Evaluation of pilot initiatives undertaken in the North Eastern and South Eastern Health Boards on the provision of General Practitioner out-of-hours services in those areas

Interim Report July 2001
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1. **Terms of reference**

To assess the efficiency and effectiveness of the management, administrative and support structures for the General Practitioner out-of-hours pilot projects in the North Eastern and South Eastern Health Boards having regard to value for money and service enhancement considerations.

2. **Background to the initiation of the Evaluation**

2.1 **Introduction**

2.1.1 Throughout the early 1990s a trend emerged in the delivery of General Practitioner services in concentrating that delivery within a normal working week. Accordingly, scheduled General Practitioner surgery hours have increasingly moved away from night-time, weekends and public holidays. That trend was recognised and facilitated by agreements reached in 1997 and 1998 between the Department of Health and Children and the Irish Medical Organisation which allowed for significant adjustments in the provision of scheduled General Practitioner services which were (and are) directly relevant to the out-of-hours context.

2.1.2 The movement away from personally provided General Practitioner out-of-hours services resulted in a reliance on a number of commercial deputising services in large urban areas where the critical mass of General Practitioners allowed for such commercial ventures (Dublin and Cork cities). The fact that deputising services were not available outside of those areas, coupled with concerns about the availability of a regular supply of qualified and experienced locums, led to consideration of the out-of-hours co-operative model which was increasingly relied on in the United Kingdom particularly from the early 1990s.
2.1.3 The first General Practitioner Co-operatives were established in the United Kingdom in the late 1970s against the background of an increasing demand from patients for comprehensive out-of-hours services coupled with an increasing General Practitioner workload during the core working week. Initial attempts to deal with the additional workload throughout the contractual commitment centred on revised contractual arrangements in 1990 which provided for additional remuneration for personally provided General Practitioner services out-of-hours. Public information campaigns on encouraging a more responsible attitude towards availing of out-of-hours services did little to arrest the ever-increasing workloads. Accordingly, significant funding was made available in the United Kingdom in 1995 to encourage an innovative and flexible approach to the provision of such services. One of the cornerstones of that approach was to provide funding for the expansion of the General Practitioner Co-operatives. As a result, the number of General Practitioner Co-operatives in the UK increased from six to approximately 125 in a six-year period from 1990 and current estimates indicate that 80% of UK General Practitioners are members of Co-operatives.

2.2 National Agreements

2.2.1 The agreements between the Department of Health and Children referred to in paragraph 2.1.1 above provided for significant adjustments in arrangements whereby General Practitioners could claim Special Type Consultation (STC) fees where services were delivered outside of normal scheduled surgery hours and outside of particular time periods. The arrangements prior to May 1997 allowed for claims to be made by General Practitioners only within the period 10 p.m. to 8 a.m. each day. The result of the 1997 and 1998 agreements provided for such claims to be made outside the hours of 9 a.m. to 5 p.m. Monday to Friday and all hours on Saturdays, Sundays
and Public Holidays (other than in the period where a scheduled surgery was taking place).

2.2.2 The introduction of the revised out-of-hours arrangements inevitably led to a greater numbers of claims being made as reflected in the statistics outlined in 2.2.3 below.

2.2.3 Total number and cost of out-of-hours claims 1995-2000.

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<tbody>
<tr>
<td>Number of claims</td>
<td>81,461</td>
<td>90,000</td>
<td>198,000</td>
<td>390,000</td>
<td>455,674</td>
<td>525,247</td>
</tr>
<tr>
<td>Cost of claims</td>
<td>£1.9m</td>
<td>£2.1m</td>
<td>£4.6m</td>
<td>£9.5m</td>
<td>£11.5m</td>
<td>£13.5m</td>
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2.2.4 The 1997/1998 revisions did little however to alleviate many of the fundamental concerns expressed by General Practitioners at that time, and recognised by the Department of Health and Children, which included:

- The concentration of core General Practitioner services within the normal working week
- The encouragement of Co-operative rostering arrangements among General Practitioners
- The promotion of group as opposed to single-handed General Practices
- The recruitment and retention of General Practitioners in rural areas
- The accommodation of flexible working arrangements within General Practice
2.3 The establishment of pilot General Practitioner Co-operatives

2.3.1 The first General Practitioner Co-operative to be established in the Republic of Ireland was Caredoc in June 1999. Caredoc initially provided out-of-hours General Practitioner services within Carlow and surrounding areas in the South Eastern Health Board as part of a national pilot project and extended to County Kilkenny on 1 November 2000 and to South Tipperary on 9 May 2001.

2.3.2 A second pilot Co-operative was established for the North Eastern Health Board Area in November 2000 (NEDoc) covering the entire region with the exception of some areas where General Practitioners have opted not to become involved in providing out-of-hours cover within the Co-operative.

2.4 Initiation of Evaluation

2.4.1 In the interests of ensuring that the co-op model was appropriate to their needs and, more importantly, to the needs of the public, all the parties to the pilots in the South Eastern and North Eastern Health Board agreed that the projects would be subject to a rigorous independent evaluation. It was further agreed that evaluation would consist of two exercises.

(a) Assessing the efficiency and effectiveness of the management, administrative and support structures for the General Practitioner out-of-hours pilot project

(b) A qualitative evaluation

2.4.2 It was subsequently agreed to extend the terms of reference of (a) above to provide for a greater concentration on the views of the wider community and establish due confidence among General Practitioners in the long-term future of the Co-operatives. (This element of the Evaluation will issue by way of a supplementary report.)
2.4.3 In accordance with agreements reached with the Department of Health and Children, the GMS Payments Board, the two Co-operatives and both Health Boards, this element of the Evaluation will address the following management and structural issues:

- Assess the efficiency and effectiveness of the management, administrative and support structures for the General Practitioner out-of-hours pilot initiatives in both Health Board Areas
- Determine whether clear lines of accountability exist in respect of value for money being achieved from the resources allocated
- Establish whether sufficient infrastructural supports exist to provide patient centred out-of-hours G.P. cover
- Compare and contrast the two pilot initiatives with standard out-of-hours cover being provided
- Point out the strengths and weaknesses of the models in question both comparatively and absolutely
- Address the issue of possible alternative models
- Prepare a template for the consideration of future projects
3. Methodology used in the course of the Evaluation

3.1 Introduction

3.1.1 This element of the Evaluation was conducted in two specific phases. Phase one dealt primarily with establishing the efficiency and effectiveness of the pilot initiatives in delivering a timely and effective General Practitioner out-of-hours service on a value for money basis.

3.1.2 The second phase related to identifying the relevant strengths and weaknesses of the pilots with a view to determining whether revisions to existing structures should be explored and whether the experience of the pilots could provide a template or a series of options for other Health Boards and General Practitioner Co-operatives contemplating similar initiatives.

3.2 Methodology

3.2.1 All available documentation relating to the two pilot initiatives was assessed.

3.2.2 Major stakeholders involved in the initiatives were interviewed including:

- Department of Health and Children
- GMS Payments Board
- Officers of the North Eastern and South Eastern Health Boards
- General Practitioners involved in the Co-operatives
- Staff engaged by the Co-operatives
- Chief ambulance officers in each of the two Health Boards
- Departments of Public Health in both Health Boards
- Public Representatives
3.2.3 General Practitioners providing standard out-of-hours cover were interviewed in each Health Board area.

3.3 **Confidentiality**

3.3.1 Some interviewees sought assurances that responses to questions or any comments volunteered in the course of the interviews would not be attributed to any individual or to any organisation. Accordingly, this Report is structured in such a way as to avoid the possibility of attribution.

3.4 **Sequence of interviews**

3.4.1 Interviews took place with key stakeholders and influencers over a period of three months between 4 April and 28 June 2001.

3.5 **Literature search associated with the Evaluation**

3.5.1 Documentation examined in the course of the Evaluation is outlined in Appendix I to this Report. Relevant extracts from some of that documentation is outlined in paragraph 9 below.
4. **Description of structure and operation of the South Eastern Health Board Pilot Co-operative (Caredoc)**

4.1 **Nature of the service provided**

4.1.1 Caredoc provides a General Practitioner out-of-hours service from 6.00 pm to 9.00 am Monday to Friday and from 12 pm Saturday through to 8.00 am Monday mornings and 24 hours on Bank and Public Holidays.

