
Developing out-of-hours care in England

A position paper from the BMA General Practitioners Committee

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Introduction

Out-of-hours care¹ has been brought into sharp public focus recently by misleading Government statements² and subsequent media coverage. The 2004 GP contract has been blamed for perceived failings in out-of-hours services and linked to pressures on hospital emergency departments.³ It has also been asserted that GPs are no longer involved in out-of-hours care.⁴ Some, including the Secretary of State for Health, have suggested that these problems could be solved by GPs taking on greater responsibility for out-of-hours care, or at least becoming more involved in its supervision.⁵ This is an argument framed by a wider Government agenda of better patient access, improved continuity of care for the elderly, seven-day working in the NHS and a desire to move more services into the community.

The NHS urgent care system, like much of the wider NHS, is under pressure. The massive savings programme being imposed on the NHS,⁶ staff shortages and recruitment problems make it difficult to meet demographic challenges across the NHS. The General Practitioners Committee believes these problems have been compounded by increasing patient expectations for instant access to healthcare based on choice and convenience rather than need, which in turn have been driven by politics. Unwillingness or inability of some patients to self-care is widely acknowledged to contribute to the problems.⁷

In 2012-13, 70 per cent of respondents to the Government's patient experience survey said their overall experience of out-of-hours care was good,⁸ but there is undoubtedly variation in the quality of care provided to patients out-of-hours.⁹ A 2010 review of out-of-hours services concluded that 'the quality of services varies unacceptably and that there are providers and commissioners who need to improve to prevent those occasions where the care offered falls far below that which is acceptable'.¹⁰

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- 1 Out-of-hours care is defined in this paper as care delivered by primary care practitioners between 18.30 and 08.00 on weekdays, and 24 hours a day at weekends, bank holidays and public holidays.
 - 2 On 25 April 2013 for example, the Secretary of State for Health, Jeremy Hunt, blamed GPs for problems in A&E.
 - 3 On 25 April 2013, Jeremy Hunt said 'The decline in out-of-hours care follows the last Government's disastrous changes to the GP contract, since when we have seen four million more people use A&E every year...We must address these system failures and I am determined we will'. As quoted in *The Times* 26 April 2013.
 - 4 See for example, *Daily Mail*, 17 May 2013 'Airline pilots and pizza delivery boys work all hours. How arrogant of GPs to think it's beneath them'.
 - 5 See Jeremy Hunt speech to the Kings Fund, 24 May 2013.
 - 6 Ford J (2013) The NHS is facing a deepening financial crisis *BMJ* 2013; 347:f4422.
 - 7 NHS England (2013) *High quality care for all, now and for future generations: transforming urgent and emergency services in England*. This review of available evidence concluded that 'some people with minor ailments abandon self-care earlier than they need to, and depend too highly on support from formal healthcare services because they do not have the confidence or knowledge necessary' (p30).
 - 8 [The GP Patient Survey](#): July 2012 – March 2013, Summary Report.
 - 9 Primary Care Foundation (2012) *Benchmark of out-of-hours: An overview across the services*.
 - 10 Colin-Thome D & Field S (2010) General practice out-of-hours services: Project to consider and assess current arrangements.

Purpose of this paper

This paper provides a recent history of out-of-hours care in England and sets out the GPC's proposals for developing out-of-hours care to meet the challenges facing the NHS's urgent care system. It is intended to provoke policy changes in the way out-of-hours care is commissioned, delivered and supported. Though the focus of this paper is England, many of the challenges facing out-of-hours care are also found in Wales, Scotland and Northern Ireland.

This paper was partly informed by an out-of-hours roundtable meeting hosted by the BMA on 3 July 2013. The GPC is very grateful for the valuable input of all those who attended this meeting.¹¹ Their input has been taken on board, though the paper does not necessarily reflect the position of the organisations involved.

