



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health and NHS England

Out-of-hours GP services in England

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Department of Health and NHS England

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Report by the Comptroller and Auditor General

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Commons in accordance with Section 9 of the Act

Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

9 July 2014

This report examines the performance, oversight and assurance arrangements, and integration of out-of-hours GP services.

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Key facts

5.8m

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

800,000

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

£400m

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

£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 Cornwall¹ and the subsequent report by the Committee of Public Accounts,² 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 2005-06³ – 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.

Part One

How out-of-hours GP services are delivered

What are out-of-hours GP services?

1.1 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. This means that out-of-hours GP services cover almost 70 per cent of the hours in an average week.

1.2 Out-of-hours GP services give patients treatment and advice for medical problems that are not life-threatening, but where the patient cannot wait to see their own GP. The nature of the work is different to mainstream in-hours services as every case an out-of-hours GP sees should be urgent.

1.3 Since April 2013, the usual route for people to access out-of-hours GP services is to call NHS 111. Non-clinical call handlers then use a clinical assessment tool called NHS Pathways to get information about the caller's symptoms and direct them to the appropriate service. This process is called triage. When an NHS 111 call handler assesses that a person needs urgent primary care, they:

- arrange for a clinician from the out-of-hours GP service to call the patient back and conduct a further, clinical assessment; or
- book the patient an appointment at the nearest out-of-hours clinic; or
- arrange for an out-of-hours GP to visit the patient at home.⁴

In some areas of England, people can also call a designated out-of-hours GP telephone line.

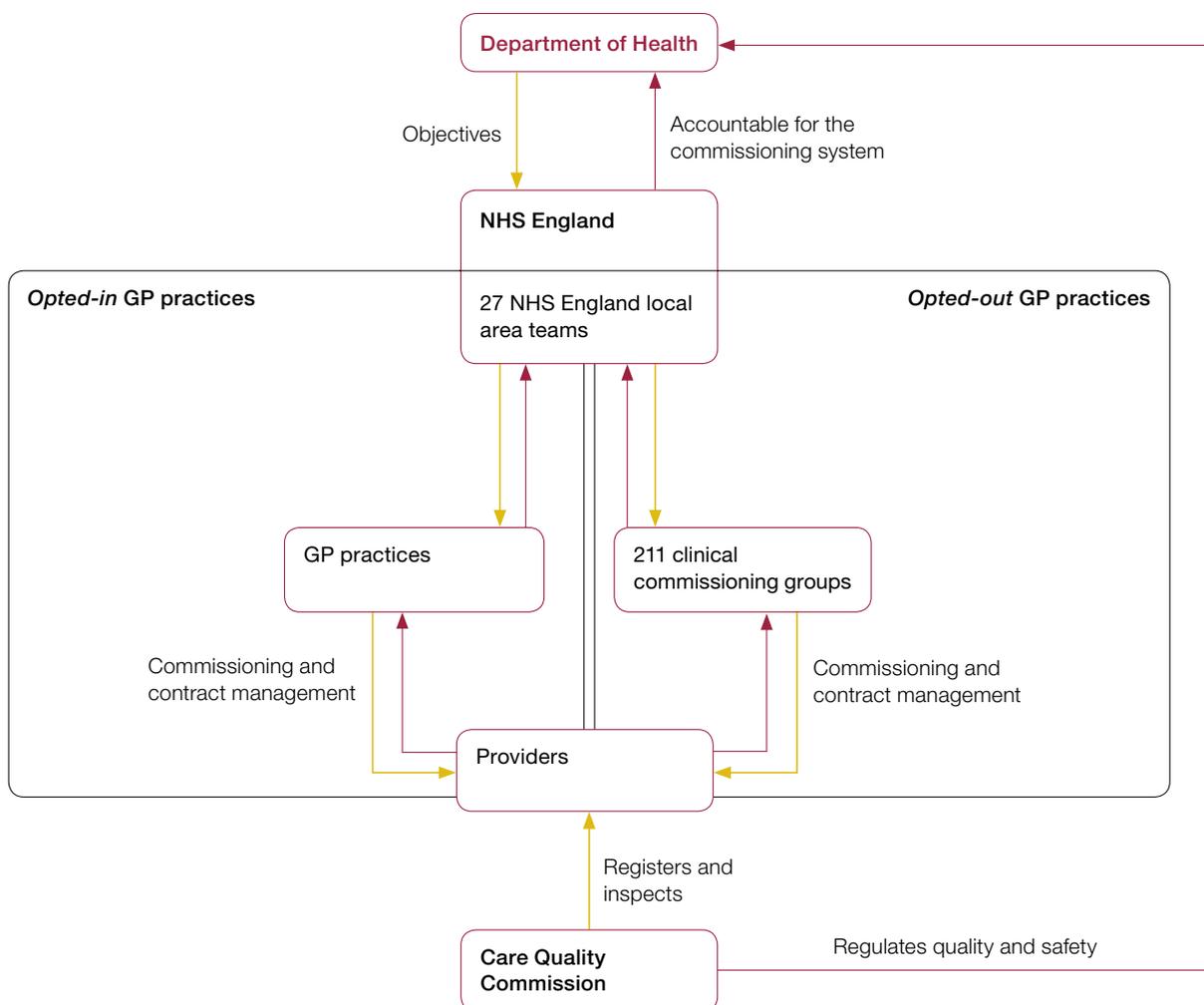
1.4 The way out-of-hours GP services are provided varies across the country. Services differ in the number of GPs employed, the number of cars available for home visits, and the use of other clinical staff to support GPs.

⁴ Otherwise, NHS 111 call handlers assess cases as: emergencies, either calling an ambulance or sending the patient to an A&E department; or more routine, giving advice or telling the caller to contact their in-hours GP.

Who is responsible for the services?

1.5 The system for out-of-hours GP services is complex (Figure 1). The Department of Health (the Department) is ultimately responsible for securing value for money for spending on health services. Following the reforms to the health system in April 2013, the Department is the steward of the system as a whole.

Figure 1
Responsibilities and accountabilities for out-of-hours GP services



- ▶ Accountability for performance
- ▶ Oversight and assurance monitoring

Note

1 Where services are *opted-in*, the GPs concerned can provide out-of-hours care directly themselves or subcontract to other bodies.

1.6 The Department fulfils its stewardship responsibility partly by setting objectives for the NHS through an annual mandate to NHS England. NHS England is the Department's largest arm's-length body and is responsible for the system for commissioning healthcare. In 2013-14, the Department gave NHS England £96 billion, 68 per cent of which it passed to 211 clinical commissioning groups. NHS England is accountable to the Department for the outcomes the NHS achieves. One measure in the Department's mandate for 2014-15 covers out-of-hours GP services – patients' overall experience of these services, as reported in the GP Patient Survey.

Commissioning services

1.7 Since 2004, GPs have been able to choose whether to provide out-of-hours services or transfer responsibility to the NHS. NHS England is responsible for commissioning out-of-hours GP services but in practice the commissioning arrangements vary depending on the choice GPs have made:

- An estimated 90 per cent of GP practices have *opted-out of* providing out-of-hours GP services. Where this is the case, NHS England has delegated responsibility for commissioning services to clinical commissioning groups.
- For the remaining 10 per cent of GP practices which have retained responsibility for out-of-hours care, NHS England commissions services directly from the practices. Such services are known as *opted-in* services.

1.8 As part of the reforms to the health system, in April 2013, responsibility for contracts for *opted-out* out-of-hours GP services transferred from 151 primary care trusts to 211 clinical commissioning groups. The changes in geographical boundaries resulted in a complicated contractual picture. Of the 175 clinical commissioning groups that responded to our survey, 105 were taking the lead in managing an out-of-hours contract. Some contracts (42 per cent) covered several clinical commissioning groups. Some clinical commissioning groups (6 per cent) received services under more than one contract.

Providing services

1.9 NHS England does not have information on who provides out-of-hours GP services in each area of the country. We used our survey of clinical commissioning groups and other information to build up a picture. Where services are *opted-out*, clinical commissioning groups commission services from a range of different organisations:

- Social enterprises (often former cooperatives of GPs) hold 49 per cent of contracts.
- Commercial organisations (such as Care UK) hold 31 per cent of contracts.
- NHS bodies (e.g. ambulance trusts) hold 20 per cent of contracts.

1.10 NHS England data show that some 10 per cent of GP practices have retained responsibility for out-of-hours services. *Opted-in* GP practices receive more funding than others given their extra responsibilities, typically equivalent to 6 per cent of their total budget (around £4 per registered patient). Where services are *opted-in*, the GPs concerned can provide out-of-hours care directly themselves or subcontract to other bodies. NHS England centrally has no information on the extent to which provision is subcontracted and to whom.

Regulating services

1.11 Since April 2012, the Care Quality Commission has regulated the quality and safety of out-of-hours GP services. The Commission registers and inspects providers. The General Medical Council regulates individual GPs.

How many people use the services?

1.12 From our survey, we estimate that in 2013-14, out-of-hours GP services handled around 5.8 million cases. Of these, 3.3 million (57 per cent) were face-to-face consultations, including 800,000 home visits. Most of the remainder were consultations or triage by telephone.⁵

1.13 This compares with an estimated 8.6 million calls made to out-of-hours GP services in 2007-08.⁶ The fall of a third is likely to relate mainly to the introduction of NHS 111, which now provides the telephone 'front end' of most out-of-hours GP services. By comparison, in-hours GPs provide over 300 million consultations a year⁷ and 21.7 million people attend A&E departments.⁸

What do the services cost?

1.14 Extrapolating from the results of our survey, we estimate that out-of-hours GP services cost some £400 million in 2013-14. This is consistent with the figure of £396 million, for 2012-13, reported by the Health and Social Care Information Centre.⁹

1.15 In real terms, both estimates are lower than previous calculations. In our 2006 report on out-of-hours GP services, we estimated that services cost some £390 million in 2005-06.¹⁰ For the same year, the NHS Information Centre reported a cost of £380 million.¹¹ If our figure had increased in line with inflation, services would now cost £476 million a year.¹²

5 Calculation of total cases based on a sample of 98 contracts. Calculation of face-to-face consultations and home visits based on a sample of 91 contracts.

6 NHS England, *High-quality care for all, now and for future generations*, June 2013.

7 J Hippiisley-Cox and Y Vinogradova, *Trends in consultation rates in general practice 1995-96 to 2008-09: analysis of the QResearch database*, 2009.

8 Comptroller and Auditor General, *Emergency admissions to hospital: managing the demand*, Session 2013-14, HC 739, National Audit Office, October 2013.

9 Health and Social Care Information Centre, *Investment in General Practice 2008-09 to 2012-13 England, Wales, Northern Ireland and Scotland*, September 2013.

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

11 NHS Information Centre, *Investment in General Practice 2003-04 to 2007-08 England, Wales, Northern Ireland and Scotland*, April 2009.

12 Adjusted using HM Treasury's GDP deflator.

1.16 The reasons for the real-terms cost reduction are unclear. In its market analysis, Urgent Health UK, a federation of social enterprise primary care providers, indicates that some commissioners have negotiated price reductions with providers.¹³ In addition, the introduction of NHS 111 has removed call-handling duties from many out-of-hours providers. This has been reflected in reductions in the value of some contracts (see paragraph 3.14).

1.17 The national average cost-per-head of out-of-hours GP services in 2013-14 was £7.50, drawing on our survey data, but there was wide variation between contracts (**Figure 2** overleaf). Because most members of the public seldom use out-of-hours GP services, the cost-per-case was higher: a national average cost, for *opted-out* services, of £68.30 in 2013-14, again with significant variation between contracts.¹⁴ This compares with an average cost per A&E attendance of between £69 and £129.¹⁵

1.18 Across the three types of provider, NHS bodies had the highest cost-per-head (£8.90) with commercial organisations having the lowest (£6.40). Social enterprises had a cost-per-head of £7.70. On average, commercial providers dealt with the fewest cases per head and NHS bodies the most. As a result, the average cost-per-case was virtually the same for all three types of provider.

1.19 Geographic and demographic factors are likely to influence costs significantly. NHS England has undertaken work to group clinical commissioning groups into similar 'clusters' based on such characteristics. Combining this work with our cost data indicates that rural clinical commissioning group clusters with older populations tend to spend more on their out-of-hours GP services. This is likely to reflect the higher costs that providers face in these settings, including more demand for urgent primary care and greater travel costs.

¹³ Urgent Health UK, *Market Analysis Report England*, April 2014.

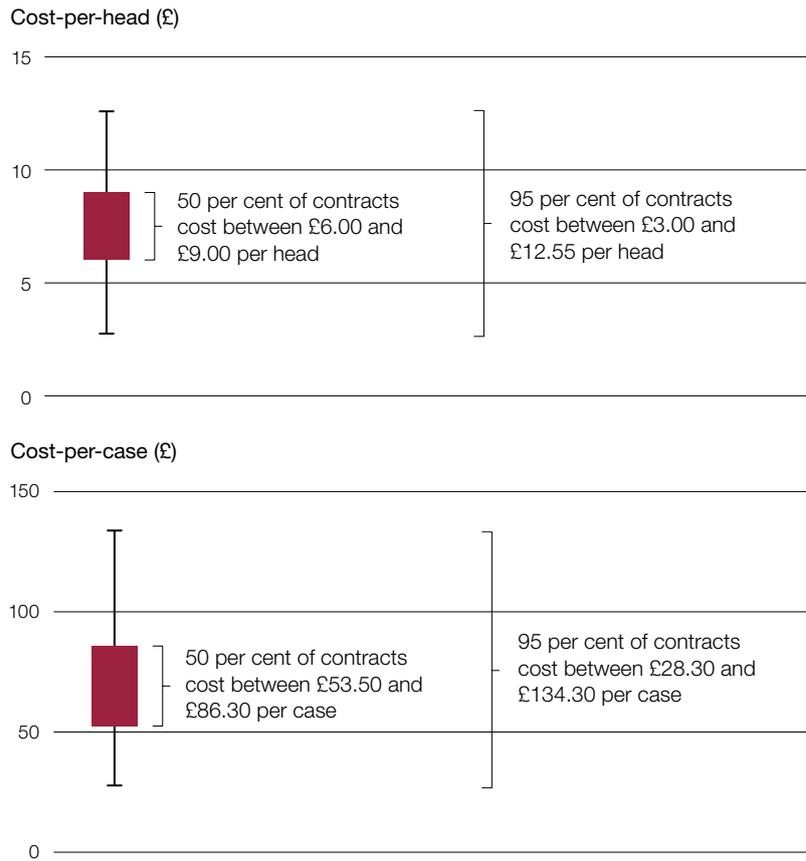
¹⁴ We could not estimate the cost-per-case for *opted-in* services because no data are available on the number of cases.