4.1.2 The service is provided on a whole population basis other than to patients of General Practitioners who have opted not to join the Co-operative (approximately 5 out of 125 doctors). However, where emergencies arise for the 5 non participating General Practitioners these patients are seen by Caredoc G.P.s. Caredoc also arranges for services to be provided at the request of the Gardai in accordance with the schedules set out from time to time by the Department of Justice and Law Reform as well as services under the Mental Treatment Act 1945.

4.1.3 The Caredoc service is accessed by the public in Carlow, Kilkenny and South Tipperary through a standard low cost telephone number which is connected to a Central Call Assessment Centre in Carlow District Hospital. The service also extends to parts of West Wicklow and South Kildare (SWAHB) and Co. Laois (MHB). Calls are initially fielded by receptionists who log the patient’s registration details on to a networked computer system within the call assessment centre utilising Ad Astra software. Calls are then forwarded to a nurse who provides a triage service and will either provide advice or arrange for the patient to be seen by a doctor on duty.

4.1.4 In accordance with preset protocols there are three doctors on duty in each of the three counties currently covered by the pilot. One
each is based in Carlow District Hospital, Our Lady’s Hospital, Cashel and a privately owned Health Centre in Kilkenny City. Two other doctors in each county are assigned to geographical areas in each county. The General Practitioners based in the three main centres may deal with the referral from the triage nurse through

- Contacting the patient and providing telephone advice
- Seeing the patient at the base centre
- Being driven in Caredoc vehicles by designated drivers to provide a home visit
- Scheduling the patient to attend one of a number of designated primary care centres where the G.P. on duty for that area will be transported for a consultation with the patient

4.1.5 The doctors on duty who are covering the geographical areas are conveyed by way of the Caredoc vehicles to either a home visit or to a designated primary care centre but are not specifically based in any single centre. These doctors are on duty up until 12 midnight and are on call from midnight until 8 am.

4.2 Infrastructure and equipment

4.2.1 The main Caredoc call assessment centre in Carlow acts as the base centre and is well equipped with multiple ISDN and analogue telephone lines, networked computers and call management and call recording technology. Adjacent to the call assessment centre is a treatment room with a range of equipment and emergency drugs appropriate to the provision of out-of-hours primary care services as well as limited accommodation facilities for the doctor on duty.

4.2.2 The Co-operative provides two cars per county to transport General Practitioners for either home visits or pre-arranged calls to the relevant primary care centre. These cars carry a defibrillator,
resuscitation equipment, oxygen, nebulisers, suturing kits and a limited supply of emergency drugs.

4.2.3 There are three other main primary care centres each serving the county of Kilkenny and two serving the administrative area of South Tipperary. The Kilkenny centre is leased privately and provides a modern well-equipped facility for patients attending and a good physical working environment for General Practitioners and receptionist/nurse on duty in the centre. The centre has computer access to the Carlow call assessment centre and can also receive information on a patient call by way of fax. The centre also maintains a supply of emergency drugs appropriate to a primary care setting.

4.2.4 As the South Tipperary Centres, based in Our Lady’s Hospital, Cashel, came into operation only shortly before this evaluation concluded it would not be appropriate to comment in any detail on the facilities available there. There are plans for a significant Primary Care Centre on the Our Lady’s Hospital campus.

4.2.5 There is a second Primary Care Centre currently based at the Community Care Clinic in Clonmel.

4.3 **Rostering arrangements**

4.3.1 Monday to Friday 6.00 pm – 12 midnight

- 4 G.P.s in South Tipperary on duty per county/area
- 1 triage nurse per county - on Bank Holidays staffing is increased by 1 extra nurse
- 1 clinical nurse per county, (currently weekend only)
- 1 receptionist call taker per county/region
- 2 drivers per county/region – 3 drivers for South Tipperary
4.3.2 Monday to Friday 12 midnight to 8.00 am
- 1 General Practitioner on duty at base, 2 on call per county, 3 on call for South Tipperary
- 2 triage nurses (Carlow base)
- 1 driver per county

4.3.3 Saturday 12 midday until 12 midnight
- 3 doctors in each county and 4 in South Tipperary
- 1 triage nurse per county
- 1 clinical nurse, 2 clinical nurses in South Tipperary
- 1 receptionist per county (12 midday to 10 pm)
- 2 drivers in each county

4.3.4 Saturday midnight until Sunday 8.00 am
- 1 locum General Practitioner per county (3 General Practitioners on call and 4 in South Tipperary on call)
- 2 triage nurses
- 1 driver per county

4.3.5 Sunday 9.00 am until midnight
- 3 doctors in each county, 4 in South Tipperary
- 1 call taker county (9.00am – 12 midnight)
- 2 drivers per county, 3 drivers in South Tipperary
- 1 triage nurse per county

4.3.6 Sunday midnight until Monday 8.00 am
- 1 locum General Practitioner (3 General Practitioners on call per county, 4 G.P.s on call in South Tipperary)
- 2 triage nurses
- 1 driver per county
4.4  **General Practitioner remuneration**

4.4.1 General Practitioner members of the Co-operative claim Special Type Consultations in the normal way when rostered for duty to the Co-op and when called to provide services either by way of home visit or attendance at one of the primary care centres. Such attendance is normally triggered by the triage nurse.

4.4.2 Accordingly, General Practitioners will only receive a fee in the event of a face-to-face consultation either by way of Special Type Consultation fee or through the collection of a fee from non General Medical Services (GMS) card holders. General Practitioners are also obliged to pay a monthly fee to subvent the cost of employing locum General Practitioners on the ‘red eye’ shift on Saturday and Sunday.

4.4.3 General Practitioner members of the Co-operative also make claims for out-of-hours payments outside of the hours covered by the Co-operative i.e. 5 pm to 6 pm Monday to Friday and Saturday 8 am until 12 midday.

4.4.4 Fees are also collected for services provided at the request of the Garda Siochana, private nursing homes and under the Mental Treatment Act.
4.5 **Funding of the Co-operative**

4.5.1 **Set up costs**
- Capital expenses £60,000
- Other costs £15,000
- Total £75,000

4.5.2 **Running expenses**
- 8 June 1999 to 31 December 1999 £150,000

4.6 **Monitoring patient satisfaction**

4.6.1 The South Eastern Health Board introduced an on-going process of distributing questionnaires (based on McKinley’s questionnaire widely used by U.K. Co-operatives) to a sample of the population who had used the services provided by the Co-operative. Questionnaires are distributed to 1 in 10 patients availing of services provided through Caredoc. This ongoing monitoring of patient satisfaction by way of a questionnaire to a sample number was supplemented by a questionnaire being forwarded to all patients who contacted Caredoc during a period 4 January 2000 – 4 February 2000.

4.6.2 The responses to the ongoing questionnaires consistently indicated high levels of satisfaction expressed (upper 90%) among those patients who were prepared to be identified with the completed questionnaire.

4.7 **Monitoring of General Practitioner satisfaction**

4.7.1 All General Practitioners involved in the original Caredoc area (Carlow and environs) were forwarded anonymous postal questionnaires by the Primary Care Unit SEHB with the aim of ascertaining satisfaction rating with the Caredoc service. The
questionnaire, which was distributed in January 2000 was based on minor modifications to Salisbury's questionnaire which has been widely used in UK studies for evaluating General Practitioner satisfaction.

4.8 Governance

4.8.1 Caredoc is established as a Company limited by guarantee having a Board of Directors made up of nine General Practitioners, one of whom is Chairman, with two representatives nominated by the South Eastern Health Board. The administrator of Caredoc also acts as Company Secretary. General Practitioners participating in the Co-operative are members of the Company.

4.8.2 The relationship between Caredoc and the South Eastern Health Board (which is statutorily responsible for the delivery of out-of-hours General Practitioner care to GMS patients), is governed by a Service Agreement between the Board and the Company.

4.8.3 The ongoing management of the relationship between the Company and the Board is by way of a Liaison Committee consisting of two representatives of the Company and two representatives of the Health Board. The current members of the Liaison Committee are the Chairman and Secretary of the Company and the Deputy Chief Executive Officer and Director Primary Care, South Eastern Health Board.