Recent history of out-of-hours care

Before the introduction of the new contract in 2004, GPs had a personal responsibility for providing out-of-hours care to their patients. However, for a long time before the contractual change in 2004, many worked collaboratively to provide this care to patients. By 2000, about a third of practices, particularly in urban conurbations, delegated their out-of-hours cover to deputising services. The majority of the remaining two-thirds of practices used a cooperative to provide this care to patients.¹²

GPs' personal responsibility for providing out-of-hours care to their patients ended with the introduction of the new contract in 2004. Change was necessary to protect recruitment into general practice in the face of unmanageable workload and altered expectations of out-of-hours coverage since the advent of the NHS. As *Investing in general practice (2003)* said:

'The existing default responsibility for all GPs to provide 24-hour care for their patients makes general practice unattractive for many prospective and current general practitioners and works against the achievement of an appropriate work/life balance.'¹³

Since 2004, practices have been able to forfeit 6 per cent of their global sum each year to opt out of out-of-hours-provision. In these cases, the commissioning of out-of-hours services fell to primary care organisations (PCOs),¹⁴ which were able to commission care from a wide range of providers including GP-led cooperatives and private companies. Since 2004 there has been little new investment in out-of-hours care.¹⁵ Funding pressures meant that PCOs sometimes underinvested in out-of-hours care and providers have been encouraged to tender at prices that have reduced clinical staffing levels. Providers have occasionally employed GPs unfamiliar with local protocols and processes. This was tragically exemplified in 2008 when treatment provided by a German locum doctor flown in to provide cover for a private company, Take Care Now, led to the death of David Gray.

11 The Patients Association, The RCGP, The NHS Alliance, representatives of the BMA's general practitioners and consultants committees and a Community Healthcare Trust Medical Director.

12 Department of Health (2000) *Raising standards for patients: New partnerships in out-of-hours care*.

13 The NHS Confederation and BMA (2003) *New GMS Contract 2003: Investing in General Practice*, p10 2.17

14 Previously Primary Care Trusts (PCTs) in England. On 1 April 2013, CCGs in England formally became responsible for the commissioning out-of-hours services and other unscheduled care services.

15 The Information Centre for Health and Social Care (2011) *Investment in General Practice 2006/07 to 2010/11 England, Wales, Northern Ireland and Scotland*.

Quality markers have sometimes been ignored when retendering or monitoring contracts. A 2010 report found 'varying levels of challenge from PCTs regarding performance management of providers'.¹⁶ More recently, the Committee of Public Accounts, after an inquiry into failings in the out-of-hours service provided by Serco in Cornwall, concluded that 'the primary care trust was deeply ineffective in managing Serco's performance, and made some bonus payments despite the fact Serco's performance was falling well short of what was required. Even when it knew that Serco staff had massaged the figures, the trust did not fine the contractor or terminate the contract.'¹⁷

Most recently, the disastrous launch of NHS 111, despite the calls from GPC that there were major problems and it should be delayed, has put both out-of-hours services and A&E departments under additional pressure. This has been significantly worse where NHS 111 has been separated from out-of-hours triage from treatment. This has been in part due to the use of inexperienced staff following a script based on an algorithm, which leads to highly risk-averse outcomes. In one area, 999 call volumes are said to have increased by 8 per cent after NHS 111 went live.¹⁸ A&E attendance is reported to have increased in some areas as a result of the introduction of NHS 111.¹⁹

Out-of-hours primary care is part of a wider system of NHS urgent and same-day care services, including NHS Direct, walk-in centres, minor injury units, 'Darzi' clinics and NHS 111. The plethora of different services and their fragmented delivery has caused confusion amongst patients about which services to access when.²⁰

Not everything about out-of-hours care requires improvement. There are many examples across the UK of GP-led organisations, sometimes based on former out-of-hours cooperatives, providing excellent out-of-hours care for commissioners or opted-in practices. These services frequently integrate different aspects of the local urgent care service with local general practice. The Primary Care Foundation has found that overall performance of out-of-hours services is improving and that access to out-of-hours services is easy and rapid.²¹

Contrary to frequent press stories, many GPs have retained an involvement in out-of-hours since 2004. Around 10 per cent of practices are still responsible for organising their own out-of-hours work. Many of the pre-2004 cooperatives remain operational (albeit sometimes de-mutualised and larger as a result of the pressures of competitive tendering). Urgent Health UK claims that social enterprises deliver care to nearly 50 per cent of the population. Around 40 per cent of GPs still provide out-of-hours services for cooperatives, not-for-profit and for-profit organisations – not dissimilar to the 1996-2004 situation. Contrary to some public perceptions, out-of-hours services are staffed almost wholly by the GPs working in practices or as locums in the areas in which they operate.²²

16 Colin-Thome D & Field S (2010) *General practice out-of-hours services: Project to consider and assess current arrangements*.

