable group of patients and their carers.

One possible option may be that providers could proactively engage with their co-located HSC Trust Pharmacy and Medicines Management Service to develop pathways for the provision of urgent palliative care medicines to GP Out-of-Hours Services, via the Pharmacy Extended Hours/ Emergency Duty Service.

Providers informed us that some individual GPs carried their own stock of controlled drugs when working during the out-of-hours period. In such cases, individual GPs were responsible for the administration and security of these drugs. This was concerning to the Expert Review Team, particularly in relation to limited governance systems , as the providers did not appear to have any/ sufficient oversight of this practice.

While GPs were subject to an inspection of their controlled drugs register approximately every three years, by an HSC Board Pharmacy Advisor or member of the Regional Practice Support Pharmacist Team, the outcomes of this were not necessarily shared with the providers. Consequently, providers had limited oversight of which GPs were carrying their own supply of controlled drugs and the frequency and level of administration of controlled drugs to patients during the out-of-hours period.

---

[61] Business Services Organisation information on the Palliative Care Supply Service. Available from http://www.hscbusiness.hscni.net/services/2481.htm (Cited: May 2020)

The following recommendation was made within the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

Each out-of-hours Provider should review its governance arrangements for the supervision and use of controlled drugs. Within HSC trusts this should involve the accountable officer. [*Appendix B: Recommendation 24*].

The Expert Review Team considered that while providers had arrangements in place for oversight of controlled drugs stocked in Primary Care Centres, they were concerned that there was limited oversight in relation to controlled drugs held and administered by individual GPs during the out-of-hours period. Most providers reported that not holding a stock of controlled drugs did not create problems for patients; however the Expert Review Team considered that there is the potential for considerable delay in the administration of necessary palliative care medication during the out-of-hours period.

Recommendation 11	**Priority 2**
Providers should collaborate with the HSC Board to develop robust arrangements for the management of controlled drugs within the GP Out-of-Hours Services. These arrangements should: a) provide effective oversight of the management of all aspects of controlled drugs within and from premises and also in relation to individual GPs carrying their own stock of controlled drugs, and b) should support timely access to controlled drugs for palliative patients.	

Medication Audits

It is important to assure the effective use of medicines to enable the best possible outcomes for patients to be achieved.

However, we found limited evidence of medication audits being undertaken by providers. We were not provided with evidence of established programmes for regular audit of the number of repeat prescriptions, prescription content and quantities, alignment with the Northern Ireland Drugs Formulary or the appropriateness of use of antibiotics. Clinical Leads reported they had limited capacity to oversee and undertake such a programme of regular audit and we acknowledged this was a significant constraint.

All providers reported that HSC Board Pharmacy Advisors collected data on the use of prescriptions and medications and this information was reported to the providers every four months; some providers reported using this data during meetings with GPs to review their prescribing practices.

The Belfast Trust told us of an audit of antibiotic prescribing completed as part of a Quality Improvement Project. The data were compared with regional guidelines and data from other providers. Using information from the Adastra System, they identified that in the Belfast Trust GP Out-of-Hours Service:

- 71% of prescriptions complied with the Northern Ireland Drugs Formulary;
- 57% of antibiotic prescriptions were prescribed in telephone consultations; and
- 50% of antibiotic prescriptions were prescribed between 6:00 pm and 7:00 pm during the weekday period.

The Expert Review Team considered that the learning arising from such audits could inform the development of an appropriate programme for the audit of prescribing, as well as contributing to improved practice in antimicrobial stewardship[62] .

The Expert Review Team acknowledged providers had some arrangements in place for the management of medications, in terms of supply and stock control. However, we were not assured that providers had allocated sufficient resources to develop and maintain comprehensive governance arrangements in relation to prescribing, including regular audits.

The Expert Review Team considered the limited available dedicated resource left to the Clinical Leads had contributed to weaknesses within the assurance arrangements in relation to prescribing and medicines management. The Expert Review Team acknowledged that, while development of a meaningful audit programme may have been a challenge, it was essential to provide evidence that safe care is delivered and/or to identify areas for improvement in the safety of GP Out-of-Hours Services.

Recommendation 12	**Priority 2**
The HSC Board should lead an ongoing programme of work with GP Out-of-Hours Providers to assure good practice in respect of the management of medicines within these services. This would include: a) to agree on appropriate assurance arrangements in respect of medications dispensed and prescriptions issued during the out-of-hours period, **b)** utilisation of pharmacists to support a programme of regular audit and monitoring of stewardship in respect of antimicrobial prescribing, and **c)** regional agreement on the content and frequency of a programme of medication audits and onward reporting of the outcomes of these audits.	

5.4 Safeguarding

The Expert Review Team was particularly interested in the processes and training in relation to safeguarding children and adults at risk of harm, or in need of protection. These need to be particularly robust within GP Out-of-

[62] Antimicrobial stewardship is the systematic effort to improve the use of antimicrobial medications (including antibiotics). It aims to improve patient health outcomes, reduce resistance to antibiotics, and reduce unnecessary costs. It tries to achieve this by educating and persuading prescribers to follow evidence-based prescribing. Available from https://www.nice.org.uk/guidance/qs121 (Cited: May 2020)

Hours Services as patients were likely to be unknown to clinicians, and access to full detailed histories and patient notes could be limited. There is also a potential risk that patients with safeguarding issues might be more likely to present at GP Out-of-Hours Services rather than at their own GP.

We heard that the three Trust providers were guided by their respective HSC Trust safeguarding policies and procedures, while Dalriada Urgent Care and Western Urgent Care had developed their own bespoke policies and procedures. All providers submitted these policies and procedures in relation to safeguarding children and adults and these were available to all staff, either on their respective intranet networks or as hard copies in Primary Care Centres. We considered these policies and procedures to be comprehensive.

Safeguarding Training

We found that safeguarding training was provided for all staff within GP Out-of-Hours Services, although there were differences in how this was provided. HSC Trust providers reported that safeguarding training was mandatory for Trust staff and was delivered via an eLearning package. The Southern Trust also reported that an initial safeguarding course was compulsory for all new GPs and attendance at this course was monitored. Dalriada Urgent Care and Western Urgent Care reported that safeguarding was included in the induction training provided to all staff.

Providers however, could not accurately tell us the number of staff who had completed safeguarding training, particularly GPs. Providers confirmed they asked GPs to ensure they had undertaken safeguarding training, but there was no evidence that checks were then carried out to determine whether the training had actually been completed or evidence of completion provided. The level of understanding of safeguarding among staff was unknown and there were limited mechanisms for identifying patients who may have required an onward referral in respect of safeguarding.

The Expert Review Team was not convinced that robust training was provided by Dalriada Urgent Care and Western Urgent Care, particularly as it was only included as part of induction and not subsequently reinforced by eLearning packages undertaken by staff in the HSC Trust providers.

Western Urgent Care reported that two managers had been trained as safeguarding trainers and that they were developing plans to provide safeguarding training for all staff.

The Expert Review Team noted that declarations from all providers indicated that all staff in GP Out-of-Hours Services had been appropriately trained in safeguarding; however, the Review Team considered that providers could not supply the evidence to support these declarations.

We noted that previously NIMDTA had delivered safeguarding training to GPs and GP trainees. However, we were informed that funding constraints meant NIMDTA no longer delivered this training to GPs; however they continued provide it for GP trainees.

Providers reported that arrangements for carrying out safeguarding checks for children and vulnerable adults were outlined within their procedures for safeguarding. However, as they could not provide assurance in relation to GPs safeguarding training they could not then verify whether GPs were familiar with their provider policies and procedures.

It was a requirement that GPs have up-to-date safeguarding training if they were to remain on the PMPL. With safeguarding training no longer delivered by NIMDTA, the Expert Review Team could not determine how GPs were now accessing safeguarding training. The Expert Review Team was not assured that adequate arrangements, in terms of oversight and assurance, were in place to confirm and record whether GPs had completed up-to-date safeguarding training.

Recommendation 13	**Priority 2**
Providers should work in collaboration with the HSC Board and the Northern Ireland Medical and Dental Training Agency to develop an appropriate mechanism that will enable providers to have oversight that GPs and GP trainees are up-to-date in relation to their safeguarding training.	

We identified that a key challenge for GPs working in GP Out-of-Hours Services, was identifying safeguarding cases where children were at risk of harm. GPs did not have access to the electronic systems which recorded information in relation to child protection status, such as the Social Services Client Administration and Retrieval Environment (SOSCARE) System[63] or the relevant section of a patient's Northern Ireland Electronic Care Record (NIECR)[64] .

Providers told us that increased attendances at an ED or GP Out-of-Hours Service were triggers which GPs considered when assessing whether a child may be at risk of harm. In addition to this, the Southern Trust, Dalriada Urgent Care, and Western Urgent Care reported that the algorithm-based software used during triage by nurse practitioners could assist with identifying whether a child was at risk.

The Expert Review Team acknowledged these potential triggers, but was concerned that GPs have to rely solely on their experience of dealing with child protection cases in order to easily pick up on such triggers.

[63] SOSCARE (Social Services Client Administration and Retrieval Environment) is the main system used by social workers in Northern Ireland to record and communicate information on social care clients in both the Adult and Family Child Care elements of social work.
[64] The Northern Ireland Electronic Care Record (NIECR) is a computer system that health and social care staff can use to get information about a patient's medical history. It can provide information about any allergies, long-term health conditions, or medicines taken by the patient.

The following recommendation was made by the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

Out-of-hours providers should review their arrangements for carrying out checks in relation to the protection of children and vulnerable adults in view of the establishment of the Independent Safeguarding Authority. [*Appendix B: Recommendation 4*].

The Expert Review Team concluded that this recommendation had not been implemented, as GPs working in GP Out-of-Hours Services continued to have no electronic means, either within the Adastra System or any other system, to identify whether a child is on the Child Protection Register.

All providers had access to the NIECR, albeit limited, and the Review Team considered that the capabilities of NIECR should be investigated, to determine if there is potential for these to be used to improve the safeguarding arrangements for children. This could be through the addition of an identifier which would highlight the current child protection status.

Recommendation 14	**Priority 2**
The HSC Board should work in collaboration with the Business Services Organisation and providers to explore whether an identifier can be added to NIECR that highlights whether a child is on the Child Protection Register.	

5.5 Information Management

Patient Information and Records

We examined how data and patient records were used to support the provision of effective care. Providers confirmed they all used the Adastra system to manage patient cases in GP Out-of-Hours Services. This system created and retained a record of contacts with GP Out-of-Hours Services going back five years.

Call handlers used Adastra to access basic information to identify the patient and their GP and to search for previous history and contact with GP Out-of-Hours Services. Adastra was also used to monitor the status of cases within the system.

The NIECR system was linked to the Adastra system to facilitate access to patient medical histories. This arrangement ensured that staff in all providers could access essential patient information. Providers reported that GPs could use the NIECR to view a patient's previous interaction with hospitals and clinics throughout Northern Ireland including:

- laboratory tests;
- x-rays;
- referrals;
- investigation requests;
- appointments; and

- appointment and discharge letters from various HSC systems.

The following recommendation was made by the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

The HSC Board and Business Services Organisation should consider rolling out the emergency care summary throughout Northern Ireland. [*Appendix B: Recommendation 19*].

If a patient consented for information about their medicines and allergies to be shared by their GP through the Emergency Care Summary then this would appear on the patient's record on NIECR. Providers confirmed that practitioners could view a patient's Emergency Care Summary on the NIECR.

We noted that for patients with long-term health conditions, the NIECR had a facility to store their Key Information Summary (KIS) record. The KIS record included details of:

- relevant medical history, including any long- term conditions;
- agencies involved with the patient;
- list of care plans or self-management plans;
- the patient's preferred treatment arrangements;
- resuscitation status; and
- arrangements for the Advance Decision to Refuse Treatment.

We agreed that access to this information was particularly valuable; assisting the practitioner with assessment to ensure patients received the best care. The Expert Review Team considered it to be in a patient's best interest if this information was shared. This was, however, out of the control of GP Out-of-Hours Services as the patient's GP must have obtained the patient's consent for their KIS to be shared on NIECR.

