

The new GMS contract explained

Focus on...

Out-of-hours

This guidance note has been produced by the General Practitioners Committee to help GPs and Local Medical Committees with the out-of-hours arrangements under the new GMS contract, and is one of a series of guidance notes on the new contract. The guidance will be updated as progress is made throughout the implementation discussions and negotiations. We would advise all GPs to read the contract document and supporting documentation, available on the BMA website at www.bma.org.uk. The GPC has produced a list of frequently asked questions and answers which can also be found at the website address.

Although there may be some differences in process in each of the four countries of the UK, the principles of this guidance apply to all.

Definition of out of hours

The out-of-hours period is from 6.30pm to 8.00am on weekdays, the whole of weekends, Bank Holidays and public holidays. [The out-of-hours period is detailed in part 1 of the NHS (GMS contract) regulations 2004].

Transfer of responsibility

Full details of the procedures for transferring responsibility for out-of-hours are contained in Schedule 3, sections 4 and 5 of the NHS (GMS contract) regulations 2004. LMCs and practices are advised to read these.

- Between 1 April 2004 and 1 January 2005, with the agreement of the PCO, practices can transfer responsibility for out-of-hours provisions.
- From 1 January 2005, where practices have handed over responsibility, PCOs will take full responsibility for making sure there is effective out-of-hours provision:

"PCOs will be required to have a contingency plan in place which can be put into immediate operation should an out-of-hours provider fail. The default option will lie with the PCOs, not practices as is currently the case." [Paragraph 2.22 contract documentation]
- Once a date has been agreed between the PCO and practice (OOH day), and has passed the PCO will not be able to transfer out-of-hours back to GPs who handed over responsibility, if the PCO has any problems providing or commissioning the services.
- Between 1 April 2004 and 1 January 2005, after OOH day (the date on which the out-of-hours transfer of responsibility is to commence) has arrived, and in the absence of a service of notice by the PCO under schedule 3 para 5(10)(a) of the NHS (GMS) regulations 2004 or an application to the Strategic Health Authority under para 5(1)(b) having been made before OOH day, then the PCO will not be able to transfer out-of-hours responsibility back to the practice.

- Contractors will have a right to transfer responsibility for out-of-hours from 1 January 2005, except where the strategic health authority has agreed (or the Assessment Panel in Scotland) with the PCO that there are exceptional circumstances.

Transferring responsibility for out-of-hours

- Practices that do not want to retain responsibility for out-of-hours, can hand over responsibility for providing the service from 1 January 2005 (or before 1 January 2005 if the PCO has arrangements in place to allow this). The PCO will not have a veto on this. If you want to transfer responsibility from 1 January 2005, you can do this without the approval of the PCO unless at least one month before 1 January 2005, the PCO serves notice that it has made an application to postpone or refuse the transfer. This should only occur with regard to those practices in very remote or isolated areas and where the SHA (or in Scotland, the Assessment Panel) has agreed with the PCO that there are exceptional circumstances (see below).
- Practices can continue to provide out-of-hours services if they choose to do so.
- Transferring responsibility is not possible on an individual doctor basis. Under the practice-based contract, the transfer of responsibility is on a practice basis only. How a practice makes that decision will be subject to the arrangements in their partnership agreement.
- PCOs can consider a range of alternative providers for out of hours:

“By 1 January 2005 it is expected that all PCTs will be fully responsible for securing out-of-hours services for their local populations, whether through APMS contracts, specialist PMS contracts, contracts with GMS or PMS contractors, or by providing services themselves. The Department issued guidance to PCTs on setting up new out-of-hours arrangements in October 2003. This is available at www.out-of-hours.info/. “

[Paragraph 2.69 of the Department of Health’s guidance *Delivering investment in general practice: implementing the new GMS contract*].
- From 1 January 2005, a contractor who provides out-of-hours services must, in the provision of such services, meet the quality standards set out in the document entitled ‘*Quality standards in the delivery of GP out-of-hours services*’ published on 20 June 2002. These quality standards are available at: www.dh.gov.uk/assetRoot/04/06/68/30/04066830.pdf. They are currently being reviewed, and will be re-published in 2004. In Scotland, the standards for out-of-hours services are currently being developed by Quality Improvement Scotland
- Any practice that hands over responsibility for out of hours will not automatically be entitled to provide the service if they wish to move back at a later date. Practices that transfer responsibility or new practices that want to provide out-of-hours services “will be considered alongside other potential providers” [paragraph 2.19 contract document]. All potential providers will have to show that they meet the relevant accreditation standards.
- GMS and PMS practices do not have preferred-provider status for out-of-hours services that other contractors have chosen not to provide.
- A practice may not withdraw an out-of-hours transfer of responsibility notice once it has been approved by the PCO without the PCO’s agreement.
- Transfer of responsibility is all or nothing. The practice cannot, for example, hand over only at weekends.

