



National Audit Office

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## **Report**

by the Comptroller  
and Auditor General

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**Department of Health and NHS England**

# Out-of-hours GP services in England

## Key facts

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**5.8m**

estimated cases handled  
by out-of-hours GP  
services, 2013-14

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**800,000**

estimated home visits by  
out-of-hours GPs, 2013-14

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**£400m**

estimated cost of  
out-of-hours GP  
services, 2013-14

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**£7.50**

estimated average cost per person of out-of-hours GP  
services, 2013-14

**10 per cent**

estimated proportion of GP practices that have retained  
responsibility for out-of-hours care

**66 per cent**

of people rated their experience of out-of-hours GP services  
as 'very good' or 'fairly good', reported in July 2014

**85 per cent**

of providers started at least 90 per cent of face-to-face  
consultations with urgently ill patients within two hours,  
September and December 2013

**87 per cent**

of clinical commissioning groups that manage an out-of-hours  
contract receive performance information at least monthly

**26 per cent**

of people have not heard of out-of-hours GP services,  
according to a nationally representative survey in May 2014

# Summary

**1** Out-of-hours GP services provide urgent primary care when GP surgeries are typically closed, from 6.30 pm to 8.00 am on weekdays and all day at weekends and on bank holidays. We estimate that out-of-hours GP services in England handled around 5.8 million cases in 2013-14, including 3.3 million face-to-face patient consultations, of which 800,000 were home visits. The Department of Health (the Department) has set national quality requirements which establish minimum standards for all out-of-hours GP services.

**2** Since 2004, GPs have been able to opt out of providing out-of-hours services and most have done so. In these cases (known as *opted-out* services), the NHS commissions out-of-hours services separately from in-hours services. Since April 2013, NHS England, the Department's largest arm's-length body, has delegated responsibility for commissioning such services to 211 clinical commissioning groups. These groups also commission hospital, community and mental health services for their local populations.

**3** An estimated 10 per cent of GPs have retained responsibility for out-of-hours care. NHS England commissions these services (known as *opted-in* services) directly from GP practices.

**4** Out-of-hours GP services have changed in the last two years with the introduction of NHS 111, which now handles incoming calls in most parts of the country. The impact of NHS 111 has varied, but overall the number of cases being handled by out-of-hours GP services has fallen. In addition, the make-up of the cases being handled has changed as NHS 111 should divert people not needing urgent primary care to other parts of the health system.

## Our report

**5** People turn to out-of-hours GP services when they are worried about their own health, or that of family or friends, and want urgent advice or treatment. Out-of-hours services are not intended to offer an equivalent service to in-hours GPs but, reasonably, people expect to receive care that is prompt, high-quality and safe. NHS England and clinical commissioning groups, and ultimately the Department, are responsible for ensuring the value for money of spending on out-of-hours GP services.

**6** In the light of our 2013 memorandum on the out-of-hours GP service in Cornwall<sup>1</sup> and the subsequent report by the Committee of Public Accounts,<sup>2</sup> we carried out a wider review of these services across England. This report examines performance, oversight and assurance arrangements, and how out-of-hours GP services are integrated with other urgent care. We set out our audit approach in Appendix One and our evidence base in Appendix Two.

## **Key findings**

### Costs

**7** **We estimate that out-of-hours GP services cost less now, in real terms, than they did in 2005-06, but the introduction of NHS 111 has made comparisons difficult.** On the basis of our survey of clinical commissioning groups, we estimate that the cost in 2013-14 was £400 million, similar to the estimate we made in 2005-06<sup>3</sup> – or some £75 million less, after adjusting for inflation. The value of some, but not all, out-of-hours contracts has been reduced to reflect the fact that NHS 111 now handles incoming calls. In 2013-14, the average cost per person was £7.50 but there was wide variation between contracts (paragraphs 1.14 to 1.18).

**8** **The number of cases being handled by out-of-hours GP services has fallen significantly.** The number of cases fell by a third from an estimated 8.6 million in 2007-08 to 5.8 million in 2013-14, partly because of NHS 111. The average cost-per-case was £68.30 in 2013-14, again with significant variation between contracts. Out-of-hours service providers told us that they are finding it harder to recruit and retain GPs for out-of-hours work, meaning they may need to pay more to ensure they have enough staff (paragraphs 1.12 to 1.13, 1.17 and 2.7 to 2.9).