We would suggest that a patient's GP could decide if it was appropriate for them to have a KIS record completed and obtain consent in advance to share this on NIECR. To ensure that the best possible care was provided to patients during the out-of-hours period, particularly for those with long-term conditions, the Expert Review Team considered it would helpful if GPs could encourage patients with long-term conditions to share their KIS record on NIECR.

The following recommendation was made within the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

The regional standards for out-of-hours services should include standards for the provision and updating of special notes on patients provided by their own GP to the out-of-hours services. [*Appendix B: Recommendation 18*].

Special notes could relate to information about pending investigations, laboratory results or advice about the patient's care or wishes. We found that the Regional Standards for out-of-hours had not been updated to include

special notes; however, we were informed that the special notes system had worked well in practice and had provided useful additional information that supported the triage or assessment of patients.

All providers informed us that the Adastra system had the capability to store special notes against a patient's record. These notes would originate from the patient's GP, either via email or telephone, and were recorded on the Adastra system by GP Out-of-Hours Service staff.

The following recommendation was made within the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

All out-of-hours providers should review their arrangements to ensure effective communication with primary care daytime services and transfer of responsibility during the evening and morning handover periods. [*Appendix B: Recommendation 20*].

GP Practices were able to contact GP Out-of-Hours Services to update them about patients' medical conditions.

At the end of each out-of-hours shift, in GP Out-of-Hours Services, all information relating to each patient contact was electronically transferred to the respective patient's GP by 9:00 am the following day. This allowed GP Practices to update their patient medical records with details of the contact with the service and any applicable treatment.

The Expert Review Team considered that the transfer of information from the GP Practice to the GP Out-of-Hours Service may be less detailed than information provided by the GP Out-of-Hours Service to the GP Practice.

To help contribute to safe and effective patient care, the Expert Review Team considered that the HSC Board should write to GPs to ask them to:

- encourage their patients to consent to their Emergency Care Summary being available on NIECR in order for it to be available to GP Out-of-Hours Services;
- encourage their patients to consent to their KIS information being available on NIECR so that GP Out-of-Hours Services provide the best care for those patients with long-term conditions, and
- proactively forward special notes to GP Out-of-Hours Services, where appropriate.

5.6 Working Effectively with Other Services

During the out-of-hours period, access to Trust community healthcare services was mostly limited to nursing, palliative care and mental health services. These services usually only supported patients known to them; direct access to these services was not always possible, with a referral being necessary. The only direct access to services in the community during the out-of-hours period was with the RESWS.

All providers informed us that they liaised with, or supported, several other healthcare services when required and some examples of the working relationships between these healthcare services were highlighted during the review:

- **Nursing teams, such as District Nursing, 24 hour Nursing teams and Rapid Response:** Some providers were co-located with out-of-hours nursing teams; this had resulted in good working arrangements and co-operation.
- **Regional Emergency Social Work Service:** Providers considered the relationship with the RESWS worked well and they were well supported. The only challenge was when there was a need to detain a patient under the Mental Health Order, in respect of co-ordinating the work of the GP and the Approved Social Worker.
- **Marie Curie:** Providers worked closely with Marie Curie and other hospices in relation to palliative patients. Advice on palliative care and medication, if required, was available from hospice doctors. Marie Curie nurses assisted with acute nursing issues, such as catheterisation of patients and were also able to provide confirmation of death in many situations.
- **Mental Health Services:** Providers reported good relations with mental health services. Each HSC Trust had a 24-hour Crisis Resolution Team (in the Belfast Trust this was known as the Unscheduled Care Team), which aimed to respond to emergency cases within two hours. The GP Out-of-Hours Providers reported that it was particularly helpful when a mental health practitioner could be contacted directly to support a patient with a mental health condition.
- **Community Pharmacies:** Practitioners could contact community pharmacists operating extended hours or participating in the Palliative Care Supply Service to discuss or advise on issues with patients' medication or prescriptions.
- **Northern Ireland Ambulance Service:** Providers considered the relationship with NIAS to be good and described that the organisations had developed protocols for joint working. NIAS paramedics were able to provide confirmation of death, which helped the GP Out-of-Hours Service by reducing the number of home visits. NIAS was continuing to engage with some providers to identify opportunities for collaborative working, such as a model in which paramedics would undertake home visits rather than the GP in particular cases. The Expert Review Team considered there was significant potential within the ongoing work with NIAS; and they believed some of the initiatives should be taken forward on a regional basis rather than by individual providers only.

We were able to confirm that information about these other services was available to Out-of-Hours staff. We found that service directories, which contained information on contact details and operating times, were used to assist call handlers and practitioners in referring and signposting patients to other services, when required.

Providers reported that staff had good understanding of the roles and responsibilities of the other healthcare services available during the out-of-hours period and that information about these services was provided during induction; updates to these services were communicated to staff when changes occurred.

The Expert Review Team acknowledged the benefits of service directories which assisted with directing and referring patients to alternative services.

5.7 Innovation and Quality Improvement

Shared Learning

We explored the opportunities for shared learning that would help to drive improvement across GP Out-of-Hours Services and found these were somewhat limited and varied between providers.

Providers confirmed they were sharing results of their audits and information in relation to complaints and incidents with the HSC Board; this information was subsequently discussed at the quarterly Performance and Governance meetings with the HSC Board. The HSC Board's Regional Complaints Office shared some quantitative information about complaints but not in a format that would have promoted regional learning.

We have made a recommendation in relation to provision of analysed complaints reports in Section 4.7 of this Report.

We acknowledged the efforts to facilitate some sharing of information and learning but considered that, due to a low volume of audits, complaints and incidents there were limited opportunities to identify meaningful learning.

In order for providers to undertake meaningful service improvement they would first require access to better information about the quality of their service.

We found that where learning was identified, this was often shared separately with GPs and other core staff. Providers told us that learning was shared internally with core staff at learning lunches, staff meetings and highlighted through email and newsletters. They reported that such activities might instigate a review of their policies and procedures, or an update to working practices. All providers facilitated learning for GPs through attendance at Hot Topics courses and other specific events provided by NB Medical Education[65]. The HSC Trust providers reported that learning relating to governance issues was shared through their Trust governance structures.

Recognising that learning needs may differ between GPs and other staff and the logistical challenges arising from GPs' commitments to day time services, we considered the potential benefits of these different groups coming together

[65] NB Medical Education is a provider of a wide range of clinical education resources for GPs and other clinical staff. Courses are relevant to the work undertaken in GP Out-of-Hours Services.

to jointly consider issues and potential improvements that could be made to services. This multi-professional collaboration could inform broader solutions and provide greater support for any suggested changes.

All providers advised of a group set up to support learning arising from improvement activities, incidents, audits and complaints. This forum was considered an ideal mechanism for providers to share ideas and discuss issues such as audit, data analysis, quality improvement and patient experience from a regional perspective.

Overall, we found limited opportunities for direct sharing of information arising from incidents, accidents and complaints, between providers, daytime GP Services and other Urgent and Emergency Care services. Providers should consider developing a regional newsletter or e-bulletin to facilitate direct sharing of learning across all GP Out-of-Hours Services.

The Expert Review Team considered that the limited time available to Clinical Leads for such activities was likely to be the main factor impacting on the degree to which information and learning was being shared between and within providers. This was a critical role which providers must undertake to exercise their duty to provide a quality service and as such, must be included when identifying the number of sessions required for clinical leadership of the service.

Recommendation 15	**Priority 2**
Providers should collaborate with the HSC Board to strengthen and expand the existing mechanisms for dissemination of learning and information arising from incidents, accidents, complaints and audit, with key stakeholders including the GP out of hours services, daytime GP Services; Emergency/Urgent Care services and the HSC Board.	

Quality Improvement

A simple definition of Quality Improvement (QI), proposed by the Health Foundation, describes QI as 'a systematic approach that uses specific techniques to improve quality'[66]. These techniques need to be deliberate and targeted with a key objective and measurable outcome in mind. The key policy aimed at driving QI throughout the HSC is Quality 2020[67], this described that QI activities should be core to all services and embedded within organisations.

[66] Quality Improvement made Simple. The Health Foundation. Available from http://www.health.org.uk/sites/default/files/QualityImprovementMadeSimple.pdf (Cited: May 2020)

[67] Quality 2020: A Ten Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland. Department of Health. Available from https://www.health-ni.gov.uk/publications/quality-2020-ten-year-strategy-protect-and-improve-quality-health-and-social-care (Cited: May 2020)

During this review, all providers described the QI work they undertook. Following further discussion about these activities it was assessed that these were often more generalised service improvements, rather than being measurable and targeted QI activities. We did not find evidence of a systematic approach to quality improvement within any provider. The capacity of the clinical leads was a contributory factor to the lack of a systematic approach.

The HSC Board advised that it did not have a specific role to promote or drive QI within GP Out-of-Hours Services but rather this was the responsibility of individual providers. However, we heard that the HSC Board had supported QI within GP Out-of-Hours Services by establishing a Regional Quality Improvement Group which included provider representatives.

The HSC Board had also commissioned the HSC Leadership Centre to facilitate some regional QI training which provided an introduction to the PDSA (Plan, Do, Study, Act) methodology. Clinical Leads reported that setting up the Regional Quality Improvement Group had been a positive development but they found it difficult to dedicate sufficient time to it. Following the QI training, each provider had developed an improvement project and presented the results at a regional workshop.

It was commendable that some staff within each provider had completed some QI training however the embedding of QI activities was likely to be limited by the availability of the Clinical Leads to provide leadership to such activities.

Recommendation 16	**Priority 3**
Providers should consider strengthening arrangements for embedding Quality Improvement (QI) approaches within their GP Out-of-Hours Service including: a) increasing the number of core staff trained in QI methodology, b) actively participating in the Regional Quality Improvement Group, and c) ensuring Clinical Leads have sufficient time to dedicate to QI activities.	

Section 6: Patient Centred Services

The Expert Review Team considered that appropriate access to the service, the healthcare professional's attitude towards a patient, and listening to the patient are key elements of ensuring that patient-centred services were provided.

The majority of patients were likely to have only one interaction with GP Out-of-Hours Services, as any further or ongoing care would be provided by other services. However, patients with complex needs or long-term conditions could sometimes experience multiple interactions with GP Out-of-Hours Services.

In assessing if GP Out-of-Hours Services were patient-centred, we used both online and postal surveys to engage with patients to obtain their views and experiences of using GP Out-of-Hours Services.

6.1 Accessing Services

As previously described, GP Out-of-Hours Services were available every day from 6:00 pm to 8:00 am the following day and all day at weekends and public holidays. Patients normally contacted the service by telephone; however some patients arrived at the Primary Care Centres without an appointment and without telephoning the service first.

The following recommendation was made within the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

The Regional Out-of-Hours Project should establish an agreed timescale for the introduction of a single telephone number for out-of-hours services in Northern Ireland. [*Appendix B: Recommendation 15*].

This recommendation had not been implemented. The HSC Board reported that the communication infrastructure was not in place to facilitate the implementation of a single telephone number across the region. The HSC Board informed us they continued to assess the capability for such an arrangement; however, a decision to endorse this approach had not been taken and would require a policy direction from the DoH.

The Southern Trust, Dalriada Urgent Care and Western Urgent Care each had a single telephone number to access their Service. Based on a historical arrangement the Belfast and South Eastern Trusts continued to have two telephone numbers; however, call handlers in each respective Trust could answer calls received to either of these numbers.

Within our patient surveys, no respondents reported difficulties in contacting GP Out-of-Hours Services. Providers emphasised that they considered the current number of contacts correlated with the capacity of the service to respond to the demand rather than what the actual demand was. This was

because at periods of high demand a number of callers may not get through to the service. Providers told us that if more call handlers were available, more calls could be taken.

Arrangements for Patients when First Language is Not English

All providers confirmed access to the Northern Ireland Health and Social Care Interpreting Service (NIHSCIS)[68], which provided face-to-face interpreters for appointments and consultations. However, given the urgent nature of service provided by GP Out-of-Hours, it was not always appropriate or feasible to delay assessment by waiting for access to the NIHSCIS.

