
“Within many out-of-hours providers there are no regular peer-to-peer meetings to discuss significant events.”

interconnect the service in Scotland, but in England only a small number of providers share significant events confidentially and compulsory national quality markers are benchmarked by non-government organisations such as the Primary Care Foundation.

Out-of-hours care is now provided by many professions who are discretely trained, such as unscheduled care nurses via a range of routes, paramedics with different guidelines and drugs in their kit, and BASICS trained doctors, anaesthetists, and emergency care clinicians all with stakes in unscheduled care. Coordination is needed.

What to be done? Creating a national quality spine/contract running through all providers of NHS patient care (both private and public) would answer these points. Such a contract signed by all providers and their employees would preclude any access to NHS patients. This would necessitate regular significant event meetings with a duty of candour with all interprofessional same-sector peers contracted and paid to attend, linked to appraisal, chaired by experienced outside monitors. National standards are also required for provision of equipment and drugs in out-of-hours care. The seeds are there following the Francis and Berwick reports and the College can lead the debate.

Conscription of practice-based GPs again into 24/7 practice? (*‘Oh! we don’t want to lose you, but we think you ought to go...’*; as the WWI recruiting song had it). No, a better solution would be to buddy-up willing out-of-hours GPs with practices to embed them locally to maintain their all-round practice and allow them to be link workers between the services, particularly with reference to vulnerable patients. And funding to achieve this public purpose.

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HOW PRIMARY AND SECONDARY CARE SHOULD WORK TOGETHER



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Accident and emergency department (A&E) visits and ambulance utilisation are rising in the UK despite a very strong network of GPs and universal coverage. The renegotiation of the GP contract has created a new gap in services in some parts of the country, where there are insufficient GPs to cover the emergency out-of-hours workload. Patients’ perceptions of their clinical problem and their GPs’ availability has changed such that their default position is increasingly to attend A&E. The NHS began to address this issue some years ago by creating alternative services that patients could access for advice and management of their urgent healthcare problem such as NHS Direct, latterly replaced by NHS 111, and walk-in centres or urgent care centres. Studies have shown that paradoxically, these alternative services have led to an overall increase in demand for A&E services, often because of confusion among the public about which

service is available and when, and because of an increased expectation by the public of availability of 24/7 care. However, evidence to date suggests that collocation of services may have some impact on reducing A&E attendance.

It is clear from this evidence that out-of-hours services need to be joined up, easily accessible and focused on what patients actually want. There is simply no point in trying to redirect patients or prevent them from attending. The consumer mentality that exists in society today partly encouraged by the increased expectations that the NHS advertise, such as being seen and treated within 4 hours or calling ‘999’ if we experience chest pain, have created a challenge for how we are going to meet these demands in a cost-effective and safe manner. Ultimately we have to accept that patients want an easily accessible one-stop shop where they can reliably access health care in an emergency. The simple solution is a collocated emergency centre staffed by GPs, nurse practitioners, and emergency medicine doctors offering a range of services for the public. However, key to the success of such ventures are funding streams that cross primary–secondary care boundaries, appropriate care pathways to refer patients into the centre and back out to the community and social care, GPs who want to undertake this work, and full support of local clinical commissioning groups. In addition, top-down initiatives, targets, and quality improvement strategies that actively disincentivise this joined-up approach must be removed. The time for working in silos and not taking a totally patient-focused approach to out-of hours care is over and to protect our future as clinicians, and the future care of our patients, we have a duty to convince government and the Department of Health that this is the future of out-of-hours health care.

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