### Performance

**9** **Most patients are positive about their experience of out-of-hours GP services.** The GP Patient Survey in July 2014 found that 66 per cent of people rated their overall experience as ‘very good’ or ‘fairly good’. However, there is significant geographical variation in patients’ experience, and satisfaction with out-of-hours GP services has been consistently lower than with GP surgeries and dental services (paragraphs 2.19 to 2.22).

1 Comptroller and Auditor General, *Memorandum on the provision of the out-of-hours GP service in Cornwall*, Session 2012-13, HC 1016, National Audit Office, March 2013.

2 HC Committee of Public Accounts, *The provision of the out-of-hours GP service in Cornwall*, Fifteenth Report of Session 2013-14, HC 471, June 2013.

3 Comptroller and Auditor General, *The provision of out-of-hours care in England*, Session 2005-06, HC 1041, National Audit Office, May 2006.

**10 Out-of-hours service providers are generally responsive, measured against the specified time frames.** Data on performance against the national quality requirements are not centrally collated, but our survey found that in September and December 2013 (paragraphs 2.4 to 2.5 and Figure 4):

- More than half of providers complied fully with five of the six criteria that measure responsiveness. This means that, in the areas covered by these contracts, GPs assessed and treated at least 95 per cent of patients within stipulated time frames.
- All providers complied fully or partially with the requirement to pass emergencies to the ambulance service within three minutes. This means that, in the areas covered by these contracts, at least 90 per cent of patients with life-threatening conditions were passed to an ambulance within three minutes.
- Eighty-five per cent of providers complied fully or partially with the requirement to begin face-to-face consultations with patients classed as ‘urgent’ within two hours.

**11 The emerging view of the Care Quality Commission is that out-of-hours GP services generally provide ‘safe, effective, caring, responsive and well-led care’.** The Commission is introducing a new approach to regulating and inspecting these services. At the time of our work, it had completed 30 inspections. In addition, our work indicated that out-of-hours GPs typically received induction before working their first shift and were subject to regular clinical audit (paragraphs 2.14 to 2.18).

Oversight and assurance

**Clinical commissioning groups’ contract management of *opted-out* services**

**12 The large majority of clinical commissioning groups manage their contracts for out-of-hours GP services actively, including monitoring compliance with national quality requirements.** For example, 87 per cent of clinical commissioning groups that manage a contract reported receiving performance information from providers at least monthly. We saw evidence of clinical commissioning groups using this information and analysing patient feedback to challenge providers (paragraphs 3.5 to 3.9).

**13 Some clinical commissioning groups could manage their contracts better.** We found instances where contract managers could not explain some aspects of the performance information, and some clinical commissioning groups responding to our survey did not provide data on compliance against some national quality requirements. Clinical commissioning groups make limited use of financial incentives (penalties or extra payments) to encourage providers to perform well (paragraphs 3.9 to 3.13 and Appendix Four).

**14 Our eight case studies showed that some commissioners had procured out-of-hours GP services competitively when contracts ended while others had rolled contracts forward without competition.** The public procurement framework, including the NHS procurement regulations, effective from April 2013, does not mandate competitive tendering of healthcare contracts. Monitor's statutory guidance explains that there will be circumstances where a decision to procure services without running a competitive tendering process will be appropriate and considers three situations in which commissioners may do so. NHS England's guidance notes that the law in this area is complex and carries an inherent risk of challenge. In five of our eight case studies, contracts had been re-awarded without competitive tendering, in three cases by the clinical commissioning group and in two cases dating back to before April 2013 when primary care trusts procured the contracts under non-statutory administrative rules. The purpose of our work was not to test compliance with procurement law, and we did not review in detail the particular circumstances of these procurement decisions or, where contracts had been re-awarded since April 2013, what assurance there was that clinical commissioning groups had complied with the procurement regulations (paragraphs 3.15 to 3.18).

#### **NHS England's oversight of *opted-in* services**

**15 NHS England has very limited oversight of out-of-hours services where GP practices have retained responsibility.** Its local area teams appear to do little to monitor performance, for example against the national quality requirements. This means there is little assurance that people whose GPs continue to provide out-of-hours care are receiving an acceptable service (paragraph 3.20).

#### **National assurance**

**16 NHS England did little during 2013-14 to assure itself of the quality and value for money of out-of-hours GP services.** NHS England informed its 27 local area teams that they needed to seek assurance about these services in March 2013, but did not give guidance about how to gain such assurance until a year later in March 2014. The seven local area teams we interviewed were undertaking very little assurance work on out-of-hours GP services. NHS England was also not using data from the GP Patient Survey to identify services where patients were particularly satisfied or dissatisfied (paragraphs 3.20 to 3.24).

