Out of Hours Primary Medical Care Services (OOH) Buckinghamshire

Clinical and Public Engagement Report December 2014
NHS Aylesbury Vale Clinical Commissioning Group
NHS Chiltern Clinical Commissioning Group

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Executive Summary

Introduction
This report presents the outcomes of a pre-engagement programme that was held with stakeholders from across Buckinghamshire through autumn of 2014; to gather their feedback at the early stages of creating the service specification for Out of Hours Primary Medical Care Services (OOH).

Stakeholders for this purpose include patients using the existing OOH services, clinicians, staff from all localities, partner organisations, community and voluntary groups and the public.

At the same time that this engagement work was undertaken, the Buckinghamshire County Council Health and Adult Social Care Select Committee undertook an inquiry into General Practice Services in Buckinghamshire. The recommendations from their report (See Appendix 1) relate mainly to in-hours services. Wycombe District Council conducted a review into urgent health care in Wycombe district and a report is due in February 2015. Healthwatch Buckinghamshire has undertaken a survey on access to health care services in Buckinghamshire, also soon to report.

During 2013/14 NHS Aylesbury Vale CCG and NHS Chiltern CCG conducted “A Call to Action” programme of engagement to gather feedback to help in broadly planning future health services. The re-commissioning of the out of hours service was already on the horizon at that point and so the service was included in the engagement programme.

All information gained from clinical and patient engagement has been used to inform the service specification for Out of Hours primary medical care services for Buckinghamshire.

Methodology
The clinical commissioning groups in Buckinghamshire – NHS Aylesbury Vale CCG (AVCCG) and NHS Chiltern CCG (CCCG) conducted engagement through September, October, November and December of 2014.

This engagement took place with clinicians at locality meetings across the county and at protected learning time sessions; with the general public and community and voluntary groups online using the Lets Talk Health Bucks engagement platform www.letstalkhealthbucks.com, and with patients of the OOH services being offered a paper based questionnaire directly after being seen by a GP.

Both the Bucks CCGs engaged widely with clinicians and the public on primary care services during the same autumn 2014 period and questions relating to GP Out of Hours services were incorporated within this work.
These activities were promoted widely through appropriate channels including the CCG bulletins and the media to encourage participation.

**Overall key themes from feedback**
The following main themes emerged from all the audiences relating to areas that could be improved:

- **Better integration between OOH and other health services** – this to be achieved through:
  - Information Technology – connectivity with other systems to enable access to patient notes and care plans
  - Improved communication between all health care professionals to ensure that OOH GPs are better linked in and can access social care, ACHT, night nursing service etc.

- **Common pathways**

- **Ease of access and equity of provision throughout the county**

- **Better awareness of how to access the service** (although generally people said they found it easy to access the service).

- **Appropriately qualified health care professionals to triage patients and make use of services such as ACHT (Acute and Community Healthcare Team) to reduce use of 999 and A&E referrals.**

- **Patients do not want to travel far to an OOH base. The public online survey suggested people would travel between 2 to 5 miles. However, most patients at time of using the service felt unable to travel far.**

**A Call to Action**
The recent responses support earlier responses to engagement from the 2013/14 A Call to Action engagement programme, which were:-

- **Joined up, integrated care with much better communication between health care professionals**
- **Continuity of care** – people wanted to see the same GP who knew their medical history
- **Better communication about services and choices available**
- **Earlier screening and diagnosis**
- **Making use of the benefits of new technology.**
Clinical Consensus

- Improved handover from OOH to GP service
- OOH provider access to special patient notes (SPN) and care plans – connectivity with other health care systems
- More appointment slots to make it easier for people to see an OOH doctor
- Work more closely with ACHT
- Ability to manage LTC (long term conditions) better
- GPs to be local with knowledge of local services
- More emphasis on providing self-care advice
- Provider to have access to overnight carers service to try and keep people at home where appropriate
- Consistency of pathway / tools wherever a patient presents – e.g. 111, OOH, MIIU, A&E etc.
- Equity of patient journey from home to OOH base, wherever they live to reduce unnecessary A&E attendances
- Quick access for provider to consultant support
- Ability to increase number of GPs on duty in times of high demand
- Access to a standardised prescribing policy and list of medication

Patient/Public Consensus

- Closer working with other healthcare professionals – e.g. district nurses, social care, night nursing
- Better information about local services
- OOH GP to have access to records
- More local GP with knowledge of local services and system
- Better medicine/drug availability
- Better trained or clinical call handlers/admin

Patients - satisfaction with current services:

The response to the OOH patient survey was low but we were advised by the provider that patient feedback rates are always very low and that our response rate was better than they were used to. A low response rate is not surprising as patients are generally unwell and providing feedback on the service is probably low on their list of actions. We wanted to be sure that the offer to give feedback would be made sensitively and appropriately and the provider advised the best time to offer the survey would be at the end of the appointment with a clinician – and only if the clinician felt it appropriate.