All providers also reported using The Big Word Telephone Interpreting Service[69] (Big Word Service) for consultations with patients whose first language is not English; providers told us that the Big Word Service was a responsive and valuable resource for GP Out-of-Hours Services.

Providers described the challenges when patients, whose first language was not English, contacted GP Out-of-Hours Services. The communication barrier between the patient and call handler could make it difficult to establish which language or interpreter was actually required. We recognised this as a significant challenge facing services and encouraged providers to consider possible solutions.

Recommendation 17	**Priority 2**
All providers should improve access to information about services to those whose first language is not English; this should advise how to access interpreting services.	

Arrangements for Patients with Hearing Difficulties

We confirmed that a sign language interpreting service, available through the NIHSCIS only operated during daytime hours which may impact upon those who are hearing impaired and needing to access GP Out-of-Hours Services.

Providers reported that the number of people with a hearing impairment who had contacted GP Out-of-Hours Services was low and those that did contact the service usually had a family member or friend to act as their interpreter.

We acknowledged the difficulties in accessing sign language interpreters and understood that those who require interpreters mitigate this difficulty by attending with a family member or friend. We also noted however the

[68] The Northern Ireland Health and Social Care Interpreting Service provides face-to-face Interpreters for the five Health and Social Care Trusts, Primary Care Services and other approved HSC Providers. Available from http://www.hscbusiness.hscni.net/services/2749.htm (Cited: May 2020)

[69] The Big Word Telephone Interpreting Service. Available from http://www.hscbusiness.hscni.net/services/2754.htm (Cited: May 2020)

requirement for providers, under the Disability Discrimination Act[70], to ensure deaf people were not discriminated against in terms of access to services.

To ensure equality of access for those with hearing impairments, providers should review and document their current arrangements for access to sign language interpreters, during the out-of-hours period and provide evidence of how they are managing these issues in line with legislative requirements. Information relating to these arrangements should be made available for staff and patients and placed on each provider website.

During observation visits, no issues were observed or reported in relation to general accessibility of Primary Care Centres for people with physical disabilities.

AREA OF GOOD PRACTICE

The South Eastern and Belfast Trusts reported engagement with a number of groups representing people with a disability to improve access to their services.

Both Providers met with representatives from the deaf community to review access to their Primary Care Centres. The outcome of this engagement was that a private telephone number has been provided to deaf people attending the centre, so they could text staff when they arrive.

The South Eastern Trust also provided details of their engagement with physical disability groups, who had undertaken visits and walked through their Primary Care Centres, making suggestions to improve accessibility.

The Expert Review Team commended these examples of engagement.

We concluded that there were some positive initiatives to improve accessibility for patients; however, we found no evidence of work at a regional level to actively identify the gaps in accessibility for particular groups and the needs and mitigations for these groups.

Arrangements for Patients in Prison

We noted that the South Eastern Trust had responsibility for prison healthcare and for any individuals in prison requiring access to their GP Out-of-Hours Service. The Trust reported that the majority of contact with this group tended

[70] Disability Discrimination Act 1995. Available from https://www.nidirect.gov.uk/articles/protection-against-disability-discrimination (Cited at 28/05/20)

to be for telephone advice; no consultations at Primary Care Centres or visits to prisons were undertaken. We acknowledged that physical assessment, where required, could be effectively undertaken by healthcare professionals within the prison who wereavailable outside of core GP service hours.

6.2 Provision of Information

We found that the availability of information for patients about GP Out-of-Hours Services varied between providers. With the exception of the Southern Trust, information relating to GP Out-of-Hours Services was limited. Most providers supplied basic information about the service, such as locations and contact details. There was limited guidance offered in relation to when it is appropriate to contact the service, what to contact the service about or what other guidance, help or support was available.

Providers displayed the above information on their respective websites; with the exception of Western Urgent Care which informed us it was exploring the possibility of developing its own website in the future. The HSC Board also hosted a regional Out-of-Hours website[71]; however, this was not regularly updated and did not contain comprehensive detail about providers and services.

It is important that patients have the information that would support them to make appropriate choices about the use of GP Out-of-Hours Services; the Expert Review Team considered that providers should examine ways of improving the information contained in their websites. Websites could contain:

- contact details and times of operation;
- information about the appropriate use of GP Out-of-Hours Services;
- information on other sources of help including locations and opening times; of community pharmacies; and
- information on self-management of common conditions.

The Expert Review Team further considered that the HSC Board should also update the regional out-of-hours website to reflect the current information contained on provider websites, as described above to ensure accurate and consistent information is available for the public.

The Expert Review Team agreed that the level of public understanding about the purpose of the service could in part be associated with insufficient quality of information being provided about the services.

[71] http://www.gpoutofhours.hscni.net/ (Cited: May 2020)

AREA OF GOOD PRACTICE

The Southern Trust shared examples of the information they provided about its service which includes information:

- about the locations and contact details;
- when to use the service; and
- an information sheet for patients; translated into multiple languages.

The Southern Trust also actively provided information for the public in relation to their GP Out-of-Hours Services, which included regular updates on social media and the Trust website, and a Trust poster campaign to highlight the appropriate use of GP Out-of-Hours Services.

The Expert Review Team commended this area of good practice. They considered it to be a positive initiative and a good use of resources, as it had the potential to reduce inappropriate use of GP Out-of-Hours Services. Other providers could learn from this and deploy a similar initiative within their own organisations.

With the exception of the Southern Trust, providers were not regularly informing patients when it is, or is not, appropriate to contact the service. Although it was not confirmed during the Review, there could have been a correlation between the low number of inappropriate contacts in the Southern Trust and their proactive communication about their GP Out-of-Hours Service.

6.3 Patient Feedback

Patient feedback is a valuable source of information for providers of GP Out-of-Hours Services, as patient views can help to identify areas for improvement. Engagement with patients on an on-going basis was difficult as most patients usually have a short one-off interaction with GP Out-of-Hours Services. There were no specific patient groups which could be utilised to collect patient views on GP Out-of-Hours Services.

All providers reported they received patient feedback through patient satisfaction/experience surveys and complaints; however the most common technique used by all providers to obtain the views of patients was via questionnaires which were posted to patients who had recently used their service.

We found there was variation between providers in relation to how often they sought patient feedback. Dalriada Urgent Care sent out patient surveys on a weekly basis, the Belfast Trust sent out patient surveys on a six monthly basis, while the South Eastern Trust, Southern Trust and Western Urgent Care sent out intermittent patient surveys.

All providers submitted copies of their patient questionnaires, which on examination had some minor differences in the information they were seeking. The Expert Review team considered it unlikely that these patient surveys would accurately reflect patient views on the overall quality or performance of the service.

The Expert Review Team determined that:

- Providers should jointly consider and agree the development of a single regional patient feedback questionnaire, which could facilitate direct comparisons of patient satisfaction across the region.
- Providers should undertake a review of the information being gathered from their patients to determine whether it was appropriate for informing improvement within their Service.

Providers told us that they considered complaints to be another method of obtaining patient views. The Southern Trust reported that it tended to learn more from complaints and incidents than from patient surveys.

The Expert Review Team did not agree that complaints in isolation could be relied upon to provide adequate feedback in relation to the quality of the service, as the number of complaints and incidents was low across all providers.

Providers provided examples of learning and improvement that had resulted from patient feedback which included:

- better access to Primary Care Centres for patients with hearing difficulties (Belfast Trust);
- upgrading the waiting area within the Primary Care Centre to accommodate people with physical disabilities (South Eastern Trust); and
- promotion of the “Hello, my name is" campaign[72], so that staff introduced themselves to patients (Southern Trust).

There was no evidence of shared learning from patient feedback between providers and this was considered by the Expert Review Team as a missed opportunity. Moving forward, methods of obtaining patient feedback and improvements made as a result could be included in the sharing of learning.

The Expert Review Team considered that providers needed to develop new mechanisms to improve on and increase the amount of patient feedback they receive. The mechanisms for patients to provide feedback about GP Out-of-Hours Services should consider all technological and media options and be prominently advertised across the service.

[72] The ‘Hello my name is’ campaign is focused on reminding staff to introduce themselves to patients properly as it advocates that a confident introduction is the first step to providing compassionate care and is often all it takes to put patients at ease and make them feel relaxed whilst using our services. Available at https://www.health-ni.gov.uk/articles/hello-my-name (Cited: May 2020)

Recommendation 18	Priority 2
All providers, in collaboration with, the HSC Board should: a) agree a range of mechanisms for ensuring regular and timely feedback from patients which is analysed in a way which supports service improvement activities, b) define arrangements to facilitate the sharing of learning from patient feedback between providers and with the HSC Board, and c) prominently advertise the mechanisms to provide feedback about the service across GP Out-of-Hours Services.	

6.4 Understanding Expectation and Needs

A total of 427 patients responded to our online and postal surveys and their responses are reflected throughout the following section.

Although the purpose of GP Out-of-Hours Services was to provide care for urgent problems that cannot wait until the normal GP service is available, providers, GPs and GP trainees all perceived that a considerable number of patients use the GP Out-of-Hours Service as a continuation of daytime GP services.

Of the 427 patients who responded to the survey 9% (39) reported that they used the service because they were unable to get an appointment with their own GP on the same day, or that the times of GP Out-of-Hours Service were more accessible to them because of work commitments.

Additionally, unlike daytime GP services, they reported that patients expect a response to be provided on the same evening they contact the GP Out-of-Hours Service.

Patient perception as to the seriousness of their condition often influenced their decision to contact the service and increased the expectation that they would be seen on the same day. This perception was reflected in the data from our patient engagement, which highlighted that approximately 78% of patients believed they had an urgent medical problem that could not wait until their own GP Practice opened the next day. The Expert Review Team agreed this was consistent with their own experiences of working within these services.

Survey comments indicated that some patients did not appreciate the difference between daytime and GP Out-of-Hours Services and that that primary care services were not currently provided 24 hours a day, seven days a week in Northern Ireland.

GP Out-of-Hours Services staff, GPs and GP trainees all reported experience of patients who had contacted GP Out-of-Hours Services with what they described as non-urgent conditions.

In 2016/17, approximately 56,109 (10%) of the total contacts with GP Out-of-Hours Services were referred back to in-hours Primary Care Services, as practitioners deemed these patients to have non-urgent conditions. Providers reported it was difficult to quantify the true number of patients who contacted GP Out-of-Hours Services with non-urgent conditions, as many did in fact receive treatment. Since this Review was not designed to specifically look at the appropriateness of use of GP Out-of-Hours Services, we did not seek to validate these figures.

GPs reported that when they worked in GP Out-of-Hours Services, they were employees and had limited ability to influence and manage patient expectations; if complaints were received from patients they also had limited involvement in the complaints process. As reported earlier, the lack of direct involvement was a concern for GPs, as poorly handled complaint investigations could have a negative impact on them.

GPs told us that they felt unsupported in the management of patient expectations and complaints; they were fearful of being subject to a complaint if they turned away a patient whom they considered to be non-urgent. GPs stated that it was sometimes easier to treat, what is considered a non-urgent patient, rather than engage the patient in an explanation of the purpose of the service and appropriate alternatives.

We acknowledged that there may have been differing expectations between providers and some patients seeking to access GP Out-of-Hours Services for what the service would consider to be non-urgent conditions. However, we also recognised that there were a limited number of alternative services available.

The provision of reassurance and information about alternative options of where to seek appropriate care is likely to be extremely helpful to patients who may be inappropriately contacting GP-out-of-Hours services.

We agreed that GPs should be encouraged and supported by service managers and Clinical Leads to fully identify the needs of patients and their expectations and then appropriately deal with those expectations; however, those designing and planning services in the future must also consider the entire network of services available across the 24 hour period, seven days a week and provide effective communication channels that direct patients to the most appropriate services at times that patients require them.

