National Audit Office

The Provision of Out-of-Hours Care in England

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SUMMARY

1 Most primary medical care takes place during the working day, but patients sometimes need care at other times as well. Such care is known as out-of-hours care, the term currently being used to describe the period from 6:30pm until 8:00am on weekdays, and all weekends, bank holidays and public holidays.

2 Out-of-hours services have undergone significant change since 2000, when the Department of Health (the Department) commissioned a review of these services in order to consider issues such as quality of care and links with wider NHS services. This review, known as the Carson Review[1], made recommendations which, combined with the NHS Plan, set the foundations for current out-of-hours services.

3 Many General Practitioners (GPs) had already used powers granted in the mid-1990s to delegate out-of-hours provision to a third party. However, a new General Medical Services (GMS) contract came into force in 2004, which allowed GPs to opt out of the responsibility of organising out-of-hours care entirely from 1 April 2004. Where GPs opted out, they gave up an average of £6,000 per annum and passed on responsibility to their Primary Care Trust (PCT).

4 This report examines whether the Department is on the right track towards providing high-quality out-of-hours services. Appendix 1 sets out our methodology. Our work has found that:

- There were some shortcomings in the initial commissioning process because PCTs lacked experience, time and reliable management data. There is also confusion over whether out-of-hours services should be restricted to urgent care.
- Out-of-hours providers are beginning to deliver a satisfactory standard of service but most are not yet meeting all the national Quality Requirements, particularly on speed of response.
- In a survey of PCTs we found that the actual costs of providing out-of-hours are £392 million, considerably more than the £322 million allocated by the Department.
- Commissioners are entering into contracts with multiple providers and the market is maturing.

1 Named after the review panel's Chairman, Dr David Carson, a GP, who was head of primary care strategy and performance at East London & the City Health Authority at the time of his appointment, and who had already assisted the Department of Health with its reviews of GP pay and GP postgraduate education.

5 Our more detailed findings are as follows.

There were some shortcomings in the commissioning process

6 In 2005, many PCTs had not previously managed or delivered out-of-hours services and so lacked both knowledge and experience in this area. There was little, if any, reliable management information, for example on demand, activity and cost. This shortfall in information made it very difficult for PCTs to write service specifications and commission effectively. Some PCTs were, and remain, confused as to whether the out-of-hours service should be restricted to urgent care, or should respond to any request for medical care from members of the public. In addition, many PCTs allowed insufficient time for commissioning out-of-hours services, reducing the quality of the process.

7 Many contracts were signed late or not at all, with significant legal implications. This was due to poor service specifications, disagreements between commissioners and providers over risk-sharing, and the inability to reconcile PCTs' limited budgets with providers' estimated costs of meeting all the Quality Requirements. Our survey of PCTs, carried out jointly with the Audit Commission, found that, where external providers deliver services, signed contracts were in place in only nine per cent of cases by the time the service began. This increased to 34 per cent by 30 September 2005. Whilst services continued to be provided despite the lack of signed contracts, several providers told us that the lack of a formal contractual agreement forced them to carry extremely high operational and legal risks.

8 Our survey found that 39 per cent of PCTs ran a competitive tendering process to award a contract. Those that did not often cited departmental guidance, which stated that there was no requirement to undertake a formal tender exercise. Our survey found that the more rural a PCT was, the less likely it was to have undertaken formal tenders. The lack of competition from commercial providers in rural areas stems from the difficulty of achieving economies of scale. However, overall we found that services which had been subject to a tendering process were no cheaper or better than those which had not.

Out-of-hours providers are beginning to deliver a satisfactory standard of service

9 Anecdotal evidence suggests that patients suffered longer waits in at least 50 per cent of England during the first few days of the new service, but there is no indication that safety was compromised. Providers are not yet meeting all the Quality Requirements, particularly on Saturday mornings when demand peaks. Patient surveys run by PCTs show extremely high levels of satisfaction with the service provided. However, our survey of patients' views of out-of-hours and other urgent care services found that they had had broadly good experiences, but one in five were dissatisfied. This suggests that there may be shortcomings in patient experiences that are currently not being captured by PCTs.

10 Despite upgrades and improvements to IT systems, management information is still poor, as demonstrated by the difficulties PCTs experienced in obtaining management data to complete our survey. This is not helped by inadequate call management technology in some areas or difficulties in using the Department's reporting template. There is also some confusion over the definition of compliance with the Quality Requirements, despite clear explanations in the accompanying commentary.