- The new arrangements for out of hours will not prevent practices being able to offer surgeries or consultations during the out-of-hours period, for example, Saturday morning surgeries. In addition, PCOs can commission services during the out-of-hours period to deliver longer hours of operation:
 - PCOs may contract to deliver this as an enhanced service at the request of the practice
 - where the PCO asks the practice to open at any time during the out-of-hours period, the PCO must contract for this as an enhanced service
 - where the PCO does not agree to contract for this as an enhanced service, the practice will be under no obligation to provide this but, if it chooses to do so, it will have to fund this out of the practice's global sum.

Procedure for handing over responsibility for out of hours

Full details of the procedures for transferring responsibility for out-of-hours are contained in Schedule 3, sections 4 and 5 of the NHS (GMS contract) regulations 2004. Practices intending to transfer responsibility for out of hours are strongly advised to read chapter 2 of the Department of Health's guidance *Delivering investment in general practice: implementing the new GMS contract*.

- Practices which decide to hand over responsibility must give notice to the PCO, in writing, and specify the date from which it would like the transfer to take effect. This must be either three or six months after the date of service of the out-of-hours transfer of responsibility notice. The practice does not have to give reasons for handing over responsibility.
- PCOs should approve the transfer of responsibility notice as soon as is reasonably practicable or within 28 days of receiving the notice and specify the date on which the out-of-hours transfer is to commence.
- Where a practice relinquishes responsibility for out of hours it must comply with any reasonable request for information relating to the provision of that service. All GMS contracts include a term requiring contractors to co-operate with other people who provide out-of-hours services to their patients. [Paragraph 43.2 of the GMS contract].
- When responding to the notice (within no more than 28 days), the PCO cannot refuse the transfer of responsibility request. For notices given before 1 October 2004, it can however set a different target date for the transfer to take effect. This can be any day from the date specified by the contractor up to 1 January 2005. For notices given after 1 October 2004, the PCO must specify the date given by the contractor in its transfer notice (that is, 3 or 6 months from the date of the notice)
- The PCO must do its best to put in place the necessary arrangements for the contractor to transfer responsibility by that target date. Where this is not possible the PCO can, if necessary, extend the period to 9 months. The nine month rule means that, for example, a contractor that gives notice on 1st May 2004 may not be able to hand over responsibility until 1st February 2005, if the PCO is unable to secure alternative provision before then
- The PCO can only refuse or further delay transfer of responsibility in exceptional circumstances, for example if the contractor's location is so remote or isolated that there is no realistic alternative to the contractor continuing to provide its own out-of-hours services. In England, exceptional circumstances are expected to be extremely rare and the PCO would require the SHA's permission. SHAs will also be performance managing PCO progress towards effective re-provision, to ensure that there is no slippage. In Scotland it is anticipated that only a very few of the most isolated practices will be unable to hand over responsibility. PCOs must obtain the agreement of the Assessment Panel before the Practice's application to transfer responsibility is refused or postponed.

- Nothing in the transfer procedures prevents PCOs and contractors at any time agreeing a different date for the transfer to take effect.

Out-of-hours funding

The global sum calculation includes the cost of providing out-of-hours services.

Where a practice hands over responsibility, a UK-wide sum per practice has been agreed for 2004/05. This sum will be subject to the practice weighted population formula for each practice and works out at 6% of the global sum. [paragraph 2.5 of the statement of financial entitlement]

This amount was negotiated to provide a realistic opportunity for those practices that want to transfer responsibility, and to allow those that choose not to transfer, not to be disadvantaged compared to their current earnings and is not meant to cover the cost of re-provision.