The Expert Review Team considered that public education and communication were critical factors in ensuring that users of services fully understand the purpose of the service and how to use it responsibly.
The following recommendation was made by the 2016 DoH Review of GP-Led Primary Care Services in Northern Ireland:

By November 2016, run a targeted media campaign to clearly articulate the role of the out-of-hours service. [*Appendix C: Recommendation 4.4*].

At the time of this Review, no media campaign had been undertaken; the HSC Board had advised that it was awaiting direction from the DoH before moving forward with such a campaign. Before any media campaign is undertaken, the Expert Review Team considered providers and the HSC Board should collaborate to complete work to explore and better understand the expectations of those accessing GP Out-of-Hours Services.

Recommendation 19	**Priority 2**
The HSC Board should work in collaboration with all providers to examine and clarify patient needs and expectations of these services; this work should underpin production of guidance for the public.	

The Expert Review Team recognised that people can only make informed judgments about appropriately accessing services if they have all necessary information about their purpose and available alternatives. The Expert Review Team supports the recommendation from the 2016 Review and that a public facing information campaign should again be considered .This campaign should not be time-limited and should be refreshed periodically.

Recommendation 20	**Priority 1**
The HSC Board should agree, develop and implement a refreshed media campaign for GP Out-of-Hours Services, as previously outlined in the 2016 DoH Review of GP-Led Primary Care Services in Northern Ireland.	

The Expert Review Team considered that a possible change of the name of the service may be beneficial to better communicate to and establish its core purpose with the public. Rather than GP Out-of-Hours Service, the name could be more reflective of the urgent care provided and the skill-mix of practitioners delivering the care. Suggestions included:

- Urgent Care Service;
- Urgent Care Out-of-Hours; and
- Emergency Primary Care.

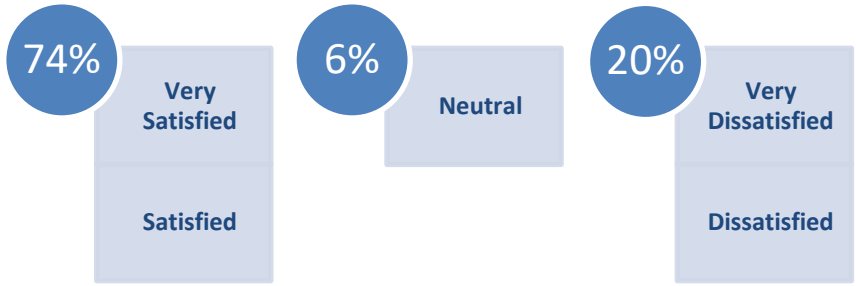
This should be explored by the DoH Working Group.

6.5 Patient Satisfaction

The results of our online and postal patient survey indicated high levels of satisfaction with GP Out-of-Hours Services. During our discussions with providers they reported that they had received similar results from their own surveys.

Of the 427 patients who responded to the survey, 317 (74%) reported being satisfied or very satisfied with the service they received following their initial contact (Figure 8).

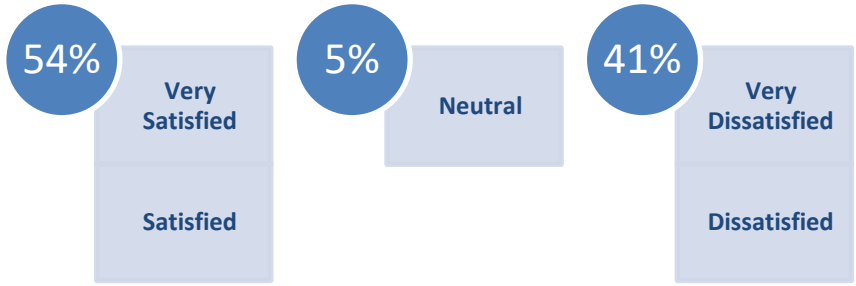
Figure 8: Patient satisfaction after initial contact with GP Out-of-Hours Services



Source: RQIA Online and Postal Patient Survey Data - January 2018

Following their initial contact, 54 patients reported no further contact with the GP Out-of-Hours Service, as a result of being referred to another service, or receiving advice from a call handler. Of these 54 patients, 29 (54%) reported being satisfied or very satisfied with the service they received (Figure 9).

Figure 9: Patient satisfaction after no further contact with GP Out-of-Hours Services



Source: RQIA Online and Postal Patient Survey Data - January 2018

However, 22 patients (41%) reported being dissatisfied or very dissatisfied following their initial contact with the GP Out-of-Hours Service. Analysis of these patient comments show they believed they should have received other input into their care, such as a consultation with a GP or a prescription.

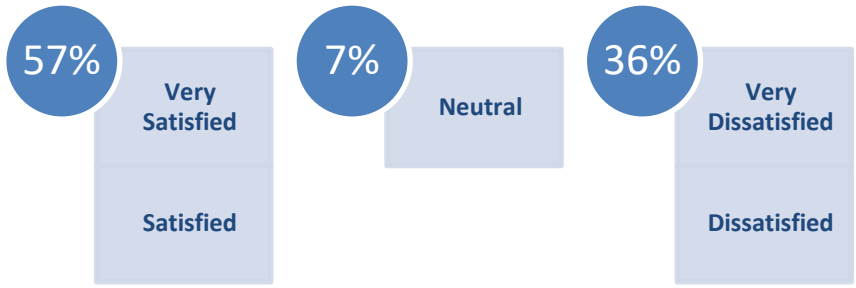
Patients who received Telephone Advice

Telephone advice was provided to 120 patients who responded to the online and postal survey. Overall, 69 patients (57%) reported being satisfied or very satisfied with the service they received (Figure 10). However, 43 patients (36%) reported being dissatisfied or very dissatisfied after receiving telephone advice.

Of the 43 patients who were dissatisfied the following reasons for their response were provided:

- 18 (43%) were dissatisfied because they believed they should have received additional care, such as a consultation with a GP or a prescription;
- 16 (38%) were dissatisfied because they were told that no further care was necessary; and
- 8 (19%) were dissatisfied because they were advised to contact another service, such as the ED or their own GP.

Figure 10: Patient satisfaction after telephone advice from GP Out-of-Hours Services



Source: RQIA Online and Postal Patient Survey Data - January 2018

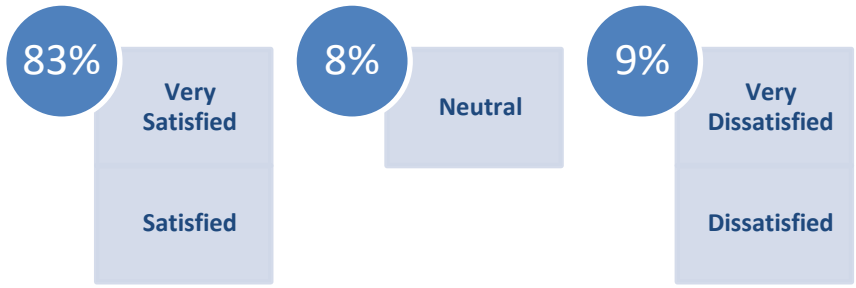
Patients who received an Appointment

Of patients who responded to the survey, the largest number, 229 (54%) had been given an appointment for a consultation at one of the Primary Care Centres. Of these 229 patients, 190 patients (83%) reported being satisfied or very satisfied with the service they received (Figure 11). 20 patients (9%) reported being dissatisfied or very dissatisfied after receiving an appointment for a consultation at one of the Primary Care Centres.

With the exception of one respondent who provided no explanation, dissatisfied patients provided the following reasons for their response:

- 12 (65%) were dissatisfied because of the length of time they waited before receiving treatment; and
- 7 (35%) were dissatisfied because they believed they should have received care other than what they received from the service; they reported that they ended up requiring further care later.

Figure 11: Patient satisfaction after consultation at a Primary Care Centre.



Source: RQIA Online and Postal Patient Survey Data - January 2018

Patients who received a Home Visit

Those patients who received a consultation at home (24 patients), all reported being satisfied or very satisfied with the service they received (Figure 12).

Figure 12: Patient satisfaction after a home consultation.

Source: RQIA Online and Postal Patient Survey Data - January 2018

Overall, the Expert Review Team considered that underlying patient expectations were an influencing factor in the level of satisfaction with the service. The Expert Review Team considered that when patients' expectations of the GP Out-of-Hours Service were met there was a higher level of satisfaction. Conversely, patient satisfaction reduced when patients do not receive the type of care or outcomes they expected. Higher levels of satisfaction were found in the cohorts of patients who had received a face to face consultation or a home visit, which was probably what they had wanted. Higher levels of dissatisfaction were found in those patients who had not been seen directly as it is likely they also had expected some face to face contact.

The Expert Review Team acknowledged that overall, patients were mostly satisfied following their interaction with GP Out-of-Hours Services but that further examination of patient expectations and understanding of needs is required as part of the future development of the service and to help inform any media or awareness campaigns.

6.6 Responsiveness to Patient Need

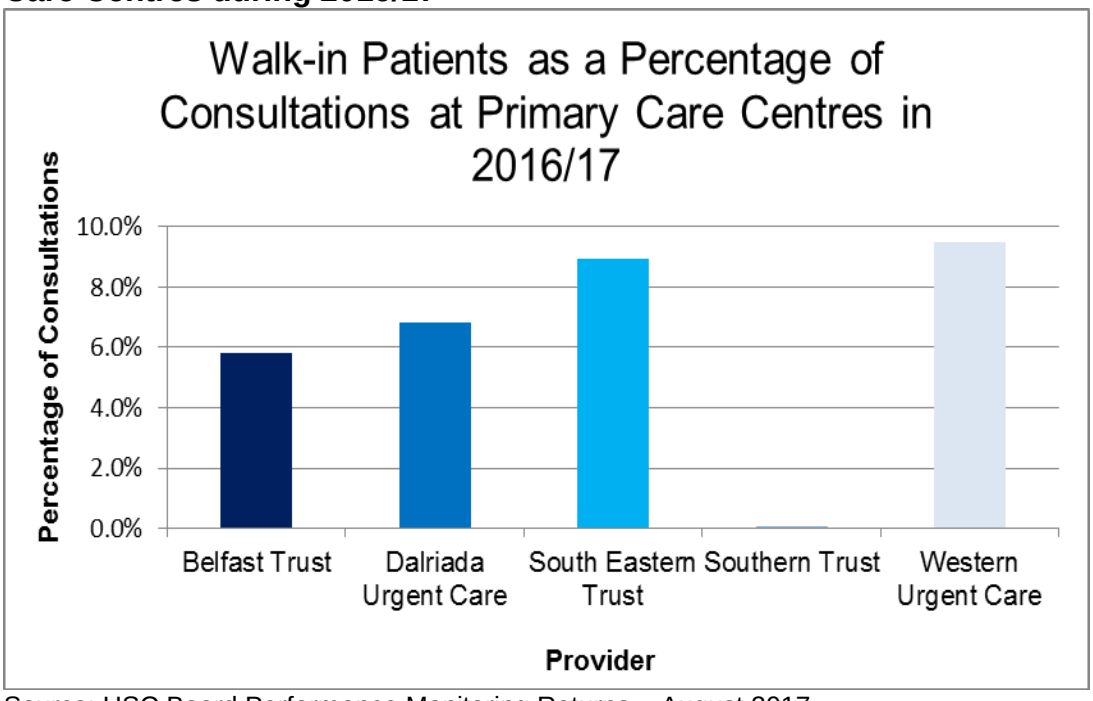
Walk-in Patients

All providers informed us they provided consultation at a Primary Care Centre by appointment and discouraged patients from presenting unannounced.

The number of walk-in patients varied by provider as outlined in Figure 13. During 2016/17, there were 13,882 walk-in patients. This represented approximately 2.4% of the total contacts with GP Out-of-Hours Services and accounts for approximately 6.1% of the total consultations at Primary Care Centres.

- The highest number was recorded in Western Urgent Care, with 4,694 walk-in patients, which accounts for 9.5% of total consultations at their Primary Care Centres.
- The lowest number was recorded in the Southern Trust with 32 walk-in patients, which accounts for 0.1% of total consultations at their Primary Care Centres.

