

# Public Health On-Call

## Joint work between the PCT and Health Protection Unit to develop, audit and revise locally agreed standards for on-call

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### Introduction

In 2005, a formal agreement on collaborative Public Health on-call arrangements was developed following discussion between the local Health Protection Unit (HPU) and the four PCTs in North Yorkshire and York at that time. The agreement included sections covering specific aspects of the On-call service and other collaborative arrangements which were shared between the HPU and the four PCTs. These included:

- Standards for the recording and reporting of enquiries received whilst on-call, and actions taken in response;
- Procedures to ensure robust confidentiality and data protection arrangements for sensitive or patient identifiable information;
- Standards for handover, at the start and end of a period of on-call;
- Standards for response times and availability (for on-call and also during normal working hours).

### Rationale and method for the audit of On-call activity

Following the merger of the four North Yorkshire PCTs in 2006, it was agreed that it would be timely to review and update the on-call agreement. To inform this review, it was felt that an audit of on-call activity should be undertaken, to include an assessment of compliance with the explicit standards in the on-call agreement, and an assessment of the quality of public health case management (i.e. the appropriateness of advice given and action taken by the on-call consultant).

Audit criteria were developed by the HPU, which were then included in a template audit form to be used to assess the information contained in each on-call case record (see proforma, below). The criteria related to (a) the explicit on-call standards (where applicable), and (b) to a judgement as to the quality of the public health case management, including adherence to policies & guidelines, where relevant. The completion of the audit form was undertaken by the HPU, normally the following day, based upon the reported information from the on-call PCT and HPU staff involved in the case. Responses on the audit forms were summarised in an Excel spreadsheet. Wherever a non-compliant response was noted, a review of the case notes was undertaken to identify the nature of the problem.

#### Audit of Out Of Hours Health Protection Activity:

Date	Time	Record Number
Nature of Call		
On-call consultant	1st on-call	CCDC on-call

Component Activity	Satisfactory Performance	Problem identified (brief description of issue and outcome)	Action and Learning points
Contacting PHP			
Correct PHP contacted			
PHP response / availability			
<b>Case Management</b>			
Appropriate advice given and action taken			
Appropriate notification of relevant stakeholders			
Appropriate referral to out of area teams			
Appropriate dialogue with specialist resources			
<b>Case Handover</b>			
Verbal handover if appropriate			
Completion of HPU records			
Data protection compliance			
Documentation filed appropriately in NYHPU			

### Results

48 episodes of on-call activity were recorded and audited, over a period of approximately two and a half years. 23 of these were in respect of meningitis, 3 were gastro-intestinal outbreaks, 2 chemical incidents, 2 water quality incidents, 2 E Coli O157 cases, 2 flooding related, and the other 14 were a variety of different diseases and queries. It was noted that not all on-call episodes were documented and/or audited, for a variety of reasons.

Overall compliance with the standards was high, and the quality of case management was satisfactory in 92% of episodes.

#### (a) Availability of, and timely contact with, on-call Public Health staff

This was generally good, but there were 11 instances of delays or problems in communication with on-call Public Health staff, which were due to:

- clinicians being unaware of the need to contact Public Health out-of-hours;
- the relevant Trust switchboard failing to adhere to agreed call-out processes;
- clinicians bypassing the normal call-out processes;
- the wrong service initially being contacted for cross-boundary cases;
- the Public Health on-call person's phone accidentally being left on "silent" mode, or being in an area with poor reception.

#### (b) Case Management

Advice given and action taken were deemed satisfactory in all but one episode, due to:

- delegation to ward staff without sufficient advice, resulting in inappropriate prescription of prophylaxis.

Notification of relevant stakeholders (e.g. partner agencies) was satisfactory in all but 3 episodes:

- unable to contact external stakeholder despite reasonable attempts being made;
- one instance of notification in excess of requirements.

There were no problems identified with accessing specialist advice or resources, or with referring to teams in other areas when indicated.

#### (c) Case Handover and record keeping

A significant proportion of handovers (17%) were deemed not to meet agreed standards:

- in 7 episodes (15%) the information provided was deemed inadequate or incomplete;
  - in 1 episode (2%), the handover was unacceptably late (after 11.00am).
- Data protection and transfer of patient-identifiable information was the weakest area of performance, with 17% of episodes not meeting agreed standards, due mainly to:
- failure to use password-protected (or encrypted) e-mails when sending handover information in to the HPU

Dr Phil Kirby, Associate Director of Public Health (Health Protection) NHS North Yorkshire and York; Dr Louise Coole, Consultant in Communicable Disease Control and Mrs Ann Morris, Health Protection Nurse Specialist; both North Yorkshire and the Humber Health Protection Unit

### Action taken in response to the audit ("Closing the audit loop")

A meeting was convened by the HPU Director and the PCT DPH, to enable feedback and discussion of the audit results, inviting all the PCT and HPU Public Health staff who participated in the out-of-hours rota.

The key findings (and the limitations of the audit methodology) were discussed, and priorities for improvements to local on-call practice were identified. The standards themselves were also reviewed and amended, and it was agreed to include them in the new "On-call pack". Individuals agreed to undertake specific actions (e.g. to update the standards and the handover documentation, and to explore how encryption of handover e-mails could be made easier).

There was general agreement that this audit of on-call activity had been worthwhile, but also that future audits should generally be targeted on specific issues of concern. There was agreement in principle that such an audit should be performed for a limited period once each year, and that "hot" feedback should also be routinely provided to on-call staff by the HPU. It was also agreed that it would be desirable for HPU and PCT on-call staff to hold joint meetings on at least a 6-monthly basis, to discuss on-call incidents of interest, both to support CPD and to maintain or strengthen working relationships.

### Summary of Conclusions

- The collaborative process to agree standards for on-call activity between the HPU and the PCT was valuable (a) in securing ownership of those standards by staff on the rota, and (b) in enabling objective monitoring and feedback on performance on-call.
- Such standards can then be used to support formal audit of on-call activity, although it is preferable to first agree the primary purpose of the audit and then target the audit methodology accordingly.
- Many of the important issues identified by such audits will relate to other parts of the on-call system, which are outside the direct control of the HPU or PCT Public Health Department, e.g. the contactability of partners, weaknesses in IT infrastructure or support, or problems with version control of rotas by switchboards.
- It seems likely that new ways of delivering the Public Health on-call function will emerge over the next few years. There will be a need to maintain clarity on the respective roles of PCT and HPA staff. Whilst some of this will be determined nationally, local dialogue to agree roles and standards is likely to be a key element in ensuring that there are robust and responsive local arrangements to protect public health on a "24-7" basis.