On the whole we found that patients were satisfied with the current services.

1. All our respondents said that it had been either fairly easy or very easy to contact the OOH GP service by telephone
2. Most of our respondents felt that the time it had taken to receive care from the OOH service had been about right – one felt it had taken too long.

3. All our patient respondents had confidence and trust in the out of hours clinician that they saw or spoke to.

4. Most of our respondents felt their experience to be either very good or fairly good, with one describing it as very poor.

5. One patient suggested improvement to the service as “by having painkillers with them and not just someone to listen to your problem. Suitable dressings would also be useful. Empty promises of a district nurse coming.”

6. We asked patients how far they would travel to the OOH service. Responses were quite clear. No respondents would travel further than five miles, but most felt they would not be able to drive whilst unwell and that this would represent a hazard.

Public – online survey

Access
We asked the public if they knew how to contact the OOH service – as this service is not actively promoted – it’s accessed through calling NHS 111. GP surgeries have answerphone messages directing people to call NHS 111 when they are closed and NHS 111 is widely advertised locally.

We found that 93% of people said they know how to contact an out-of-hours GP service when their surgery is closed.

Roughly half of our public respondents had tried to contact the GP OOH service during the last year.

Most said it was either very easy or fairly easy with only a small proportion describing this as difficult.

Speed
With regard to the time it took to receiving care from a clinician, 67% said “It was about right” but 26% said “it took too long”.

Confidence and Trust in the Clinician
Positive response but split – 41% said “yes definitely” with “48% “yes to some extent” with only a very small number saying not. This is an interesting comparison to the patient survey where majority were “yes definitely”.

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Overall Experience
This was varied and again is an interesting comparison to the patient survey where the majority of patients felt the service to be very good. The results were:

- Very good: 37%
- Fairly good: 30%
- Neither good nor poor: 4%
- Fairly poor: 22%
- Very poor: 7%

Travel Distance
The most common distance that people were prepared to travel was 2 to 5 miles.

Public Survey – Suggestions for Improvement
- OOH care to be delivered by patients own GP practice
- GP practices to be funded to enable them to offer OOH services
- OOH GPs to have access to patient records
- Quicker response
- Easy to understand clinician – clinician to ensure patient has understood
- Better knowledge of local services
- Better signposting at OOH locations
- Better advertising of the service
- Better linking with pharmacies – or map to show where pharmacies are and opening times
- Ability to discuss online or via email
Introduction

In line with their commitment to commissioning high quality healthcare services for the people of Buckinghamshire, NHS Aylesbury Vale CCG and NHS Chiltern CCG have jointly been reviewing the Out of Hours Primary Medical Care Service (OOH); as the contract for this is due to be re-commissioned.

As part of the CCGs on-going commitment to designing services around the needs of patients, they invited members of the public to share their views and experiences of the GP out-of-hours service in Buckinghamshire. The surveys were designed to explore patients’ experiences of the service, whether it met their needs and whether there was anything they thought could be improved. See Methodology for details.

The CCGs also consulted widely with clinicians from all health services, through Protected Learning Time sessions, at Locality Meetings. Engagement with everyone involved in the OOH pathway was undertaken during 2013.

Service Description

Out-of-hours GP services provide urgent primary care when GP surgeries are typically closed – from 6:30 pm to 8:00 am on weekdays and all day at weekends and on bank holidays. This means that out-of-hours GP services cover almost 70 of the hours in an average week.

Out-of-hours GP services give patients treatment and advice for medical problems that are not life-threatening, but where the patient cannot wait to see their own GP. The nature of the work is different to mainstream in-hours services as every case an out-of-hours GP sees should be urgent.

