Monitoring the standard of deputizing services

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SUMMARY. The standard of medical care provided by deputizing services is important for patients receiving care and for doctors using the service. The monitoring of these standards is discussed here in terms of what should be measured, how this should be done, and who should carry out this monitoring. The features to be taken into account include professional values, accessibility, clinical competence, and ability to communicate. Various bodies, such as the deputizing services, family health services authorities, and individual doctors and patients will usefully be involved in assessing standards.

The future might hold radical solutions to the management of out-of-hours calls. These solutions could involve patients, general practitioners and the deputizing services. The result must be that patients receive the best possible care.

Keywords: deputizing services; quality of health care; quality assurance.

Introduction

THE use of deputizing services in the United Kingdom is increasing[1] and a recent survey for the General Medical Services Committee of UK general practitioners showed that 73% of practitioners would like to opt out of the existing 24-hour commitment.[2] If out-of-hours care is to be provided mainly by a deputizing service, rather than general practitioners, then the standards of this care become particularly important to both the patients receiving care and also to the doctors using the service. Society at large is likewise concerned about the standards of all medical care. The standard of care provided by deputizing services needs to be measured, but what should be monitored, how should the monitoring process take place, and who should carry it out?

Background

General practitioners can carry out all their own out-of-hours care, but they need to be alert and available during normal surgery hours for the continuing care of their patients. Alternatively, general practitioners can form into local groups to carry out this out-of-hours work.

The term deputizing services usually refers to a commercial organization which arranges for out-of-hours calls to be made on behalf of the general practitioner; general practitioners subscribe to the commercial service.[3] Deputizing services have been a part of general practice in the UK since 1955.[3] By 1987, 45% of all general practitioners had permission from family practitioner committees to use a deputizing service,[4] and in large towns such services consistently handle one third or more of all first contacts for medical care out of hours.[5] The use of deputizing services varies with the size of the practice and its geographical location; deputizing services are not always available outside urban areas.[6]

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Submitted: 9 September 1992; accepted: 18 November 1992.

Out-of-hours calls may represent only a small proportion of general practice consultations (approximately 1–3%[7]), but these calls are a particular source of stress to general practitioners. The increased use of deputizing services may reflect increased general practitioner workload during the day — general practitioners may feel that out-of-hours calls are one part of their work that they can offload elsewhere.[6]

Monitoring of deputizing services

What should be measured?

The Department of Health and Social Security issued a circular in 1984 setting down guidelines for the monitoring of deputizing services.[8] The circular set out a code of practice for deputizing services and suggested several features which need to be taken into account when determining the acceptability of such services:

- Competence and sufficiency of doctors on duty.
- Continuity of care.
- Support staff.
- Transport
- Communications.
- Priority of calls.
- Response to calls.
- Records.
- Information requirements.
- Complaints against general practitioners using deputizing services.

These features can be usefully grouped into four sections and extended (Figure 1). They then resemble the features of good general practice exemplified in *What sort of doctor?*[9]

How should the monitoring process take place?

A mechanism for the monitoring of deputizing services was laid

Professional values
- Patients' views about the service.
- Doctors' views about the service.
- Continuity of care.
- Complaints against GPs.
- Complaints against the deputizing service.

Accessibility
- Telephone answering.
- Support staff on duty.
- Time to respond to calls.
- Medical staff.
- Transport of staff.
- Priority of calls.

Clinical competence
- Appointment of deputizing doctors and criteria used.
- Clinical acumen.
- Prescribing patterns.
- Referral data.

Ability to communicate
- Communication between patient and service.
- Communication between deputizing doctor and patient.
- Communication between deputizing doctor and registered doctor (written and oral reports).
- Continuity of care.

Figure 1. Features which can be used to monitor deputizing services.

down in the Department of Health and Social Security circular of 1984.[8] This circular instructed each family practitioner committee to establish a deputizing services subcommittee to advise on the acceptability of deputizing services. It instructed that these services should be effectively monitored and periodically reviewed. It further instructed that the subcommittee should appoint a liaison officer to check that any procedures that the deputizing service had undertaken to observe, continued to be followed. However, the deputizing service subcommittee structure no longer exists, following the management restructuring in the change from family practitioner committees to family health services authorities. The circular can therefore only be interpreted in broad concepts.

The following is a mechanism of how monitoring could take place:

- Attendance at interviews for deputies and setting of minimum standards for the appointment of deputies.
- Visits to deputizing services to assess the number of duty doctors available and the number of support staff on duty.
- Examination of written records looking at the time taken to visit, legibility of written records, clinical content, where prescriptions were issued, and referral patterns. Prescriptions issued by the deputizing service can now be analysed further using specific PACT (prescribing analyses and cost) data available for deputizing services. PACT data enable deputizing services, like all general practitioners, to review their prescribing habits and costs, and enable the comparison of prescribing by deputizing services with colleagues in the family health services authority and nationally.
- Visits carried out with the deputizing doctor.
- Setting definite criteria, for example, the time taken to answer urgent calls or the number of staff on duty.