¹⁵ Foundation Trust Network, *Driving Improvement in A&E Services*, October 2012.

Figure 2

Cost-per-head and cost-per-case of out-of-hours GP services, 2013-14

There is wide variation in the cost of out-of-hours GP services, especially in the cost for each patient dealt with (cost-per-case)



Note

1 Out of 105 relevant survey respondents, 98 clinical commissioning groups provided cost, population and activity data.

Source: National Audit Office survey of clinical commissioning groups

Part Two

Performance of out-of-hours GP services

2.1 This part of the report covers the performance of out-of-hours GP services. Specifically, we examine:

- responsiveness, measured against the national quality requirements;
- quality and safety, drawing in particular on the findings of the Care Quality Commission; and
- patient experience, using results from the GP Patient Survey.

2.2 Overall, out-of-hours GP services are performing well. They generally meet essential standards of quality and safety; most providers fully or partially comply with responsiveness criteria in the national quality requirements; and most patients have a positive experience. We did not find any statistically significant correlation between patient satisfaction and service responsiveness. This suggests that a range of measures may be needed to give a full picture of performance.

Responsiveness

2.3 The Department of Health (the Department) has set standards – national quality requirements – for all out-of-hours GP services to meet (Appendix Three). The 13 requirements are designed to ensure that patients receive the same levels of high-quality and responsive care across the country. Data on performance against the national quality requirements are not centrally collated. To generate a view of the position across the country, as part of our survey of clinical commissioning groups, we collected data on performance against the main requirements relating to responsiveness (**Figure 3** overleaf).

2.4 We collected data for two sample months, September and December 2013, on the time taken to start: telephone clinical assessments; and face-to-face consultations. Performance varied, but most out-of-hours service providers complied fully with five of the six criteria (**Figure 4** on page 19). This means that the providers in question processed at least 95 per cent of cases within the specified time frames. Performance was best for cases classed as 'emergencies', and poorest for those classed as 'urgent'.

Figure 3 National quality requirements relating to responsiveness

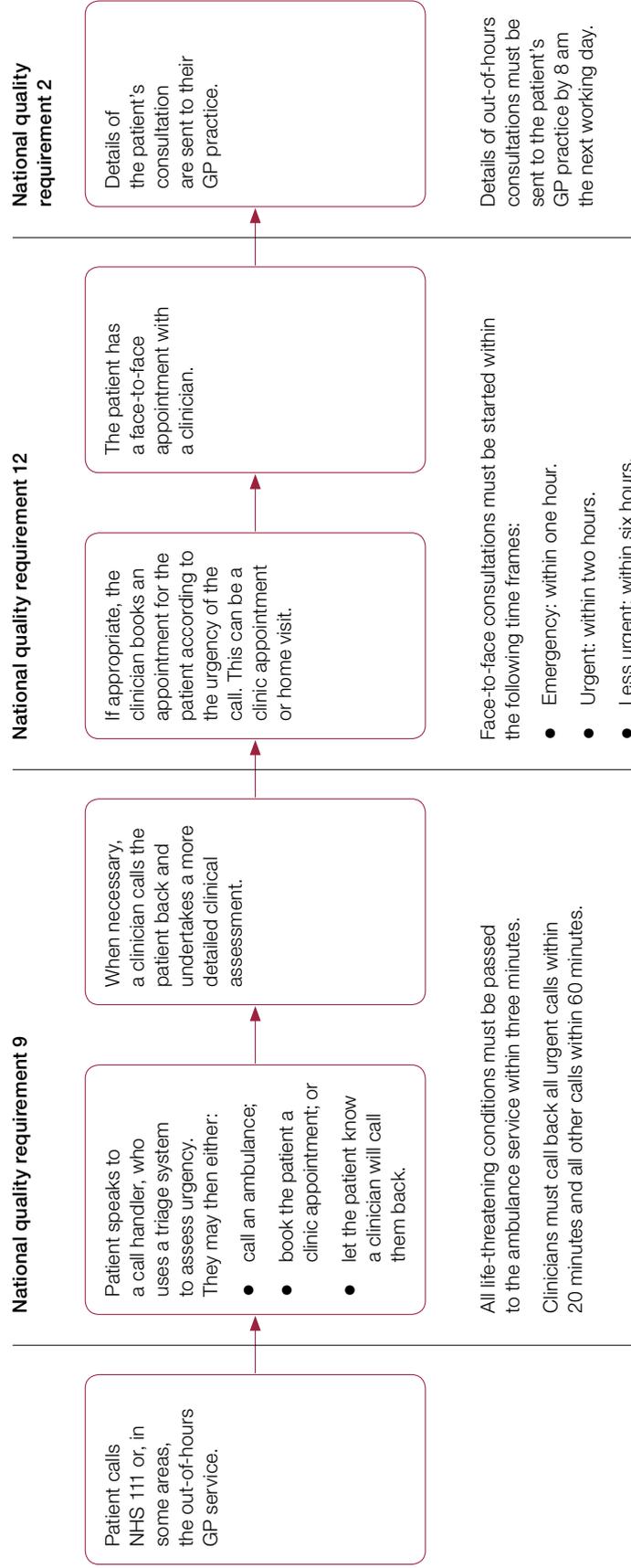


Figure 4

Performance against the national quality requirements for responsiveness, September and December 2013

Most providers of out-of-hours GP services were fully compliant with five of the six criteria

Requirement	Percentage of providers		
	Fully compliant	Partially compliant	Non-compliant
National quality requirement 9 – time to start telephone clinical assessments			
A: Life-threatening cases passed to the ambulance service within three minutes	91	9	0
B: Urgent cases started within 20 minutes	41	33	26
C: All other cases started within 60 minutes	54	19	27
National quality requirement 12 – time to start face-to-face consultations			
A: Emergencies started within one hour	85	5	10
B: Urgent cases started within two hours	60	25	15
C: Less urgent cases started within six hours	80	16	4

Notes

- 1 Performance between 95 and 100 per cent is considered fully compliant, 90 to 94.9 per cent is partially compliant, and below 90 per cent is non-compliant.
- 2 The percentages are based on survey responses, and do not include those contracts about which we received no information. Out of 105 relevant survey responses, the number of clinical commissioning groups providing data was: 32 (NQR 9A), 61 (NQR 9B), 63 (NQR 9C), 41 (NQR 12A), 81 (NQR 12B), and 79 (NQR 12C). For NQR 9A and NQR 12A a number of out-of-hours GP services had no calls in scope – see Appendix Four.
- 3 The table shows average performance for September and December 2013.

Source: National Audit Office survey of clinical commissioning groups

2.5 Where providers comply fully or partially with responsiveness requirements, their performance is broadly in line with other areas of the NHS. For example, 96 per cent of patients attending A&E departments were admitted, transferred or discharged within the four-hour standard between October and December 2013; and 92 per cent of admitted patients (and 97 per cent of non-admitted patients) started treatment within the 18-week referral to treatment standard in December 2013.

2.6 Nevertheless, some providers performed poorly against certain national quality requirements, particularly aspects of the requirement relating to the time taken to start telephone clinical assessments. Appendix Four shows performance by clinical commissioning group against each of the requirements in Figure 4. We did not receive performance data from some clinical commissioning groups and, therefore, do not know how their providers performed.

2.7 We identified several reasons why providers sometimes failed to respond as quickly as they should. On occasion, dealing with individual cases simply took longer than expected and GPs were delayed in seeing other patients. However, the causes often related to staffing. Sometimes providers failed to roster enough clinicians during peak periods, for instance over bank holiday weekends. More generally, providers told us that recruiting and retaining enough GPs was difficult.

2.8 Our survey found that, in September and December 2013, providers filled 98 per cent of their GP rota hours. However, 59 per cent of providers failed to fill some of their rota hours during these two months. Providers used contracted GPs to cover the vast majority of hours, with agency GPs filling the rest.

2.9 The providers we interviewed preferred to employ local GPs who were familiar with local health services. But not all local GPs want to work out-of-hours. Some providers said it was getting harder to attract GPs for a number of reasons, including:

- a general rise in GPs' in-hours workload, a point the Royal College of GPs and the British Medical Association also highlighted;
- the cost to GPs of buying indemnity insurance to cover the out-of-hours period, which providers reported had increased markedly in the last two years; and
- competing employment opportunities, with GPs increasingly working in other parts of the NHS, including A&E departments.

Responsiveness over time

2.10 It is difficult to compare current and past performance against the national quality requirements because no body consistently or regularly collects data. The Primary Care Foundation, which the Department appointed in 2009 to benchmark out-of-hours GP services, published its most recent benchmarking in April 2012.¹⁶ This was a voluntary exercise and not all primary care trusts took part. The Primary Care Foundation told us that it plans to collect up-to-date performance data from participating clinical commissioning groups later in 2014.

2.11 Comparisons are also difficult because the introduction of NHS 111 has changed the way some requirements are measured. For example, timings for telephone clinical assessments are calculated only from when the out-of-hours provider receives the call, usually from NHS 111. Most patients now call NHS 111 initially and spend time talking to call handlers there. Data are not available on the total time from patients calling to the provider starting the clinical assessment. This contrasts with the position when the Primary Care Foundation undertook its analysis when calls were received directly by the out-of-hours provider.

2.12 The limited available data indicate that responsiveness may have improved over recent years, although further work would be necessary to confirm this. One national quality requirement is that, in urgent cases, telephone clinical assessments should start within 20 minutes. In 2011, the Primary Care Foundation found that 50 per cent of providers either fully or partially complied with this requirement, compared with 74 per cent in our survey. Also, in urgent cases, face-to-face consultations should start within two hours. In 2011, 76 per cent of providers fully or partially complied with this requirement, compared with 85 per cent in our survey.

2.13 Responding to a recommendation by the Committee of Public Accounts, the Department stated in September 2013 that NHS England would discuss with clinical commissioning groups how to make additional information available to the public on the performance of out-of-hours GP services.¹⁷ No further information has been made available.

¹⁶ Primary Care Foundation, *Benchmark of out of hours: An overview across the services*, April 2012.

¹⁷ HM Treasury, *Government responses on the First, the Third to the Fifth, the Seventh to the Twelfth, and the Fifteenth and Sixteenth Reports from the Committee of Public Accounts*, Session 2013-14, September 2013.

Quality and safety

2.14 The Care Quality Commission, under the direction of the Chief Inspector of General Practice, is introducing a new approach to regulating out-of-hours GP services.¹⁸ In early 2014, the Commission started a consultation on a new inspection methodology that in future will include a rating system.¹⁹ In January 2014, it started a new wave of inspections, which it is using to test the methodology.

2.15 At the time of our work, the Care Quality Commission had completed 30 inspections of out-of-hours providers and found that most were providing ‘safe, effective, caring, responsive and well-led care’. The Commission issued some compliance actions, but no warning notices.²⁰

2.16 In February 2008, a patient died after an out-of-hours GP gave an excessive dose of diamorphine. The doctor concerned practised in Germany and worked, through an agency, for Take Care Now, an out-of-hours provider. Training or practising abroad does not preclude doctors from working in England as long as they hold relevant registrations, as the doctor in this case did.

2.17 The Care Quality Commission found the main factor that led to the patient’s death was the doctor’s poor knowledge and practice.²¹ However, there were also shortcomings in the provider’s processes, including inadequate induction. During recent inspections, the Commission found that most out-of-hours GP service providers had robust processes in place for recruitment and induction. The providers we interviewed confirmed that new doctors had to complete induction before starting their first shift.

2.18 The national quality requirements for out-of-hours GP services contain guidance on quality and safety. However, they do not measure outcomes or, in most cases, specify the frequency or depth with which a particular quality-related activity should occur. For example, providers are required to carry out ‘regular’ clinical audit of GPs, meaning that an experienced clinician should review a random sample of the GP’s patient contacts. The requirement does not define what regular means, however. Forty-five per cent of clinical commissioning groups reported in our survey that GPs working in their out-of-hours services could expect to receive a clinical audit at least once a month, and over 90 per cent said this would happen at least once a year (**Figure 5**). By contrast, GPs working in-hours do not necessarily receive any clinical audit of their patient contacts.²²

18 Care Quality Commission, *A fresh start for the regulation and inspection of GP practices and GP out-of-hours services*, December 2013.

19 Care Quality Commission, *Provider handbook consultation: NHS GP practices and GP out-of-hours services*, April 2014.

20 Compliance actions are generally issued in response to breaches of the regulations with a minor impact on people, or where the impact is moderate but it has happened for the first time. Warning notices are one type of enforcement action taken where the breach is more serious, or where a compliance action has not worked.