Since April 2013, the usual route for people to access out-of-hours GP services is to call NHS 111. Non-clinical call handlers then use a clinical assessment tool called NHS Pathways to get information about the caller’s symptoms and direct them to the appropriate service. This process is called triage. When an NHS 111 call handler assesses that a person needs urgent primary care they:

• arrange for a clinician from the out-of-hours GP service to call the patient back and conduct a further, clinical assessment; or

• book the patient an appointment at the nearest out-of-hours clinic; or

• arrange for an out-of-hours GP to visit the patient at home.

Otherwise, NHS 111 call handlers assess cases as: emergencies, either calling an ambulance or sending the patient to an A&E department; or more routine, giving advice or telling the caller to contact their in-hours GP or pharmacy.
Overall Key Themes Emerging from Feedback
The following main themes emerged from all the audiences relating to areas that could be improved:

- Better integration between OOH and other health services – this to be achieved through:
  - Information Technology – connectivity with other systems to enable access to patient notes and care plans
  - Improved communication between all health care professionals to ensure that OOH GPs are better linked in and can access social care, ACHT, night nursing service etc.

- Common pathways

- Ease of access and equity of provision throughout the county

- Better awareness of how to access the service (although in surveys generally people found it easy to access the service).

- Appropriately qualified health care professionals to triage patients and make use of services such as ACHT (Acute and Community Healthcare Team) to reduce use of 999 and A&E referrals.

- Patients do not want to travel far to an OOH base. The public online survey suggested people would travel between 2 to 5 miles. However, most patients at time of using the service felt unable to travel far.
Methodology

Clinical Engagement
The clinical engagement on the OOH service during autumn 2014 has been led by the two Clinical Urgent Care Leads for each CCG - Dr Kevin Suddes (Aylesbury Vale) and Dr Rebecca Mallard-Smith (Chiltern).

Each clinical commissioning group has locality meetings, three in Aylesbury and four in Chiltern, which represent all of the GP practices (19 in AVCCG and 53 in CCCG). Chiltern CCG also has four Urgent Care Forums.

A workshop was held with potential providers of the service to gather innovation, thoughts and ideas.

At each of these the GPs representing each Practice were asked the following:-

**AVCCG is leading the re-procurement of the OOH service and we want to ensure we put in place a service which meets the needs of patients and works effectively with Primary Care. So we are consulting with localities and other Providers to identify the key components of the new OOH service which we need to describe clearly in the service specification. Please can you tell us?**

1.  **What works well in the existing service and needs to be kept in the service specification**

2.  **What needs improving and your description of what would be better, so we can include it in the service specification. These may include pathways e.g. an improvement to end of life or operational practicalities e.g. shorter more focused messaging back to practices**

Public Engagement

The public engagement took the form of an online survey and some public meetings with direct emails to community and voluntary groups and proactive media work to encourage attendance at the meetings and take up of the survey.

The survey was set up jointly for both CCGs on their online engagement platform https://www.letstalkhealthbucks.nhs.uk/consult.ti/BucksOOH/consultationHome

If reading after the engagement has closed - see page clip below.
Poster to GP Practices and Community and Voluntary Groups
Media release to all Bucks media outlets, press and radio
Poster and media release to advertise public meetings
http://www.chilternccg.nhs.uk/events_p7202.html?a=0

Public Meetings
The CCGs held public meetings in Amersham, Wycombe, Burnham, Beaconsfield and Buckingham.
Patient Engagement
The current OOH provider Bucks Urgent Care kindly agreed to implement our patient survey. We wanted to be sure that the offer to give feedback would be made sensitively and appropriately and the provider advised the best time to offer the survey would be at the end of the appointment with a clinician – and only if the clinician felt it appropriate. The survey was also advertised by a poster in the waiting areas.

See appendices for the poster and the patient questionnaire
Clinical Feedback Summary

- Improved handover from OOH to GP service
- OOH provider access to special patient notes (SPN) and care plans – connectivity with other health care systems
- More appointment slots to make it easier for people to see an OOH doctor
- Work more closely with ACHT
- Ability to manage LTC (long term conditions) better
- GPs to be local with knowledge of local services
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- Equity of patient journey from home to OOH base, wherever they live to reduce unnecessary A&E attendances
- Quick access for provider to consultant support
- Ability to increase number of GPs on duty in times of high demand
- Access to a standardised prescribing policy and list of medication