4.8.4 The Service Agreement provides a description of the obligations of the contracting parties and individual practitioners as well as the mission, vision, aim and values of the Company. The Agreement also details the times within which the Co-operative provides a service (see paragraph 4.4 above).
4.8.5 Individual General Practitioners who are registered members of the Co-operative are obliged to provide an out-of-hours service within the hours specified. This does not extend however to pre-designated ‘red-eye’ shifts (midnight to 8 am) on Saturday, Sunday and Bank holiday nights, as the agreement allows for locum doctors who are...

“...in receipt of current medical registration, current medical indemnity, references, Garda clearance and with no objections from any of the Practitioners”

(Section 8.2.8 of Agreement between the South Eastern Health Board and Carlow Emergency Doctors on Call Limited, 4 April 2001)

4.8.6 Many of the locums utilised by Caredoc are sourced via a locum agency. The majority of these locums are overseas doctors, primarily from Australasia, and are assigned for periods of up to six months following assessment by a local group of Co-op representatives.

4.8.7 The Service Agreement stipulates that all assets including cars, telephone, computer, medical and security equipment are in the ownership of the South Eastern Health Board. The Agreement also provides at paragraph 8.3 that....

“...Designated personnel within the Health Board shall have access to all data on the Company system for the purposes of analysis of morbidity trends and referral patterns and workloads.

4.8.8 Support staff engaged by the Co-operative such as the nursing staff, administrator, car drivers and receptionists are employees of the Company and no responsibility for these staff resides with the Health Board. The likelihood of the Health Board being vicariously liable for the actions of these staff is not alluded to. The funding for such staff is through out-of-hours development monies from the
exchequer (Department of Health & Children). Locum staff engaged to cover the weekend ‘red-eye’ shifts are funded directly by the General Practitioner members of the Co-operative.
5. Description of out-of-hours cover arrangements in areas of the South Eastern Health Board not covered by Caredoc

5.1 There are a variety of General Practice out-of-hours cover arrangements in the areas of the South Eastern Health Board not covered by Caredoc. These arrangements would range from a 1:10 rota in a large urban area to single-handed and 1:2 rotas in remote rural areas or where individual General Practitioners have not availed of opportunities to join with other local doctors to provide an agreed rota.

5.2 There is widespread use of locum cover for whole weekends outside of the Caredoc areas. These locums are sourced from locum agencies, directly from Registrars in General Practice or off duty Non Consultant Hospital Doctors. There is also a limited availability of vocationally trained General Practitioners who have flexible self structured working arrangements and who are available for out-of-hours cover on an episodic basis.
6. Description of structure and operation of the North Eastern Health Board regional pilot Co-operative (NEDoc)

6.1 Nature of the service provided

6.1.1 NEDoc provides a General Practitioner out-of-hours service from 6 pm to 8 am Monday to Friday and from 6 pm Friday to Monday 8 am, as well as 24 hour cover on Public/Bank Holidays.

6.1.2 The service is provided on a whole population basis other than to patients of General Practitioners who have opted not to join the Co-operative. NEDoc also arranges for services to be provided at the request of the Gardai in accordance with the schedules as set out from time to time by the Department of Justice and Law Reform. Services are also provided under the Mental Treatment Act 1945.

6.1.3 NEDoc provides services throughout the North Eastern Health Board region apart from the Dundalk / North Louth and Monaghan Town areas where practitioners have opted to remain within pre-existing rota arrangements. NEDoc also extends to the Balbriggan area of North County Dublin within the Northern Area Health Board. Many General Practitioners in that area have opted to provide out-of-hours cover in partnership with NEDoc.

6.1.4 The NEDoc service is accessed by the public through a standard low cost telephone number which is connected to a central communications base or hub in the grounds of St Bridgid’s Hospital, Ardee, Co. Louth. Calls are initially fielded by a receptionist who will log the caller’s registration details on to a networked computer system within the hub using Ad Astra software. That software is also widely used in United Kingdom G.P. Co-operatives. Calls are forwarded to a triage doctor based in the Ardee hub from 6 pm to midnight on weekdays and 8am to midnight weekends, Bank and
Public Holidays. The triage doctor on duty will either provide advice or arrange for the patient to be seen by a doctor in a Primary Care Centre of through a home visit. Alternatively, in the event of an acute emergency requiring hospital attendance, Ambulance Control Headquarters is directly contacted to dispatch an ambulance.

6.1.5 There are two doctors on duty on site in each of the four main Primary Care Centres in the region up until midnight in Cavan, Castleblayney, Drogheda and Navan, with one doctor on site and one doctor on call after midnight. General Practitioners based in the main primary care units in the region will receive a computerised print-out or fax message from the Ardee hub which will indicate the following specific actions to be undertaken by the General Practitioner:

- Being driven in a NEDoc vehicle supplied by the NEHB and driven by designated drivers to provide a home visit
- Being driven in an NEDoc vehicle for a consultation with a patient who has agreed to attend one of a number of satellite primary care centres
- Being scheduled to attend a patient in the primary care centre for an appointment with a patient scheduled by the Ardee hub
- Attending at the scene of an accident at the request of the Ambulance Service or Gardaí

6.1.6 General Practitioners based in each of the four main Primary Care Centres also undertake triage duties after midnight. Work is underway however on introducing a centralised nurse triage/supervisor presence in the Ardee hub from midnight to 8 am on a trial basis.
6.2 *Infrastructure and equipment*

6.2.1 The main Ardee communications hub is staffed and equipped to a high standard with multiple ISDN telephone lines, networked computers, vehicle tracking systems and call recording technology. The call centre was specifically refurbished to provide NEDoc with a full call centre and triage service and to act as administrative headquarters for the pilot project. Additional facilities are also available within the hub to provide supplementary call-centre related activities going forward while maintaining a good physical working environment.

6.2.2 The four Regional Primary Care centres share facilities with Health Board provided day services and are well equipped to receive telephone, computer and fax generated information from the Ardee hub and to provide appropriate primary clinical care to patients attending for treatment. Sleeping accommodation is also provided for the doctors on duty in each site.

6.2.3 Each of the four centres is stocked with a pharmaceutical supply in accordance with a schedule agreed between the NEHB Primary Care Unit Pharmacist and NEDoc. That supply is funded by way of direct grant from the GMS Payments Board and is supplemented by ‘samples’ provided by pharmaceutical company representatives. Medications prescribed and dispensed out-of-hours are budget neutral for the purposes of the individual doctor’s GMS indicative drugs budget.

6.2.4 The NEHB provides drivers and fully equipped cars assigned to each of the four Primary Care Centres in accordance with the roster outlined in Paragraph 6.2.5 below. These cars transport General Practitioners on duty in each of the four centres to satellite clinics,
home visits or to the scene of an accident at the request of Ambulance Control. There are other occasions when the triage doctor will direct a car to the scene of an accident using his/her clinical judgement.

6.2.5 The fleet of NEDoc cars are monitored centrally in Ardee by way of a vehicle tracking system. The cars are equipped with a defibrillator, resuscitation equipment, oxygen, nebulisers, suturing kits and a limited supply of emergency drugs.

6.3 **Rostering arrangements (subject to some variation to cope with workload peaks)**

6.3.1 Monday to Friday 9.00 am to 6.00 pm (Ardee hub only)
- 1 Hub Manager
- 1 grade IV
- 3 grade IIs

6.3.2 Monday to Friday 6.00 pm to midnight
- Ardee – 1 supervisor, 2 receptionists, 1 triage doctor
- Castleblayney – 2 doctors, 1 Community Nurse Manager (CNM)/Staff Nurse, 1 receptionist, 2 drivers
- Cavan – 2 doctors, 1 CNM/Staff Nurse, 1 receptionist, one driver
- Drogheda – 2 doctors, 1 CNM/Staff Nurse, 1 receptionist, one driver
- Navan – 2 doctors (supplemented by Registrar in General Practice), 1 CNM/Staff Nurse, 1 receptionist, 1 driver

6.3.3 Monday to Friday midnight to 8.00 am
- Ardee – 1 supervisor, 1 receptionist (1 triage nurse being introduced on a trial basis)
- Castleblayney – 1 doctor on duty (one on call) 1 driver
6.3.4 Saturday, Sunday, Public/Bank Holidays 8.00 am to midnight

- Ardee – 3 triage doctors, 1 supervisor, 4 receptionists
- Castleblayney – 2 doctors, 1 Community Nurse Manager (CNM)/Staff Nurse, 1 receptionist, 2 drivers
- Cavan – 2 doctors, 1 CNM/Staff Nurse, 1 receptionist, one driver
- Drogheda – 2 doctors, 1 CNM/Staff Nurse, 1 receptionist, one driver
- Navan – 2 doctors, 1 CNM/Staff Nurse, one receptionist, two drivers

6.3.4 Saturday, Sunday, Bank/Public Holidays midnight to 8.00 am (as Monday to Friday rosters)

6.4 General Practice Remuneration

6.4.1 NEDoc on behalf of the General Practitioner members of the Co-operative negotiates directly with the North Eastern Health Board on the allocation of an annual grant to fund payments to those General Practitioners for out-of-hours work. A total of £1.65 million was agreed for the year 2001 for General Practitioners providing Primary Care Centre and triaging duties. This amount was based on the historical expenditure for Special Type Consultations in the Health Board for the previous year.