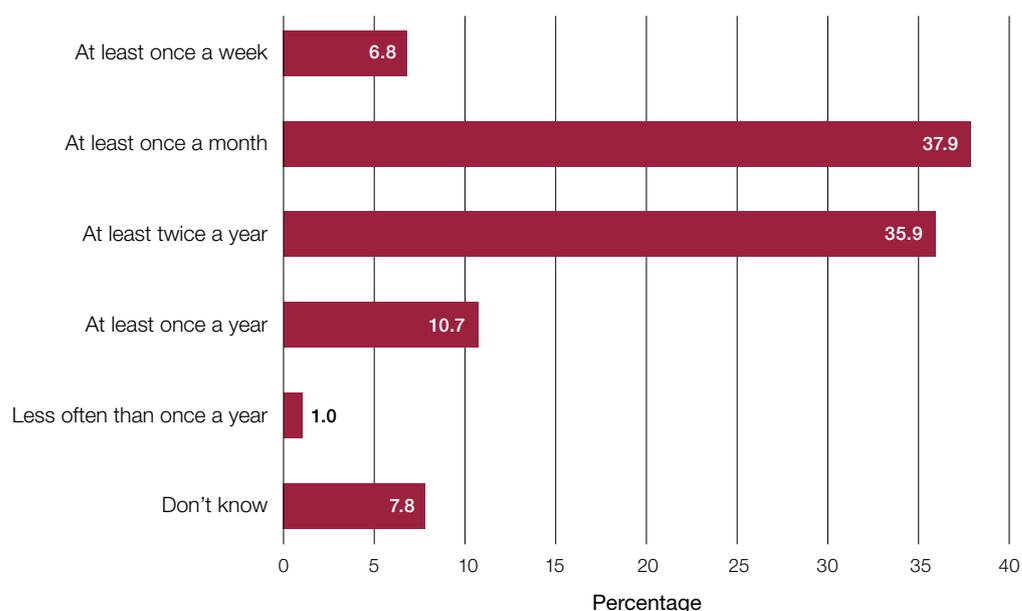
21 Care Quality Commission, *Investigation into the out-of-hours services provided by Take Care Now*, July 2010.

22 All GPs, irrespective of the setting in which they work, have to undergo regular appraisals of their practice in order to re-validate their professional status.

Figure 5

Frequency of clinical audits by providers of out-of-hours GP services

Clinical commissioning groups reported that over 90 per cent of GPs could expect to receive a clinical audit at least once a year

**Notes**

- 1 Out of 105 relevant survey respondents, 104 clinical commissioning groups responded to this question.
- 2 Percentages do not sum to 100 due to rounding.

Source: National Audit Office survey of clinical commissioning groups

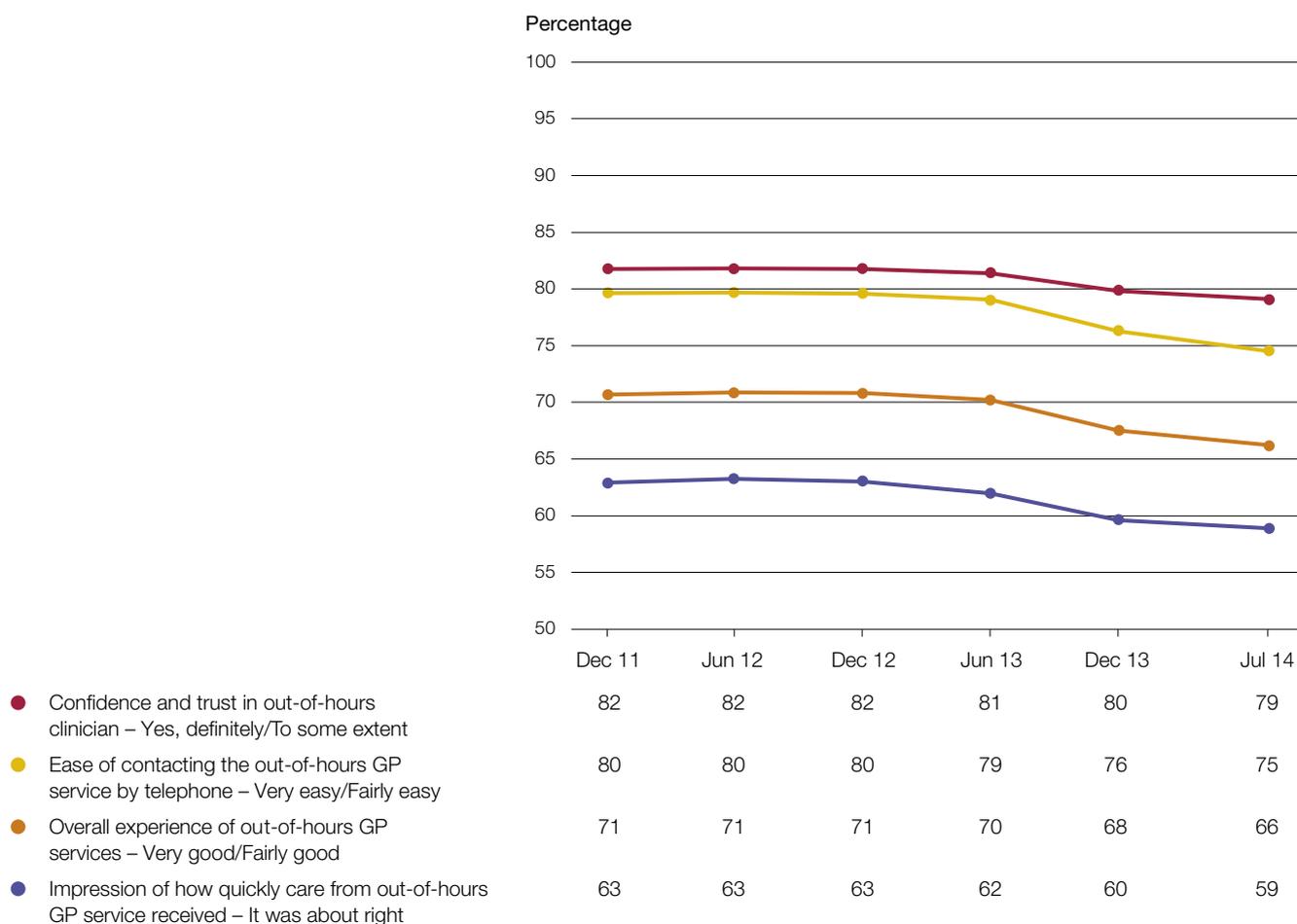
Patient experience

2.19 Patients are generally positive about their experience of out-of-hours GP services. The GP Patient Survey published in July 2014 found that 66 per cent of patients rated their overall experience as 'very good' or 'fairly good', and 79 per cent said they had confidence and trust in their out-of-hours clinician (**Figure 6** overleaf). The lowest results were for timeliness, with 59 per cent considering that the time they waited had been 'about right'. Combined with our findings on responsiveness, this result may indicate that patients expect to receive care more quickly than the timescales in the national quality requirements. The results from the GP Patient Survey have fallen slightly in each of the three sets of data published in 2013 and 2014.

Figure 6

Patients' experience of out-of-hours GP services, 2011 to 2014

Most patients have been satisfied with out-of-hours GP services, although satisfaction dropped slightly in 2013 and 2014 against all indicators

**Notes**

- 1 Results are based on data that have been weighted to allow for variations in the response rates of certain demographic groups, to give a more accurate representation of the country.
- 2 Results are rolling, with data collated every six months and combined with the previous dataset to give an annual picture.
- 3 Sample sizes for the out-of-hours GP questions in the GP Patient Survey in July 2014 were: overall experience 119,343; ease of contact 120,649; impression of speed of care 120,010 and confidence and trust in clinician 119,820.

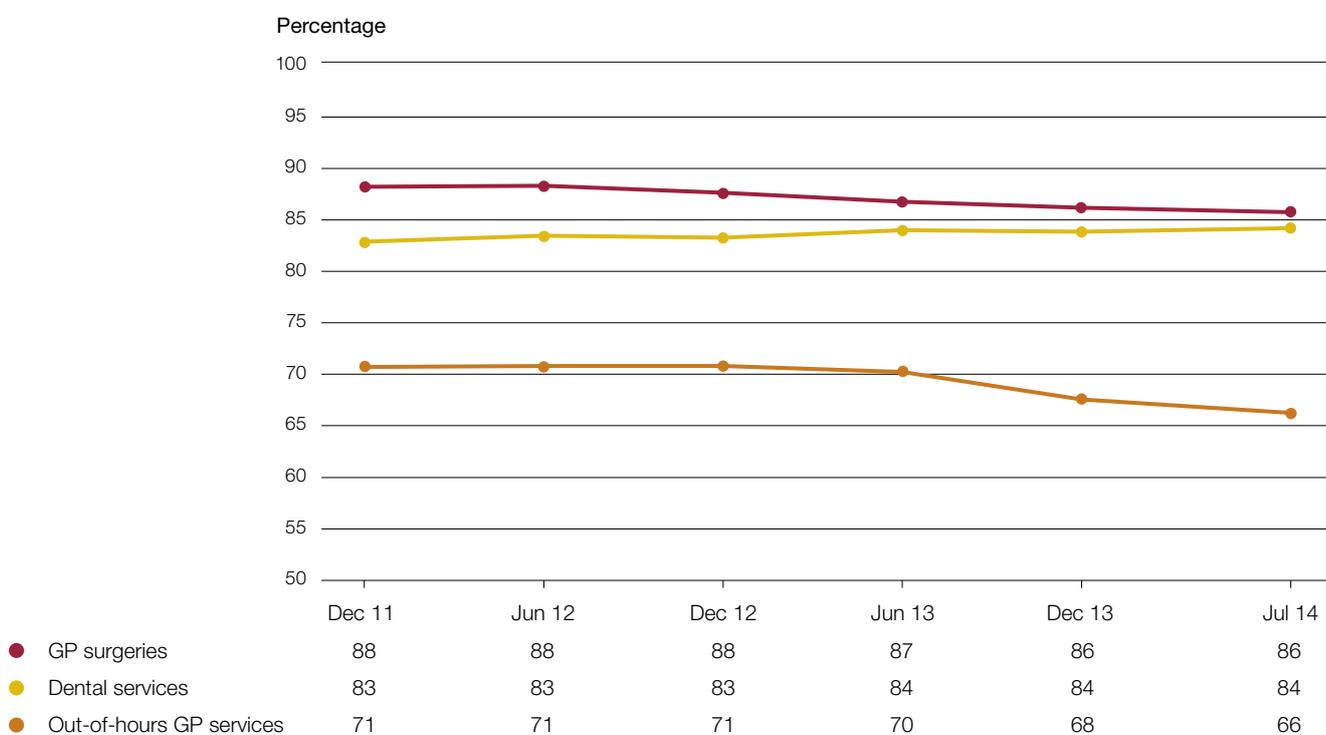
Source: GP Patient Survey

2.20 The GP Patient Survey also asks patients about other primary care services. Between December 2011 and July 2014, satisfaction with out-of-hours GP services was consistently lower than with GP surgeries or dental services. Overall, around 70 per cent of people rated their experience of out-of-hours GP services as ‘very good’ or ‘fairly good’ during this period. This compared with over 80 per cent for dental services and over 85 per cent for GP surgeries (**Figure 7**).

Figure 7

Patients’ experience of primary care services, 2011 to 2014

Patients’ overall experience of out-of-hours GP services is less positive than for other primary care services



Notes

- 1 Percentages shown are for patients responding ‘very good’ or ‘fairly good’ when asked about their overall experience of the service.
- 2 Results are based on data that have been weighted to allow for variations in the response rates of certain demographic groups, to give a more accurate representation of the country.
- 3 Results are rolling, with data collated every six months and combined with the previous dataset to give an annual picture.
- 4 Sample sizes for the GP Patient Survey in July 2014: GP surgeries 884,083; dental services 263,637; and out-of-hours GP services 119,343.

Source: GP Patient Survey

2.21 There is significant geographical variation in patients' experience of out-of-hours GP services. The proportion of people in each clinical commissioning group who reported that their overall experience was 'very good' or 'fairly good' ranged from 86 per cent to 49 per cent in July 2014 (**Figure 8**).

2.22 We analysed data from the June 2013 GP Patient Survey along with other statistics to investigate possible reasons for the variation. Based on the previous strategic health authority regions, patients in London and the East of England were generally less positive about their experience. In addition, the results show that little of the variation can be explained by demographic factors such as age, gender and deprivation. Much of the variation is therefore unexplained, but could reflect genuine differences in how people perceive service quality, although further work would be necessary to confirm this.

Figure 8

Patients' experience of out-of-hours GP services, by clinical commissioning group, July 2014

There is significant variation in patients' experience across the country

Percentage of respondents that answered 'very good' or 'fairly good'

- 51% to less than 58%
- 58% to less than 65%
- 65% to less than 72%
- 72% to less than 79%
- 79% or more



Notes

- 1 Data shows percentage of patients who rated their overall experience of out-of-hours GP services as 'very good' or 'fairly good'.
- 2 Results are based on data that have been weighted to allow for variations in the response rates of certain demographic groups to give a more accurate representation of the country.
- 3 Data cover all 211 clinical commissioning groups.

Source: GP Patient Survey

Part Three

Oversight and assurance of out-of-hours GP services

3.1 This part of the report covers oversight and assurance of out-of-hours GP services. Specifically, we examined: at local level, clinical commissioning groups' management of the contracts for *opted-out* services, and NHS England's oversight of *opted-in* services; and, at national level, the assurance arrangements that NHS England and the Department of Health (the Department) have put in place for all out-of-hours GP services.

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

3.2 We evaluated how clinical commissioning groups were managing their contracts for out-of-hours GP services, using the good practice framework that we published jointly with the Office of Government Commerce (**Figure 9**).²³ We assessed the arrangements using data from our survey of clinical commissioning groups (where 105 of 175 respondents took the lead in managing an out-of-hours contract) and our case studies of local areas.

People and relationships

3.3 In general, clinical commissioning groups have adequate resources to manage their contracts for out-of-hours GP services. All the clinical commissioning groups that we visited had experienced contract management teams, most of whom had worked previously in primary care trusts or strategic health authorities. Our survey found that almost two-thirds of clinical commissioning groups were buying support from commissioning support units.²⁴ Over 90 per cent of these groups were satisfied with the support they received.

3.4 The clinical commissioning groups and providers we interviewed described their relationships as constructive. We saw evidence of beneficial collaboration between commissioners and providers. For example, a number of clinical commissioning groups told us of the additional call-handling support that their providers had given at short notice during the difficult period immediately after the introduction of NHS 111 during 2012 and 2013.

