Enhanced Duty Doctor Contract
Service Specification

Introduction

This specification covers the commissioning requirements of a new service: providing a duty doctor service at each practice during the working day/core hours. The specification is for a service spanning two years.

Rationale for commissioning service

The CCG is seeking to commission a duty doctor service to support practices with additional GP workforce capacity to meet the demand for urgent care. This should reduce primary care attendances at A&E and enable practices to provide better proactive care for more complex patients. This service enhances the national avoiding unplanned admissions service, through providing a key contact point for a range of new and additional health and social care services that have been developed to support care out of hospital and reduce unnecessary A&E attendances and hospital admissions. The CCG intends to commission sufficient clinical support in general practices to ensure communication with these new services and the expected increase in workload at a practice level, as well as to ensure GPs are available to make urgent home visits or respond to other requests and in doing so prevent an emergency presentation at hospital. This commissioned service will provide an enhanced range of urgent care interventions, beyond supporting transfers and admissions, in addition to the national service. It will also ensure that practices provide an urgent care response to a wider variety of patients than just those on the vulnerable person’s register.

Aims of the service

The new service has the following three main aims:

1. To ensure each general practice has the capacity to triage all urgent requests received and to respond appropriately - this will be achieved by the practice providing additional GPs who can undertake an urgent intervention – e.g. a home visit

2. To provide practice-based responses to health and social care providers which limits A&E attendances and admissions
3. To deliver practice-based responses to health and social care providers which facilitate discharges from hospital

The new service will provide a co-ordination role for wide range of health and social care services, over and above the key stakeholders highlighted in the national service. The new duty doctor service will ensure GPs are available for referral co-ordination from the range of new services, such as multi-professional integrated care teams, established by the CCG through its Urgent and Integrated Care Strategy.

**Service Description of the Duty Doctor Service**

*How the service will operate*

1. In all 44 practices, a duty doctor will be available. Practices will need to provide a contact telephone number for the duty doctor.

2. The duty doctor will triage all urgent requests from patients and other providers.

3. The duty doctor will be expected to provide a rapid response or advice as required to the patient or provider.

4. Some examples are:
   a. This may be an urgent home visit at the request of a member of the Integrated care team to ensure a clinically safe community package is in place to avoid an emergency admission or to undertake an urgent assessment
   b. An urgent home visit or intervention if a patient has been assessed in A&E/OMU and is discharged
   c. At the request of a member of the integrated care team if they are concerned about a deterioration in a patient’s condition and without an intervention the patient would go to hospital,
   d. To proactively follow up an attendance by the LAS/Paradoc service
   e. To respond to a post discharge assessment by the integrated care team, to support

5. Practices will need to ensure that the duty doctor can undertake home visits and follow up activities.

6. Practices will be able to offer extended consultations with vulnerable patients
7. The provider will have the responsibility for ensuring equitable distribution of additional staffing to practices to deliver the duty doctor role

8. It will be for the provider and individual practices to decide whether the additional funding will provide additional clinical manpower to allow and release regular practice GPs to undertake the duty doctor role

Who the service will liaise with

The duty doctor will liaise with health and social care services to avoid admissions and facilitate discharge. These services include but are not limited to:

- Multi-Disciplinary Locality Teams (as set out in the new integrated care initiative)
- Accident & Emergency
- Observational Medical Unit
- Acute Care Unit
- Hospital Wards
- Social Services
- Community Health Services
- London Ambulance Service
- PARADOC
- Rapid Assessment Interface and Discharge (RAID)
- Re-ablement and Intermediate Care Service (RICS)
- Hackney Frequent Attenders Project
- East London Foundation Trust
- 111

Outcomes and Performance Indicators

1. A reduction in A&E attendances

2. A reduction in emergency admissions

3. Greater health and social care staff satisfaction with accessing GP practices. The provider is expected to take an annual response from stakeholders around their satisfaction of being able to access the Duty Doctor.

4. Activity levels and timeliness of response: The timeliness of response of the duty doctor to other health and social care professionals will be
monitored, along with activity levels for the service — **we are proposing that the timeliness of response is as follows: 98% of patients are called back within 4 hours**

5. Service issues: It is important to ensure that the service works with other relevant health and social care staff and in the course of the delivery the service identifies where service improvements can be delivered — we propose that where a healthcare professional requires a call back that this is taken live where clinically urgent, for example, LAS or A&E department. If this is not possible practices should endeavour to provide a response within 30 minutes. Health and social care partners must have a feedback mechanism to enable the commissioner to be made aware of any issues partners have in accessing the service.

6. Patient experience: It is important to ensure that the service meets the needs of patients — this will be monitored through the annual GP survey.

7. Supporting practices with managing complex patients: the introduction of this service should enable practices to better target existing resources at providing longer appointment for complex multi-morbid patients.

**Quality standards**

The CCG expects that the workforce/resource delivering the service must follow existing standards and policies that meet the CQC essential standards of care that are in place through the core GP contract.

Where a practice has failed any of the essential CQC standards then the commissioner expects the GP confederation to alert the CCG and to advise on the recovery plan for delivery of the CQC standards of care.

**How the CCG will pay for this service**

The total cost of contract will be £1,465,000 plus £400,000 to cover costs incurred for use of locums and back-fill.

**Contractual mechanism**

The Provider will submit a report on the timeliness of the response by service on a quarterly basis with detail at individual practice level. It is anticipated that
all practices will provide a call back by the duty doctor to all patients within 4 hours. Where a healthcare professional requires a call back that this is taken live where clinically urgent, for example, LAS or A&E department. If this is not possible practices should endeavour to provide a response within 30 minutes.

The Confederation will achieve 98% in total for call backs to patients with each practice achieving no less than 80%. If less than 98% is achieved in any quarter at total contract level then 1p of the service fees (per registered patient) will be withheld.

Where a practice fall below 80% in any one quarter then an improvement plan will be required from the provider.

On the second or subsequent quarter where less than 80% is achieved then a penalty will be applied to the contract claim, therefore quarterly, of £100 per practice with less than 5,000 patients and £300 per practice for those of 5,000 registered patients or more.

For performance falling below 98% the following thresholds will apply:

- 1p penalty for 95% to 98%,
- 2p penalty for 92% to 95%,
- 3p penalty for 89% to 92%
- 5p penalty for falling below 89%

Notes
1. The provider, as holders of the overall contract, will to determine the remuneration to each practice in the context of the overall contractual agreement with the CCG: the practice figures are indicative
2. It is anticipated the CCG will fund the provider for the delivery of this service for the patients of each member practice; this funding will be used to increase clinical capacity
3. The provider will need to agree with each practice whether they provide this service themselves or look to the provider to deliver it on their behalf