6.4.2 In accordance with the Service Agreement between NEDoc and the North Eastern Health Board monies paid from the annual agreed
grant in respect of out-of-hours services are in lieu of members claiming individual STC payments for out-of-hours work.

6.4.3 NEDoc distributes the grant received as an hourly rate to General Practitioners following deduction for administering the Co-operative. The grant is divided into Primary Care Centre duties and doctor triaging duties.

6.4.4 Fees are also collected by individual General Practitioners on duty where face to face consultations arise with non-GMS medical card holders. Those fees, as well as fees accruing from services requested by the Gardai, nursing homes and Mental Treatment Act, are channelled centrally into the Co-operative and distributed as an hourly rate in accordance with rostered duty in addition to the rate set by the Co-op based on the grant received from the NEHB/GMS Payments Board.

6.4.5 Fees are not charged for telephone advice given by triage doctors, irrespective of patient eligibility.

6.5 **Funding of the Co-operative**

6.5.1 **Set up Costs**

Capital Grant £500,000

National Development Plan £ 213,083

6.5.2 **Running Expenses**

Staffing Costs (non medical) £1.3 million for 2001 charged to NEHB payroll costs.
6.6 **Monitoring Patient and General Practitioner Satisfaction**

6.6.1 A comprehensive qualitative evaluation of patient satisfaction is being carried out by Professor Tom O’ Dowd, Trinity College, on the out-of-hours initiative within the Board. There were no outcomes available at the time of this report being finalised.

6.6.2 A separate quantitative evaluation of attitudes of patients and the wider community on the out-of-hours initiative is also being undertaken. This evaluation will also assess the due confidence in the future of the Co-operative among Practitioners as well as community representatives and the wider public.

6.7 **Governance**

6.7.1 An Agreement between NEDoc Ltd and the North Eastern Health Board dated 20 March 2001 forms the legal basis for the relationship between the parties on the provision of General Practitioner out-of-hours services by those doctors who are members of the Co-operative. The Agreement sets out the practical obligations on both parties in respect of the provision of services on the part of the General Practitioners and the provision of supports on the part of the Health Board. However, detailed contractual obligations on the part of NEDoc are not stipulated.

6.7.2 The March 2001 Agreement stipulates that all non-GP staff engaged in the support and provision of services to the Co-Op will be employed by the North Eastern Health Board.

6.7.3 Although the Agreement is describes a partnership model the formal structure of that partnership is not set out in detail other than that the parties NEDoc and NEHB will have *regular minuted meetings to
review and improve all aspects of the service provided by the GP Out-of-Hours Co-op.'
7. **Description of out-of-hours cover arrangements in an area of the North Eastern Health Board where General Practitioners have opted not to take part in the Co-operative.**

7.1 The area examined in the course of this evaluation was the Dundalk/North Louth area where there is the greatest concentration of General Practitioners in the North East region providing out-of-hours services outside of the Co-operative framework.

7.2 There are two significant rotas in the Dundalk urban area ranging from a 1:9 to a 1:12 depending on whether it is a core week or weekend rota. One rota operates a weekend service from a base on the grounds of Louth County Hospital delivered by locum doctors on site, the other rota operates from a variety of General Practice surgeries delivered by a locum doctor privately accommodated within the town. Weekend cover in Dundalk town and its environs is provided by overseas doctors or off-duty non consultant Hospital doctors. Monday to Friday night cover will normally be provided by a General Practitioner member of the rota.

7.3 The two Dundalk urban-based rotas do not extend cover to the Cooley Peninsula with the result that the two General Practitioners practising in that large rural and relatively remote area operate a 1:2 rota.
8. Summary of Key Points Emerging from Interviews with Key Stakeholders and Influencers

8.1 Introduction

8.1.1 Interviewees directly associated with the pilot initiatives were asked a series of questions related to the following common areas.

(a) Levels of consultation with General Practitioners prior to setting up of Pilots.

(b) How the impact of the Co-operatives was outlined to the wider community.

(c) Whether the initiatives helped to integrate General Practitioner care with other Health Board provided services and whether the Co-operative infrastructure allowed for additional services to be included over time.

(d) Whether the initiatives assisted in the recruitment and retention of doctors particularly in rural areas.

(e) What were the greatest threats to the future of the Co-operatives.

(f) Whether the pilot Co-operatives represented an efficient and effective improvement in the service provided to patients having regard to value for money considerations.

(g) Whether structural and organisational adjustments were required to promote the establishment of the Co-operatives on a permanent basis.

8.1.2 Interviewees who had no direct relationship with the Co-operatives were asked a series of general questions relating to

(a) The levels of public awareness of and support for the Co-operative initiatives.

(b) Whether the initiatives represented an improvement in the services provided to patients.
(c) The perception of the efficiency and effectiveness of General Practitioner out-of-hours service within the Board.
(d) What priorities were required to be addressed to sustain the long-term future of the Co-operative initiatives nationwide.

8.2 Key Extracts from Interviews

8.2.1 In accordance with the undertaking not to attribute comments to individuals or organisations, key extracts from the interviews undertaken are outlined under the headings set out in 8.1.1 and 8.1.2 above. Relevant responses are categorised under the following in respect of both pilot projects
- General Practitioners Participating
- General Practitioners Non-Participating
- Other Health Board Service Providers
- Health Board Corporate/Management
- Government Departments/ State Bodies

8.3 Level of Consultation with General Practitioners prior to setting up of Pilots

8.3.1 North East
(a) General Practitioners participating
- A greater amount of time was spent convincing the Health Board and Government Departments than was devoted to selling the Co-operative to the G.P.s
- A series of meetings were held in all areas to discuss the advantages/disadvantages of the Co-operative ideal.
- There was a two-year period prior to setting up which gave sufficient time and opportunity for consultation.
(b) General Practitioners non participating
- Two to three meetings were held at which benefits of Co-operative were outlined
(c) Other Health Board Service providers
   • *This was clearly identified as a G.P. driven initiative supported by the Primary Care Unit*

(d) Health Board Corporate/Management
   • *Once a partnership approach had been established with General Practitioners promoting the establishment of the pilot, the Health Board provided every opportunity for wider consultation with all General Practitioners prior to the pilot being finalised.*

(e) Government Departments / State Agencies
   • *This was primarily a General Practice initiative and involved widespread consultation within General Practice and with the relevant funding agencies.* *(Applicable also to South East initiative)*

8.3.2 South East

(a) General Practitioners participating
   • *There has been intensive consultation with all General Practitioners in an area well in advance of extending the Co-operative to other counties/administrative areas*

(b) General Practitioners not participating
   • *Whereas the Co-operative has not extended to this area as of yet, there has been ongoing consultation with G.P.s in the area on the structure of the co-op and the service to be provided once it is extended*

(c) Other Health Board Service Providers
   • *General Practitioners in the region appear to be satisfied with the levels of consultation*

(d) Health Board Corporate/Management
   • *The Primary Care Unit and the Board have worked in partnership with the General Practitioners to ensure*
that widespread meaningful consultation takes place with G.P.s in the Health Board area.