²³ National Audit Office and Office of Government Commerce, *Good practice framework for contract management*, October 2008.

²⁴ Commissioning support units, hosted by NHS England, provide a range of services including procurement and contract management.

Figure 9

Key elements of good contract management used in our assessment

People and relationships

Contract management resources proportionate to the importance of the contract

Contract manager with appropriate skills

Contract manager with detailed knowledge of the contract

Collaborative working between commissioner and provider

Performance management

Performance assessed using clear metrics

Focused performance information on a 'by exception' basis

Provider self-reporting, but with independent checking mechanisms

Regular performance reporting

Regular formal performance review meetings

Incentives and contract development

Incentive structures (financial or non-financial) relate clearly to desired outcomes

Where appropriate, value-for-money testing of existing services takes place through benchmarking or other processes

A re-procurement strategy is put in place in a timely manner

Source: National Audit Office

Performance management

3.5 Clinical commissioning groups took up their responsibilities in April 2013, although all operated in 'shadow form' during 2012-13. Some clinical commissioning groups are still developing their approach to performance management. In most of our case studies, contract managers had considered the riskiness of out-of-hours GP services, relative to other services, when deciding how closely to manage the contract. Most had settled on monthly meetings with providers, and some had more frequent contact. However, one of the eight clinical commissioning groups we interviewed had held no formal contract management meetings since April 2013.

3.6 Clinical commissioning groups use the national quality requirements to monitor performance. Our survey found that 98 per cent of those clinical commissioning groups that manage a contract received information on performance against at least some of the requirements. The vast majority (87 per cent) received this information at least monthly. In addition, 80 per cent of clinical commissioning groups that do not manage the contract for their out-of-hours service also received monthly performance reports, although 11 per cent told us that they received no information at all.

3.7 The information that clinical commissioning groups receive varies. Of our case studies:

- some received information on all the national quality requirements while others on only a subset;
- some received data that let them compare current performance with previous months and years;
- some had access to extra information about contractual key performance indicators; and
- over 90 per cent regularly received details of serious incidents and complaints and the action taken to address them, and some also held separate meetings with their providers to discuss clinical quality.

3.8 Our survey found that almost all clinical commissioning groups thought the national quality requirements were useful for monitoring out-of-hours GP services. However, most wanted the requirements to be updated. Of clinical commissioning groups that manage a contract, 95 per cent said that the requirements had to be supplemented with other information to provide a complete picture of performance (**Figure 10**). The clinical commissioning groups and providers that we interviewed also considered the requirements did not focus enough on patient outcomes. Meanwhile, introducing NHS 111 has made the requirement relating to call handling obsolete and changed how a number of other requirements are measured.

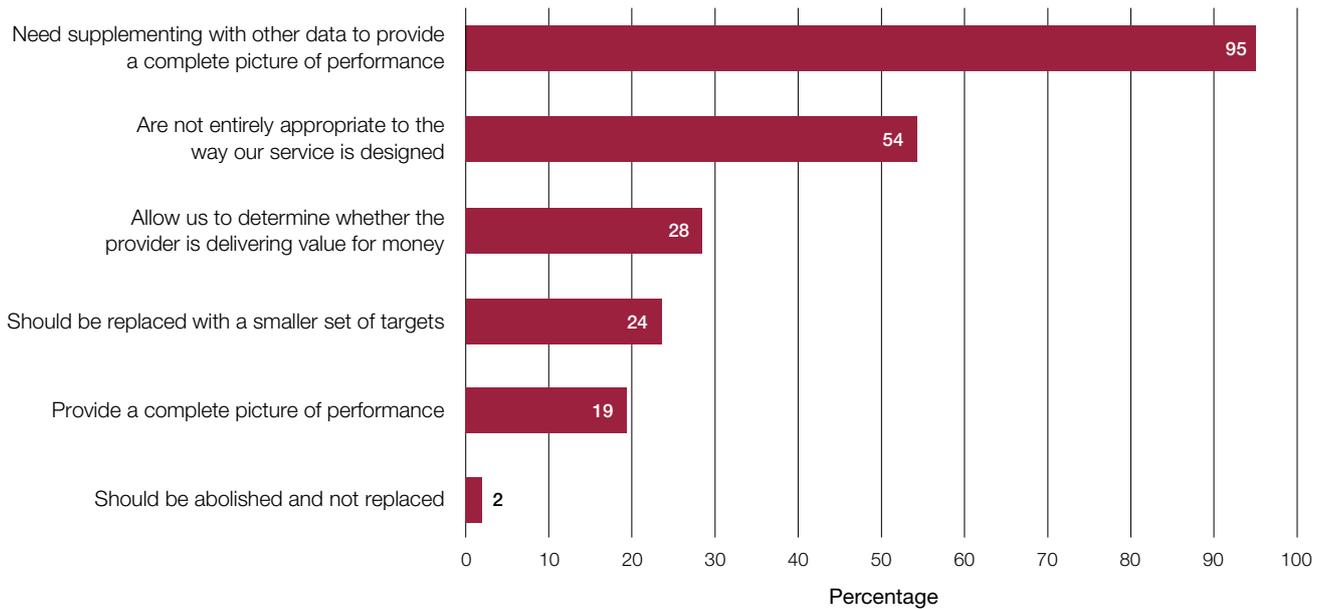
3.9 Generally, the clinical commissioning groups we interviewed were using performance information to challenge providers, but there was room for improvement. We saw examples where clinical commissioning groups held pre-meetings to review performance information and to draw up questions to put to the provider, and also where they increased the frequency of reporting when problems arose. However, on some occasions clinical commissioning groups could not explain some aspects of the performance information when we raised queries. In addition, some clinical commissioning groups that responded to our survey did not provide complete data on performance against the national quality requirements.

Figure 10

Clinical commissioning groups' views about the national quality requirements

Most clinical commissioning groups need to supplement the national quality requirements with other information for a complete picture of performance

The national quality requirements:



Notes

- 1 Percentages show those answering 'strongly agree' or 'agree' to the statements.
- 2 Out of 105 relevant survey respondents, 103 clinical commissioning groups responded to this question.

Source: National Audit Office survey of clinical commissioning groups

Data assurance

3.10 In our 2013 memorandum on out-of-hours GP services in Cornwall, we reported that two employees of Serco, the provider, had made unauthorised changes to data, with the result that performance reported to the primary care trust was overstated.²⁵ Serco took steps to strengthen controls, including giving the primary care trust access to the raw data that underpinned performance reports.

3.11 We asked the clinical commissioning groups we interviewed whether they checked raw data or sought independent assurance about performance. Most did not, beyond the local patient surveys that providers have to conduct as part of the national quality requirements. Two clinical commissioning groups, however, had performed unannounced visits to the provider's out-of-hours clinics.

3.12 Most out-of-hours contracts do not provide for performance-related payments (paragraph 3.13). This reduces to some extent the risk that providers may overstate performance. Clinical commissioning groups considered that they would know if providers significantly misreported performance through other channels, such as patient experience surveys and the reporting of serious incidents and complaints. They also felt that other stakeholders would draw problems to their attention. From April 2014, GP practices are contractually required to monitor the quality of local out-of-hours services and report concerns to clinical commissioning groups.

Incentives and contract development

Incentives

3.13 Clinical commissioning groups are making limited use of financial incentives to encourage providers to perform well. Our survey found that 40 per cent of out-of-hours contracts allowed for financial deductions when the provider's performance fell below specified standards. A smaller proportion of contracts (14 per cent) included financial incentives to reward high-quality performance. Clinical commissioning groups reported that they had used these mechanisms to withhold payments worth a total of £1,022,000, and to pay incentives worth £242,000, since April 2013. The combined value of these amounts is just over 0.3 per cent of the total estimated spending on out-of-hours GP services.

Adjusting contracts for NHS 111

3.14 On occasion clinical commissioning groups may need to make adjustments during a contract's duration to protect value for money. One such example was the introduction of NHS 111 during 2012 and 2013. Our case studies show, however, that some clinical commissioning groups did not reduce the value of their out-of-hours contracts to reflect the fact that NHS 111, rather than the out-of-hours service, now handles incoming calls in the first instance. The failure of clinical commissioning groups to reduce the value of their contracts means that the public purse could in effect be paying twice for call handling.

²⁵ 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.

Recommissioning services

3.15 Clinical commissioning groups re-commission out-of-hours GP services when contracts end. Forty-two clinical commissioning groups reported that their contracts had been signed on or after 1 April 2013. Before then contracts will have been signed by primary care trusts. By March 2015, 56 of the 105 contracts now in place will have ended.

3.16 The public procurement legal framework, including the NHS procurement regulations, effective from April 2013, does not mandate competitive tendering of healthcare contracts.²⁶ The NHS procurement regulations require commissioners to procure healthcare services from one or more providers that offer best value for money and are most capable of delivering the following objectives: securing patient interests and improving quality of and efficiency in the provision of services. 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 more detail.²⁷ These are: where commissioners are satisfied that there is only one capable provider of those services; where a detailed review of local services identifies the most capable provider of those services; or where the benefits of publishing a contract notice would be outweighed by the costs of doing so. Commissioners must decide which procurement approach is appropriate on a case-by-case basis. NHS England's guidance notes that the law in this area is complex and carries an inherent risk of challenge.²⁸

3.17 Our case studies showed that some commissioners had procured out-of-hours GP services competitively when contracts ended. Others had re-awarded contracts to existing providers without competitive tendering. This had been done in five of our eight case studies,²⁹ 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.³⁰ Most commonly, clinical commissioning groups told us that contracts had been rolled forward to align out-of-hours GP services with other services, which they then intended to tender jointly as a single contract.

3.18 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 regulations. Any of the three circumstances described in paragraph 3.16 might be relevant to the commissioning of out-of-hours GP services, depending on local circumstances. The clinical commissioning groups also presented us with limited evidence that the decisions to roll contracts forward had been informed by any formal quality or price benchmarking, which could have helped demonstrate value for money.

²⁶ The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013.

²⁷ Monitor, *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*, December 2013.

²⁸ NHS Commissioning Board, *Procurement of healthcare (clinical) services Briefing 2: What are the procurement options?*, September 2012.

²⁹ The five clinical commissioning groups commissioned services on behalf of ten clinical commissioning groups in total.

³⁰ Primary care trusts procured under the administrative rules '*The Principles and Rules for Cooperation and Competition*'.

3.19 Clinical commissioning groups face particular risks of conflicts of interest in relation to out-of-hours GP services. Clinical commissioning groups are led by GPs, as are many out-of-hours providers. This creates the risk that people making decisions about contracts are also sometimes postholders or shareholders in organisations that are bidding. Our case studies showed that clinical commissioning groups understood these risks and were acting to manage them, although the safeguards relied on the individuals concerned disclosing their interests.

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

3.20 NHS England is responsible for overseeing out-of-hours services where GP practices have kept responsibility. In practice, it discharges this duty through its 27 local area teams. Our interviews with the teams provided no evidence that they were monitoring performance, for example against the national quality requirements, or challenging GPs where necessary. This included one team that oversaw services in a borough where all the GP practices remained *opted-in*. There is therefore little assurance that people whose GPs continue to provide out-of-hours care are receiving an acceptable service.

National assurance

3.21 NHS England is accountable to the Department for the outcomes the NHS achieves and for securing value for money for spending on NHS services. It therefore needs to assure itself of the quality and value for money of out-of-hours GP services. Although our audit indicates that these services are generally performing well, before our work NHS England did not have enough information to be assured that this was the case.

3.22 NHS England informed its local area teams that they needed to obtain assurance about out-of-hours GP services in March 2013.³¹ It did not, however, give guidance about how to gain such assurance until a year later in March 2014.³² At the time of our fieldwork, the seven local area teams we interviewed were undertaking very little assurance work on out-of-hours GP services. Some did not seem to know who provided the services in their area.

3.23 The guidance issued in March 2014 included two forms for clinical commissioning groups to complete and return to NHS England: one to be completed by 30 April 2014 with information about 2013-14 and another, slightly longer, to be completed in due course for 2014-15. The templates are shown in full in **Figure 11**. However, in our view, they are unlikely to produce meaningful or objective assurance because of the yes-or-no format and the self-reporting approach. When we finalised our report in June 2014, NHS England had not collated the returns for 2013-14, and could not tell us how many had been completed or what the results were.

³¹ NHS England, *Primary medical care functions delegated to clinical commissioning groups: Guidance*, March 2013.

³² NHS England, *Primary medical care functions delegated to clinical commissioning groups: Guidance*, March 2014.

Figure 11

NHS England reporting templates for out-of-hours GP services for clinical commissioning groups to complete

Template 2013-14

Do you have appropriate arrangements in place for assuring the quality of out-of-hours services?	
Can you confirm that any conflicts of interest have been appropriately managed?	
If no, give details:	

Template 2014-15

Do you have appropriate arrangements in place for assuring the quality of out-of-hours services?	
Can you confirm that any conflicts of interest have been appropriately managed?	
If no, give details:	
Is the CCG participating in a benchmarking scheme to monitor the performance of out-of-hours provision against the National Quality Requirements?	
Date of publication of results or planned publication	
Link to published results when available:	
Do you have systems in place for GP practices to report concerns on the quality of out-of-hours provision (where a practice has opted out).	

Source: NHS England

3.24 NHS England lacks the necessary information to assess the relative riskiness or adequacy of different out-of-hours GP services. It cannot therefore make informed decisions about where it ought to focus its oversight and assurance work. And it cannot identify services that are innovative or performing particularly well in order to promote good practice. It also does not currently analyse the rich longitudinal data from the GP Patient Survey, for instance to investigate why patient experience has dipped in 2013 and 2014.