Figure 13: Walk-in Patients as a Percentage of Consultations at Primary Care Centres during 2016/17



Source: HSC Board Performance Monitoring Returns – August 2017

All providers reported that walk-in patients were accommodated and not turned away.

Patient Consent and Chaperoning

The following recommendation was made within the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

All out-of-hours providers should have written policies on patient consent and chaperoning of staff involved in intimate care and examination of patients. [*Appendix B: Recommendation 16*]

Consent and Chaperoning Policies were in place across all providers, with the exception of the Southern Trust which reported that there was no Trust policy for chaperoning within GP Out-of-Hours Services.

The Expert Review team considered that the Southern Trust could collaborate with the other HSC Trust providers to discuss their policies in order to facilitate the efficient development of their own policy.

Patient consent was required before providers access the NIECR system to view a patient's previous medical history and also as part of assessment treatment and examinations; currently consent was not recorded in writing.

All providers reported that only a small number of examinations requiring a chaperone were carried out; all had suitable arrangements in place to facilitate this when required. On most occasions, the chaperone was a nurse, although another doctor or health care professional could also assist. Patient consent for the presence of a chaperone was always sought prior to any examination.

We found that the ability to provide a chaperone was limited for those periods of time when GPs may be alone in a Primary Care Centre. Providers indicated this scenario was more likely to occur during the early hours of the morning and in more remote Primary Care Centres. If a patient required a chaperone and none was available, we were advised that the patient may be offered an appointment at another Primary Care Centre, where this could be facilitated, or alternatively referred to ED. We considered this to be a proportionate and pragmatic approach.

6.7 Personal and Public Involvement (PPI)

In March 2015, the PHA launched standards for Personal and Public Involvement – Setting the Standards[73], which set out expectations for HSC organisations and staff in relation to PPI. The standards were designed to help improve practice and support the drive towards a truly person-centred health and social care system.

PPI is a statutory duty for HSC organisations and intended as a two-way process of engagement and not solely to be used when organisations want to hear the views of patients and carers as part of a consultation exercise. As mutual organisations, Dalriada Urgent Care and Western Urgent Care do not fall within the remit of this statutory duty.

The following recommendation was made within the 2010 RQIA Review of GP Out-of-Hours Services in Northern Ireland:

[73] Personal and Public Involvement – Setting the Standards 2015. Public Health Agency. Available from http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/allied-health-professions-and-personal-and-publi-5 (Cited: May 2020)

All providers should establish agreed arrangements for collaboration with the Patient and Client Council as part of their approach to user engagement. [*Appendix B: Recommendation 13*].

The Expert Review Team considered that this recommendation had not been implemented as there had been no engagement with the PCC. The Expert Review Team also considered that meaningful involvement of patients in GP Out-of-Hours Services, as defined by PPI, had not taken place. While patients had been involved in some specific pieces of work, such as initiatives to improve accessibility, they had limited involvement in the overall planning, development, delivery or evaluation of GP Out-of-Hours Services.

In order to fully meet their statutory responsibilities under PPI, the HSC Board and providers could work together, to determine how best to use the PPI standards as the basis on which to regionally involve patients in GP Out-of-Hours Services.

6.8 Equality and Diversity

Addressing equality and diversity issues in today's society requires an inclusive approach which is responsive to the needs of the patient. Most providers reported that they provided training in relation to fairness and diversity, or equivalent training focused on equality; however Western Urgent Care advised that it has not yet developed such training for staff.

We identified that different arrangements were in place across the providers and between operational staff and GPs:

- three Trust providers (Belfast, Southern and South Eastern) reported that equality and diversity training was mandatory for operational staff, and was delivered via an eLearning package. The Southern Trust also reported that a new module on 'Quality, Good Relations and Human Rights' had been made available on the Trust eLearning system;
- Dalriada Urgent Care provided equality and diversity training for operational staff. No training was provided for GPs, and all providers worked on the assumption that GPs had availed of equality and diversity training during their daytime general practice; and
- Western Urgent Care had not secured training for staff in relation to fairness and diversity.

Providers advised that data was available to enable monitoring of completion of equality and diversity training by operational staff. None of the providers were able to produce figures or provide an estimate as to the number of GPs that have completed equality and/or diversity training.

The Expert Review Team considered that the HSC Board should collaborate with providers to develop an appropriate mechanism to record details of GPs completion of the required equality and diversity training.

Section 7: Conclusions and Recommendations

7.1 Conclusions

This detailed Review of GP Out-of-Hours Services provided important insights into the current governance systems in place for GP Out-of-Hours Services in Northern Ireland.

During the course of this Review we engaged a full range of key stakeholders and undertook five observational site visits to Primary Care Centres, one in each provider area. As such, we can be confident that the findings of this Review reflect accurately the operational and governance arrangements at the time and their impact on the effectiveness of the service and safety of patient care.

We were impressed by many examples of good practice; including improving access to consultations for patients residing in border areas; proactive engagement with nursing homes to reduce calls, audits of clinical notes to improve recording of safety netting advice for patients, the establishment of a staff forum to facilitate collaboration between different operational staff and management; and engagement with disability groups to improve accessibility of services.

We commended the providers for their exceptional commitment to delivering high quality, safe and effective care; however, we found that their ability to do so was impacted by a reduction in the number of GPs working in GP Out-of-Hours Services and limited support being provided by HSC Trusts for these services.

This Review highlighted the urgent need for a new operating model for GP Out-of-Hours Services for Northern Ireland in the context of the wider HSC transformational agenda; to address the immediate challenges and to stabilise services.

Steps must be taken urgently to encourage many more GPs to work in GP Out-of-Hours Services by introducing both more flexible working options, more home triage and by taking steps to address issues surrounding remuneration.

The development and implementation of KPIs, which reflect patient outcomes, experience and quality of care must be agreed and measured through effective performance monitoring arrangements. Unless this system is working effectively Trust Boards and the HSC Board cannot be assured that the service provided is of an acceptable standard.

Clinical Leads demonstrated exceptional commitment to their services, but it was evident that they did not have sufficient capacity to dedicate the required time to important issues such as risk management, performance audits and developing quality improvement initiatives for the service. We found that many risks, both operational and clinical, were common to all providers and

that there was a great opportunity for common approaches to be taken to collectively manage these risks.

Several of the recommendations from this Review related to leveraging the benefits of high quality information and data. There were several opportunities to improve the use of the available information from the Adastra system to audit outcomes achieved for patients in respect of their condition; to drive improvements in service delivery.

In general there was a strong consensus among members of the Review Team that, given our discrete population there was much potential for greater regional collaboration. This would ensure sharing of learning arising from incidents, adverse incidents and complaints to support change and drive improvement in services. If this was underpinned by the development of a regional core dataset, collaboration would also support clinical audit and quality assurance requirements relating to triage, assessment and treatment.

We found the management of medicines within GP out of hours services would benefit from stronger oversight and assurance in relation management of controlled drugs. We also identified a need for improvement in the current arrangements for managing repeat prescription requests and medication audits.

Another key finding was that providers did not have full oversight of the completion of safeguarding training and that the Adastra system did not have a trigger to flag up children on the Child Protection Register.

We observed that although patient feedback was sought by all providers the information obtained was not always meaningful and we agreed that further work was required to examine and better understand patient behaviours to ensure appropriate use of the service and to inform improvements.

Overall, a considerable number of recommendations contained within this report require a regionally co-ordinated implementation led by a DoH established regional Working Group with appropriate senior clinical representation. Clinical leadership, as envisioned in Health and Wellbeing 2026: Delivering Together (2016)[74] and Systems, Not Structures: Changing Health & Social Care, Expert Panel Report (2016)[75] will be key to driving forward the necessary reforms with clinical ownership and an understanding of the role of GP put of Hours as one part of a wider urgent care system in Northern Ireland.

It is hoped that our assessment of progress against previous recommendations and the new recommendations within this report will inform both the regional work to deliver the transformation of Northern Ireland GP out of Hours services but also local improvement initiatives. Full consideration of

[74] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf
[75] https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf

these recommendations by providers in collaboration with the DoH, HSC Board and Regional Working Group should support the delivery of services in future which meet the changing needs of our population.

7.2 Summary of Recommendations

The recommendations identified during the Review have been prioritised in relation to the timescales in which they should be implemented. However, a pragmatic approach to the implementation of the recommendations should be considered against the practicalities of operating within the confines of a pandemic.

Priority 1 - completed within 6 months of the publication of this report
Priority 2 - completed within 12 months of the publication of this report
Priority 3 – completed within 18 months of the publication of this report

Implementation of the recommendations will improve GP Out-of-Hours Services delivered throughout Northern Ireland.

Rec. Number	Recommendation	Priority
1	The Department of Health should establish a Working Group with the necessary authority to design a new model for GP Out-of-Hours Services within the programme of the wider Transformation Agenda. The Working Group should: a) Define a new model, with an agreed definition, describing the purpose of the Service and specifying its scope; b) Ensure the new model is embedded within the wider unscheduled care infrastructure and ensure that it is complementary to other options such as walk-in centres, minor injury units and internet/ telephone advice; c) Examine options for modernisation of triage, remote working and leveraging technology; d) Determine the sustainable number of locations, required staffing resources and preferable skill-mix to provide a sustainable service; e) Develop a comprehensive communication and engagement strategy to promote the renewed model; f) Agree interim measures to stabilise the current GP Out-of-Hours Services in the interim; and g) Actively progress the implementation of recommendations from this Review and the 2016 DoH Review.	1
2	The Health and Social Care Board and HSC Trusts, in collaboration with providers, should: a) review the current GP Out-of-Hours Escalation Plan	1

	and Escalation Status Report arrangements for escalating and addressing issues during the Out-of-Hours period; and b) develop arrangements which clearly define the range of possible options and actions to be taken to address identified risks, particularly those relating to service continuity.	
3	The Out-of-Hours Providers should ensure Clinical Leads have sufficient capacity to effectively undertake their management and governance responsibilities to ensure safe and effective oversight of their Service.	1
4	The GP Out-of-Hours Providers, with advice from the HSC Board, should develop an effective system, with agreed metrics, to assess the performance of GPs within GP Out-of-Hours Services (See also Recommendation 6). The learning from initiatives undertaken by Dalriada Urgent Care and the Southern Trust should be considered.	3
5	Providers should ensure a shared understanding of respective roles GPs and the other staff groups within their GP Out-of-Hours Service.	3
6	The DoH Working Group established in Recommendation 1 should: a) develop and implement a suite of new Key Performance Indicators (KPIs) for GP Out-of-Hours Services which reflect patient outcomes, patient experience and quality of care; and b) develop a system to ensure the data collected is used to inform clinical audit and quality assurance requirements, relating to triage, assessment and treatment and is used to inform staff appraisal.	1
7	Providers should work collectively with support from HSC Board, GPs and other staff to develop regional guidance for accurately coding and recording patients' clinical conditions on Adastra.	2
8	The HSC Board should collaborate with providers to design a regional programme of clinical audits, therefore ensuring more effective use of the data and information captured by the Adastra system.	3
9	Providers should ensure they have robust risk management systems and processes which accurately describe all the key the risks facing GP Out-of-Hours Services. These must include:	1

	a) systems which ensure staff identify all risks including common core risks across providers (both operational and clinical), b) identification of effective actions to mitigate and manage the identified risks on a regional basis where necessary and c) risk registers which document in detail identified risks and effective actions to mitigate them.	
10	All providers should strengthen the arrangements for raising and managing complaints, which include: a) active promotion of the complaints procedure to all patients, b) developing arrangements that ensure GPs are appropriately involved in the assessment and management of complaints, c) ensuring appropriate support arrangements are in place for both complainants and GPs, and d) mechanisms to collect and disseminate regionally and locally any learning arising in a timely way.	2
11	Providers should collaborate with the HSC Board to develop robust arrangements for the management of controlled drugs within the GP Out-of-Hours Services. These arrangements should: a) provide effective oversight of the management of all aspects of controlled drugs within and from premises and also in relation to individual GPs carrying their own stock of controlled drugs, and b) should support timely access to controlled drugs for palliative patients.	2
12	The HSC Board should lead an ongoing programme of work with GP Out-of-Hours Providers to assure good practice in respect of the management of medicines within these services. This would include: a) to agree on appropriate assurance arrangements in respect of medications dispensed and prescriptions issued during the out-of-hours period, **b)** utilisation of pharmacists to support a programme of regular audit and monitoring of stewardship in respect of antimicrobial prescribing, and **c)** regional agreement on the content and frequency of a programme of medication audits and onward reporting of the outcomes of these audits.	2