8.4 How the impact of the Co-operatives was (and is) being outlined to the wider community

8.4.1 North East

(a) General Practitioners (participating)
   • Objections and criticisms are being responded to rather than the benefits of the service being highlighted

(b) General Practitioners (non participating)
   • The Co-operative is not seen by our patients as an improvement on the service we currently deliver

(c) Other Health Board Service Providers
   • The advantages and improvements in service associated with the Co-operative were not adequately sold to the public

(d) Health Board Corporate/Management
   • Whereas members of the public who use the service are largely enthusiastic and appreciative, not enough time has been spent on promoting the advantages and the service improvements to the wider community

(e) Government Department / State Agencies
   • Any initiative which involves a variation to an established service requires to be adequately communicated to the general public prior to its introduction. (Applicable also to South East)
8.4.2 South East

(a) General Practitioners (participating)

- There has been a comprehensive locally-based public relations campaign to explain the advantages of the Co-operative before it is rolled out to that area.

(b) General Practitioners (non participating)

- The public are aware of the success of the Co-operative particularly in areas bordering on counties where the Co-operatives are up and running.

(c) Health Board Service Providers

- The lack of public opposition to the Co-operatives is a measure of the understanding of the advantages in the communities served by the Co-operatives.

(d) Health Board Corporate / Management

- The fact that individual General Practitioners were willing to openly promote the Co-operative and to explain the advantages through local media was central in avoiding any conflict and confusion on the introduction and extension of the Co-operative.
8.5 Whether the initiatives helped to integrate General Practitioner care with other Health Board provided services and whether the Co-operative infrastructure allows for additional services to be included over time

8.5.1 North East

a) General Practitioners (participating)
   • The Co-operative provides a locally based entity for discussing service initiatives with the Health Board on a partnership basis
   • Additional services can be seamlessly applied to the infrastructure including: duty social worker, pharmacies, “wristcare” (remotely monitors pulse movement, body temperature and skin conductivity), Public Health crises

(b) General Practitioners (non-participating)
   • G.P.s distrust management and would wish to be in a position to resist changes in service which would affect patient care such as the downgrading of local acute hospitals

(c) Health Board Service Providers
   • There is significant potential to use the call centre infrastructure on a full 24 hour basis

(d) Health Board Corporate / Management
   • The Ardee call centre has been developed with a view to incorporating additional services both during the core day and in respect of out-of-hours activity
   • There is the potential to introduce a single low cost number for all Health Board services through the call centre
- The development of joint services with Health and Social Services Boards in Northern Ireland through CAWT (Co-operation and Working Together) is envisaged. Having parallel General Practitioner out-of-hours Co-operatives either side of the border will greatly facilitate that development

(e) Government Departments / State Agencies

- Investment to date in the infrastructure supporting the Co-operative can only be justified if additional services can be supported by that infrastructure

8.5.2 South East

a) General Practitioners (participating)

- The fact that Caredoc support staff are not Health Board employees will make it more rather than less likely that additional services can be introduced without difficulty
- The goodwill and co-operation that has been established between Caredoc and the Health Board will ensure that additional services can be introduced using existing call centre facilities

(b) General Practitioners (non-participating)

- The prospect of additional services being introduced using existing Caredoc facilities would not be seen as something which would dissuade doctors from joining the co-operative when it extends to their area

(c) Health Board Service Providers

- The full benefit of Caredoc has yet to be realised particularly in respect of morbidity data collected. The difficulties that have beset General Practitioner involvement in cardiovascular strategy in the region, for example, would need to be examined however in
the context of introducing additional services in partnership with Caredoc

(d) Health Board Corporate / Management

- The Health Board is committed to the introduction of additional services utilising the infrastructure developed with Caredoc as well as the experience gained in introducing a successful G.P. out-of-hours service.

8.6 Whether the initiatives assisted in the recruitment and retention of General Practitioners, particularly in rural areas

8.6.1 North East

a) General Practitioners (participating)

- This is the first major initiative which will support the retention of a locally based General Practitioner in rural and village semi-rural communities providing personalised services to those communities during the core working week.
- Without this initiative many communities would face losing their locally based G.P.s to larger urban areas within the region.
- This initiative is a G.P. collegiate response to an ongoing crisis in respect of the retention of G.P.s in rural areas.

(b) General Practitioners (non-participating)

- While the Co-operative may be of benefit to rural doctors there are no advantages for the urban doctor on a large well-organised rota.

(c) Other Health Board Service Providers

- Not only has the Co-operative helped to retain General Practitioners based in rural communities it has also
helped to fill gaps in existing emergency ambulance
cover in the centre of the region (Kingscourt, Cootehill, Bailieborough).

(d) Health Board Corporate / Management

• There have been persistent ongoing difficulties in filling
vacant GMS practices in some rural areas in the region. The prospect of a newly appointed doctor being
expected to provide 24 hour cover seven days per
week along or with another colleague or two was a
huge disincentive. These doctors can now be
guaranteed an average 58 hour week from the Co-
operative rather than a potential 168 hour working
week.

(e) Government Departments / State Agencies

• There is widespread recognition that it is preferable to have General Practitioners providing services to rural communities based in those areas (also applicable to South East)

8.5.2 South East

(a) General Practitioners (participating)

• In the absence of a Co-operative model of out-of-hours G. P. cover the future viability of rural based General Practitioners is seriously at risk.

(b) General Practitioners (non-participating)

• Some of the most remote and rural practices in the region are outside of the areas covered by Caredoc. The prospect of retaining doctors based in those areas or recruiting replacements would be seriously undermined if the Co-operative were not extended throughout the region.
(c) Other Health Board Service Providers

- As some of the most remote and rural practices are outside of the areas currently covered by Caredoc, it is too early to say whether a Co-operative alone will address the G.P. recruitment/retention difficulties in these areas.

(d) Health Board Corporate / Management

- The Health Board has experienced significant difficulties filling a number of GMS posts in remote areas and envisages increasing difficulties in replacing some existing General Practitioners. Tackling this issue of recruitment/retention has been one of the central influences in the Health Board actively supporting and promoting the Co-operative initiative.
8.6 What are the greatest threats to the future of the Co-operatives?

8.6.1 North East

(a) General Practitioners (participating)
- The ‘red-eye’ shift immediately followed by day surgery duties.
- Urban based doctors reverting to urban rotas.
- Inadequate funding compared to national spend on Special Type Consultations (STCs)
- Failure to adequately explain the advantages of the Co-operative to the public and community and public representatives and groups.
- Reluctance at national level to wholeheartedly endorse the Co-operative because of the equal treatment and service being afforded to GMS and non-GMS patients

(b) General Practitioners (non-participating)
- That management (NEHB) is seen to have too much control over the Co-operative
- That there are no advantages for urban-based doctors who have satisfactory locum arrangements for weekend duties through established rotas.

(c) Other Health Board Service Providers
- Confusion between out-of-hours primary care role and emergency services
- Absence of formal agreement on out-of-hours pharmacy availability
- Absence of established protocols with emergency ambulance service.
- Political opposition
• Onerous rotas (‘red-eye’ shift) being followed by duty in day surgeries

(d) Health Board Corporate/Management

• Retention of a sufficient number of doctors in the Co-operative to provide triage and Primary Care Centre services.
• Retention of urban doctors
• Onerous ‘red-eye’ shift followed by normal day surgery duties
• Reducing number of doctors available (associate members of Co-operative) to cover on an episodic basis.
• Communications gap between benefits of Co-operative and public perception.

(e) Government Representatives/State Bodies

• Failure to provide additional services so that infrastructural investment can be fully exploited.
• Withdrawal of General Practitioners from the Co-operative
• Failure to deal effectively with public opposition to the Co-operative
• Whether distinction should be made between funding for out-of-hours services for GMS patients as against whole population cover

8.6.2 South East

(a) General Practitioner (participating)

• Loss of independence of the Co-operative
• Being forced to agree on ‘hourly’ rate for out-of-hours work
• Prohibition on the use of locums
• The ‘red-eye’ shift followed by day surgery duties
• Lack of investment from the Department of Health and Children in infrastructure
• Lack of funding to extend Co-operative to Wexford and Waterford

(b) General practitioners (non-participating)
• Elimination of Saturday morning surgeries
• The adoption of an hourly rate

(c) Other health Board service Providers
• Political opposition
• Opposition from medical professional/representative groups

(d) Health Board Corporate/Management
• Insufficient funding to extend Co-operatives to Wexford and Waterford
• Continuation of locum cover via a locum agency
• ‘red-eye’ shifts followed by daytime surgery duty
• Commitment at national level to support co-op initiatives.