Who should carry out the monitoring process?

The monitoring of the standard of deputizing services needs to be carried out at several levels — by the deputizing services themselves, by family health services authorities and liaison officers, and by individual doctors and patients. The family health services authority (or a joint deputizing committee, if one exists) needs to decide on criteria that are considered important. Actual performance then needs to be measured against these criteria and this may well be the work of a liaison officer or another officer of the family health services authority.

The deputizing service must monitor itself. It should decide on criteria of its own, for example, the number of staff on duty, acceptable delays in visiting, and the appointment of deputy doctors. There should then be some form of self regulation carried out by officers of the deputizing service.

Individual doctors using the service must be prepared to monitor the service themselves by, for example, looking at written communication received from deputies, and also by listening to patients' accounts of visits received from the deputizing service. An individual doctor and patient can probably comment more appropriately about the care received than a family health services authority or a liaison officer looking at the records of unknown patients.

What has already been studied?

It is useful to look at published work about deputizing services and out-of-hours calls, to see what criteria have been studied and with what results. It is known that out-of-hours calls are diagnostically demanding and occur when general practitioners are tired and prone to cope rather than deal with problems.[6] The most frequent type of call is from parents about children,[10] with elderly people the second most frequent callers.[6] From this previous work, it is clear that deputies need to be of high calibre and have wide ranging experience of general practice, with particular expertise in the management of children and elderly patients.

Published work has also looked at patient satisfaction. Between 70% and 80% of people seen by deputizing service doctors appear to be satisfied with the service received.[4,10] This is similar to the overall satisfaction with National Health Service general practitioner services and better than hospital services.[11] Satisfaction appears to be highest among older people and lowest among parents of young children.[10] Asian patients appear to dislike deputizing services more than non-Asian patients.[12]

Doctors' attitudes to deputizing services have also been studied but appear to be mixed. Many doctors see deputizing services as a disadvantage to patients.[13] However, a vast majority of doctors using the service find the care satisfactory.[14]

The time taken for services to respond to calls has frequently been studied. It appears that deputizing services respond to calls reasonably quickly[3,4,15,16] but the appropriateness of delays is often difficult to judge. Patients seem more likely to criticize delays in visiting when the visit is carried out by doctors outside the practice.[10] Referrals to hospitals from deputizing services appear to be as appropriate as referrals from general practitioners,[3,4] although the referral rate may on occasion be higher.[17] There is certainly an increase in the amount of night visiting with the use of deputizing services.[18]

The future

Out-of-hours care in general practice should be of no lesser standard than that provided during normal working hours.[8] However, if general practitioners provide their own out-of-hours cover and then continue to work during normal hours, the standard of all their work may fall. They need to be alert, compassionate and competent and to communicate effectively for their own sake and the sake of their patients. General practitioners may feel that the stress of out-of-hours work can be usefully delegated, but they remain responsible for the care then given on their behalf by such a service. It was noted several years ago that deputizing services, and the doctors working for them, should be of a high quality.[19] Quality needs to be monitored on a nationally agreed basis by local networks. However, there need to be many levels of responsibility for monitoring deputizing services. The deputizing services themselves must be responsible for some monitoring, and the family health services authorities need to set criteria that they regard as acceptable. Individual doctors and their patients, however, can probably be most helpful when assessing the care provided by individual deputies to individual patients.

The whole system of out-of-hours care may need to be changed radically. Currently, patients who are mobile and could relatively easily attend a central medical office serviced by local doctors may be visited out of hours at home. Hospital casualty departments or modified small cottage hospitals may be appropriate for the provision of out-of-hours care for mobile patients in certain areas.

The primary health care team may need to reconsider the provision of out-of-hours health care, perhaps with the involvement of nurse practitioners, nurses and receptionists in this care. The team would then be a true partnership and its members would need to be rewarded for this, both financially and in terms of hierarchy.

Some practices may wish to opt out of 24-hour care entirely and it should be possible for this to be negotiated with health service managers. Family health services authorities might then make arrangements for care to be carried out by deputizing services, but the issue of ultimate responsibility would need to be resolved.

Deputizing services themselves may also need to change. Not

all patients requiring treatment out of hours will need to be visited; some may only want telephone advice and some may be mobile enough to attend a centre, for assessment by a deputizing doctor.

The rewards of working as a deputizing doctor need to be sufficient to attract high calibre doctors. A career structure may be necessary to keep such doctors working for a deputizing service. Whatever changes are made, doctors working for deputizing services need to be clinically competent and have the necessary experience to give patients the best possible care.

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