3.25 The Department is ultimately accountable to Parliament for the overall value for money of health services. Its mandate to NHS England includes one indicator on out-of-hours GP services, based on the overall experience question in the GP Patient Survey. The Department receives updates on this part of the mandate twice a year through the mandate assurance report. Beyond this, the Department has no specific information or assurance about out-of-hours GP services.

Part Four

Out-of-hours GP services and other urgent care

4.1 This part of the report covers people's awareness of out-of-hours GP services, and how these services are integrated with other urgent care services.

Awareness

4.2 The urgent care system comprises a variety of different services and providers. **Figure 12** on pages 38 and 39 shows the range of options open to people who feel urgently ill.

4.3 NHS England recommends that, when people need urgent medical treatment or advice out of hours, they should call NHS 111. The aim is for the NHS to treat people quickly, in the appropriate place, for the lowest cost. However, NHS England assesses, and people we interviewed in our case study areas agreed, that too many patients choose to go straight to A&E departments, which increases their workload.

4.4 To use a particular option, people need to be aware of it, know how to contact it, and judge it appropriate for their situation. Our research shows that notable proportions of the population do not know that out-of-hours GP services and NHS 111 exist. In May 2014, we commissioned Ipsos MORI to ask a representative sample of adults in England about urgent care services. This survey found that:

- 26 per cent of respondents had not heard of out-of-hours GP services;
- 19 per cent had not heard of NHS 111;
- 11 per cent, although they had heard of NHS 111, did not know what it was for; and
- awareness among certain groups, including younger people and people from black and minority ethnic communities, was considerably lower than among others (**Figure 13** on page 40).

Figure 12
Consultation and treatment options for urgently ill people

	Services offered	Intended range of cases handled	Opening hours
NHS choices	Information and advice	●	24 hours a day, 7 days a week
NHS 111	Information and advice Triage Referral to other services	● ●	24 hours a day, 7 days a week
GP practices	Triage Diagnosis Treatment Referral to other services	● ●	Access typically by appointment during weekdays, 8 am–6.30 pm. Some evening and weekend opening at the discretion of individual practices
Out-of-hours GP services	Triage Diagnosis Treatment Referral to other services	●	6.30 pm–8 am, weekdays. 24 hours a day, Saturdays, Sundays and bank holidays
Walk-in centres	Triage Diagnosis Treatment	● ●	Varies
Minor injury units	Triage Diagnosis Treatment	● ●	Varies
Urgent care centres	Triage Diagnosis Treatment	● ●	Varies
Ambulance	Transport Diagnosis Treatment	● ●	24 hours a day, 7 days a week
Accident and Emergency departments	Triage Diagnosis Treatment	● ●	24 hours a day, 7 days a week

Notes

- 1 Not all these options are available in all parts of England.
- 2 Routine cases include persistent coughs or colds. Urgent cases include infected wounds and broken bones. Emergency cases include loss of consciousness and suspected strokes.
- 3 NHS bodies include NHS trusts, NHS foundation trusts and ambulance trusts.
- 4 All data are for 2013-14 with the exception of ambulance services which is for 2011-12.
- 5 Accident and Emergency departments include Type 1 (major centres) and Type 2 (single specialty centres).

Source: National Audit Office analysis of Department of Health information

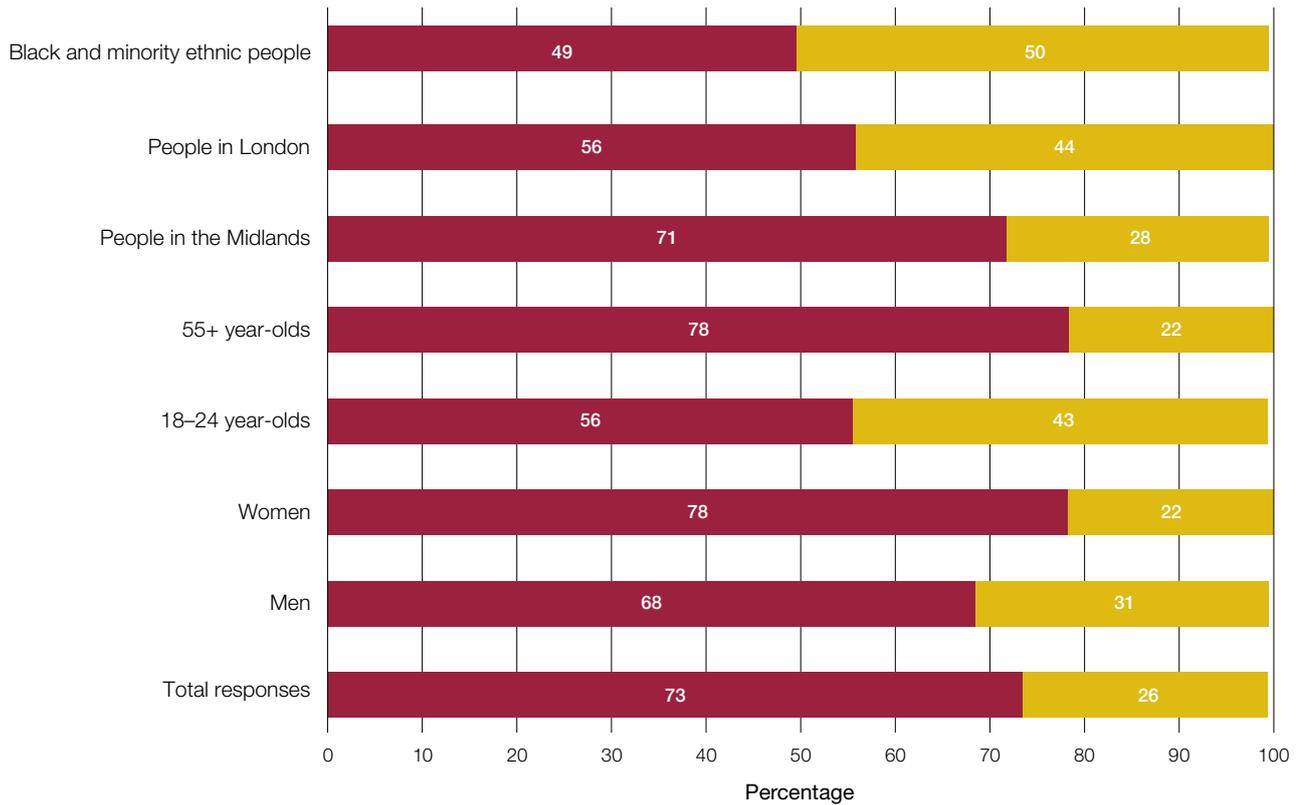
Commissioners	Providers	Estimated annual volume of work
		324 million visits to website
Clinical commissioning groups	NHS bodies/social enterprises/ private providers	8 million calls in 2013-14 (however, not fully operational for whole year)
NHS England	GPs	300 million GP consultations
Clinical commissioning groups/ GP practices	NHS bodies/social enterprises/ private providers	5.8 million cases
Clinical commissioning groups	NHS bodies	
Clinical commissioning groups	NHS bodies	7 million attendances
Clinical commissioning groups	NHS bodies	
Clinical commissioning groups	NHS bodies	6.7 million emergency journeys
Clinical commissioning groups	NHS bodies	14.8 million attendances

- Routine/non-urgent
- Urgent
- Emergency

Figure 13

Awareness of out-of-hours GP services, May 2014

Older people and women are more likely to have heard of out-of-hours GP services than other groups



- Yes – Had heard of GP out-of-hours services
- No – Had not heard of GP out-of-hours services

Notes

- 1 Percentages may not sum to 100 due to rounding and excluding 'don't know' responses.
- 2 Sample size: 878 respondents.

Source: Ipsos MORI survey for the National Audit Office

4.5 The most recent GP Patient Survey in July 2014 found that 44 per cent of people did not know how to contact an out-of-hours GP service. This included large proportions of people who are more likely to need such services, including 40 per cent of those with long-term health problems and 38 per cent of those with caring responsibilities.

4.6 In May 2014, on our behalf, Ipsos MORI asked people what they would do first if they or their family felt unwell during the night or at the weekend. During the night the highest proportion of people (28 per cent) would phone NHS 111. At the weekend the highest proportion (23 per cent) would go to A&E departments. Overall, 30 per cent of people thought they would be seen more quickly at A&E than by the out-of-hours GP service. The survey found that people who had not heard of out-of-hours GP services or NHS 111 were more likely to call 999. In particular, those who had not heard of out-of-hours GP services were almost five times as likely to call 999 at night than those who had heard of out-of-hours GP services (14 per cent compared with 3 per cent) (**Figure 14** on pages 42 and 43).

4.7 No one body is responsible for raising awareness of out-of-hours GP services and other urgent care options. During the course of our work, we saw examples of local campaigns to increase awareness and encourage people not to go to A&E departments unless they needed to (for example, the ‘A&E won’t kiss it better’ campaign).

4.8 However, the relationship between awareness and appropriate usage is complex. Our analysis suggests that higher awareness of, and patient satisfaction with, out-of-hours GP services may not reduce demand in major A&E departments. Other research indicates that expanding urgent care options may increase demand for healthcare overall and reduce the likelihood of patients engaging in self-care.³³ Nevertheless, people who are unaware of out-of-hours GP services or NHS 111, or do not have confidence in them, are unlikely to use them.

Integration with other urgent care services

The case for integration

4.9 Once an urgently ill person has contacted the NHS, it is important that the services they use are integrated with other parts of the system. Good integration means that:

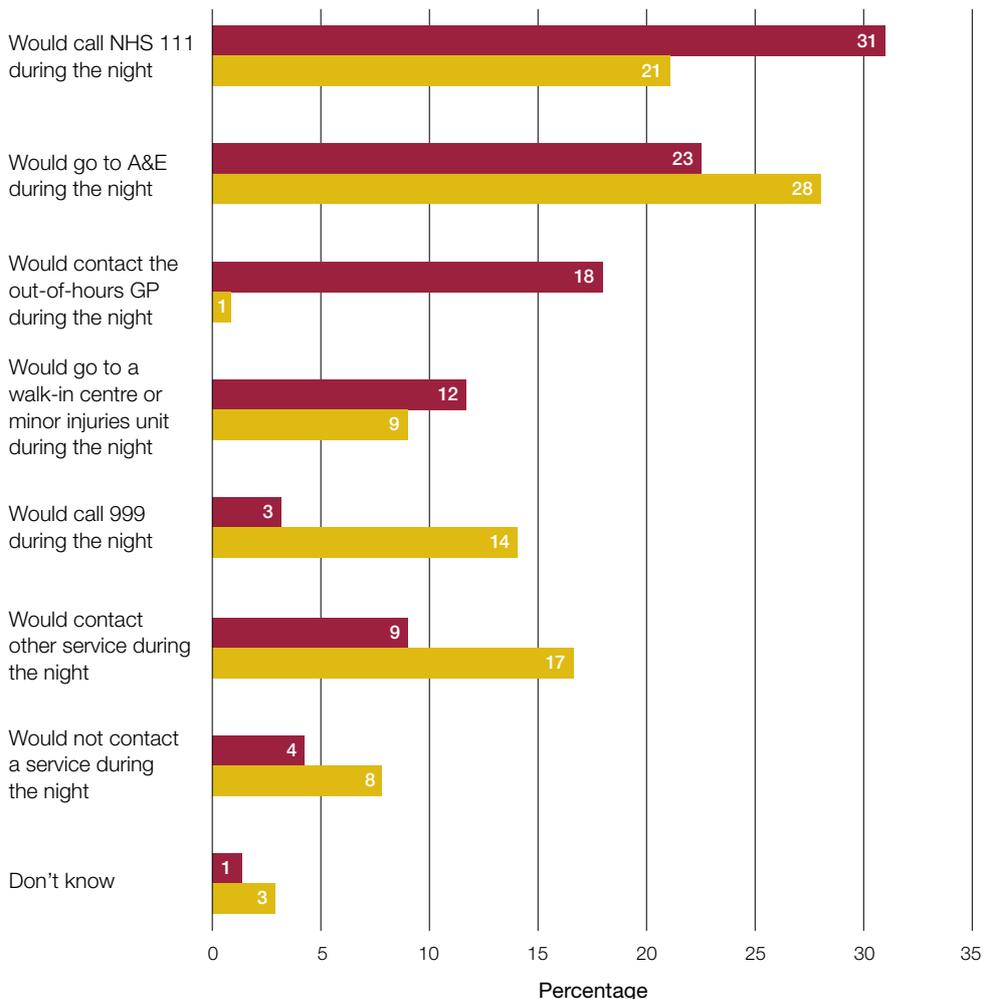
- patients are directed to the right care setting as often, and as quickly, as possible;
- clinicians can see information about patients’ medical histories;
- clinicians can, if needed, move patients easily between care settings, for instance transferring a patient from A&E to the out-of-hours GP service, if appropriate; and
- commissioners design services that complement one another without wasteful duplication or gaps in provision.

³³ J. Turner, A O’Cathain, E Knowles and J Nicholl, *Impact of the urgent care telephone service NHS 111 pilot sites: a controlled before and after study*, BMJ Open, 2013.