13	Providers should work in collaboration with the HSC Board and the Northern Ireland Medical and Dental Training Agency to develop an appropriate mechanism that will enable providers to have oversight that GPs and GP trainees are up-to-date in relation to their safeguarding training.	2
14	The HSC Board should work in collaboration with the Business Services Organisation and providers to explore whether an identifier can be added to NIECR that highlights whether a child is on the Child Protection Register.	2
15	Providers should collaborate with the HSC Board to strengthen and expand the existing mechanisms for dissemination of learning and information arising from incidents, accidents, complaints and audit, with key stakeholders including the GP out if hours services, daytime GP Services; Emergency/Urgent Care services and the HSC Board.	2
16	Providers should consider strengthening arrangements for embedding Quality Improvement (QI) approaches within their GP Out-of-Hours Service including: a) increasing the number of core staff trained in QI methodology, b) actively participating in the Regional Quality Improvement Group, and c) ensuring Clinical Leads have sufficient time to dedicate to QI activities.	3
17	All providers should improve access to information about services to those whose first language is not English; this should advise how to access interpreting services.	2
18	All providers, in collaboration with, the HSC Board should: a) agree a range of mechanisms for ensuring regular and timely feedback from patients which is analysed in a way which supports service improvement activities, b) define arrangements to facilitate the sharing of learning from patient feedback between providers and with the HSC Board, and c) prominently advertise the mechanisms to provide	2

	feedback about the service across GP Out-of-Hours Services.	
19	The HSC Board should work in collaboration with all providers to examine and clarify patient needs and expectations of these services; this work should underpin production of guidance for the public.	2
20	The HSC Board should agree, develop and implement a refreshed media campaign for GP Out-of-Hours Services, as previously outlined in the 2016 DoH Review of GP-Led Primary Care Services in Northern Ireland.	1

Appendix A: Summary of Progress in relation to Recommendations from local reviews focusing specifically on the 2010 RQIA Review of the General Practitioner (GP) Out-of-Hours Service and the 2016 Department of Health Review of GP Led Primary Care Services in Northern Ireland.

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
1. The work of the Regional Out-of-Hours Project should be progressed to clarify the future strategic direction for the services and to take forward planned initiatives including a regional user survey and an agreed approach to quality performance monitoring.	**The Expert Review Team determined that this recommendation has not been implemented.** A number of previous Reviews, as outlined in Section 1.2, made recommendations designed to shape the future model of GP Out-of-Hours Services. However, we did not find there was a clear vision for the future model for GP Out-of-Hours Services in Northern Ireland which was informing service planning or the different developments being taken forward.	4.1 - During 2016/17, service providers should explore opportunities to build the skills mix in out-of-hours services, including through the use of nurse triage services and pharmacist prescribers. Providers should also consider the scope for partnership working with other services, such as community pharmacies, to ensure that patients are directed to the most appropriate health professional.	**The Expert Review Team determined that this recommendation has been partially implemented.** At the time of the Review, four providers have introduced either nurse practitioners or pharmacists into their workforce. Belfast Trust has not introduced nurse practitioners or pharmacists into their skill mix; here GPs continue to solely deliver care.

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
2. Out-of-hours Providers should have specific risk registers which are kept under regular review.	**The Expert Review Team determined that this recommendation has been partially implemented.** Providers demonstrated a clear understanding of the risks associated with their services. Risks were regularly reported to the HSC Board and were discussed at monthly meetings as part of monitoring arrangements. The quality of the risk registers in capturing all known risks varied among providers and a number of risks highlighted in discussions had not been listed on all risk registers. Some risk registers did not clearly identify who was responsible for the risks and some did not set out any actions in place to mitigate against the risks detailed in the registers.	4.2 - During 2016/17, to reduce demand on GP out-of-hours, run an emergency supply pilot to allow pharmacists to provide an emergency supply of medication to patients free of charge, without the need for a repeat prescription.	**The Expert Review Team determined that this recommendation has not been implemented.** A pilot scheme in Northern LCG area which allowed Community Pharmacists to provide an emergency supply of medication to patients free of charge, without the need for a repeat prescription was completed. The HSC Board evaluation recommended roll out of the service from all eligible community pharmacies across Northern Ireland; however, the pilot concluded on 18 December 2017 as the HSC Board was unable to extend it whilst the implementation of a Northern Ireland wide service was taken forward. This roll-out has not been progressed.

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
3. Out-of-hours Providers should consider methods of providing assurance that doctors are not working excessive hours by working shifts for different providers.	**The Expert Review Team determined that this recommendation has been partially implemented.** Monitoring was undertaken annually by staff completing a declaration of secondary employment or an appropriate opt-out form. While providers reported they were able to manage compliance with the EWTD for contracted staff, they had no mechanism for managing the compliance of sessional GPs against the EWTD. The Expert Review Team considered there were weaknesses in ensuring compliance with the EWTD.	4.3 - From June 2016, all service providers must use the Adastra patient management system to routinely analyse management information and ensure that resources are deployed as effectively as possible to meet predicted service demand.	**The Expert Review Team determined that this recommendation has been fully implemented.** The Expert Review Team was provided with evidence to demonstrate that this recommendation has been implemented. When providers identify issues, such as waiting times or call volumes, they use data from Adastra to help determine the cause of the issues and to ascertain what operational improvements can be made.
4. Out-of-hours Providers should review their arrangements for carrying out checks in relation to the protection of children and vulnerable adults in view of the establishment of the Independent Safeguarding Authority.	**The Expert Review Team determined that this recommendation has not been implemented.** At the time of this review GPs working in GP Out-of-Hours Services continued to have no electronic mechanism, either within the Adastra System or any other system, to identify whether a child is on the Child Protection Register. The Expert Review Team identified that the Adastra System did not have triggers to flag up children on the Child Protection Register; and that GPs relied upon their clinical experience to recognise potential child protection cases or that a child was on the register.	4.4 - By November 2016, run a targeted media campaign to clearly articulate the role of the out-of-hours service.	**The Expert Review Team determined that this recommendation has not been implemented.** At the time of this review no media campaign has been undertaken; the HSC Board advised that it is awaiting direction from the DoH before moving forward with such a campaign.

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
5. Each Provider should consider developing a training plan where this is not in place and which is reviewed on an annual basis.	*The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*	4.5 - By November 2016, review the current out-of-hours key performance indicators to assess whether they remain appropriate for the effective and efficient provision of out-of-hours services.	**The Expert Review Team determined that this recommendation has not been implemented.** The current KPIs were process measures and not indicators of service quality or outcome. Clinicians were measured on their ability to respond to a patient within a particular timescale, rather than the quality of care they provide to that patient. At the time of this review, no one was able to provide any evidence that this recommendation has been actioned.
6. The out-of-hours service should continue to work with Northern Ireland Medical and Dental Training Agency (NIMDTA) on the role of trainees in the out-of-hours service.	**The Expert Review Team determined that this recommendation has been partially implemented.** We identified that the role of the GP trainee sometimes varied between providers. This was related to the different approaches of various GP trainers rather than the expectations of the Provider. In view of this, it was considered that NIMDTA could review the variation of approaches from GP trainers with the aim of providing a more consistent approach irrespective of provider.	4.6 - By December 2016, introduce a remote triage service across the out-of-hours service to meet periods of high demand.	**The Expert Review Team determined that this recommendation has been partially implemented.** At the time of this review it was apparent that this recommendation has not been taken forward on a regional basis, but rather some providers have progressed it on an individual basis.

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
7. NIMDTA and providers should agree arrangements which should be in place for out-of-hours services to provide feedback on GP trainees' performance and for out-of-hours services to receive feedback on trainee experience of these placements	**The Expert Review Team determined that this recommendation has been implemented.** At the time of this review, the documentation used to monitor the performance of a GP trainee's placement in GP Out-of-Hours Services was provided; this was an integral part of the assurance and validation processes for GP trainees working in GP Out-of-Hours Services.	4.7 - By February 2017, develop a regional training programme for out-of-hours staff, initially concentrating on call handlers to enable better call categorisation, through improved communication and negotiation skills.	**The Expert Review Team determined that this recommendation has not been implemented.** At the time of this review, this recommendation had not been progressed.
8. Regional guidelines for out-of-hours providers should be developed on referral pathways for mental health patients and services in each trust area should be reviewed in relation to this guidance.	*The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*	4.8 - By February 2017, review the home visit arrangements across the region to identify opportunities for improving the service and making more effective and efficient use of the GP out-of-hours vehicles.	*The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*
9. The development of a regional system for the collation of learning from incidents occurring in out-of-hours services should be considered during the development of the new Regional Adverse Incident Learning System (RAIL) for health and social care in Northern Ireland.	**The Expert Review Team determined that this recommendation has not been implemented.** The RAIL system has not yet been developed and implemented in out-of-hours services.	4.9 - By March 2017, consider trialling the Ask My GP in out-of-hours following the outcome of the in-hours pilot.	**The Expert Review Team determined that this recommendation has not been implemented.** The HSC Board has considered this model and determined that asking patients to complete a web-based form could potentially delay access to urgent care. Therefore, it was not taken forward as a trial in the out-of-hours setting.

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
10. All out-of-hours providers should review their arrangements to ensure that all staff understand the importance of reporting incidents and near misses to maximise opportunities for learning and to reduce the risk of recurrence.	**The Expert Review Team determined that this recommendation has been implemented.** The review found that providers had established arrangements in place for the management of incidents, adverse incidents and accidents, which were supported by policies and procedures.	4.10 - By June 2017, develop and commence a trial of an interface service delivery model (times to be considered but potentially between the hours of 4pm to 9pm), with a view to rolling it out across the region.	**The Expert Review Team determined that this recommendation has not been implemented.** At the time of this review, the implementation of an interface service delivery model had not been progressed in Northern Ireland.
11. A programme of agreed regional clinical audits should be carried out across all out-of-hours providers to enable them to compare their clinical services. This could be considered as part of the regional programme supported by the Guidelines and Audit Implementation Network (GAIN).	**The Expert Review Team determined that this recommendation has been partially implemented.** While clinical audits were being undertaken in each Provider, the level of clinical audit varied between providers, but overall was limited. The Expert Review Team found insufficient use of clinical audit within the GP Out-of-Hours Service and insufficient data available to drive improvements across and within these services.	4.11 - By June 2017, review the number of out-of-hours bases	**The Expert Review Team determined that this recommendation has not been implemented.** At the time of this review, this has not been undertaken. The Expert Review Team considered that this action should be the responsibility of the DoH established Working Group, and carried out as part of the activity of revising the model for GP Out-of-Hours Services.
12. All out-of-hours service providers should explore opportunities to increase service resilience by having joint arrangements for further co-operation across boundaries during the red eye period.	*The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*		

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
13. All providers should establish agreed arrangements for collaboration with the Patient and Client Council as part of their approach to user engagement.	**The Expert Review Team determined that this recommendation has not been implemented.** The Expert Review Team considered that this recommendation has not been implemented as no engagement with the PCC has been undertaken. The Expert Review Team also considered that meaningful involvement of patients in GP Out-of-Hours Services, as defined by PPI, is not taking place.		
14. The HSC Board in its role as commissioner of unscheduled care should review arrangements to ensure the effective integration of emergency services. These include primary care out-of-hours, A&E, ambulance services, community nursing, social care and mental health crisis services.	*The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*		

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
15. The Regional Out-of-Hours Project should establish an agreed timescale for the introduction of a single telephone number for out-of-hours services in Northern Ireland.	**The Expert Review Team determined that this recommendation has not been implemented.** Each of the five providers utilise their own individual telephone numbers and a single telephone number for contact with GP Out-of-Hours Services in Northern Ireland has not been introduced.		
16. All out-of-hours providers should have written policies on patient consent and chaperoning of staff involved in intimate care and examination of patients.	**The Expert Review Team determined that this recommendation has been partially implemented.** We were provided with evidence of Consent and Chaperoning Policies, with the exception of the Southern Trust who informed us that there is no Trust policy for chaperoning within GP Out-of-Hours Services. Patient consent was required before providers access the NIECR system to view a patient's previous medical history and also as part of assessment treatment and examinations; currently consent was not recorded in writing. All providers informed us that only a small number of examinations which require a chaperone were carried out in GP Out-of-Hours Services; however, all providers have arrangements in place, when his is required. The Expert Review Team identified lone working as being a challenge to provision of chaperoning arrangements.		