Aylesbury Vale Locality Meetings

Central Locality Meeting
9th October 2014

Good components to include in the service specification

1. At the start of the day it would be good for the OOH doctor to phone the practice and verbally hand over any patients which have not had their calls completed. Similarly at the end of the working day it would be good for GPs to verbally handover any patients to OOH who have called just before the GP Practice closed but require input from OOH.
2. OOH service to be able to book into GP appointments would be good
3. There are benefits of same provider for NHS 111 & OOH as they could use more highly skilled clinicians to triage calls and close more without onward referral.
4. OHH currently are ignoring the Shared Patient Notes (SPN) because they can’t see them due to technical difficulties.
5. It would be better to have more appointment slots, so patients don’t have to wait so long to see a doctor. This is especially true for small children, when anxious patients may be tempted to not wait but take the child to A&E instead.
6. Integration with over 75’s DES possibly by linking with EMIS web
7. The service to include OOH GP, nurse and ACHT to give greater flexibility
8. More GP’s in A&E to reduce A&E primary care attendances
9. To link with Web GP (Western Grove Practice and Trinity Practice are starting to pilot this)

**South Locality Meeting**

**9th October 2014**

**Good components to include in the service specification**

1. Short waiting times for patients to be seen
2. Good communications in practices which includes brief summary of the History; Examination & Outcome, at the front with the other detail of the NHS111 triage in an appendix.
3. Access to GP records
4. Ability to do LTC management, OOH to suit adults of working age
5. Direct access to GPs in OOH (Health Care Professional Line)
6. Minimal variation in doctors defaulting to call an ambulance
7. Ability to use special notes
8. Positive aspect of the current service is that patients are usually dealt with completely
9. Involvement of nurses as well as doctors, making full use of skill mix
10. Dead patients, wait 6-7 hrs to be certified in community hospitals, which is distressing for families, so shorter waiting times would be better.
11. Rotas, to get ‘local’ doctors who have better knowledge of the local services e.g. alternatives to hospital admission.
12. Handover between Practice and OOH service at the start and end of the working day requires clarity so both Practices and OOH know what is reasonable to expect for patients who call just before the changeover time.
13. More emphasis on self-care advice

**North Locality Meeting**

**5th November 2014**

1. Connectivity with GP Systems to view and input to GP records
2. Use of Community Hospitals or other local buildings for consultations, even better if they have useful facilities e.g. X-Ray which Buckingham community hospital does.
3. The ability to link with ACHT overnight so able to get patients access to ACHT input overnight
4. Provision of face to face assessment overnight
5. Ability to get overnight carers in place to keep people at home. This is similar to hospice care. e.g. from staff on-call from home. Ian Rennie hospice services provide this already.
6. Handover between OH and GP Practices in the morning and evening: The preference was for OOH to keep their patients who call the service just before it closes and vica versa.
7. It would be good to have a brief clinical summary at start of report that goes to the GP practice.
8. The north locality was open to the idea of an option for local provision of the service in the evening and daytime weekends, possibly by a different provider than the one which provides the core service in the middle of the night.
### Case 1

**Individual table feedback**

<table>
<thead>
<tr>
<th>Clinical review</th>
<th>Social review (bereavement/Befriending organisations)</th>
<th>Mental Health VS LTC</th>
<th>Holistic decisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAG</td>
<td>Prevention Matters</td>
<td>Allocate a key worker</td>
<td>Give John advice on when he can call</td>
</tr>
<tr>
<td>Pulmonary Rep (resp comm nurses)</td>
<td>Care plan continuity/care package</td>
<td>Give contact details</td>
<td>and give contact details</td>
</tr>
<tr>
<td>IT System. Community-111-Secondary care 24hrs social care</td>
<td>Skilled care coordinator</td>
<td>Integrating services.</td>
<td>Integrating services.</td>
</tr>
<tr>
<td>MUDAS- quick consultant support</td>
<td>Community hospitals/care homes/Day visit hospital</td>
<td>Have a social back up</td>
<td>Have a social back up</td>
</tr>
<tr>
<td>Live well</td>
<td>Care coordinator named nurse “someone to call”</td>
<td>Offer reassurance</td>
<td>Offer reassurance</td>
</tr>
<tr>
<td>Medical/social crossover</td>
<td>Knowledge of options (local/3rd sector)</td>
<td>Practice based health advisor for the elderly.</td>
<td>Practice based health advisor for the elderly.</td>
</tr>
<tr>
<td>Reassessment of social care needs</td>
<td>Computer systems talking to each other</td>
<td>Sharing info with OOH and Ambulance Feeding back to GP in a timely and appropriate manner.</td>
<td>Sharing info with OOH and Ambulance Feeding back to GP in a timely and appropriate manner.</td>
</tr>
</tbody>
</table>