Figure 14
 Services people would contact first when feeling urgently unwell

People who had heard of out-of-hours GP services were more likely to call NHS 111 and less likely to go to A&E departments

At night

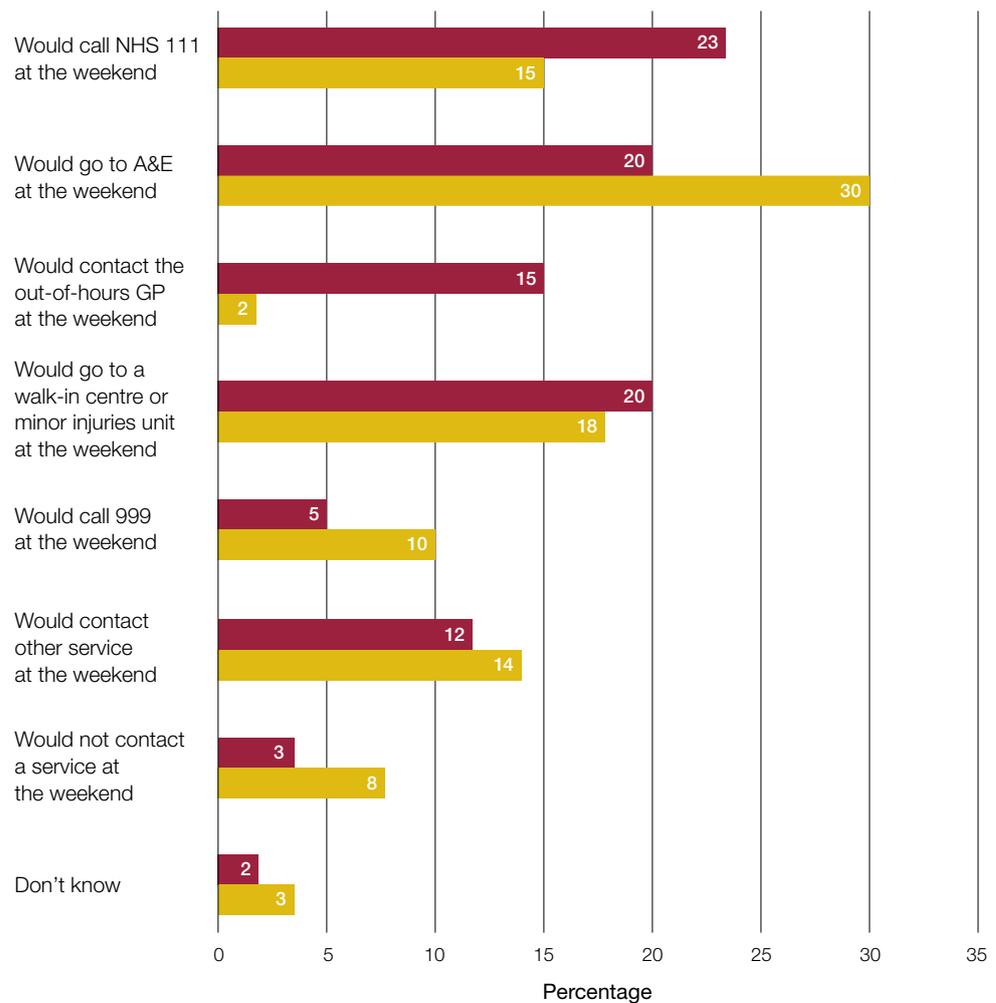


■ Of the people who responded that they had previously heard of out-of-hours GP services
 ■ Of the people who responded that they had previously not heard of out-of-hours GP services

Figure 14 *continued*

Services people would contact first when feeling urgently unwell

At weekends



- Of the people who responded that they had previously heard of out-of-hours GP services
- Of the people who responded that they had previously not heard of out-of-hours GP services

Notes

- 1 Percentages do not sum to 100 due to rounding.
- 2 Sample size: 426 respondents were asked which service they would contact if they felt unwell at night and 452 were asked which service they would contact if they felt unwell at the weekend.
- 3 'Other' services include a pharmacist or a non-NHS website.

Source: Ipsos MORI survey for the National Audit Office

Current integration

4.10 NHS 111 has become a vital part of integrating the urgent care system, including integrating out-of-hours GP care with other services. The roll-out of NHS 111 to all parts of England was completed in February 2014.

4.11 NHS 111 uses a clinical assessment tool (NHS Pathways) which lets callers access any urgent care service in their area, depending on the symptoms they report. As long as the algorithms underpinning NHS Pathways are correct and the directory of services is up to date, greater use of NHS 111 should help more patients to receive care in the right setting. However, some clinicians, including some we interviewed in our case study areas, as well as other experts, have expressed doubts about these algorithms, suggesting they may be too risk-averse. This could mean, for instance, that NHS 111 sends cases to A&E departments that could be dealt with elsewhere. NHS England told us that it is seeking to improve the software to help ensure NHS 111 directs all patients to the most appropriate place.

4.12 Our survey of clinical commissioning groups found that 60 per cent of out-of-hours GP services could see patients' electronic 'summary care records', which contain information about the medicines patients take and any allergies they have. However, only 29 per cent of services could access patients' detailed medical records if needed. Out-of-hours GP services themselves have to update records after providing treatment. In September and December 2013, 93 per cent of providers fully or partially complied with the national quality requirement to send details of consultations to patients' GP practices by 8 am the next working day.

4.13 Out-of-hours GP services regularly refer patients to other health services, most commonly in-hours GPs (**Figure 15**). Similarly, other services, particularly A&E departments and minor injury units, transfer patients to out-of-hours GP services. The people we interviewed said that transfers were easier, and therefore more likely to happen, where services were co-located. Our survey found that 93 per cent of out-of-hours GP services had at least one centre co-located with another health service.

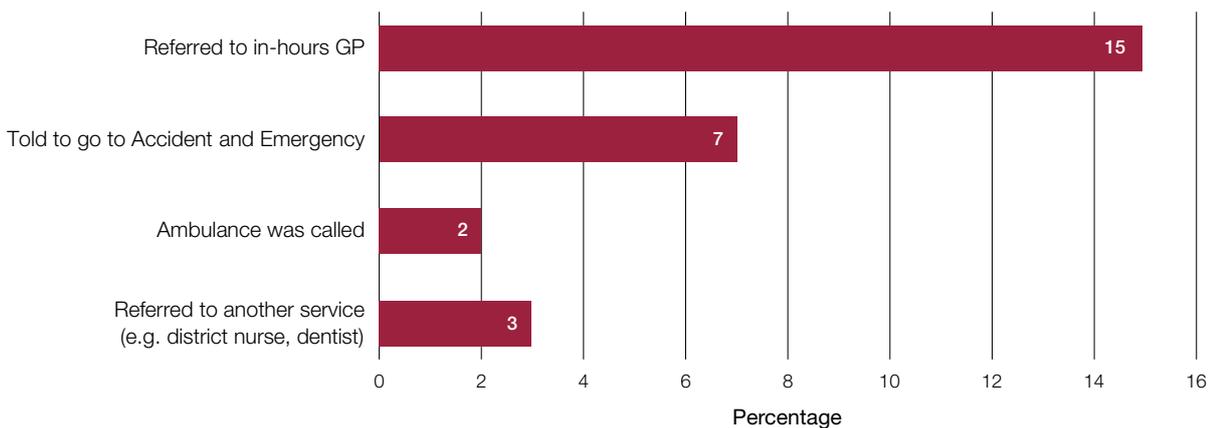
4.14 However, financial incentives can work against integration. Different bodies currently commission (pay for) and provide different kinds of urgent care (see Figure 12), using different types of contract and performance management. For example:

- Out-of-hours GP services tend to have block contracts (where payments are not based on the number of cases handled); in recent years, they have had relatively little public scrutiny of their performance against targets.
- A&E departments tend to be paid on the basis of activity (according to 'payment by results' tariffs) and their performance against targets, in particular the four-hour waiting time standard, is monitored closely.

Figure 15

Referrals by out-of-hours GP services to other health services, September and December 2013

Out-of-hours GP services referred 15 per cent of patients to their in-hours GP

**Notes**

- 1 The Figure shows weighted, average results for September and December 2013.
- 2 Out of 105 relevant survey respondents, 57 clinical commissioning groups provided referrals data.

Source: National Audit Office survey of clinical commissioning groups

4.15 It is therefore often not in the financial interests of out-of-hours GP services to take on more cases, even if nearby A&E departments are overstretched or dealing with patients who would more appropriately be treated elsewhere. And, it may not be in the interests of hospital trusts, in terms of their financial position and performance, to transfer non-emergency patients from A&E to other parts of the urgent care system. Such patients generate additional income for trusts and, if they can be treated relatively easily and quickly, can help trusts meet overall performance targets.

4.16 In addition, the fragmented nature of the urgent care system can create duplication and inefficiency. For example, some A&E departments themselves employ GPs to deal with patients who need urgent primary care. When this happens out-of-hours, it may mean that clinical commissioning groups are essentially paying twice for the same capability. They are reimbursing both trusts and out-of-hours providers. Plans to extend the opening hours of GP practices into the evenings and weekends (currently the subject of a £50 million pilot scheme) face similar value-for-money risks, as out-of-hours GP services are already paid to provide urgent primary care during these periods.

Improving integration

4.17 NHS England aims to improve the integration of urgent care. In 2013, it directed clinical commissioning groups and other local health bodies to form urgent care working groups. These groups bring together stakeholders to focus on treating more urgently ill patients in the right setting and, specifically, to reduce the volume of patients in A&E departments. Local commissioners and providers we interviewed were positive about the impact of these working groups, which, they told us, were encouraging collaboration and innovation.

4.18 In January 2013, NHS England began a comprehensive review of how urgent and emergency care services are organised and provided. The report of phase 1 of the review articulated clear principles for the future.³⁴ These are:

- providing better support for people to self-care;
- helping people with urgent care needs to get the right advice in the right place, first time;
- providing highly responsive urgent care services outside hospital so people no longer choose to queue in A&E departments;
- ensuring that those people with more serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise, to maximise chances of survival and a good recovery; and
- connecting all urgent and emergency care services so the overall system becomes more than the sum of its parts.

4.19 NHS England expects that it will take between three and five years to make what it describes as “a major transformational change” to the urgent and emergency care system. Phase 2 of the review was happening at the time of our work. NHS England is focusing on improving the initial proposals in the light of further public debate, and putting in place ways to realise the vision set out in Phase 1. It has not yet finalised an implementation plan or made clear what its role, or that of other players, will be in making these changes. NHS England told us that that it has been working through its ‘urgent and emergency care review delivery group’ (comprising stakeholders from across the system) to agree roles and responsibilities. It expects to publish an update on progress during summer 2014, with a detailed implementation plan following in autumn 2014.

34 NHS England, *Transforming urgent and emergency care services in England: End of Phase 1 Report*, November 2013.

Appendix One

Our audit approach

1 This report examines whether out-of-hours GP services are value for money. We reviewed:

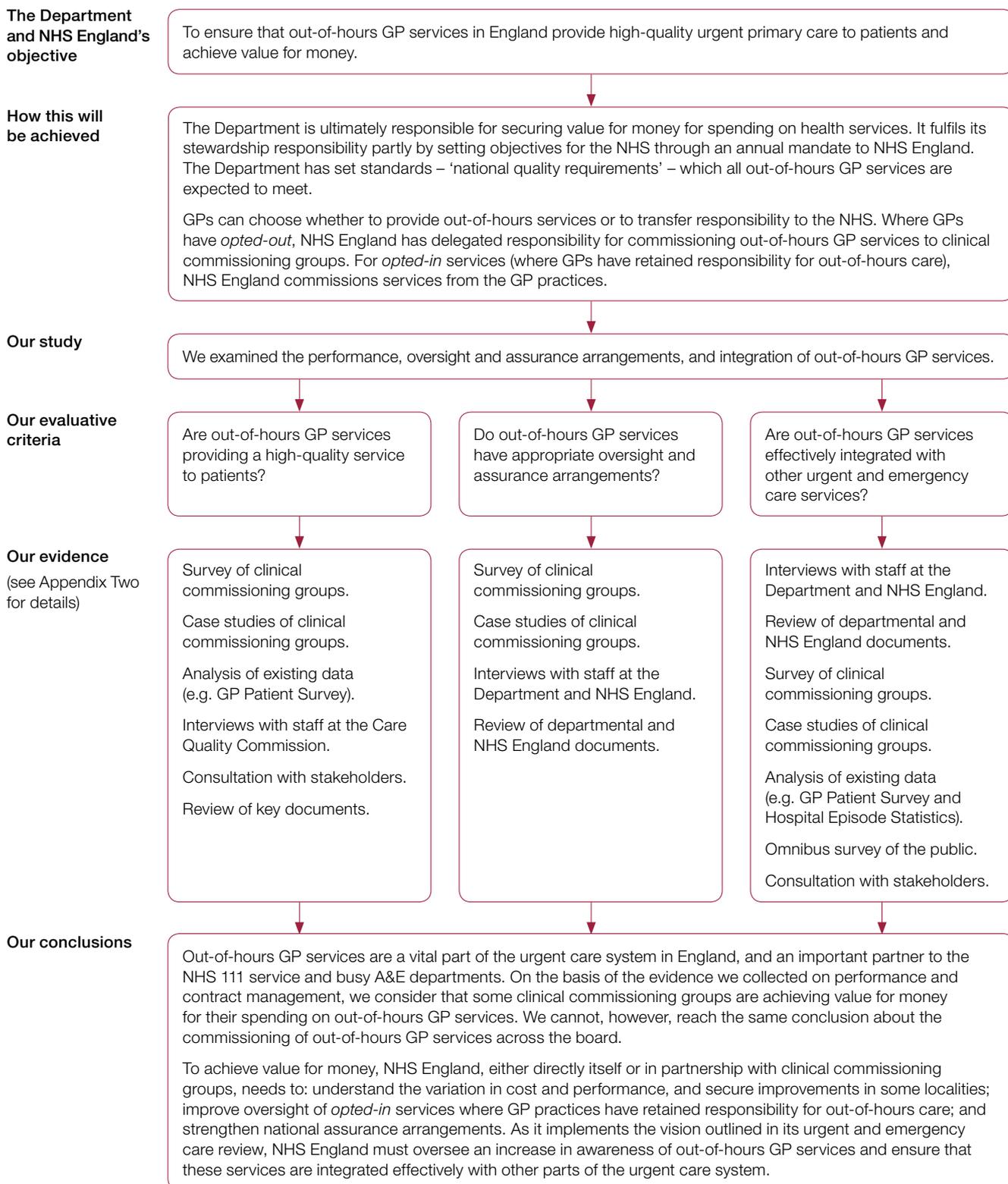
- the performance of out-of-hours GP services;
- the oversight and assurance arrangements for out-of-hours GP services; and
- whether out-of-hours GP services are integrated with other urgent and emergency care services.