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
17. Out-of-hours providers in partnership with the HSC Board and the Public Health Agency should explore the potential for maximising their contribution to health improvement and disease management programmes including the implementation of regional service frameworks.	*The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*		
18. The regional standards for out-of-hours services should include standards for the provision and updating of special notes on patients provided by their own GP to the out-of-hours services.	**The Expert Review Team determined that this recommendation has not been implemented.** The Expert Review Team found no evidence to confirm that the regional standards for GP out-of-hours services have been updated to include special notes.		
19. The HSC Board and Business Services Organisation should consider rolling out the emergency care summary throughout Northern Ireland.	**The Expert Review Team determined that this recommendation has been implemented.** The Expert Review Team confirmed that practitioners can now view a patient's Emergency Care Summary on NIECR. This is dependent upon the patient providing consent to allow their GP to share this information.		

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
20. All out-of-hours providers should review their arrangements to ensure effective communication with primary care daytime services and transfer of responsibility during the evening and morning handover periods.	**The Expert Review Team determined that this recommendation has been partially implemented.** GP Practices were able to contact GP Out-of-Hours Services to update them on patients' medical conditions. At the end of each out-of-hours shift, in GP Out-of-Hours Services, all information relating to each patient contact was electronically transferred to the respective patient's GP by 9:00 am the following day. The Expert Review Team considered that the transfer of information from the GP Practice to the GP Out-of-Hours Service may be less detailed than information provided by the GP Out-of-Hours Service to the GP Practice.		
21. All providers should ensure that medicines are labelled in accordance with the relevant legislation.	*The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*		
22. All providers should have systems to ensure that dry antibiotic powder is reconstituted accurately prior to supply to the patient.	*The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*		

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
23. The HSC Board should explore how information on patients with addictive personalities may be shared between out-of-hours centres.	*The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*		
24. Each out-of-hours Provider should review its governance arrangements for the supervision and use of controlled drugs. Within HSC trusts this should involve the accountable officer.	**The Expert Review Team determined that this recommendation has been partially implemented.** While the Expert Review Team considered that providers have some arrangements in place for oversight of the use of any controlled drugs stocked in Primary Care Centres, we were concerned that there was limited oversight in relation to of controlled drugs held and administered by individual GPs during the out-of-hours period.		
25. All out-of-hours providers should review their stock levels of drugs annually in line with prescribing trends.	*The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*		

Recommendations from the RQIA Review of GP Out-of-Hours Services (2010)	Current Status of Recommendation (RQIA Review 2018)	Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland (2016)	Current Status of Recommendation (RQIA Review 2018)
26. Services should explore ways in which the expertise and knowledge of both trust and community pharmacists may be used to improve prescribing and the management of medicines within the out-of-hours service.	**The Expert Review Team determined that this recommendation has been partially implemented.** The Southern Trust and Dalriada Urgent Care reported they have introduced Pharmacists at the weekends to triage medication queries and manage requests for repeat medication. Both providers reported this arrangement has improved the efficiency of their GP Out-of-Hours Service. At the time of this Review the South Eastern Trust and Western Urgent Care informed us they were also considering introducing pharmacists into their Service skill mix.		
27. The out-of-hours service should ensure that patients are aware of the mechanism for making a complaint.	**The Expert Review Team determined that this recommendation has been partially implemented.** Based on the Expert Review Team's experience, more complaints would have been expected for GP Out-of-Hours Services of this size. During the observation visits, information about complaints was not readily available in all the Primary Care Centres visited and while staff demonstrated an understanding of complaints processes, the Expert Review Team is of the opinion that one of the contributing factors for the low number of complaints may be because patients do not know how to complain.		

Appendix B: Recommendations from the RQIA Review of GP Out-of-Hours Services - 2010

1. The work of the Regional Out-of-Hours Project should be progressed to clarify the future strategic direction for the services and to take forward planned initiatives including a regional user survey and an agreed approach to quality performance monitoring.

2. Out-of-hours providers should have specific risk registers which are kept under regular review.

3. Out-of-hours providers should consider methods of providing assurance that doctors are not working excessive hours by working shifts for different providers.

4. Out-of-hours providers should review their arrangements for carrying out checks in relation to the protection of children and vulnerable adults in view of the establishment of the Independent Safeguarding Authority.

5. Each Provider should consider developing a training plan where this is not in place and which is reviewed on an annual basis. – *The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*

6. The out-of-hours service should continue to work with Northern Ireland Medical and Dental Training Agency (NIMDTA) on the role of trainees in the out-of-hours service.

7. NIMDTA and providers should agree on arrangements which should be in place for out-of-hours services to provide feedback on GP trainees' performance and for out-of-hours services to receive feedback on trainee experience of these placements.

8. Regional guidelines for out-of-hours providers should be developed on referral pathways for mental health patients and services in each area should be reviewed in relation to this guidance. – *The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*

9. The development of a regional system for the collation of learning from incidents occurring in out-of-hours services should be considered during the development of the new Regional Adverse Incident Learning System (RAIL) for health and social care in Northern Ireland.

10. All out-of-hours providers should review their arrangements to ensure that all staff understand the importance of reporting incidents and near misses to maximise learning opportunities and to reduce the risk of recurrence.

11. A programme of agreed regional clinical audits should be carried out across all out-of-hours providers to enable them to compare their clinical

services. This could be considered as part of the regional programme supported by the Guidelines and Audit Implementation Network (GAIN).

12. All out-of-hours service providers should explore opportunities to increase service resilience by having joint arrangements for further co-operation across boundaries during the red eye period. – *The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*

13. All providers should establish agreed arrangements for collaboration with the Patient and Client Council as part of their approach to user engagement.

14. The HSC Board in its role as commissioner of unscheduled care should review arrangements to ensure the effective integration of emergency services. These include primary care out-of-hours, A&E, ambulance services, community nursing, social care and mental health crisis services. – *The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*

15. The Regional Out-of-Hours Project should establish an agreed timescale for the introduction of a single telephone number for out-of-hours services in Northern Ireland.

16. All out-of-hours providers should have written policies on patient consent and chaperoning of staff involved in intimate care and examination of patients.

17. Out-of-hours providers in partnership with the HSC Board and the Public Health Agency should explore the potential for maximising their contribution to health improvement and disease management programmes including the implementation of regional service frameworks. – *The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*

18. The regional standards for out-of-hours services should include standards for the provision and updating of special notes on patients provided by their own GP to the out-of-hours services.

19. The HSC Board and Business Services Organisation should consider rolling out the emergency care summary throughout Northern Ireland.

20. All out-of-hours providers should review their arrangements to ensure effective communication with primary care daytime services and transfer of responsibility during the evening and morning handover periods.

21. All providers should ensure that medicines are labelled in accordance with the relevant legislation. – *The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*

22. All providers should have systems to ensure that dry antibiotic powder is reconstituted accurately prior to supply to the patient. – *The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*

23. The HSC Board should explore how information on patients with addictive personalities may be shared between out-of-hours centres. – *The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*

24. Each out-of-hours Provider should review its governance arrangements for the supervision and use of controlled drugs. Within HSC trusts this should involve the Accountable officer.

25. All out-of-hours providers should review their stock levels of drugs annually in line with prescribing trends. – *The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*

26. Services should explore ways in which the expertise and knowledge of both trust and community pharmacists may be used to improve prescribing and the management of medicines within the out-of-hours service.

27. The out-of-hours service should ensure that patients are aware of the mechanism for making a complaint.

Appendix C: Recommendations from the Department of Health Review of GP Led Primary Care Services in Northern Ireland – 2016

4.1 - During 2016/17, service providers should explore opportunities to build the skills mix in out-of-hours services, including through the use of nurse triage services and pharmacist prescribers. Providers should also consider the scope for partnership working with other services, such as community pharmacies, to ensure that patients are directed to the most appropriate health professional.

4.2 - During 2016/17, to reduce demand on GP out-of-hours, run an emergency supply pilot to allow pharmacists to provide an emergency supply of medication to patients free of charge, without the need for a repeat prescription.

4.3 - From June 2016, all service providers must use the Adastra patient management system to routinely analyse management information and ensure that resources are deployed as effectively as possible to meet predicted service demand.

4.4 - By November 2016, run a targeted media campaign to clearly articulate the role of the out-of-hours service.

4.5 - By November 2016, review the current out-of-hours key performance indicators to assess whether they remain appropriate for the effective and efficient provision of out-of-hours services.

4.6 - By December 2016, introduce a remote triage service across the out-of-hours service to meet periods of high demand.

4.7 - By February 2017, develop a regional training programme for out-of-hours staff, initially concentrating on call handlers to enable better call categorisation, through improved communication and negotiation skills.

4.8 - By February 2017, review the home visit arrangements across the region to identify opportunities for improving the service and making more effective and efficient use of the GP out-of-hours vehicles. – *The Expert Review Team agreed this recommendation was not within the scope of the 2018 Review.*

4.9 - By March 2017, consider trialling the Ask My GP in out-of-hours following the outcome of the in-hours pilot (see recommendation 5.1).

4.10 - By June 2017, develop and commence a trial of an interface service delivery model (times to be considered but potentially between the hours of 4pm to 9pm), with a view to rolling it out across the region.

4.11 - By June 2017, review the number of out-of-hours bases.

Appendix D: Patient Survey

Your experience of using the GP Out-of-Hours Service

You recently called GP Out-of-Hours Service or someone called on your behalf. Please could you answer the following questions and tell us about your most recent experience.

Was the call made:	About you ☐	About someone else ☐
About the patient at time of contact:	Age: ……Years	Male ☐ Female ☐
Did the patient have any problems due to language or disability? (you may give details in section D)		No ☐ Yes ☐

Which Out-of-Hours Provider did you contact?

Belfast Trust ☐ South Eastern Trust ☐ Southern Trust ☐

Dalriada Urgent Care ☐ (Northern Trust Area)

Western Urgent Care ☐ (Western Trust Area)

When did you contact the service? …… (Month/ Year)

What time did you contact the service? ……

Why did you contact the Out of Hours service?

I had an urgent medical problem that couldn't wait until my GP surgery reopened ☐

I was unable to get a suitable appointment with my own GP ☐

It suits me to attend the out of hours service because of work commitments ☐

I wasn't really sure who to contact and wanted advice ☐

Other reason

……

I was advised to contact the Out-of-Hours by

……(if applicable)

Please tell us about your initial contact with the GP Out-of-Hours service?					
	VERY SATISFIED	**SATISFIED**	**Neutral**	**DISSATISFIED**	**VERY DISSATISFIED**
Overall, how satisfied were you with the service you received?	☐	☐	☐	☐	☐

What was your next contact with the GP Out-of-Hours service?

I receive advice over the telephone only ☐ Go to Section A

I travelled to the Out of Hours base to be seen ☐ Go to Section B

I received a home visit ☐ Go to Section C

I had no further contact with GP Out-of-Hours ☐ Please explain…….