(e) Government Departments/State Agencies
• Parallel systems of open-ended, Special Type Consultation payments within and outside hours covered by Co-operative
• Services being provided by locum doctors
• Failure to provide additional services so that infrastructural investment can be fully exploited
• Failure to deal effectively with excessive Special Type Consultation claims from Co-operative members and non-members
• Withdrawal of General Practitioners from the Co-operative

• Whether distinction should be made between funding for out-of-hours services for GMS patients as against whole population cover.

8.7 Whether the pilot Co-operatives represent an efficient and effective improvement in the service provided to patients having regard to value for money considerations.

8.7.1 North East

(a) General Practitioners (participating)

• This initiative is good for patients and good for General Practitioners.

• There is an argument to be made that compared to the funding for the acute hospital sector the minimal investment in this initiative represents good value for money. This is particularly the case in that NEDoc guarantees patients that the out-of-hours consultation will be with a highly experienced fully trained doctor.

(b) General Practitioners (non-participating)

• Out-of-hours services provided through established rotas for weekday nights and through locum doctors at weekends has minimal financial support from the state and provides a quality out-of-hours service to patients.

(c) Other Health Board Service Providers

• The Co-operative provides a first class service out-of-hours which is in many ways, superior to the out-of-hours services provided by the acute hospitals
• The opportunity for patient callers to NEDoc to access a General Practitioner for direct telephone advice is the mark of quality for this initiative.

(d) Health Board Corporate/Management

• There is no doubt that it will be shown that patients availing of the service receive a service of a superior quality to that which existed prior to the initiative.
• The service established with the Co-operative represents value for money and this will be even more the case when additional services come on stream.

(e) Government Departments/State Agencies

• The question to be addressed is whether patient service has improved and whether the Co-operative structure is the most efficient way of managing out-of-hours service both in respect of quality and within agreed budgets (applicable also to South East)

8.7.2 South East

(a) General Practitioners (participating)

• For a minimal investment from the state Caredoc provides a quality service which achieves patient satisfaction rates at consistently high levels of 95% +

(b) General practitioners (non-participating)

• General practitioners in the areas not covered by Caredoc are anxious to participate to achieve a better quality of life for themselves and a better quality of service for patients.
(c) Other Health Board Service Providers

- There has been an overall improvement in the quality of out-of-hours cover with a high level of prompt availability and visibility of the Caredoc service.

(d) Health Board Corporate/Management

- The high levels of patient satisfaction from the regular questionnaires and the fall-off in the number of complaints points to a quality service.
- The Caredoc service as it exists provides a quality service with a relatively low level of investment. In order to expand and enhance the service additional funding will be required.

8.7 Whether structural and organisational adjustments are required to promote the establishment of the Co-operatives on a permanent basis.

8.8.1 North East

(a) General Practitioners (participating)

- Removal of the ‘pilot’ status
- Greater funding to deal with the post midnight ‘red-eye’ shift
- Greater sharing of call centre resources with other Co-operatives and with other services provided by the NEHB
- Exploring a structured Co-operative relationship with cross border Co-operatives.

(b) General Practitioners (non-participating)

- If weekend duty were to be removed as a working commitment non-participating doctors might consider participating in the Co-op.
(c) Other Health Board service providers

- Sharing triaging with other Health Board/Co-operatives
- Establishing agreed protocols with the ambulance service
- Greater structured integration with other Health Board services including acute hospitals

(d) Health Board Corporate/Management

- Develop the potential that exists with cross border bodies through CAWT.
- Establish the Co-operative/NEHB partnership on a permanent basis
- Fully utilise the existing infrastructure through additionality of service and through joint initiatives with other Health Boards.

(e) Government Departments/State Bodies

- Structures which allow for the application of a managed out-of-hours service delivered by vocationally trained General Practitioners within an agreed annual budget. (Also applicable to South East)

8.8.2 South East

(a) General Practitioners (participating)

- Any alteration in structure must allow the General Practitioners to manage the Co-operative without undue interference
- A structure which allows for the remuneration of General practitioners other than through an hourly rate is essential
(b) General Practitioners (non-participating)

- There is little point in extending Caredoc to the remainder of the SEHB unless it is on a permanent basis.

(c) Other Health Board Service Providers

- There needs to be a greater integration of Caredoc services with the services provided by the Board.

(d) Health Board Corporate/Management

- It may have been prudent in the initial stages to have Health Board Officers serve on the Board of Directors or Caredoc but if the Co-operative is to be established on a permanent basis the division of responsibilities as between Caredoc and the Health Board needs to be more transparent.

- The continued use of agency supplied locums for weekend ‘red-eye’ shifts is not sustainable into the future.

- The Health Board recognises that the existence of an out-of-hours service between 5.00 pm and 6.00 pm weekdays and up until midday on Saturdays needs to be addressed
9. Extracts from Published Literature of Relevance to the Development of General Practice out-of-hours Co-operatives

9.1.1 Cross Border Co-operation in Health Services in Ireland (Centre for Cross Border Studies March 2001)

9.1.1 The study found that a wide range of interests on both sides of the border were enthusiastic about the possibilities of developing Co-operative arrangements in primary care. It also found that if G.P. and associated services could be provided in a seamless way across the border that would improve relationships and open the way for further co-operation. Repeated reference was made to the particular problems of the Carlingford peninsula and Blacklion Co. Cavan. The study suggests that there might be a geographical realignment of G.P. Co-operatives which would aim to provide a service to patients closest to a particular primary care centre regardless of which side of the border they were on.


9.2.1 The Report recommends an integrated model of service provision that health authorities should take responsibility for planning their own patterns of provision to meet local needs. It concluded that only those currently engaged locally in the provision of out-of-hours services were in a position to determine the precise shape and form that a new integrated provision should take, if it is to deliver high quality out-of-hours care in their area.
9.3 North Down and Ards Doctors on-call (NDADOC) “Nurse Triage in a Northern Ireland Out-of-hours Co-operative” (November 2000)

9.3.1 In a limited patient survey (42 responses to 100 patient questionnaires) it was found that there were few differences in terms of outcome between doctors and nurse advisors triaging calls. However nurse advisors triaged fewer calls per session and a higher percentage of these patients sought further medical advice (50% as opposed to 29% when doctors triaged)

9.4 Presentation to the Health, Social Services and Public Safety Committee of the Northern Ireland Assembly by Dalriada Doctor on call out-of-hours Co-operative (November 2000)

9.4.1 In the course of the Dalriada Presentation the following advantages of the Co-operative were outlined to the Committee

(a) For Patients

- Service staffed by local experienced G.P.s
- More alert and focused G.P.s
- Better facilities and equipment e.g. defibrillators
- Faster response times
- Improved technology
- Equality/ease of access
- More standardised treatment
- Data base of previous contacts or special details
(b) For Doctors

- Limits to On Call time
- Improved contact with colleagues
- Improved communication (faxed details of all patient contacts each morning)
- Doctors escorted by drivers: safety especially female G.P.s free to concentrate on consultation
- Backup
- Call details logged
- Better planning
- Feedback from patients
- Accountability
- Audit
- Efficient use of manpower
- Seamless care
- Improved relationship and co-ordination with ambulance services
10. **Findings**

On the basis of the interviews undertaken and the documentation and literature examined, the Report finds as follows under the following headings:

10.1 **Efficiency and effectiveness of the management administrative and support structures for the General Practitioner out-of-hours pilot Co-operatives**

10.1.1 **North East**

(a) The Report finds that the North Eastern Health Board has provided a significant management and administrative commitment to support an effective out-of-hours initiative. With staffing levels of 65 whole time equivalents and a payroll cost to the Board of £1.3 million per annum, it is clear however that such a commitment can only be justified if services additional to General Practitioner out-of-hours services can be developed in the near future to fully utilise those resources. It must be stated however that an efficient functioning General Practitioners out-of-hours service should be seen as an appropriate starting point and ‘anchor tenant’ for the development of day and out-of-hours services utilising the services of the Ardee call centre.

(b) The Report finds that the reported total numbered calls of 250 per 1000 population (projected annualised figure of 60,000 calls) dealt with by NEDoc since its commencement on 18 September 2000 compares favourably with the average figure for U.K. Co-operatives (159 per 1000). This is despite the fact that up to 70% of the users of the service are non-medical card holders and are required to
make a payment for services other than triage doctor telephone advice.