2 In reviewing these issues, we applied an analytical framework with evaluative criteria, which consider what performance and management arrangements would be optimal for achieving value for money. By 'optimal' we mean the most desirable possible, while acknowledging expressed or implied constraints. A constraint in this context is the organisational structures for commissioning out-of-hours GP services.

3 Our audit approach is summarised in **Figure 16** overleaf. Our evidence base is described in Appendix Two.

Figure 16

Our audit approach



Appendix Two

Our evidence base

1 We reached our independent conclusions on the performance and management of out-of-hours GP services after analysing evidence that we collected between January and May 2014. Our audit approach is outlined in Appendix One.

2 We conducted a web-based survey of all clinical commissioning groups in England. The survey was designed to collect most information from those clinical commissioning groups that took the lead in managing their out-of-hours contract. Clinical commissioning groups without management responsibility were asked fewer questions, mainly about satisfaction with their out-of-hours service. The survey was designed to fill key gaps in information not available nationally. This included:

- the cost of services;
- activity levels;
- performance against the national quality requirements;
- contract management activities;
- recommissioning of services; and
- integration with other health services.

We asked each clinical commissioning group to give a collective response which the accountable officer signed off as accurate. Of the 211 clinical commissioning groups that we sent a questionnaire to, we received a response from 175: a response rate of 83 per cent. At a contract level, we received information on 105 out-of-hours GP service contracts, which covered 193 clinical commissioning groups in total (91 per cent) and 44.8 million people.

3 We conducted eight case studies of clinical commissioning groups that took the lead in managing an out-of-hours GP services contract:

- We selected an initial group of 24 clinical commissioning groups at random. We then chose the eight case studies to cover: urban and rural locations; different types of provider; and two sites from each of NHS England's four regions. Overall, the case study contracts covered 18 clinical commissioning groups in total and provided out-of-hours GP services to 5.3 million people. **Figure 17** provides a list of the case study clinical commissioning groups, the other clinical commissioning groups covered by the contracts and the providers.
- The case studies comprised interviews with: the clinical commissioning group that took the lead in managing the contract; the service provider; the NHS England local area team; a local GP practice; and either a local ambulance service or accident and emergency department. We also reviewed local performance information before the visits.
- The case studies were designed to collect evidence on a range of issues including: the performance of the service; the clinical commissioning group's contract management activities; the oversight and assurance work being undertaken by NHS England local area teams; and stakeholders' views of the out-of-hours GP service and the level of integration with other health services.

4 We reviewed key documents. This work was conducted at the early stages of fieldwork to inform the design of the survey and our audit framework for the case study visits. Documents included: Department of Health and NHS England documents; academic articles; Care Quality Commission reports; and previous National Audit Office, Committee of Public Accounts and Health Select Committee reports.

5 We interviewed staff from a range of organisations. The interviews were designed to help us understand: the current assurance framework for out-of-hours GP services; how out-of-hours GP services fit within the wider urgent and emergency care system; and other topics such as the issues around recruiting GPs to work out of hours. The organisations included: the Department of Health; NHS England; the Care Quality Commission; Healthwatch England; the British Medical Association; the Royal College of GPs; NHS Clinical Commissioners; the Primary Care Foundation; Urgent Health UK (a federation of social enterprise primary care providers); and Care UK (a provider of out-of-hours GP services).

Figure 17

Case study sites

Clinical commissioning group with lead management responsibility	Other clinical commissioning groups covered by the contract	Service provider
Barnet	Enfield Haringey	Barndoc
Eastern Cheshire	South Cheshire Vale Royal	East Cheshire NHS Trust
Fareham and Gosport	Portsmouth City South East Hampshire	Care UK
Redbridge	Barking and Dagenham Havering Waltham Forest	Partnership of East London Cooperatives
Shropshire	n/a	Shropdoc
Somerset	n/a	South Western Ambulance Service NHS Foundation Trust
South East Staffs and Seisdon Peninsular	East Staffordshire	Staffordshire Doctors
Sunderland	n/a	Primecare

Source: National Audit Office

6 We analysed existing data:

- We used benchmarking data from 2011-12, published by the Primary Care Foundation, to compare performance against the national quality requirements.
- We used data from the GP Patient Survey to analyse patients' experience of out-of-hours GP services, how this has changed and how satisfaction compares with other primary care services. For the data published in July 2014, the GP Patient Survey distributed 2.6 million questionnaires and received 900,000 responses. Of the responses, around 120,000 commented on their experience of using an out-of-hours GP service.
- We performed a multi-level regression analysis to investigate the relationship between patients' experience of out-of-hours GP services (using data from the GP Patient Survey) with attendances at accident and emergency departments. We also investigated factors that might explain the variation in patients' overall satisfaction with out-of-hours GP services across clinical commissioning groups.

7 We included questions in an omnibus survey of the public. We included four questions relating to out-of-hours GP services in the omnibus survey conducted by Ipsos MORI. The data are weighted by age, gender, region and working status to ensure a representative sample of people aged over 18 in England. The survey was conducted between 2 May and 12 May 2014 and had 883 respondents. Questions covered: what action people would take if they felt urgently unwell in the evening or at weekends; people's awareness of out-of-hours GP services and NHS 111; and people's perceptions of the service they would receive from out-of-hours GP services.

Appendix Three

The national quality requirements

From 1 January 2005, all providers of out-of-hours services have been required to comply with the national quality requirements, first published in October 2004. The Appendix provides the full text of the national quality requirements as published by the Department of Health.³⁵

Compliance

1 In a number of areas, providers have to demonstrate 100 per cent compliance (see in particular Quality Requirements 8, 9, 10 and 12). In many circumstances, achieving compliance at all times would require a disproportionate provision of resources and, for that reason, compliance with these standards is defined as follows:

- Full compliance: Normally, a provider would be deemed to be fully compliant where average performance was within 5 per cent of the Requirement... Thus, where the Requirement is 100 per cent, average performance of 95 per cent and above would be deemed to be fully compliant.
- Partial compliance: Where average performance was between 5 per cent and 10 per cent below the Requirement, a provider would be deemed to be partially compliant and the commissioner would explore the situation with the provider and identify ways of improving performance. Thus where the Requirement is 100 per cent, average performance of between 90 per cent and 94.9 per cent would be deemed to be partially compliant.
- Non-compliance: Where the average performance was more than 10 per cent below the Requirement, the provider would be deemed to be non-compliant and the commissioner would specify the timescale within which the provider would be required to achieve compliance. Thus, where the Requirement is 100 per cent, average performance of 89.9 per cent and below would be deemed to be noncompliant.

³⁵ Department of Health, *National Quality Requirements in the Delivery of Out-of-Hours Services*, July 2006.

The quality requirements

NQR 1: Providers must report regularly to PCTs on their compliance with the Quality Requirements.

NQR 2: Providers must send details of all OOH consultations (including appropriate clinical information) to the practice where the patient is registered by 8.00 a.m. the next working day. Where more than one organisation is involved in the provision of OOH services, there must be clearly agreed responsibilities in respect of the transmission of patient data.

NQR 3: Providers must have systems in place to support and encourage the regular exchange of up-to-date and comprehensive information (including, where appropriate, an anticipatory care plan) between all those who may be providing care to patients with predefined needs (including, for example, patients with terminal illness).

NQR 4: Providers must regularly audit a random sample of patient contacts and appropriate action will be taken on the results of those audits. Regular reports of these audits will be made available to the contracting PCT.

The sample must be defined in such a way that it will provide sufficient data to review the clinical performance of each individual working within the service. This audit must be led by a clinician with suitable experience in providing OOH care and, where appropriate, results will be shared with the multi-disciplinary team that delivers the service.

Providers must cooperate fully with PCTs in ensuring that these audits include clinical consultations for those patients whose episode of care involved more than one provider organisation.

NQR 5: Providers must regularly audit a random sample of patients' experiences of the service (for example 1 per cent per quarter) and appropriate action must be taken on the results of those audits. Regular reports of these audits must be made available to the contracting PCT.

Providers must cooperate fully with PCTs in ensuring that these audits include the experiences of patients whose episode of care involved more than one provider organisation.

NQR 6: Providers must operate a complaints procedure that is consistent with the principles of the NHS complaints procedure. They will report anonymised details of each complaint, and the manner in which it has been dealt with, to the contracting PCT. All complaints must be audited in relation to individual staff so that, where necessary, appropriate action can be taken.

NQR 7: Providers must demonstrate their ability to match their capacity to meet predictable fluctuations in demand for their contracted service, especially at periods of peak demand, such as Saturday and Sunday mornings, and the third day of a Bank Holiday weekend. They must also have robust contingency policies for those circumstances in which they may be unable to meet unexpected demand.

NQR 8: Initial Telephone Call

Engaged and abandoned calls:

- No more than 0.1 per cent of calls engaged.
- No more than 5 per cent calls abandoned.

Time taken for the call to be answered by a person:

- All calls must be answered within 60 seconds of the end of the introductory message which should normally be no more than 30 seconds long.
- Where there is no introductory message, all calls must be answered within 30 seconds.

NQR 9: Telephone Clinical Assessment

Identification of immediate life threatening conditions:

Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those calls must be passed to the ambulance service within 3 minutes.

Definitive Clinical Assessment:

Providers that can demonstrate that they have a clinically safe and effective system for prioritising calls, must meet the following standards:

- Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person.
- Start definitive clinical assessment for all other calls within 60 minutes of the call being answered by a person.
- Providers that do not have such a system, must start definitive clinical assessment for all calls within 20 minutes of the call being answered by a person.

Outcome:

At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

NQR 10: Face to Face Clinical Assessment

Identification of immediate life threatening conditions:

Providers must have a robust system for identifying all immediate life threatening conditions and, once identified, those patients must be passed to the most appropriate acute response (including the ambulance service) within 3 minutes.

Definitive Clinical Assessment:

Providers that can demonstrate that they have a clinically safe and effective system for prioritising patients, must meet the following standards:

- Start definitive clinical assessment for patients with urgent needs within 20 minutes of the patient arriving in the centre.
- Start definitive clinical assessment for all other patients within 60 minutes of the patient arriving in the centre.
- Providers that do not have such a system, must start definitive clinical assessment for all patients within 20 minutes of the patients arriving in the centre.

Outcome:

At the end of the assessment, the patient must be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and the location of any face-to-face consultation.

NQR 11: Providers must ensure that patients are treated by the clinician best equipped to meet their needs, (especially at periods of peak demand such as Saturday mornings), in the most appropriate location. Where it is clinically appropriate, patients must be able to have a face-to-face consultation with a GP, including where necessary, at the patient's place of residence.

NQR 12: Face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

- Emergency: Within 1 hour.
- Urgent: Within 2 hours.
- Less urgent: Within 6 hours.

NQR 13: Patients unable to communicate effectively in English will be provided with an interpretation service within 15 minutes of initial contact. Providers must also make appropriate provision for patients with impaired hearing or impaired sight.

Appendix Four

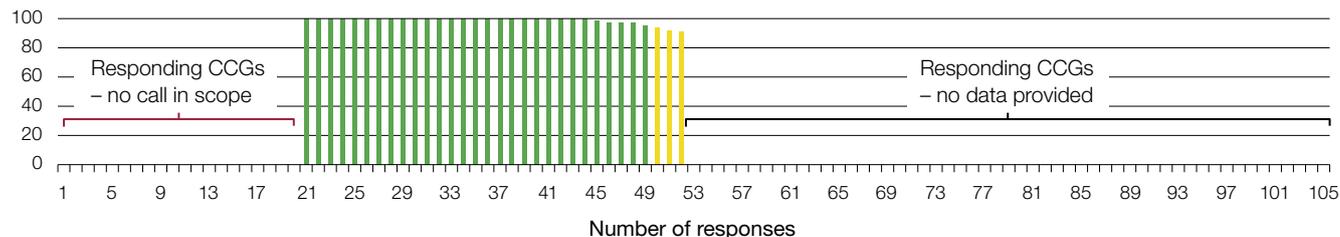
Performance against national quality requirements 9 and 12, September and December 2013

Figure 18 on pages 58 and 59 shows performance against the six criteria which make up national quality requirements 9 and 12. Performance is shown for all 105 clinical commissioning groups (CCGs) that responded to our survey and took the lead in managing an out-of-hours contract. Data were collected for September and December 2013 and averaged to provide an overall level of performance across these two months.

