Out-of-hours care

Twenty-four hour responsibility for a registered patient list was one of the cardinal features of NHS general practice for many years. In the almost unimaginable days before mobile telephones, a relatively untrained spouse often had the unenviable task of triaging phone calls from worried patients and trying to track down the GP who was out on calls, perhaps with a cumbersome radio-telephone with unreliable reception. These unsatisfactory and potentially unsafe arrangements were gradually superseded by a more structured approach to out-of-hours care, but for many years practices or groups of practices not only retained personal responsibility for their patients but were also personally involved in doing house calls at night. The Monday morning team meeting was a good opportunity to review the illest, most vulnerable, and most problematic patients on the list. Changes in the GP contract over more recent years have resulted in a retreat from these responsibilities and a growing division between those GPs doing in-hours care and those providing emergency care at night and weekends. The professional, clinical, educational, ethical, and political ramifications of these changes have been discussed endlessly, and there are real concerns about the erosion of continuity, the safety of handovers from sessional doctors about patients seen at weekends, the training opportunities that have been lost when trainees see so little emergency primary care medicine, and the impact on public trust and esteem of the apparent increasing unavailability of GPs. The topic has most recently reappeared in the spotlight because of a perception that accident and emergency departments are now reeling under a greatly-increased patient load which, it is claimed, is at least in part caused by poor provision of out-of-hours services in primary care.

How should urgent primary care be provided? Who are the key players and how should they form an effective out-of-hours team? Is it worth trying to re-connect with some of the values and commitments that set British general practice apart — the jewel in the crown of the NHS — or should we give up the idea of a lost, golden age and get real about the aspirations and working lives of medical professionals in the 21st century? We asked four well-placed colleagues for their views.

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DOI: 10.3399/bjgp13X673955

THE ROLE OF PATIENTS

Renata Drinkwater

Out-of-hours provision is absolutely crucial and patients should be at the centre of this debate, not at the periphery. It is not only about giving patients a say. They too have an active role to play and, given the right tools — support and information — they will do well at it, contributing to an NHS that is more sustainable and fit for purpose. The two key areas where patients can actively help in alleviating pressure on out-of-hours services are self-management and information.

Patients with long-term conditions represent 55% of GP appointments; 68% of outpatient, accident and emergency (A&E) attendances, and 77% of inpatient bed days. By giving these patients the tools and confidence to self-manage, demand on the health system would decrease significantly. Self-management programmes can save an average of £451.73 per patient per year by reducing healthcare professional visits, outpatient appointments, A&E attendances, and hospital bed days. Self-management helps patients to feel empowered, more confident and in control of their health. It also contributes to improved clinical outcomes and quality of life.

Patients who engage in self-management also have access to information and learn how to navigate the complex health system and to access the services they need. Many patients simply don't know where to go and use emergency services as a default option. More information is needed about what type of health care is available when GP surgeries are closed. GP surgeries can and should do better to provide more flexible and longer hours to suit patients' needs. We need to take the example of other sectors in which the level of services and staff is organised according to demand. For example, why not have GP surgeries open on Saturday and Sunday, offering consultations as well as minor procedures and tests? The increasing demand experienced by some private clinics is testimony to the fact that patients' needs are changing and solutions are needed to accommodate them. There is no reason why services such as specialist consultations, diagnostics, radiology, pharmacy, hospital transport, and social care could not be made available every day. This would give patients continuous access to health care; those in hospital could be discharged quickly over weekends, and non-emergency cases would have access to their usual GP or other out-of-hours provision. A healthcare system where people are more likely to die if they have elective surgery at the end of the week is clearly not fit for purpose.

We do not yet have a system where a patient's record is shared across services and/or held by the patient. At the very least, patients and their carers should have access to their medical records. A patient who has his or her records at hand is able to contribute to more efficient and effective care; sharing that information with clinicians and other healthcare

"A healthcare system where people are more likely to die if they have elective surgery at the end of the week is clearly not fit for purpose."

professionals. Patients want to play an active role in their health care: it is about time we truly listened to them.

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DOI: 10.3399/bjgp13X673856

PITFALLS OF GPs GETTING BACK DIRECTLY INTO OUT-OF-HOURS CARE

Michelle Drage

Recent ministerial pronouncements and media hyperbole around GPs being personally responsible and even personally providing out-of-hours care have sent shock waves throughout the profession. Such a reversal of an agreement that suited government as recently as 2004, is regarded by three generations of GPs as the last straw. For rural and city GPs alike, that agreement brought an end to constant battle against exhaustion, absence from family and home, marital breakup, neglect, and deterioration of personal health with no respite in sight. Demand for out-of-hours visits could not be stemmed, even by long, open-ended evening surgeries.

There was a terrible knock-on effect on daytime surgery; fatigue, decreased efficiency, irritability, increased risk of clinical error, and defensive practice. Despite our best efforts, patient dissatisfaction and complaints about in-hours and out-of-hours care rose inexorably and in an increasingly risk-averse, performance-driven environment the glue of collegiality and mutual support began to break down.

All of these are as relevant now as they were then, only more so. In-hours days are longer and far more complex than ever before, with consultation time being stretched to the absolute limit with the demands of QOF, the transfer of secondary to primary care, the multimorbidities that accompany longevity and medical advances, as well as ever-rising patient expectations and government targets.

While the GPs of the post-war baby boom era were prepared to both provide and be responsible for out-of-hours care, the GPs of the new baby boom are not. Now equal in numbers, male and female GPs are highly likely to have portfolio careers and less of a tie to life-long job security and satisfaction. They have grown up with different values in terms of work-life balance, shared parental roles, dual incomes, and other societal expectations.

Moreover, they are not trained to take back this archaic role of the clinically-unnecessary 3 am visit for earache, based on politicians' rose-tinted memories of childhood. Nor are they prepared to take on responsibility for its organisation, in effect becoming the provider of last resort. How would they fit it into the 12-hour days they do already? How would patients receive continuity of care in hours? With doctors no longer living in the communities they serve, what about the journey times? What about the safety risk in our cities, towns, and rural highways? Who would look after the children at night when life partners are often living and working away from home to pursue their careers?

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Life in New Zealand suddenly looks quite appealing, and if this notion is pursued we can expect many more GPs to pick up their families and go.

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DOI: 10.3399/bjgp13X673865

ARGUING FOR MORE GP ENGAGEMENT IN OUT-OF-HOURS CARE

Denys Greenhow

There are three major disconnects causing problems with the quality of out-of-hours care provision (outside funding and staffing levels) that call on GPs to provide leadership. In the long term, GPs working exclusively in out-of-hours care shouldn't be revalidated as GPs unless they demonstrate keeping up to date with chronic disease management. Equally GPs mainly working in hours can be challenged by unscheduled care shifts. An out-of-hours session in is not equivalent to one in hours.

Disconnect two: no coherent clinical governance. Some private companies delivering out-of-hours care are designated bodies with their own responsible officers. However, most require their GPs to be on a performers list which will have its own responsible officer taking priority for their revalidation: why? Within many out-of-hours providers there are no regular peer-to-peer meetings to discuss significant events. Confidentiality clauses also stymie transparency. The report by Colin-Thome & Fields on general practice out-of-hours services in England noted supervision of out-of-hours GPs was mainly through medical directors and indeed urged commissioners to separate discussions on service delivery from quality with providers to maintain focus. The National Out-of-Hours Operations Group meets monthly to