11 Limited progress has been made towards integration with other parts of the NHS, such as local Accident & Emergency Departments and ambulance services, but there are some individual examples of strong efforts to join up services. Further planning and commissioning of integrated services should reduce duplication and improve value for money.

Costs of providing out-of-hours services are higher than anticipated

12 Prior to the conclusion of the new GMS contract negotiations, the Department conducted an economic analysis of GP co-operatives to estimate the cost to GPs of providing the service and arrived at an approximate average figure of £9,500 per GP. The outcome of the negotiations for the new GMS contract was an agreed average opt-out figure of £6,000, although the precise amount for individual GPs varied depending on list size. The Department increased its out-of-hours development funding to around £3,500 per GP to help establish the new service, giving an average total of £9,500 for every GP opting out. Some 90 per cent of GPs decided to opt out, in line with what the Department told us were their expectations.

13 The Department established a programme for PCTs to support the implementation of the new out-of-hours arrangements. The programme set out the expected average cost - of £9,500 per GP – to provide out-of-hours services using the analysis that was completed in advance of the new GMS contract negotiations. The Department also explained their resource support package, which totalled an average of £9,500 per GP. Despite this, some PCTs failed to understand that the £6,000 'opt-out' sum was not intended to represent the true cost of the service, which led to many underestimating their costs. Our survey found that the actual costs of providing out-of-hours for 2005-06, the first full year of the new arrangements, were £392 million, 22 per cent more than the £322 million allocated by the Department, and an average of £13,000 per whole-time equivalent GP.

14 The above funding gap may impact on investment in out-of-hours infrastructure and staff training in the short term, but there is significant scope to reduce costs in future. Our analysis identified the best performing PCTs for each rural/urban classification in terms of quality levels and cost per head. Benchmarking PCTs in each category against the best suggested that if all PCTs matched the best, a saving of £134 million could be achieved without compromising quality. PCTs could make savings through a number of actions, including benchmarking themselves against similar PCTs and analysing local demand patterns to help patients access the service more appropriately.

Commissioners are entering into contracts with multiple providers and the market is maturing

15 There is now a wide array of new out-of-hours providers, including GP co-operatives, NHS Direct, PCTs themselves and private sector companies, and it is common for commissioners to enter into contracts with multiple providers to provide different elements of the service.

16 Whilst the GP-led model still predominates in both PCT-provided and commissioned services, we have seen evidence of various different models of skill mix, i.e. the employment of health professionals other than doctors in out-of-hours primary care. Providers tell us that changing skill mix increases the cost of the service in the short term, for example due to training costs, but savings are expected to materialise in the longer term. Many of the emerging staffing models are still quite small-scale and it is not yet clear how successful they will be in providing cost-effective performance. Our survey analysis found that the most cost-effective models varied depending on the rural classification of the PCT.

17 Providers are becoming more responsive to commissioners, who now have better management information and are taking decisions to penalise poor providers. England compares well both within the UK and internationally in terms of service structure and quality monitoring.

RECOMMENDATIONS

18 The Department should:

- Although PCTs have the primary responsibility for out-of-hours services, the Department should nonetheless use all the levers at its disposal to encourage PCTs to improve the cost-effectiveness of the service through benchmarking of costs, improvements to local commissioning processes, and making available training and best practice.
- Ensure that commissioners and providers understand the Quality Requirements and that they are aware that full compliance is an average performance of 95 per cent rather than 100 per cent, as set out in the Department's guidance. The Department should also clarify the term 'definitive clinical assessment' and consider how to focus the Quality Requirements further on quality and patient experience.
- Provide adequate training to ensure that providers can use its reporting template effectively, and work in partnership with Adastra[2] to improve the management information which its various systems are producing to support performance management.

19 PCTs should:

- Benchmark their costs against those of other geographically comparable PCTs to identify areas for improvement.
- Improve commissioners' capacity in terms of writing service specifications and market management in preparation for subsequent rounds of commissioning.
- Ensure that they understand local drivers of demand to see if they can help patients to access the service more appropriately. They should conduct a thorough analysis of patient flows into all unscheduled care services in order to see the detail of case-mix and socio-economic groups using the different services.
- Ensure that they, or their providers, improve the quality of their patient questionnaires and make the most of best practice from pilot and academic work to ensure realistic patient feedback.
- Use all the contractual and performance management levers at their disposal to ensure that they or their providers meet the access requirements within the national Quality Requirements.

2 The main commercial IT supplier for out-of-hours operations.