**Summary feedback - Themes**

**Appropriate and timely patient care**

- Identification of those at risk
- Timely intervention
- Crisis Management
- Quicker discharge
- Integrated patient care plan
- Less time in secondary care

**Healthcare Resources required**

- Named GP
- LTC Nurse Specialities
- Role of Voluntary Sector
- Quick access to consultant support
- Care coordinator model
- Reablement
- ACHT
- Adult Social Care

**Excellent Communication**

- Between professional involved in care
- Communications to the patient need to be simple

**IM &T**

- Access to real time patient records
**Case 2**

Rafiq is two years old. He developed a fever yesterday and today came out in a rash and also started vomiting. His mother is single. She relies on public transport. Rafiq has one sibling, Tanwir, aged 6, who has autism. She contacted the OOH service last night and contacts her GP today at 6.25pm.

What issues are raised by this case history?

How would you respond to this call:

- a. with your current practice arrangements?
- b. in an ideal world?

<table>
<thead>
<tr>
<th>Individual table feedback</th>
<th>Summary feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient may need urgent assessment:</td>
<td><strong>Access</strong></td>
</tr>
<tr>
<td><strong>Issues are:</strong></td>
<td>• Patient Education</td>
</tr>
<tr>
<td>Autistic sibling/family support</td>
<td>• Alternative methods of access e.g. Skype</td>
</tr>
<tr>
<td>Has OOH contact been seen?</td>
<td>• Provision of transport (access)</td>
</tr>
<tr>
<td>Late call in day</td>
<td><strong>Out of Hours</strong></td>
</tr>
<tr>
<td>Patient education</td>
<td>• How to access and when</td>
</tr>
<tr>
<td><strong>Ideal World:</strong></td>
<td>• A locality model</td>
</tr>
<tr>
<td>Transport system</td>
<td>• Communication between care professionals</td>
</tr>
<tr>
<td>Sound support system</td>
<td>• Continuity of care during the handover period</td>
</tr>
<tr>
<td>Triage and handover/book an OPM</td>
<td>• Integrated care – less boundaries / differences of in and out of hours care</td>
</tr>
<tr>
<td>Apt for them</td>
<td>• Need for shared IT and protocols etc.</td>
</tr>
<tr>
<td>OOH gives some clinical advice: re ABX Prescribing</td>
<td><strong>Patient Support Networks</strong></td>
</tr>
<tr>
<td>Crossover of routine and OOH</td>
<td><strong>Appropriate care</strong></td>
</tr>
<tr>
<td>Further triage needed... urgency with fever- 999, home visit, what is going on back in the surgery?</td>
<td></td>
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<tr>
<td>Needs to see a doctor via Skype/visual assessment</td>
<td></td>
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<tr>
<td>Able to book in with OOH</td>
<td></td>
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<tr>
<td>Education for mum</td>
<td></td>
</tr>
<tr>
<td>Support with childcare</td>
<td></td>
</tr>
<tr>
<td>Meningitis risk but why did she wait until 6.25pm?</td>
<td></td>
</tr>
<tr>
<td>Social care for brother</td>
<td></td>
</tr>
<tr>
<td>Transport provider- can the surgery help?</td>
<td></td>
</tr>
<tr>
<td>Language/culture barriers</td>
<td></td>
</tr>
<tr>
<td>Info sharing between OOH and GP</td>
<td></td>
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<tr>
<td>Case 3</td>
<td>Individual table feedback</td>
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</tbody>
</table>
| Monica is a 46 year old working in the financial sector in London. She works long hours and commutes daily during the working week. She is overweight. She was diagnosed through a NHS health check with diabetes the previous year. She is worried because she has been getting headaches and also feels anxious about her diabetes. She contacts the surgery from her workplace, anxious to get an appointment to address both of these issues. **What issues are raised by this case history?**