The money 'released' by those practices that transfer responsibility will be available to the PCO to provide out-of-hours services. The Out-of-Hours Development Fund (OOHDF) will continue to be available to PCOs and the allocation for 2004/2005 was announced on 1 November 2003 (see www.out-of-hours.info). The OOHDF will remain ring-fenced for out-of-hours primary medical services (however provided) but the detailed rules on its use contained in the Statement of Fees and Allowances will no longer apply. In Scotland, the OOHDF allocation contained in the allocation letter of 11 May 2004 is not ringfenced, but Health Boards will be required to meet the requirement of the GMS contract documents including the delivery of the enhanced services floor.

PMS practices are also entitled to transfer responsibility of out of out-of-hours and their contract price will be reduced by a fixed amount. For 2004/2005, this will be based on a tariff broadly equivalent to that for GMS contractors, namely, £6000 per average doctor in the average practice.

When determining how to secure integrated out-of-hours services, PCTs will need to consider all the resources available to them both in the unified budget (eg resources used for emergency care networks) and elsewhere.

Those that cannot hand over responsibility

The PCO may, if it considers there are exceptional circumstances, make an application to the relevant SHA (or the Assessment Panel in Scotland) for approval of a decision to either refuse transfer of responsibility or postpone its commencement. Exceptional circumstances are expected to be extremely rare and all PCOs will be expected to take on their commissioning responsibility by 1 January 2005. Delivery against this objective will be performance managed in England by SHAs. [Paragraph 2.63 (ix) of the Department of Health's guidance *Delivering investment in general practice: implementing the new GMS contract*].

Practices in particularly remote and isolated areas may not be able to hand over responsibility for the provision of out of hours. The category of practice that falls into this group can only be determined locally. This should be done by agreement between the LMC and the PCO. Practices in remote and isolated areas should discuss their options with their LMC and PCO, before giving any indication to the PCO about whether they intend to transfer responsibility.

Practices that cannot transfer responsibility "will be supported by the Out-of-Hours Development Fund".

Paragraph 48 of the new contract supporting information for Scotland sets out the arrangements that will apply to those few practices in the most isolated areas of Scotland, where after local

determination and any appeal process, the transfer of responsibility is not possible. They are as follows:

- the retention of the out-of-hours abatement
- payment of the weighted capitation share of the OOHDF and any increased investment by the NHS Boards for providing out-of-hours services
- an additional payment to cover any differential between the total of these and the locally determined premium payable to salaried GMS practitioners for providing out-of-hours services.

The supporting documentation for Scotland can be found on the BMA website at: [www.bma.org.uk/ap.nsf/Content/ Hub+GPC+contract](http://www.bma.org.uk/ap.nsf/Content/Hub+GPC+contract).

Practices and LMCs

LMCs have begun work on out of hours in preparation for the new contract. In addition:

- LMCs may wish to consider developing model letters for use by practices informing patients of the change in out-of-hours services.
- Fewer practices will be providing out-of-hours services in the new contract world. This is an opportunity for PCOs and for co-ops to review and consider the services they are providing and to plan new ways of providing these services. Examples of innovative out-of-hours schemes are attached at annex 1. These can also be found in the contract supporting documentation
- LMCs could consider working with the PCO to ensure that any service commissioned by the PCO will be of equal or improved standard to current out-of-hours services, and comprehensive enough to prevent increasing amounts of work cascading back to practices in hours. All the services PCOs commission will need to meet the national quality standards.

Informing patients of the transfer of responsibility for out of hours

Patients need to be fully informed about how they can access out-of-hours services and PCOs should have developed plans for effective public engagement well in advance of the change of responsibility taking effect.

Before transferring responsibility for the out of hours, the PCO and the contractor should discuss how the contractor's patients will be informed of this change of service.

Should the PCO request it, the contractor must inform its registered patients of a hand over and details of the out-of-hours arrangements by placing a notice in the practice waiting room and include information in the practice leaflet.

LMCs (or their equivalents) may have produced model letters which practices can use/adapt for their own use to inform patients of the new out-of-hours management.

Annex 1

Innovative out-of-hours schemes

The following innovative out-of-hours schemes have been identified by NHS Confederation members and considered during the new GMS contract negotiations.

Exemplar 1

- Large co-op (500 GPs) incorporating visiting service, five primary care centres
- Integration between NHS Direct and co-op. All A&E calls intercepted and routed as appropriate
- In A&E department nurses triage patients in waiting area where there are also phone boxes for patients to speak to NHS Direct.