17 Rt. Hon Margaret Hodge, Public Accounts Committee, 11 July 2013.

18 Statement made by ambulance trust representative to Lord Earl Howe at Ambulance Confederation Annual General Meeting November 2012.

19 Health Committee Inquiry on Emergency Care 25 June 2013.

20 NHS England (2013) *High quality care for all, now and for future generations: transforming urgent and emergency services in England*. This review of available evidence concluded that 'Urgent care services are highly fragmented and difficult to navigate causing many patients to experience difficulty choosing the service most appropriate to their needs.' (p25).

21 Primary Care Foundation (2012) *Benchmark of out-of-hours: An overview across the services*.

22 Primary Care Foundation (2012) *Benchmark of out-of-hours: An overview across the services*.

Case study: Derbyshire Health United (DHU)

DHU has provided integrated GP out-of-hours services in Derbyshire since 2006. During the out-of-hours period, in addition to operating the GP service, it also covers all nine community hospitals and operates the District Nursing Service, as well as being the 111 service provider – thus providing seamless integrated healthcare in the community. DHU has no shareholders and is a not-for-profit Social Enterprise limited by guarantee and was awarded a Social Enterprise mark in 2006. DHU was formed from the merger of the two GP-led cooperatives in North and South Derbyshire.

Strong engagement with local practices and GPs

To this day DHU has tremendous engagement with local GPs and their practices. 95 per cent of all GP sessional shifts are filled by local GPs and the remainder filled with selected locums many of whom have trained locally. The Board of DHU is GP led – often leaders in their own localities – thus ensuring the quality of care out-of-hours is continuous with the quality of in-hours services. DHU has always been in the upper quartile of Primary Care Foundation benchmarks against other out-of-hours services and is highly regarded in the 2012 GP patient survey. The GP Patient Survey 2012-13 revealed in Derbyshire an average 80 per cent ease of contacting the out-of-hours GP service, 85 per cent confidence and trust in out-of-hours clinicians and a 75 per cent average for the overall experience of out-of-hours GP service in Derbyshire.

Innovation in record sharing for 24/7 continuity of care

In 2010 the GPs of DHU created RightCare®. This is a patient consented care plan that shares the key clinical information of patients with the most complex health needs and long term conditions including end of life care. RightCare® is integrated with primary and acute healthcare and the plans can be viewed by the ambulance trust. RightCare® has over 6000, patients a year who have used this care plan measurably improving 24/7 care and positively supporting end of life and the patients and carers preference of place of death. RightCare patients can now use 111 to connect into a fully integrated service keeping their care fully consistent 24/7. RightCare plans connect for patients with the most complex health needs across the whole of the urgent care pathway.

Case study: Devon Doctors (courtesy of Urgent Health UK)²³

Devon Doctors is committed to the provision of exceptional, GP-led, out-of-hours and primary care; is owned by the county's GP practices and has provided urgent out-of-hours care to its 1.25m residents since 1996 when it was a GP cooperative. In 2004 it became a company limited by guarantee and was commissioned by NHS Devon, NHS Plymouth and Torbay Care Trust to provide the out-of-hours service under the new GP contract.

Devon Doctors is one of the largest social enterprise organisations in the South West and all its profits are reinvested into improving services for patients, which has seen it consistently benchmarked as one of the country's leading OOH providers by the Primary Care Foundation.

Quality, safety and patient experience

Quality, Safety and Patient Experience is paramount to Devon Doctors, illustrated by their recent success in HSJ Patient Safety Award 2013 winning the Education and Training in Patient Safety category for their *Putting Patients First* training programme. Also In 2013, Devon Doctors were finalists in the National Customer Service Training Awards for the work the organisation has undertaken in promoting an open and fair learning culture through Incident Reporting.

Strong links with local GP practices and the community we serve

Devon Doctors is owned by the 176 GP practices in Devon (not the individual GPs); the benefits of this unique model are that there are no individual GP conflicts of interest and the Practices have influence on and interest in the standards of their registered patients OOH service. Practices vote for a GP to represent their area on the Board. They have a direct influence over the service provided to their patients, providing better continuity between in-hours and out-of-hours primary care.