**What could Monica realistically expect from your practice as it currently is?**

**What if Monica can’t access usual GP care as currently provided?**

<table>
<thead>
<tr>
<th>Issues:</th>
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</thead>
<tbody>
<tr>
<td>Appointment times for workers</td>
</tr>
<tr>
<td>Convenience - is it what you need/want?</td>
</tr>
<tr>
<td>What care post health check?</td>
</tr>
<tr>
<td>Engaging with PT</td>
</tr>
<tr>
<td>Realistic</td>
</tr>
<tr>
<td>Offer appointment. Extend OOH apt is not available</td>
</tr>
<tr>
<td>Telephone based care</td>
</tr>
<tr>
<td>Self-care- consider life/work balance</td>
</tr>
<tr>
<td>Register at more convenient practice</td>
</tr>
<tr>
<td>Look at getting early/first thing appointment, maybe on a Saturday?</td>
</tr>
<tr>
<td>Structured education programme</td>
</tr>
<tr>
<td>Employer’s responsibility to allow time to attend appointments.</td>
</tr>
<tr>
<td>Diabetes care planning: access her own records and results.</td>
</tr>
<tr>
<td>Patient choice as of 1\textsuperscript{st} October to register at a GP nearer her place of work.</td>
</tr>
<tr>
<td>Appropriate note sharing</td>
</tr>
<tr>
<td>NHS health check</td>
</tr>
<tr>
<td>Lifestyle – Babylon</td>
</tr>
<tr>
<td>DM community team</td>
</tr>
<tr>
<td>Advice of assessment for a healthcare club.</td>
</tr>
<tr>
<td>Mixing private and NHS</td>
</tr>
</tbody>
</table>

| Is there a work place occupational health scheme? |
| Make patient more responsible for her health |
| Start Metformin |
| Offer online lifestyle advice |
| Take time off work and take responsibility for her illness |
| Does she have private healthcare? |
| 1\textsuperscript{st} and 2\textsuperscript{nd} care for one patient |

<table>
<thead>
<tr>
<th>Patient self-management enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient responsibility</td>
</tr>
<tr>
<td>Patient education</td>
</tr>
<tr>
<td>Lifestyle (Public Health)</td>
</tr>
<tr>
<td>Employer/OH responsibility</td>
</tr>
<tr>
<td>Patient access to care plan</td>
</tr>
<tr>
<td>Multiple methods of access (telephone, Skype and in person)</td>
</tr>
<tr>
<td>Diagnostic tests in one go</td>
</tr>
<tr>
<td>Support groups (weekends too!)</td>
</tr>
<tr>
<td>Register at practice of choice</td>
</tr>
<tr>
<td>Support for careers</td>
</tr>
</tbody>
</table>
NHS Aylesbury Vale Clinical Commissioning Group
NHS Chiltern Clinical Commissioning Group

OOH Procurement Consultation Feedback from Chiltern UC Forums

General Comments:

- The tender document needs to be written to address all Southern locality Needs.
- They need to show all visits completed in 6 hours (it was noted that there are no patients waiting longer than 4 hours in East Berks.)
- There is an overnight car required. It was agreed that we need a base to minimise no of visits.
- There is quality control in OOH so that the service is not used inappropriately.
- Patients call in from 111
- Nursing homes/paramedics/district nurses/palliative care nurses – priority number
- ALL advice line shifts/PCC bases/car visits/nursing shift/Driver slots for that day **MUST** be filled even if this means having to increase the hourly rate to fill a particular slot.
- As much as possible the service should be run by local Doctors – to make this happen a REALISTIC rate of pay per hour is needed.
- If bucks wide OOH provision then should - refer patients to their closest minor injuries unit, not A&E; include patients living in East Berkshire but registered to Buck’s doctor
- If East Berkshire type service covering our patients then it should align with Bucks services such as ACTH, Ian Rennie, and any new Bucks services

Advice line:

- routine calls completed within 60mins
- Urgent calls within 20mins
- Emergency calls with 10mins

Advice line Dr:

- appropriate advice/make appt for a PCC consultation/arrange a HV
- Able to do emergency script for patients without an appt
- Allow Drs the ability to ‘work from home’
- The OOH provider must have the ability to call on more doctors to help out on advice line at times of very high demand eg by signing on at home for advice line
- Doctors to have internet access to BNF/Toxbase
- Access to a standardised prescribing policy and list of medication

Location: PCC base to be near Wexham Park hospital or easily accessible for Southern locality patients. An OOH base in Southern should lie between the majority of patients and A&E such that the distance to the OOH base is smaller than the distance to A&E for the majority of patients.
There should be some monitoring on number of referrals to A&E (most appropriate but in the past when it has got very busy this has sometimes happened)

**Home Visits Response Time**:

- Routine to be done within 4 – 6 hrs maximum
- Urgent – to be done within 2 hrs

**Bases and Car**:

- must be adequately provisioned with all necessary standard oral medication/IM/sub cut medication.
- Cars medication must be updated at the beginning of each day

**Overnights**

- ie from midnight to 8am - one Doctor dedicated to Southern locality
- Needs to be based at the PCC so can bring in patients to avoid unnecessary home visits.