(c) The Report finds that the benefits of the out-of-hours initiative have not been adequately communicated to patients, the wider public, community groups and public and community representatives. This has resulted in Officers of the Board and NEDoc devoting time and resources to defending the initiative rather than using that time to promote the existing service and plan for further additional services.

(d) The Report finds that the absence of an ongoing patient satisfaction audit did not assist NEDoc or the Health Board in defending the benefits of the initiative.

(e) The Report finds that the Ardee call centre resources devoted to the midnight 8.00 a.m. period requires to be reassessed in light of the consistent figures which show that less than 5% of calls are made to the centre after midnight.

(f) The Report finds that the service agreement between the North Eastern Health Board and NEDoc as outlined in paragraph 6.7.1 above to be adequate for a pilot initiative but lacking in sufficient detail to underpin a long-term out-of-hours initiative.

(g) The Report finds that the initiative represents an effective and efficient response to serious difficulties which are arising in recruiting and retaining General Practitioners in some rural areas.
10.1.2 South East

(a) The Report finds that the South Eastern Health Board in partnership with Caredoc has developed an effective and efficient out-of-hours service in the counties of Carlow and Kilkenny.

(b) The Report finds that the reported total number of calls dealt with by Caredoc for Carlow and Kilkenny of 304 per 1000 and 192 per 1000 (projected) respectively compares favourably with United Kingdom figures.

(c) The Report finds that the advantages of the out-of-hours initiative were comprehensively communicated to the public and to public and community representatives prior to establishing the service (and on an ongoing basis) in each relevant County/Administrative area. The Report also finds that the practice of issuing questionnaires to patients auditing their satisfaction with the service greatly assisted in allaying concerns from public and community representatives as to the merits of the Co-operative.

(d) The Report finds that the Carlow call centre resources devoted to the midnight to 8.00 a.m. period requires to be reassessed in light of consistent figures which show that less than 5% of calls are made to the centre after midnight.

(e) The Report finds that the Service Agreement between the South Eastern Health Board and Caredoc, as outlined in paragraph 4.8 above, contains sufficient detail under appropriate headings to serve as a useful guide for other initiatives. The Report finds however that there is potential for confusion and uncertainty in having Officers of the Health Board as members of the Board of Directors.
of Caredoc and as members of a Liaison Committee representing the Health Board in discussions with Caredoc.

(f) As with the North East initiative the Report finds that the Caredoc initiative represents an efficient and effective response to the recruitment and retention of General Practitioners in some rural areas.

10.2 Whether clear lines of accountability exist in respect of value for money being achieved from the resources allocated

10.2.1 North East

(a) The Report finds that there are clear lines of accountability within the Health Board for the funding allocated to the initiative. The existence of a fixed agreed budget for the provision of an agreed number of service hours from NEDoc delivered by individual General Practitioners extends that line of accountability to the individual General Practitioner member of the Co-operative. The Report also finds that the existence of an agreed budget for the delivery of the service promotes the prudent management of out-of-hours services and helps to emphasise the necessity for a quality telephone component to the service. The Report particularly noted that members of the Co-operative agree not to claim Special Type Consultation payments for the weekday period not overtly covered by the Co-operative (5.00 p.m. - 6.00 p.m. and Saturday 8am to mid-day)

(b) The report finds that the direct employment by the Health Board of out-of-hours services support staff greatly assists in avoiding the potential for confused lines of accountability and reporting. Direct
employment also serves to remove an administrative burden from participating General Practitioners whose time would be more effectively employed in enhancing the quality of out-of-hours services provided to patients.

**10.2.2 South East**

(a) As discussed in paragraph 10.1.2(e) above, the Report finds that there are Governance issues to be addressed in respect of the membership of Health Board officers of the Limited Company (Caredoc) providing out-of-hours service. Whereas this arrangement may have been practical and appropriate in a pilot scenario a clearer distinction between the contracting parties in a more permanent out-of-hours arrangement will assist in clarifying lines of accountability.

(b) The Report finds that the existence of open-ended payment arrangements for out-of-hours services is not consistent with promoting prudent management of those services and achieving value for money. This is particularly the case where Special Type Consultation claims for payment are possible outside of the hours covered by the Co-operative i.e. 5.00 p.m. to 6.00 p.m. and Saturday a.m. The Report noted a significant number of STC claims being made by some Co-operative members in those periods. The Report also finds that a payment system which only acknowledges ‘face to face’ consultations with patients does little to encourage the development of telephone advice services or the availability of General Practitioners out-of-hours on the site of the relevant Primary Care Centre.

(c) The Report finds that although there is nothing inherently untoward with the Co-operative employing support staff with state funding there is little doubt but that actions or omissions on the part of
these staff would have serious implications for the Health Board, possibly extending to vicarious liability. The Report also noted that whereas the funding for those support staff posts is derived almost entirely from public monies, the accountability of those staff is to Caredoc. Whether that accountability extends through the service agreement between Caredoc and the South Eastern Health Board is unclear from that agreement. Accordingly, the Report finds little to recommend direct employment of support staff by the Co-operative.

10.3 **Whether sufficient infrastructural supports exist to provide patient centred out-of-hours G.P. cover**

10.3.1 **North East**

(a) The Report finds that a comprehensive regional integrated, infrastructure has been put in place in the North Eastern Health Board to support the delivery of timely out-of-hours care by General Practitioners to the whole population of the region served by the Co-operative. The Report also finds that the investment in the Ardee call centre facilitates the introduction of additional day and out-of-hours services utilising that facility.

(b) The Report finds that the consequences of placing the out-of-hours initiative on a permanent footing will be to invest in the Primary Care Centre infrastructure throughout the region.

10.3.2 **South East**

The Report finds that there have been insufficient levels of capital investment in the Carlow call centre and the three Primary Care Centres established in the region. The Report noted that the Centre currently used in Kilkenny is privately developed but leased by the Health Board for out-of-hours services. The Report finds that whereas this form of public/private partnership is to be welcomed in the short term, it would be in the interests of the Health Board to
match its strategic planning on additional services with the development of associated infrastructure which would be under the control and ownership of the Health Board.

10.4  Comparison with standard out-of-hours cover being provided in both regions

10.4.1 North East
(a) The Report finds that out-of-hours cover outside of the Co-operative is generally delivered on a personal basis Monday to Friday and by way of a locum at weekends. There would also be a number of small rotas where locum cover at weekends is not always available because of local and geographic factors.

(b) The Report finds that whereas the major Monday to Friday rosters provide personalised quality out-of-hours services in the areas outside of the Co-operatives, the provision of only locum cover in some areas at weekends is not conducive to ensuring continuity of quality patient care.

(c) The Report finds that significant levels of Special Type Consultation claim payments are being made by a small number of individual General Practitioners who are outside the Co-operative. In one case the cost of claims for the first four months of 2001 was £13,062 with the next nearest at £6,890 (source GMS Payments Board) and averages of approximately £3,000 for the remaining doctors outside of the Co-operative.

10.4.2 South East
(a) The Report finds that areas and practices which currently provide out-of-hours services do so by way of an established rota on a
Monday to Friday and through a combination of weekend rotas and locum cover. The main rota in Carlow, which is outside of the Co-operative, invariably utilises locum cover for the weekends.

(b) The Report finds that the use of locum cover at weekends, Bank and Public holidays outside of the Co-operative and within the Co-operative from midnight to 8.00 a.m. duties is not conducive to ensuring continuity of quality patient care

(c) The Report finds that there are significant STC claims for out-of-hours duties relating to both Co-operative members and non-members within the region. Two doctors within the Co-operative had claims for the first four months of 2001 amounting to 641 (£16,820) and 480 (£12,444). Those doctors would have participated in Co-operative rotas at the same level as other participating doctors averaging £4,500 in the same period. STC claims outside of the Co-operative were as exceptionally high in two other individual cases 539 (£13,841) and 1,079 (£27,555) for the same four-month period in 2001. Average STC claims for the county where those high claims arose would have been £3,400 in the same period excluding those two claims.
10.5 **Strengths and weaknesses of the two initiatives**

10.5.1 **North East**

(a) The Report has identified the following strengths of the North East model.

