Quality standards for deputising services

David Cragg, Lesley Hallam

Department of General Practice and Centre for Primary Care Research, University of Manchester, Rusholme Health Centre, Manchester M14 5NP
David Cragg, lecturer in general practice
Lesley Hallam, research fellow

Correspondence to:
Dr Cragg.

BMJ 1994;309:1630

New proposals for remunerating general practitioners for out of hours services seem likely to reverse the decline in the use of deputising services that followed the introduction in 1990 of two rates of fees for night visits. In 1989, 46% of night visits were undertaken by deputies.¹ By 1993 only 34% of night visits attracted the lower fee paid for calls made by deputies or those in a cooperative service.²

Guidelines covering the use and operation of deputising services have existed since 1984. They give family health services authorities the duty of ensuring that "out of hours care in general practice, however it is provided, be of no less standard than that provided in hours."³ We investigated the standards set by authorities, how they were monitored, and their relevance to current developments.

Method and results

Data on the operation of deputising services and the participation of family health services authorities in recruiting staff and in setting and monitoring standards were collected during a telephone survey of authorities' knowledge of current provision of out of hours care.² Results are based on the responses of the 81 authorities in England and Wales that had one or more deputising services within their area of responsibility. Sixteen had no service, and one did not participate.

Almost all authorities required that general practitioners should notify them if they intended to use a service, but few (21) routinely collected data on the timing and extent of use. Limits on use were imposed by 66 authorities, 61 of which monitored compliance by randomly checking the fee claims for night visits. Limits predominantly specified maximum call rates per 1000 patients per month and ranged from six to 50. There was some restriction on periods of cover, but this was rarely onerous—for example, services could not be used every night or every weekend. Monitored use was well below the limits set.

The extent and nature of liaison between authorities and deputising services varied, and was complicated by arrangements between authorities about services across boundaries. Fifty seven authorities reported that they had or shared a designated liaison officer; 44 reported that they had an active deputising services subcommittee; 42 produced an annual report; and 68 were represented at regular meetings with deputising service managers.

Participation in the recruitment of deputies was widespread. Sixty authorities interviewed and appointed candidates, and the minimum standard for applicants set by 28 authorities exceeded current guidelines. In a further 12 cases the authority's participation was considered to be unnecessary as almost all the deputies were registered principals.

Although a large proportion of authorities reported setting and monitoring performance standards (table), for many such standards related only to response time to calls. Exceptionally, six authorities had produced detailed service specifications, and the degree of compliance with them governed reaccreditation.

Comment

The 1984 guidelines have been selectively implemented. Not all authorities have active deputising

Numbers of family health services authorities (n=81) setting and monitoring standards for deputising services

Aspect of service	Setting standard	Monitoring standard
Response time	57	39
Shift lengths	10	10
Recruitment	10	10
No of staff on duty	17	14
Communications	8	8
Equipment or drugs carried	6	20

services subcommittees. Although most have accepted responsibility for monitoring deputising services, initiatives vary from collecting data on limited aspects of activity to producing and implementing detailed service specifications. Restrictions on use are not as rigorous as was originally intended. Permitted levels are rarely reached and will not prohibit general practitioners from using deputising services in the light of changes in remuneration. Indeed, some authorities argued that the value of limiting access to a high standard, well monitored service was questionable.

Although concerns remain about the quality of care given by deputising services,⁴ deputies are now doctors with at least six months' experience of general practice rather than hospital doctors.⁵ Monitoring activities are generally sufficient to identify and correct obvious examples of poor response times. The setting and monitoring of more comprehensive standards should take priority, with authorities who have given it a high profile acting as models for those who have not.

1 Department of Health and Welsh Office. *General practice in the National Health Service: a new contract*. London: HMSO, 1989.

2 Hallam L, Cragg D. Organisation of general practitioner care outside normal working hours. *BMJ* 1994;309:1621-3.

3 Department of Health and Social Security. *General practitioner deputising services*. London: DHSS, 1984. (Health Circular (FP)84.)

4 Bollam MJ, McCarthy M, Modell M. Patients' assessments of out of hours care in general practice. *BMJ* 1988;296:829-32.

5 Dixon RA, Williams BT. Twelve months of deputising. 100 000 patient contacts with eighteen services. *BMJ* 1977;i:560-3.

(Accepted 22 November 1994)

A different ward round

Once a week my firm meets in the central hall of a London gallery to be greeted by our lecturer for the day. Unlike the teaching consultants of my student days, he is usually there before us and shakes us warmly by the hand. He takes us round the rooms, stopping only at a few of the pictures with the assurance of a man who knows where the most interesting cases are to be found. After a brief introduction to each one, amounting to no more than a name and date of birth in most cases, he leaves us for some minutes to examine the painting for ourselves. The essential skill of the art historian is the observation and interpretation of physical signs. Reynolds is said to have dissected three pictures of great masters, scraping them down to find out how they had been made, but this pathologist's approach is rare.

So we stand in our silent semicircle round our picture and try to spot the visual clues that reveal the school of the painting, the name of the artist, the period of his life in which it was painted, and how it differs from the previous examples we have seen. My perverse mind drives me to search for those signs that do not fit the correct diagnosis and to question our lecturer on these points.

When he rejoins the group he teaches by asking for our observations to illustrate the story that he is telling us. I am fascinated listening to such an expert talking about his great interest and I enjoy watching his teaching style, but now I can listen and admire and learn, knowing that my poor memory will not be tested by examination in the future and that I do not have to read all the recommended books. That is the privilege of retirement.—JOHN TROWELL is a retired general practitioner in Sawbridgeworth, Hertfordshire