Editorials

Out of hours and primary care:

closer and closer apart

Although responsibility for out-of-hours (OOH) general practice care (provided between 6.30 pm and 8 am and on weekends and public holidays) changed substantially in 2004, the same GPs who had previously provided this care often continued as the clinical mainstays of the service. Before 2004, patients were often seen OOH by their own GP, or at least a GP they knew from their practice, but this continuity has now been lost and has led to a lack of confidence and trust in OOH services, reflected in a greater propensity for patients to complain and to concerns about patient safety.[1,2] Primary care now needs to rise to the challenge of re-engaging with OOH care in the context of rising patient demands and expectations, and the imperatives of patient safety and clinical governance.

SHIFTING FROM LOCAL CARE

Most GPs working in OOH services cover much larger geographical areas than previously when cover was limited to the practice area or a GP cooperative of several practices. The involvement of local GPs who know the area and the local health services remains important, not least for patient safety. Lack of such knowledge appears to have contributed to OOH errors in the past.[3] The model of OOH services run by less experienced GPs, with the best trained and most experienced concentrating their efforts on daytime care in the surgery is not one that most OOH providers would like to see, although it is probably a reality in some areas.[4] While it is no longer possible for many GPs to take a major role in OOH care, most have a keen interest in the quality of OOH care provided to their patients, and need to be involved in the assessment, monitoring, and regulation of OOH services.[5] In the past, such involvement has been minimal, and monitoring mechanisms have been patchy in their effectiveness.[6] Primary care now needs to change this situation, because the landscape has changed.

The 'rota organising clubs' of the old days have now evolved into complex organisations that have to match capacity to demand, monitor performance standards, and developing robust clinical governance procedures.[7] Many are also developing their own education programmes centring on important areas in OOH care, such as telephone consultations and palliative care.

INTEGRATION

OOH providers are now benchmarking their performance against other OOH care providers in a drive to raise standards.[7] Commissioners are being urged to support OOH providers to become 'a valued and integral part of the local health community'.[6] But to improve quality, forge links with other services, and develop services further, OOH providers need some semblance of a long-term strategy. This is impossible if, as is the case of the majority of OOH providers, contracts are so short lived, lasting as little as 3 years in some cases. Often this is done because of the wish to change providers when costs rise, but it also means that time and expense are taken up preparing tenders, diverting resources that could be used to improve services. In this regard we are now repeating the mistakes of the past when in 2004, despite TUPE (Transfer of Undertakings [Protection of Employment]), the new services replacing the previous cooperatives, started at a disadvantage due to loss of key players and lack of continuity.[7]

COST OF OOH CARE

Of course there should be regular and robust monitoring and a shared push for improved quality of services, but constant change for reasons of cost alone is counterproductive. Many providers would prefer a more involved commissioner, especially with GP involvement, with a consistency of approach and project management. GPs, with their understanding of the importance of long-term investment in developing practices, should push for greater understanding of the importance of this.

Commissioners should also remember that the cheapest is not necessarily the best (and nor is the most expensive). As Colin Thomé points out, cheap OOH services often find it difficult to attain National Quality Requirements (NQRs) and a good OOH service adds value to the wider health community with fewer referrals to hospitals and reduced secondary care costs.[6] Current OOH care is seen by some as more expensive and less efficient.[8] In fact the increased costs reflect the true price of providing the service and are inevitably higher, because of the poor remuneration GPs received before 2004. This was a point not lost on the government who found that the financial situation after 2004 changed radically.[9]

We know there is a wide disparity in demand and therefore in costs in areas with similar demographics.[7] In much the same way as providers, many practices with similar demographics seem to have differing OOH use and we need further research to find out why this occurs and what could and should be changed. An example of this can be seen in the demand for repeat prescriptions at weekends which can constitute as many as 20% of calls to our service at Mastercall Healthcare on a Saturday morning. Issuing of repeat prescriptions also highlights questions about how we define the services provided in OOH.

OPTIMISING OOH CARE

The 'handover' of responsibility in 2004 from practices to primary care trusts was accompanied by a lack of clarity about what the new services were to provide. Are we providing an urgent service which only treats emergencies (the definition of which may well, like beauty, be in the eye of the beholder) or an unscheduled care service treating anything? We should be careful about blaming patients for 'unnecessary' use of an OOH service if the commissioners have yet to grasp the nettle of deciding exactly what we should be providing.

The main concern of many GPs seeking to work for us is the lack of prior information they have when they see a patient. This can lead to unnecessary admissions, treatment and, more importantly, a reduced quality of

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care for the patient. This is especially important in the care of palliative care patients where the transfer of good quality information is vital in reducing unnecessary referrals and admissions and promoting a seamless high quality care.[10] Reliable methods of shared communication should be high up on the list of requirements for any review of OOH services by our new GP commissioners.

Even though primary care no longer has responsibility for 24-hour care, it still has a duty to see that patients get the best quality OOH care. Better relationships between clinicians, commissioners, and OOH providers will go some way to securing the better continuity of care we all seek to achieve for all our sakes.

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