- Agreed annual budget for the provision of the service
- That patients contacting the service have an opportunity to speak directly to a triage doctor prior to midnight
- That the direct employment of support staff conveys Health & Safety obligations directly on the Board in respect of the physical working environment for those staff
- That experienced fully trained doctors are present and on duty in each of the Primary Care Centres for the duration of the out-of-hours period. This compares favourably with the out of hours service provided by acute hospitals in the region
- That the ownership of the infrastructure allows the Health Board to strategically plan for additional services utilising the developments associated with the Co-operative
- Represents a partnership initiative between Health Board and General Practice
- Commencing on a regional basis significantly assisted in the retention/recruitment of General Practitioners throughout the region
The Report has identified the following weaknesses of the North East model:

- The absence of central triaging after midnight
- The rostering of General Practitioners for the ‘red-eye’ shift who have day surgery commitments on the mornings immediately following that shift
- The absence of morbidity coding as part of the system in respect of patient calls and visits
- Inadequate promotion and communication of the benefits of the Co-operative
- The fact that the North Louth/Dundalk and Monaghan areas are uncovered by the Co-operative
- The absence of a comprehensive service agreement between the Health Board and NEDoc
- The absence to date of ongoing efforts at establishing patient satisfaction levels

10.5.2 South East

The Report has identified the following strengths of the South East model:

- That the benefits of the Co-operative were widely explained and promoted prior to the establishment and extension of the Co-operative
- That a coding system (ICPC-2) was introduced to collect complete morbidity data in respect of patient contacts with the Co-operative
- That a system of ongoing evaluation of patient satisfaction was introduced
- That a comprehensive service agreement exists as between the Health Board and Caredoc
• That the incremental extension of the initiative to other countries has allowed the Co-operative to point to practical examples of successful application in the region
• The Co-operative has significantly improved General Practitioner retention/recruitment considerations in the geographical areas covered

(b) The Report has identified the following weaknesses associated with the South East model

• The existence of an open ended system of STC claims outside the hours covered by the Co-operatives (i.e. 5-6 pm weekdays, 9 am – 12 midday Saturday)
• The lack of an agreed budget for the total costs of the Co-operative because of the remuneration system being based on the open ended nature of the current STC claims system
• The use of locums provided by locum agencies to deliver weekend “Red Eye” shifts
• The rostering of General Practitioners for the Monday to Thursday ‘red-eye’ shift who have day surgery commitments on the mornings immediately following that shift
11. **Recommendations**

On the basis of the findings outlined in section 10 above the Report recommends as follows

11.1 **North East**

That the partnership arrangement between the Health Board and NEDoc on the provision of General Practice out-of-hours service be placed on a permanent footing subject to the following issues being addressed:

(a) That a comprehensive service agreement be drawn up as between the Health Board and NEDoc. The service agreement to be reviewed annually and be given legal effect through incorporation into the Health Board’s Annual Service Plans

(b) That a strategic plan is drawn up by the North Eastern Health Board for the rolling out of additional day time and out-of-hours services utilising the resources made available to the General Practice out-of-hours initiative. Such a plan to include the provision of integrated cross border services

(c) That in order to sustain the future of the Co-operative that a cohort of qualified General Practitioners be recruited to provide Monday to Thursday ‘red-eye’ shifts. Those General Practitioners to be drawn from:

- Members of the Co-operative cross-covering colleagues
- Existing GMS GPs who wish to take leave of absence or resign from their practices. Such service to be reckonable for GMS pension purposes
on the basis of average contributions from both GP and Health Board

- Other vocationally qualified General Practitioners who would be paid an agreed salary from a protected grant for that purpose
- Aspirant GMS doctors who would have recently completed General Practice vocational training.

That service with the Co-operative would provide enhanced familiarisation with the out-of-hours Co-operative system. The onerous nature of the commitment to be recognised through the double counting of such experience for the purposes of eligibility to apply for GMS posts

(d) That reliance on locum cover, other than in extenuating circumstances, be phased out over a nine-month period from the publication of this Report

(e) That call centre services be shared with Caredoc for the period midnight to 8.00 a.m.

(f) That Ardee and Carlow would provide shared post-midnight call centre and triage services for other Co-operatives coming on stream

(g) That a nurse triage service be shared with Caredoc for the period midnight to 8.00 a.m. on a pilot basis to be reviewed in the course of the qualitative evaluation of the Co-operative

(h) That a more robust approach be taken by the Health Board to establish the veracity of STC claims significantly exceeding the regional average
11.2 South East

(a) That the partnership arrangement between the Health Board and Caredoc on the provision of General Practitioner out-of-hours services be placed on a permanent footing and extended to other counties of the South East region subject to the following issues being addressed.

(b) That the existing service agreement between the Health Board and Caredoc be revised to ensure that serving Officers of the Health Board are not directors of the Company. The position of employees and any liability accruing to the Health Board should also be set out in the agreement.

(c) That the revised service agreement be reviewed annually and be given legal effect through incorporation into the Health Board’s Annual Service Plans.

(d) That a strategic plan be drawn up by the South Eastern Health Board and incorporated into the service agreement with Caredoc for the rolling out of additional day time and out-of-hours services utilising the resources available to the General Practice out-of-hours initiative.

(e) That a revised remuneration system be agreed between Caredoc and the Health Board which would be based on an agreed annual pay budget. No STC claims would be permitted outside of that budget other than for special items of service. On the basis of that agreed budget it would be open to Caredoc and the Health Board to continue with a fee per item of service or to proceed to an hourly rate. It is recommended however that consideration be given to a specific fee for being on duty on site in the Primary Care Centres. In the event of unforeseen peaks in activity (e.g. epidemics), annual
brought budgets could be revisited following validation of the peak in activity from the Health Board’s Department of Public Health

(f) That in order to sustain the future of the Co-operative a cohort of qualified General Practitioners be recruited to provide Monday to Thursday ‘red-eye’ shifts. Those General Practitioners to be drawn from:

- Members of the Co-operative cross-covering colleagues
- Existing GMS GPs who wish to take leave of absence or resign from their practices. Such service to be reckonable for GMS pension purposes on the basis of average contributions from both GP and Health Board
- Other vocationally qualified General Practitioners who would be paid an agreed salary from a protected grant for that purpose
- Aspirant GMS doctors who would have recently completed General Practice vocational training. That service with the Co-operative would provide enhanced familiarisation with the out-of-hours Co-operative system. The onerous nature of the commitment to be recognised through the double counting of such experience for the purposes of eligibility to apply for GMS posts

(g) That reliance on locum cover, other than in extenuating circumstances, be phased out over a nine-month period from the publication of this Report

(h) That call centre services be shared with NEDoc for the period midnight to 8.00 a.m.
(i) That Ardee and Carlow would provide a shared post midnight call centre and triage services for other Co-operatives coming on stream

(j) That a nurse triage service be shared with NEDoc for the period midnight to 8.00 a.m. on a pilot basis to be reviewed in the course of the qualitative evaluation of the Co-operative

(k) That a more robust approach be taken by the Health Board to establish the veracity of STC claims significantly exceeding the regional average

11.3 Template for future Co-operative developments

11.3.1 The Report recommends that the initiatives undertaken in the North East and South East with the revisions outlined in paragraphs 11.1 and 11.2 above, represent the range of options open to future Co-operatives throughout the country.
12. **Conclusion**

12.1 This evaluation exercise has identified the out-of-hours Co-operative pilots in both the North Eastern and South Eastern Health Boards as highly significant initiatives for both General Practice and the Health Service as a whole.

12.2 Notwithstanding the fact that this is an Interim Report and that the evaluation will only be complete following the separate qualitative study being undertaken, I am satisfied that the relevant parties in both Health Boards should proceed to implement the findings and recommendations outlined in this Report in conjunction with the Department of Health & Children and the GMS Payments Board. I am also satisfied that other prospective Co-operatives can proceed following agreement with the respective Health Boards and the Department of Health and Children, on the basis that the findings and recommendation outlined in this Report are incorporated into any such agreement.

Signed ___________________________  Date ___________________________

Conal Devine BCL Dip Arb.
Appendix I

Published documentation referred to in the course of the evaluation


3. North Down and Ards Doctors on-call (NDADOC) "Nurse Triage in a Northern Ireland Out-of-hours Co-operative" (November 2000)

4. Presentation to the Health, Social Services and Public Safety Committee of the Northern Ireland Assembly by Dalriada Doctor on call out-of-hours Co-operative (November 2000)


7. Salisbury C.: “Postal survey of patients’ satisfaction with a General Practice out of hours co-operative”. BMJ 1997