A - If you **received advice over the telephone only**, from the doctor/nurse, please tell us about your experience:

	VERY SATISFIED	**SATISFIED**	**Neutral**	**DISSATISFIED**	**VERY DISSATISFIED**
Overall, how satisfied were you with the service you received?	☐	☐	☐	☐	☐

B - If you **attended the Out-of-Hours Base** to see the doctor/nurse, please tell us about your experience:

	VERY SATISFIED	**SATISFIED**	**Neutral**	**DISSATISFIED**	**VERY DISSATISFIED**
Overall, how satisfied were you with the service you received?	☐	☐	☐	☐	☐

C - If you **received a home visit** from the doctor/nurse, please tell us about your experience:

	VERY SATISFIED	SATISFIED	Neutral	DISSATISFIED	VERY DISSATISFIED
Overall, how satisfied were you with the service you received?	☐	☐	☐	☐	☐

D - If you have any additional comments or suggestions about the way the service could be improved, please leave details below?

Appendix E: GP Survey

Review of GP Out-of-Hours Services – Proposed GP Questionnaire

PART 1 - Questions 1 to 3 should be completed by everyone.

Q1. Are you? Male ☐ Female ☐

Q2. Your Age is between?

20-29 ☐

30-39 ☐

40-49 ☐

50-59 ☐

60+ ☐

Q3. In which HSC Trust area is your General Practice/ the General Practice where you work?

Belfast Trust Area ☐

South Eastern Trust Area ☐

Western Trust Area ☐

Northern Trust Area ☐

Southern Trust Area ☐

PART 2 - Only complete Questions 4 and 5 if you are a GP Principal.

Q4. In terms of providing a service on your behalf, to your patients during the out-of-hours period, do you think the GP Out-of-Hours Service meets your needs?

Yes ☐ No ☐

Please explain your answer:_____

Q5. Do you think the GP Out-of-Hours Service meets the needs of your patients?

Yes ☐ No ☐

Please explain your answer:_____

PART 3 - Question 6 should be completed by everyone.

Q6. Within the last year, have you ever worked for one of the OOH Providers during the out-of-hours period?

Yes ☐ No ☐

If you answered 'No' to Question 6, please go to PART 4 - Question 14

Only complete Questions 7 to 13 if you have undertaken any shifts during the out-of-hours period within the last year.

Q7. Which OOH Provider did you work for?

Belfast Trust	☐	Dalriada Urgent Care	☐
South Eastern Trust	☐	Southern Trust	☐
Western Urgent Care	☐		

Q8. On average, how many shifts would you work?

More than one per week	☐
One per week	☐
More than one per month but less than one per week	☐
One per month	☐
More than one every three month but less than one per month	☐
One every three months	☐
More than one every six month but less than one every three months	☐
Less than one every six months	☐

Q9. What would your average shift pattern?

Mainly weekdays (nights)	☐
Mainly weekends (nights)	☐
Mainly weekends (days)	☐
Mixture of the above	☐

Q10. What prevents you from working more shifts with an OOH Provider?

Please explain your answer:_____

Q11. When working on an out-of-hours shift, do you feel supported?

Yes ☐ **No** ☐

Please explain your answer:_____

Q12. When working on an out-of-hours shift, do you have the necessary resources to undertake your job?

Yes ☐ **No** ☐

Please explain your answer:_____

Q13. What challenges do you face when working an out-of-hours shift?

Please skip to Question 16

PART 4 - Only complete Questions 14 and 15 if you do not undertake any shifts during the out-of-hours period.

Q14. Why do you not undertake any shifts during the out-of-hours period with one of the OOH Providers?

Q15. What would encourage you to start to undertake shifts with one of the OOH Providers during the out-of-hours period?

PART 5 - Questions 17 and 18 should be completed by everyone.

Q16. What changes could be made to improve the OOH Service?

Q17. Please outline any other improvements that could be made to the OOH Service?

If you would like to discuss this review, or provide any additional details to help inform the Review, please contact RQIA.

Appendix F: Daily Call Volumes for Dalriada Urgent Care – December 2017

December, Daily Call Volumes

Day	Date	0 to 1	1 to 2	2 to 3	3 to 4	4 to 5	5 to 6	6 to 7	7 to 8	8 to 9	9 to 10	10 to 11	11 to 12	12 to 13	13 to 14	14 to 15	15 to 16	16 to 17	17 to 18	18 to 19	19 to 20	20 to 21	21 to 22	22 to 23	23 to 24	TOTAL
Friday	01/12/2017	13	6	5	3	1	3	7	1	1									17	56	51	38	38	25	11	276
Saturday	02/12/2017	9	7	5	1	5	6	9	23	72	113	106	101	80	77	67	56	54	46	38	40	36	33	21	15	1020
Sunday	03/12/2017	7	9	6	5	8	6	14	16	51	101	96	81	85	60	55	53	45	37	37	40	34	33	16	21	916
Monday	04/12/2017	11	8	9	7	2	5	8	5	2									5	66	62	44	42	30	11	317
Tuesday	05/12/2017	15	9	4	5	5	5	2	3										18	63	47	31	26	22	9	264
Wednesday	06/12/2017	8	3	5	3	4	3	3		2									16	74	44	29	30	23	15	262
Thursday	07/12/2017	9	9	6	1	7	2	2	5	5									8	57	42	41	24	21	15	254
Friday	08/12/2017	9	11	2	3	4	4	5	3	6									12	52	37	30	23	21	10	232
Saturday	09/12/2017	14	2	7	3	6	3	9	15	58	91	84	98	88	74	61	51	51	50	38	25	26	29	19	13	915
Sunday	10/12/2017	7	11	4	9	9	11	8	17	46	75	80	76	76	47	40	51	37	51	63	42	22	23	22	9	836
Monday	11/12/2017	8	2	6	5	1	5		7	3									11	74	50	38	27	17	16	270
Tuesday	12/12/2017	11	9	3	4	4	1	1	14	2									11	60	48	26	36	35	20	285
Wednesday	13/12/2017	12	8	5	6	8	0	2	3	1									14	50	36	43	28	18	9	243
Thursday	14/12/2017	11	5	5	3	4	4	1	8	2									13	43	32	29	22	27	15	224
Friday	15/12/2017	7	4	3	4	5	5	7	8	1									12	40	46	37	40	36	10	265
Saturday	16/12/2017	7	5	4	10	8	2	9	30	66	76	69	94	89	60	74	63	58	54	43	50	32	37	17	28	985
Sunday	17/12/2017	8	9	11	6	6	5	9	26	48	74	78	32	113	74	76	49	61	49	45	43	38	21	23	13	917
Monday	18/12/2017	7	9	7	5	4	1	6	7	3									12	58	39	44	40	27	20	289
Tuesday	19/12/2017	17	4	2	7	4	4	2	9	2									17	59	41	38	28	25	9	268
Wednesday	20/12/2017	7	6	7	2	4	2	3	4	1									14	61	40	44	33	27	16	271
Thursday	21/12/2017	12	7	5	7	8	6	2	10	2									9	55	53	32	34	23	16	281
Friday	22/12/2017	12	8	12	9	7	4	10	3	3									15	60	33	55	51	41	17	340
Saturday	23/12/2017	12	10	8	8	3	14	22	44	85	78	17	122	112	85	30	26	46	41	83	55	61	59	39	20	1080
Sunday	24/12/2017	20	10	11	14	15	8	19	48	56	71	100	124	118	59	46	43	38	37	84	50	46	37	22	16	1092
Monday	25/12/2017	12	13	12	6	4	16	14	25	53	82	63	58	46	46	42	36	40	52	46	44	36	43	21	23	833
Tuesday	26/12/2017	13	13	5	11	8	9	12	34	95	147	123	125	131	96	51	50	44	51	53	46	28	39	28	19	1231
Wednesday	27/12/2017	18	12	8	4	8	7	9	10	3									16	64	42	48	33	26	11	319
Thursday	28/12/2017	10	8	8	6	5	7	7	8	5									19	65	43	40	38	24	16	309
Friday	29/12/2017	13	10	12	6	5	9	4	7	3									22	38	53	42	40	27	14	306
Saturday	30/12/2017	21	8	11	10	8	8	15	36	63	86	98	127	119	81	72	103	79	82	72	50	32	35	34	12	1242
Sunday	31/12/2017	7	7	4	7	6	8	12	30	58	126	109	126	122	80	54	61	59	50	57	43	30	40	29	14	1139
Totals																										0

Appendix G: HSC Board Service Specification for the provision of Urgent Primary Care Out of Hours in N Ireland (Extract of Section 4.8 Standards of Service)

Access:
1. A single telephone number with sufficient telephone lines and call handlers available to answer all calls within 60 seconds after the end of any introductory message which should be no more than 30 seconds long with no more than 5% of calls abandoned.

2. Out of Hours services are available and accessible to patients and their representatives during the Out of Hours period defined in section 3.2 and any additional times agreed with the commissioner.

3. Patient contacts (either by telephone or walk-in) are assessed and responded to, based on clinical need and professional judgement with robust mechanisms to identify emergency calls and prioritise urgent contacts. Calls will be categorised on initial contact and must then be disposed of as follows:

Triage:

- Emergency (Life-Threatening): these calls should be passed to 999 ambulance within 3 minutes at whatever point they are identified as a 999 call.

- Acute (Triage Immediately): these calls should go for immediate triage

    - Urgent (Triage Within 20 Minutes): appointment given at initial contact or triage within 20 minutes by a health professional.
    - Routine (Triage Within 1 Hour): triage within 1 hour by a health professional.

- Face-to-face consultation:

    The health professional will determine if a person needs a face-to-face consultation and the appropriate timescales. A face-to-face consultation, if required, usually takes place at an Out of Hours centre or occasionally at a patient's home or place of residence.

    - Acute (Within 1 Hour): face-to-face consultation within 1 hour if required after completion of triage.
    - Urgent (Within 2 Hours): face-to-face consultation within 2 hours if required after completion of triage.
    - Routine (Within 6 Hours): face-to-face consultation within 6 hours if clinically appropriate after completion of triage.
    - Repeat callers: health professionals should ensure they are aware of and have read the notes of any previous contacts (with the respective Out of Hours Provider) concerning that patient particularly those over the 110 hours preceding the call. The health professional should ascertain the reason why the person phoned back. If the person is not

seen there should be clear documentation of the reasons why the person is not seen.

Compliance

- KPI Performance for patient contacts will be monitored and providers will be deemed to be compliant when average performance on a monthly basis is as follows:
- Full compliance when 95% and over meet the above criteria
- Partial compliance 90% to 94.9% for the above criteria
- Non-compliance when less than 90% meet the above criteria
- If call volumes are exceeding normally expected volumes providers are asked to escalate issues in line with the system outlined in Appendix 3.

RQIA Published Reviews

RQIA reviews a wide range of services across health and social care. Our review programme takes into consideration relevant standards and guidelines, the views of the public, health care experts and current research. During our reviews we examine the service provided, highlight areas of good practice and make recommendations for improvement. We report our findings and share any lessons learned across the wider health and social care sector. In addition, when required, we carry out reviews and investigations to respond to specific issues of concern or failures in service provision.

You can access a full list of all RQIA's reviews at:

https://www.rqia.org.uk/RQIA/media/RQIA/Resources/WhatWeDo/Review/RQIA_Reviews_Published_Online_May-18.pdf

Individual review reports can be accessed at:
https://www.rqia.org.uk/reviews/review-reports/

Other RQIA Reviews which may be of interest include:

Review of GP Out-of-Hours Services (September 2010)
https://www.rqia.org.uk/RQIA/files/09/09b5172a-1630-4df8-9cff-b77d3183b827.pdf

Review of Readiness for Revalidation in Primary Care in Northern Ireland (December 2011)
https://www.rqia.org.uk/RQIA/files/ee/ee369849-51d5-449c-bca3-40f0bc0d47ea.pdf

Review of Medicines Optimisation in Primary Care (July 2015)
https://www.rqia.org.uk/RQIA/files/81/81925011-3d53-4d9e-b817-a8ffdc84a503.pdf

Review of Governance Arrangements relating to General Practitioner (GP) Services in Northern Ireland
https://www.rqia.org.uk/RQIA/files/eb/eb7b84c5-62a5-4dd8-9a08-0593a09c08dd.pdf

The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews