SERVICE SPECIFICATION

Service	Duty Doctor
Commissioner Lead	Leah Herridge
Provider	GP Confederation
Provider Lead	**Claire Lister**
Period	1st April 2017 to end of March 2019
Date of Review	September 2017

1 Population Needs

National guidance on urgent care has placed telephone care as one of six key system areas for focus by CCGs[1]. It is key to focus on telephone care across General Practice, as studies have shown that managing urgent care demand through increasing face-to-face consultations in primary care is neither cost-effective nor sustainable [2].

NHS City and Hackney CCG's urgent care strategy is underpinned by GP clinical triage in hours and out of hours – patients should call their GP practice or local out-of-hours service as a first port of call, for a telephone assessment by a GP. Receiving this assessment by an experienced clinician as early as possible should improve patient experience of care and ensure that they are managed in primary care or signposted to an appropriate service. For day-time hours (8am – 6:30pm, Monday to Friday excluding bank holidays), the Urgent Care Board therefore commissions the Duty Doctor service to provide clinical triage to patients across all 43 practices for the registered population of 309,016 (CEG 01.10.2016). The Duty Doctor also facilitates urgent requests from health and social care professionals.

2 Outcomes

2.1 NHS Outcomes Framework domains & Indicators

1	**Preventing people from dying prematurely**	
2	**Enhancing quality of life for people with Long term conditions**	**x**
3	**Helping people recover from episodes of ill health or following injury**	**x**
4	**Ensuring people have a positive experience of care**	**x**
5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	**x**

[1] *Urgent and Emergency Care Review, June 2013*
[2] Royal College of Practitioners , The 2022 GP, a Vision for General Practice in the future NHS, 2013

2.2 Service Aims and Objectives

The CCG is commissioning this Duty Doctor Service to support its overall strategic commissioning intentions of:

- Improving patient access to high quality primary care for urgent assessment
- Improving patient satisfaction
- Managing demand in primary care and mitigating urgent care attendances in secondary care

Link with Five Year Forward Plan

The service supports achievement of the Five Year Forward View in improving out-of-hospital care. Additional GP capacity should ensure that wherever possible patients are managed in primary care or signposted to an appropriate service rather than attend A&E. By improving access to high quality primary care for urgent assessment the service helps deliver improved patient experience.

3 Scope of Service

Provision of additional GP capacity in each practice for a ***duty doctor*** to undertake the following:

- GP same-day clinical triage of all urgent requests received by patients to include:

  - Prioritisation of all requests according to presenting need

  - Telephone consultations with each patient

  - Subsequent clinical co-ordination of care according to need (e.g. self-management and medication advice, booking face-to-face GP appointments or secondary care referrals)

  - The duty doctor will undertake urgent home visits and follow up activities where required

- Provision of a rapid GP response service to other health & social care professionals to include:

  - Telephone consultation with professionals about a patient

  - Subsequent clinical co-ordination of care according to need

  - Acceptance and management of referrals from crisis services (which may include Paradoc, IIT, 111, LAS, A&E) for patients with an urgent care need who require same day telephone advice, or face to face GP appointments at in surgery or at home

- For direct patient referrals and referrals into Duty Doctor from health care professionals, the GP must check to see whether a CMC care plan exists, view the care plan, and update when clinically appropriate.

3.1 Service Model

The patient population served under this service is the GP registered population of City and Hackney.

Each practice will provide a duty doctor service during core hours of general practice 8.00am to 6.30pm Monday to Friday, excluding bank holidays.

The duty doctor will provide clinical triage to urgent patient requests, including relevant follow-up. Patients will access the duty doctor via the existing practice number, they will be placed on the triage list and their urgency prioritized, with a maximum call back time of 2 hours.

The duty doctor will also provide a rapid telephone response to health and social care professionals with urgent requests. Acute services (A&E and the London Ambulance Service) should be put straight through to the Duty Doctor. If this is not possible practices should provide a response within 30 minutes. All other health care providers will be placed on a triage list and called back by the duty doctor within 30 minutes.

The GP undertaking the duty doctor role needs to be allocated to delivering the duty doctor service and must meet the duty doctor tasks within the timescales set out in this specification. The lead provider must evidence to the CCG that the funding for duty doctor is used by practices to deliver this extra clinical capacity.

3.2 Care pathways

Health and social care professional who liaise with the duty doctor:

- Community nurses & therapists
- One Hackney & City Staff
- Integrated Independent Team Staff
- Social services
- Emergency department
- Observational Medical unit & Ambulatory Care
- Hackney Psychological Medicine (RAID)
- Hospital Wards
- Mental health community teams
- Mental health acute teams
- Paramedics
- ParaDoc
- NHS 111
- CHUHSE Out of Hours
- The coroner's office

Examples of duty doctor interactions with professionals

- Liaising with a member of both the ParaDoc and Integrated Care Team to put a plan in place to keep a patient at home rather than admitted to hospital
- Liaising with the A&E/OMU acute clinicians, to ensure a patient can be discharged from OMU rather than admitted to a ward, involving co-ordinating an urgent home visit
- Liaising with the acute quadrant geriatrician to arrange an admission for a high risk patient who has called the practice and requires an admission due to a deterioration in their condition
- Liaising directly with a community nurse about a patient on the frail home visiting caseload who has had an exacerbation

4 Applicable Service Standards

The service must meet the CQC essential standards of care that are in place through the core GP contract.

4.1 Applicable Local standards

The basic quality requirements for suitability to provide the clinical aspects of this service are:

- ✓ Must be a practice within NHS City and Hackney CCG
- ✓ Ability to provide a duty doctor every working day during core hours 08:00-18:30
- ✓ If a Practice "closes" for a half day during core hours they must assure that urgent patient requests are provided by a suitable alternative provider – in that scenario a Duty Doctor must still be available via the dedicated number to deal with queries from other professionals, urgent fax or email messages
- ✓ Already offering the minimum appointments requirement of 72 per 1,000 for their registered patients
- ✓ Practices provide the service every weekday for the duration of the contract.
- ✓ The practice is registered with the Care Quality Commission (CQC) with no conditions.
- ✓ GPs must hold a GMS, PMS or APMS contract to provide the clinical aspects of the service.
- ✓ A business continuity plan for delivering this service
- ✓ Practices to share information with commissioners and network peers to support quality improvements (subject to IG rules) via the Lead Provider
- ✓ Practices actively collect, analyse and act on feedback from patients and carers.
- ✓ Practices participate in clinical audit cycles and peer review external to their practice.
- ✓ Practices will demonstrate their communication of the service to their patients

- ✓ Practices must be able to demonstrate to the CCG via the Lead Provider that the service delivers additional capacity and does not simply replace existing capacity already provided at another time during the week

5 Key Performance Indicators and Reporting Requirements

All Key Performance Indicators can be reviewed after 6 months of service delivery.

Performance indicator	Indicator/Quality Requirement	Format & Frequency	Consequences of breach
Key Performance Indicators			
Process: Percentage of health and social care professionals with urgent requests called back within 30 minutes	95% (must be achieved in each practice)	Quarterly	1% deduction from total quarterly payment if average of 95% not achieved. If an average of 95% achieved across all practices but an individual practice does not achieve the target a 1% deduction from quarterly payment will be made from the practices funding.
Process: Percentage of patients with urgent requests called back within 2 hours	95% (must be achieved in each practice)	Quarterly	1% deduction from total quarterly payment if average of 95% not achieved. If an average of 95% achieved across all practices but an individual practice does not achieve the target a 1% deduction from quarterly payment will be made from the practices funding.
Patient experience: The lead provider will work with each practice to undertake a survey collecting feedback from a sample of patients who have used duty doctor. A report of feedback received	Pass/Fail	Quarterly survey completed by each practice	Action Plan

and actions taken to be submitted to the Urgent Care Board.			
Clinical: Carry out an audit of 1 week's activity in each quarter at each practice and submit the report to the Urgent Care Board (audit details in section 8).	Pass/Fail	Quarterly submission of data and report	Action Plan
Clinical: On a six monthly basis undertake a survey collecting feedback from health and social care professionals referring into the service on how effective the service had been and submit a report to the Urgent Care Board.	Pass/Fail	6 monthly submission of data and report	Action Plan
Additional Data Collection Requirements			
The lead provider must evidence to the CCG that the funding for duty doctor is used by each GP practice for extra clinical capacity required to deliver duty doctor tasks.	Pass/Fail	Evidence provided by end of quarter 2 (reported once during contract, update must be provided if circumstances change)	Action Plan
Activity reporting: The lead provider to report on the number of calls duty doctor receive broken down by calls from patients and calls from health care professionals	Pass/Fail	Quarterly reporting to CCG	Action Plan

during the quarter.			

7 Financial and Procurement Summary

The contract will be procured using a lead provider model. The Lead provider will need to demonstrate that they have membership arrangements in place with all 43 practices to enable access to the practise list size of which the service is based upon.

The service will be funded on a recurrent basis. The contract value per annum is capped at £1,481,175.

Payment terms for the contract is based on a block arrangement, subject to delivery against the specification and penalties in place for breach of KPIs.

Payment will be made to the Lead Provider, subject to delivery against the specification, on a quarterly basis. The Lead provider will make payment to sub-contractors based on list size. The population at October 2016 309,016 (CEG 01.10.2016). Based on population of 309,016 the payment per patient per year would be £4.79, this is subject to change depending on list size.

GP Confederation Overheads will be paid at a rate of £100K per quarter in 2017/18.

8 Contractual Terms

The contract will run from 1st April 2017 to end of March 2019 and will be based on the NHS Standard contract.

A review will take place in September 2017.

7.1 Expectations for the lead provider

The CCG is seeking a Lead provider that can work directly with the 43 practices – to be demonstrated through membership agreements. The provider will coordinate the clinical service with the practices and any practice that has chosen to work as part of a collaborative will be allowed to do so, with the lead provider ensuring that the service is then delivered from one site. The lead provider could also offer salaried GPs to the practices that do not have the capacity/skill mix to provide the service.

The lead provider will ensure that there is sufficient administrative, clinical and managerial support in place to manage the full contract, including all aspects of the clinical service with minimal variation across practices. Key deliverables include:

- CCG will work in constructive partnership in the event that a practice is in breach with the CQC on a case by case basis.

- Coordinate the returns from each practice on a quarterly basis and present the combined submissions to the CCG for payment, outlined in the KPIs and outcome measures.
- Report any serious incidents through their current clinical governance structure, reporting to external bodies when necessary
- Ensure that safeguarding policies are in place and imbedded into current daily practice and that safeguarding issues are flagged to the local safeguarding bodies when required
- The lead provider will work with the CCG and CEG to establish which/if Read-codes on EMIS can be used to enable the CEG to produce monthly dashboards. Once established the provider will monitor and carry out evaluations of the dashboards, highlighting any obvious variations between practices.
- Support and work with practices to investigate any variations in recorded service delivery.
- Ensure the clinical specification is reviewed with the CCG and its clinical partners, provide an evaluation of its effectiveness and make recommendations for changes to the clinical model through their internal governance and then the CCG's governance processes.
- Provide a dedicated telephone number for practices to call for support with implementation of the clinical model
- Provide training to general practice on the service to be provided, reporting mechanisms, and outcomes to be measured.
- Responsible for collating an up to date list of the bypass phone numbers for each practice and distributing the phone numbers to all relevant health and social care providers to ensure that they have direct access to the service. The list of bypass phone numbers must be kept up to date and an update list provided to providers to all relevant health and social care providers.
- The lead provider will ensure that there is a mechanism in place for all relevant Health and Social Care Providers who have any problems accessing duty doc to escalate this to them for remedial action to be taken in a timely manner. The lead provider will be responsible for liaising with the practice to ensure that any concerns over access arrangements are resolved. The lead provider is responsible for ensuring that all relevant Health and Social Care Providers are aware of the reporting process. Where there are persistent issues these should be reported back to the CCG.
- If providing a GP to the practice ensure that the relevant indemnity and professional certifications are in place.
- The lead provider will be expected to work with the Urgent Care Board to formulate formal clinical pathways and governance protocols between the duty doctor and other key agencies – for example NHS 111, A&E and the coroner's office.

- The lead provider will provide the support required to practices to ensure that patients are clearly informed on how to access urgent care services within the practice.

- Ensure that each practice has links to local patient groups to provide feedback on the service, as set out in the KPIs below.

- Ensure that for one week period in each quarter, each practice conducts a detailed audit as set out below. Accompanying each practice audit should be a one side summary of learning points. The lead provider will be required to submit a report following each audit to the Urgent Care Programme Board detailing practice and quadrant variation and an action plan to address this.

Audit:

Calls from patients (sample size by practice: 5 consultations per 1,000 registered patients)

- Number of urgent patient telephone consultations, by day of the week and time of the day (am / pm)

- What was the outcome of each consultation & could it have been dealt with in a different way

- What percentage of patients audited went onto A&E or were admitted directly after the consultation

Calls from health & social care professionals

- Number of urgent calls received, by day of the week and time of the day (am / pm)

- Source of call – eg LAS, community nurse

- What was the outcome of each call & could it have been dealt with in a different way

Feedback from Health and Social Care Professionals

As part of the audit the lead provider should seek feedback from other health and social care professionals on how effective the service had been. The lead provider will need to design a brief questionnaire for other providers to fill in which could be general rather than practice specific.