**Quality Control**

- Assess – efficiency of the OOH service by auditing the number of routine advice calls returned within 60min/urgents within 20mins/emergency within 10mins
- Assess quality of medical advice/management by having a team of Doctors to review a sample of each doctors advice/consultation – advise use of a system such as ‘Clinical Guardian’. This system would give constructive feedback on medical management and as ‘peer review’ - highly acceptable.

**Feedback to own GP**

Needs to done by 8:30 am next working day.
Clinical Engagement Feedback from senior staff at Buckinghamshire Healthcare Trust

1. The main principles and objectives underlying the service should be:

- Accessibility i.e. ease of access, and equity of provision throughout the county.
- Consistency of service i.e. the same on a weekend as on a weekday evening.
- Consistency of service i.e. the same ‘pathway’/tools whether the patient presents to 111, the out-of-hours service, the MIIU, A&E etc.
- The confidence of the public that they will receive the right care/advice/treatment in a timely fashion.
- The service should contribute to a reduction in inappropriate A&E attendances.
- The service should contribute to a reduction in A&E attendances by patients with LTCs.

2. With both the out-of-hours contract and the MIIU coming up for review, we believe this represents a real opportunity to reshape the out-of-hours service, put the patient at the heart of the ‘pathway’, and provide a service that is truly integrated with the other key agencies and stakeholders. This could be the best way of achieving the consistency of approach outlined in point 1 above.

Maximising the opportunity to introduce/embed a different approach will require all partners/stakeholders (e.g. primary care, community services, social care, acute providers) to work together. This will probably be best achieved by pooling parts of various budgets to incentivise different providers to work collaboratively.

3&4. It is important that the 111 service, or whoever is the ‘gatekeeper’ has the correct number of appropriately qualified health professionals to ‘stream’ patients and give them confidence in the service. Amongst the tools will be, for example, mobilisation of the ACHT team or night sitting service, where appropriate, to avoid a SCAS call-out or A&E attendance.

5. The patient journey should be as near as possible the same whether ‘in-hours’ or ‘out-of-hours’. The patient quite reasonably expects to receive the most appropriate treatment in the most appropriate setting regardless of the time of day or day of the week.

6. Maximising interoperability requires good linkage of IT systems. Ideally the out-of-hours provider should be able to access recent diagnostic test results and imaging reports, and the patient’s GP summary care record should also be accessible/visible.

7. BHT is keen to discuss opportunities for collaboration with any other out-of-hours providers who have expressed an interest in greater collaboration. As per your offer at the meeting, please feel free to pass our details to them.
Detailed Feedback - Public

Public Feedback Summary

- Closer working with other healthcare professionals – e.g. district nurses, social care, night nursing
- Better information about local
- OOH GP to have access to records
- More local GP with knowledge of local services and system
- Better medicine/drug availability
- Better trained or clinical call handlers/admin

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Detailed Feedback - Patient

Patient Feedback Summary

Patient Responses have now been added onto the www.letstalkhealthbucks.nhs.uk system and aggregated with the public responses, but before doing so we summarised them as below and the paper based copies are available for inspection.

On the whole we found that patients were satisfied with the current services.

1. All our respondents said that it had been either fairly easy or very easy to contact the OOH GP service by telephone

2. Most of our respondents felt that the time it had taken to receive care from the OOH service had been about right – one felt it had taken too long.

3. All our patient respondents had confidence and trust in the out of hours clinician that they saw or spoke to.

4. Most of our respondents felt their experience to be either very good or fairly good, with one describing it as very poor.

5. One patient suggested improvement to the service as “by having painkillers with them and not just someone to listen to your problem. Suitable dressings would also be useful. Empty promises of a district nurse coming.”
6. We asked patients how far they would travel to the OOH service. Responses were quite clear. No respondents would travel further than five miles, but most felt they would not be able to drive whilst unwell and that this would represent a hazard.