**17 The arrangements NHS England is now putting in place are unlikely to provide meaningful assurance.** Clinical commissioning groups are required to complete just a few simple yes/no questions. This information will not allow NHS England to assess the relative riskiness or adequacy of different out-of-hours GP services, or identify services that perform particularly well. Ultimately, this limits the assurance that NHS England can provide to the Department about quality and value for money (paragraphs 3.21 to 3.24 and Figure 11).

## Out-of-hours GP services and other urgent care

**18 The urgent care system is complex and many people do not know how to contact out-of-hours GP services or even that such services exist.** The most recent GP Patient Survey found that over 40 per cent of respondents did not know how to contact an out-of-hours GP service. The survey we commissioned found that around a quarter of people had not heard of out-of-hours GP services. Awareness among certain groups, including younger people and people from black and minority ethnic communities, was lower than among others. People who had not heard of out-of-hours GP services were more likely to go to A&E departments or call 999 if they or their family felt unwell during the night or at the weekend (paragraphs 4.2 to 4.6 and Figures 13 and 14).

**19 NHS England has a clear vision to integrate urgent and emergency care services, but has not finalised its implementation plans.** NHS England expects that it will take between three and five years to make what it describes as “a major transformational change” to improve integration. However, it has not yet set out an implementation plan or made clear what its role, and that of others, will be in making the changes. It expects to publish an update on progress during summer 2014, with a detailed implementation plan following in autumn 2014. We found that at present 93 per cent of out-of-hours GP services are partly co-located with other NHS services, and local urgent care working groups are encouraging collaboration and innovation. However, financial incentives can work against integration (paragraphs 4.13 to 4.19).

## Conclusion on value for money

**20** Out-of-hours GP services are a vital part of the urgent care system in England, and an important partner to the NHS 111 service and busy A&E departments. On the basis of the evidence we collected on performance and contract management, we consider that some clinical commissioning groups are achieving value for money for their spending on out-of-hours GP services. We cannot, however, reach the same conclusion about the commissioning of out-of-hours GP services across the board.

**21** To achieve value for money, NHS England, either directly itself or in partnership with clinical commissioning groups, needs to: understand the variation in cost and performance, and secure improvements in some localities; improve oversight of *opted-in* services where GP practices have retained responsibility for out-of-hours-care; and strengthen national assurance arrangements. As it implements the vision outlined in its urgent and emergency care review, NHS England must oversee an increase in awareness of out-of-hours GP services and ensure that these services are integrated effectively with other parts of the urgent care system.

## Recommendations

**22** Our recommendations are designed to strengthen the oversight and assurance of out-of-hours GP services, to improve services for patients and value for money for the taxpayer:

- a Clinical commissioning groups should review how they manage out-of-hours GP service contracts.** Having now been established for over a year, clinical commissioning groups should consider: whether they have enough information to assess performance; whether they effectively hold their providers to account; and whether they could use financial incentives more to encourage providers to improve performance.
- b NHS England should conduct work to satisfy itself that clinical commissioning groups understand and are complying with procurement regulations and Monitor's guidance when awarding contracts for out-of-hours GP services.** It is important that NHS England has confidence in commissioners' understanding and application of what are complex requirements.
- c NHS England should actively oversee those *opted-in* out-of-hours GP services that it commissions directly.** NHS England's local area teams appear to do little to monitor the performance of *opted-in* services. As a result, there is little assurance that people whose GPs continue to provide out-of-hours care are receiving a service that meets the national quality requirements.
- d NHS England should develop a proportionate assurance framework for out-of-hours GP services.** While light-touch assurance appears reasonable given what we have found, NHS England needs to improve its arrangements. Light-touch assurance needs to be built on a clear understanding of risks, using available information to identify poorly-performing services.
- e NHS England should raise awareness of how and when to contact urgent care services, including out-of-hours GP services.** It should focus particularly on groups with low awareness, including people from black and minority ethnic communities and people likely to make more use of out-of-hours GP services, such as those with long-term health conditions.
- f In taking forward its vision for urgent and emergency care, NHS England should support and incentivise clinical commissioning groups and other bodies to integrate.** If the vision is to be realised consistently and cost-effectively, the NHS will need guidance and sometimes central direction. Specifically, NHS England will need to: understand how patients flow through the system; identify and disseminate good practice; support clinical commissioning groups, possibly financially, to align existing urgent care contracts; and address perverse incentives in national payment and performance management frameworks.