Figure 18
Performance against national quality requirements 9 and 12

Monthly average NQR 9A – Passing life-threatening calls to the ambulance within three minutes

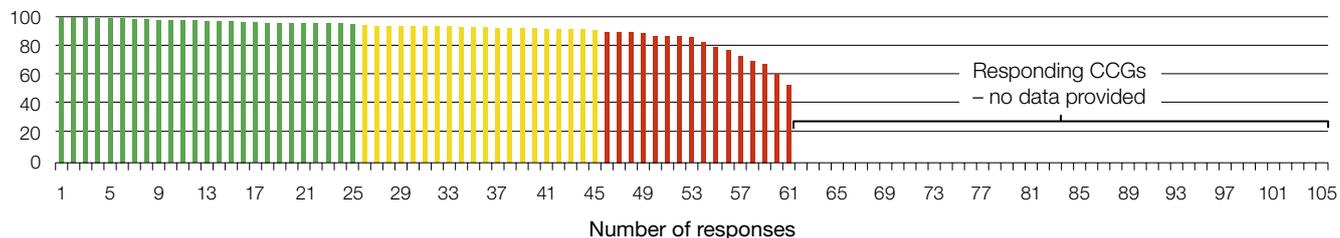
Percentage of compliant cases



	Number		Number
■ Number achieving 95 per cent or above	29	■ Number with no cases in scope	20
■ Number between 90 and 94.9 per cent	3	■ Number of CCGs that did not provide data	53
■ Number below 90 per cent	0		

Monthly average NQR 9B – Starting clinical assessments for urgent calls within 20 minutes

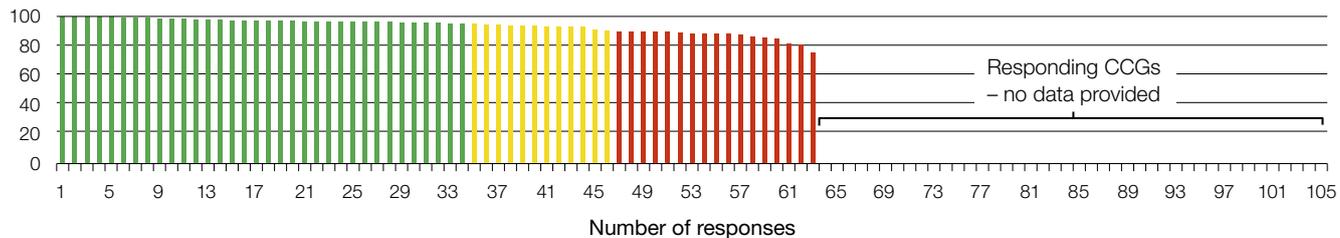
Percentage of compliant cases



	Number		Number
■ Number achieving 95 per cent or above	25	■ Number with no cases in scope	0
■ Number between 90 and 94.9 per cent	20	■ Number of CCGs that did not provide data	44
■ Number below 90 per cent	16		

Monthly average NQR 9C – Starting clinical assessments for all routine calls within 60 minutes

Percentage of compliant cases



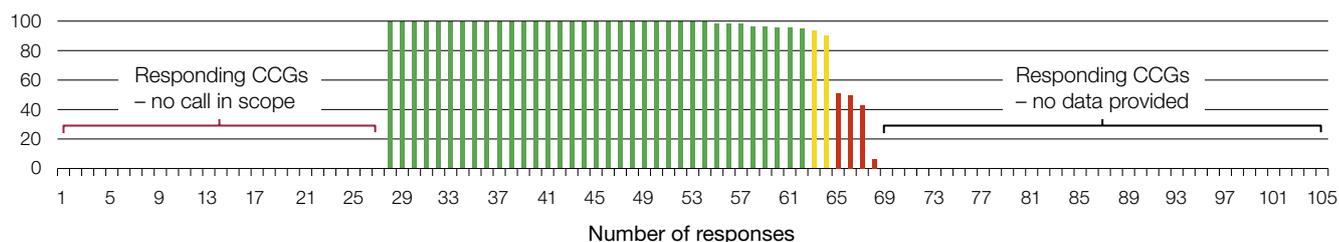
	Number		Number
■ Number achieving 95 per cent or above	34	■ Number with no cases in scope	0
■ Number between 90 and 94.9 per cent	12	■ Number of CCGs that did not provide data	42
■ Number below 90 per cent	17		

Figure 18 continued

Performance against national quality requirements 9 and 12

Monthly average NQR 12A – Starting face-to-face visits prioritised as emergency within one hour

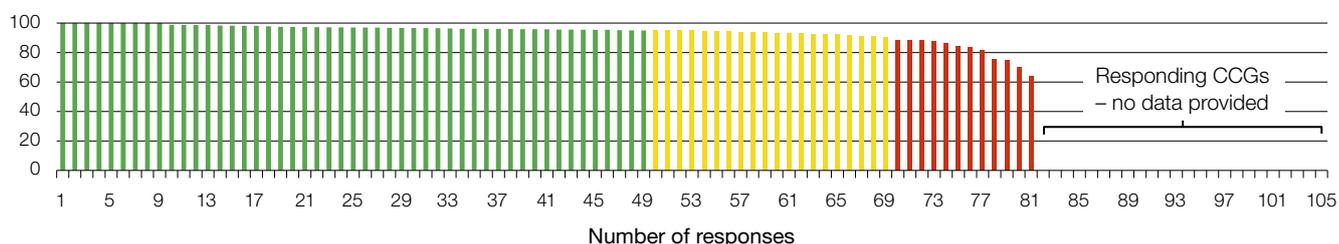
Percentage of compliant cases



	Number		Number
■ Number achieving 95 per cent or above	35	— Number with no cases in scope	27
■ Number between 90 and 94.9 per cent	2	— Number of CCGs that did not provide data	37
■ Number below 90 per cent	4		

Monthly average NQR 12B – Starting face-to-face visits prioritised as urgent within two hours

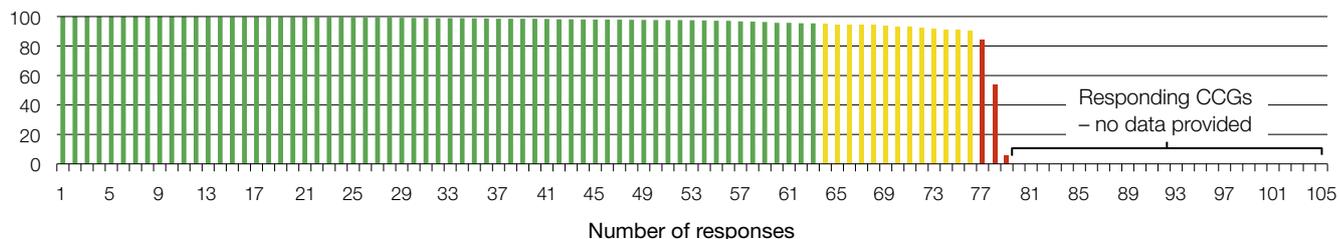
Percentage of compliant cases



	Number		Number
■ Number achieving 95 per cent or above	49	— Number with no cases in scope	0
■ Number between 90 and 94.9 per cent	20	— Number of CCGs that did not provide data	24
■ Number below 90 per cent	12		

Monthly average NQR 12C – Starting face-to-face visits prioritised as routine within six hours

Percentage of compliant cases



	Number		Number
■ Number achieving 95 per cent or above	63	— Number with no cases in scope	0
■ Number between 90 and 94.9 per cent	13	— Number of CCGs that did not provide data	26
■ Number below 90 per cent	3		

Source: National Audit Office survey of clinical commissioning groups

Report by the Comptroller and Auditor General
Out-of-hours GP services in England

HC 439 Session 2014-15

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Ordered by the House of Commons to be printed on 11 July 2014

CORRECTION

Paragraph 1.9, 2nd bullet (page 13) was produced in error and should read:

- Commercial organisations (such as Care UK) hold 31 per cent of contracts.

and not:

- Commercial organisations (such as Care UK and Urgent Care 24) hold 31 per cent of contracts.

Figure 14 (page 42) of the report was produced in error. The last 2 sets of bars entitled 'Would not contact a service during the night' and 'Don't know' contained some incorrect data.

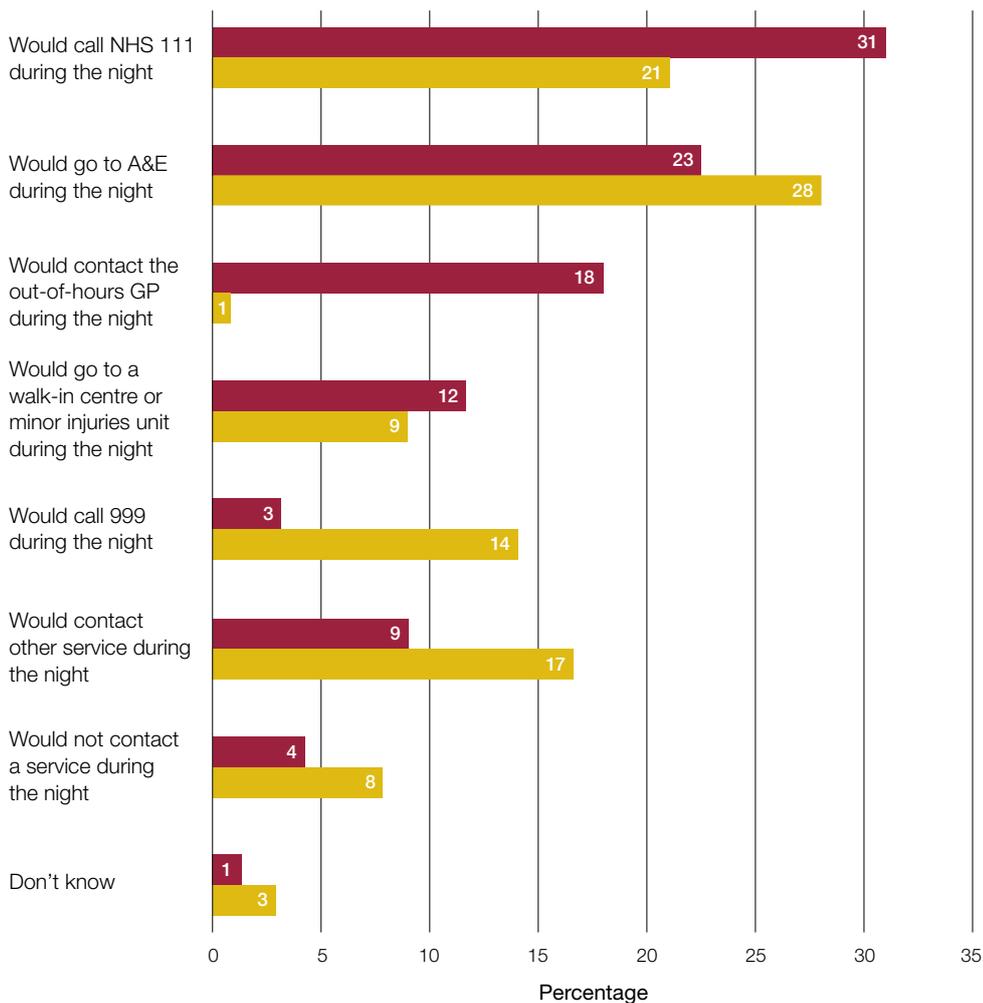
Please see the corrected figure below:

Figure 14

Services people would contact first when feeling urgently unwell

People who had heard of out-of-hours GP services were more likely to call NHS 111 and less likely to go to A&E departments

At night



- Of the people who responded that they had previously heard of out-of-hours GP services
- Of the people who responded that they had previously not heard of out-of-hours GP services

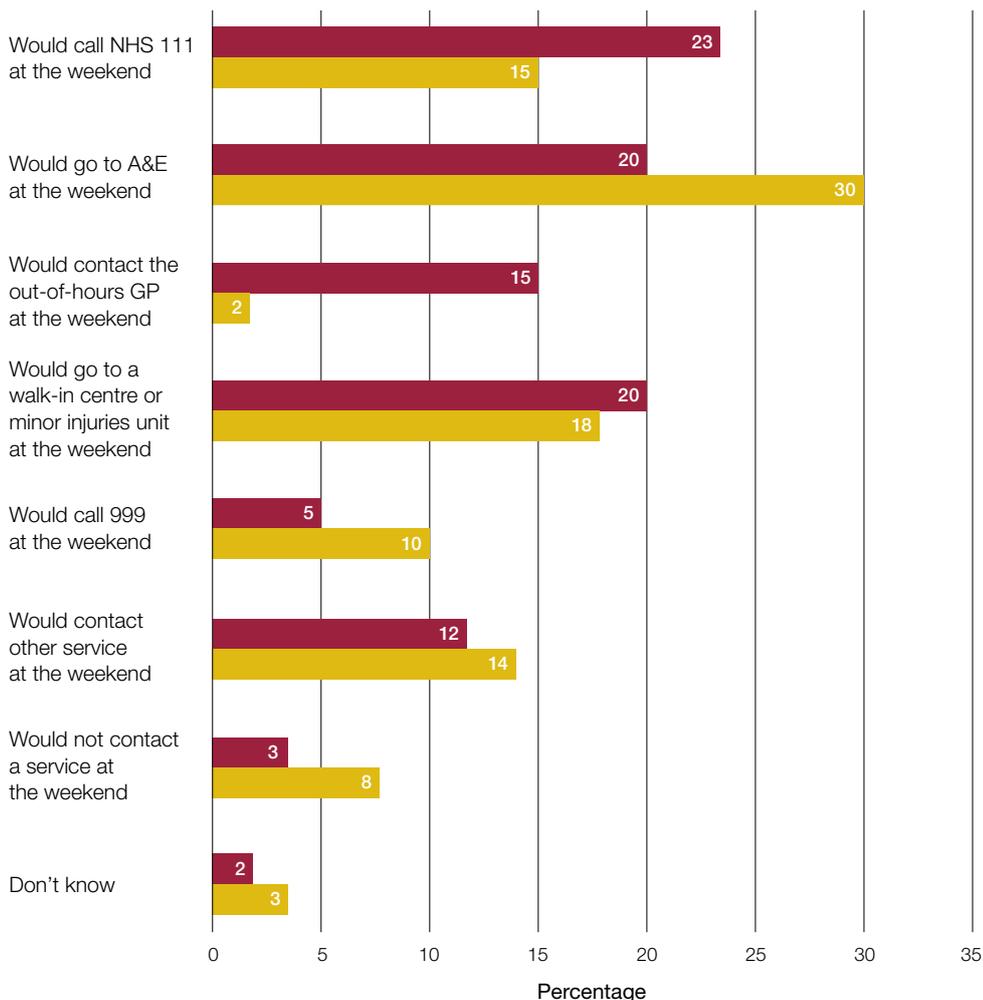
Figure 14 continued (page 43) of the report was produced in error. The last 2 sets of bars entitled 'Would not contact a service during the weekend' and 'Don't know' contained some incorrect data.

Please see the corrected figure below:

Figure 14 continued

Services people would contact first when feeling urgently unwell

At weekends



- Of the people who responded that they had previously heard of out-of-hours GP services
- Of the people who responded that they had previously not heard of out-of-hours GP services

Notes

- 1 Percentages do not sum to 100 due to rounding.
- 2 Sample size: 426 respondents were asked which service they would contact if they felt unwell at night and 452 were asked which service they would contact if they felt unwell at the weekend.
- 3 'Other' services include a pharmacist or a non-NHS website.

Source: Ipsos MORI survey for the National Audit Office



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