Exemplar 2

- Aim is to provide patients with the same experience whether accessing emergency care in person or by telephone
- Partnership between co-op, NHS Direct, PCT, A&E, acute trust, out-of-hours co-op, community pharmacists, mental health and social services
- A&E streamline patients into minor illness, minor injury and majors
- Minor injury seen by senior house officers
- Minor illness seen by nurse practitioners or GPs
- Skill mix being implemented (injury/illness)
- GPs contracted so their indemnity remains with MDOs
- Running since April 2002, and currently under evaluation

Exemplar 3

Model tested with a number of GPs – largely supportive but questions raised in relation to terminal care and out-of-hours cover for community hospitals.

Level 1

- Home visits by GPs would cease between 7pm and 8am
- An experienced doctor would be present in two centres within the PCT area
- These doctors would have admission rights to the hospitals, on-call diagnostic imaging and emergency pathology facilities
- These doctors would assume responsibility for the inpatients of the hospital

Level 2

- Three paramedics in three ambulance vehicles on the road in radio contact with medical centres and ambulance control for:
 - Urgent home assessments
 - Transportation to medical centres if necessary
 - Initiation of front line treatment e.g. pain control, catheterisation etc.

Level 3

- Nursing and social care staff (numbers required are not yet clear) on the road in radio contact with medical centre, paramedical service and ambulance control for:
 - palliative care
 - general nursing interventions to sustain people at home

- social care interventions to sustain people at home
- to remain if required in people's homes and throughout the night for crisis management.

Exemplar 4

- Integration of local co-operative and the nurse led walk-in centre onto one site by April 2003
- Service development consistent with the Carson vision, phased implementation due to some current issues connecting to NHS Direct
- Will provide base for evening and night community nursing and paramedic support team
- In the interim GPs are being resourced to cover the 'red eye' shift – there are proposals for nurses working initially in parallel with the out-of-hours doctors to determine if a nurse led service is viable
- Additional nursing required has been identified in the Access & Capacity return.

Exemplar 5

- Trust provides call answering & referral, organisation of GP out-of-hours bases and provision of vehicles, drivers and communications to local co-ops
- A variety of commercial deputising, self-funding and 'paying' GP co-operatives currently exist in the area
- All are under pressure with fewer GPs willing to participate in out-of-hours work
- In 2000, a community paramedic was based in a GP surgery in a very rural area – resulting in improved ambulance response times. GPs have integrated the paramedic into their work
- The paramedic now does emergency house calls, takes bloods and performs ECGs, assists practice nurses and responds to 999 calls
- In 2001, 29 additional paramedics were based in GP practices in community roles. They refer suitable 999 cases back to practice team, resulting in increased ambulance performance. They are being used to ease some aspects of GP and primary care workload
- The Trust is working with the Workforce Confederation to extend higher education programmes for paramedics to develop primary care emergency practitioners and thus be able to undertake more of the role of the out-of-hours GP.

Exemplar 6

- The emerging vision is to develop a high quality, integrated, multi-agency, multi-disciplinary, urgent out-of-hours service with single call access. Key features of this service are perceived to be:
 - An integrated urgent care service operating from a single set of premises, incorporating out-of-hours nursing services, GP out-of-hours services and accident and emergency care
 - A multi-disciplinary approach to triage, assessment and treatment which is nurse led, with streaming to appropriate health and social care professionals
 - Joint development of the role of nurse practitioners across A&E and primary care
 - A satellite nurse led out-of-hours service, with appropriate links to the core out-of-hours centre in terms of transport and back up from medical staff
 - Strong links with intermediate care services and social care services, and the ability to access these as and when required
 - Primary care practitioners to have access to investigations out of hours
 - Integrated information systems to facilitate communication and transfer of data between agencies
 - A seamless care pathway for people accessing services
 - Single telephone access to out-of-hours health and social care services

The PCT is currently in the process of consulting with local stakeholders including patients and service users to develop the model further. Work is currently underway to analyse the activity in and case mix of current out-of-hours services to establish a baseline against which appropriate future service provision can be planned and the new model of care evaluated.

If you wish to find out more about any of the above exemplars, please contact gmscontract@nhsconfed.org for more details.

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