Assessed to be one of the best

Devon Doctors consistently achieves all of the Department of Health Quality Standards. In some areas it exceeds them with its own, locally agreed, standards:

- urgent visits must be provided within one hour and other visits within two hours
- palliative care patients must be treated within an urgent timescale.

The MORI National Patient Survey from 2012 showed for the third successive year, out-of-hours care in all four of the PCTs served by Devon Doctors was ranked among the best in the country.

The Primary Care Foundation's 2009 benchmarking exercise reported Devon Doctors to be good value for money: it dealt with a higher level of demand per head than most other services while remaining compliant with all standards, and remaining financially competitive.

In 2008 the Care Quality Commission's investigation into urgent care services gave Devon Doctors the best scores in the country. It achieved an 'outstanding' level in several areas, including telephone access and times for face-to-face assessments.

23 www.urgenthealthuk.com

The GPC's position

Guiding criteria for development of out-of-hours care

- 1 **Patients with urgent clinical needs must be able to access good care out-of-hours.**
We believe that the economic argument for investing in this care is unarguable because of the potential savings to be made in acute care. Pressure to reduce secondary care admissions should lead logically to additional funding being made available to out-of-hours provision.
- 2 As populations, geography and healthcare providers vary so much across England, **we do not envisage a 'one size fits all' approach to improving out-of-hours care.** The most appropriate solutions must be found by local clinical commissioners within an enabling national framework. Nevertheless, we believe there are some basic principles relevant to all commissioners.

The profession has made it clear that it is **unwilling to accept any compulsory personal or practice responsibility for out-of-hours provision. Changes to the GP contract are not required** to secure improvements in out-of-hours care. We are willing to engage in discussion about improving out-of-hours provision and increasing the influence GPs have on commissioning and designing these services, but this should not be framed as GPs 'taking back' out-of-hours care. Any attempt to push this through would be likely to result in considerable recruitment and immediate retention problems.

Commissioning out-of-hours care

- 3 The urgent care system has become highly fragmented and confusing for patients. To avoid duplication and make access points more obvious to patients, **robust CCG-led commissioning should integrate the health services involved in out-of-hours unscheduled care** including telephone triage and advice, primary medical services out-of-hours, walk-in centres, 'Darzi' clinics, NHS 111, A&E tier 2 services and even some parts of the 999 service. The service should also have close links with community nursing, hospice care, pharmacy and social services. All of these services should be working towards the same goal. Consideration needs to be given to pricing structures in the system to enable this. A redesigned tariff or block funding method for the whole system could help providers work together more closely.
- 4 Out-of-hours, **call handling and triage must not be separated from the treatment team.** Triage of patients is a skilled activity and should be undertaken by the most skilled and experienced clinicians available to allow the handling of large volumes of work with accuracy and speed and executive authority, not by untrained lay people – even when supported by a computer algorithm. Non-clinical or inexperienced call handlers are forced to rely on risk-averse software which can escalate the level of response and so undo any predicted cost benefit. Skilled clinicians triage more appropriately. There are already examples of GP led out-of-hours providers with NHS 111 contracts (eg in Derbyshire).
- 5 We want GPs to be the leaders of healthcare systems. Out-of-hours care is part of the Primary Medical Services so should be GP directed. **CCGs have given GPs a role in the commissioning of out-of-hours care** (as membership organisations, CCGs make

local groups of GPs responsible for commissioning out-of-hours services by virtue of their membership). **However, with this responsibility must come real power.** In many cases CCGs have inherited contracts with years left to run so they should be able to end contracts, which are not delivering good quality care and re-commission more appropriately. Some areas find themselves tied into expensive contracts, for NHS 111 for example, with inefficient providers. **The new CCGs must be enabled to commission the best services possible** for patients without being hampered by contracts with companies providing poor quality care. **We should be looking at the conditions that would have to be met to give local GPs real influence over out-of-hours commissioning,** for example the ability to review contracts negotiated before the inception of CCGs.

- 6 **Out-of-hours providers need to be adequately funded.** At the moment, costs per head of population and costs per case vary widely, though the variation partly reflects real differences in demand and delivery costs.²⁴ A nationally defined minimum £ per head investment may be appropriate for the commissioning of out-of-hours services, though the amount allocated to each area would require a sensitive formula taking into account challenges such as rurality, population age and demand. A population-base tariff may encourage commissioners to choose providers on the basis of quality rather than price. This money must not be taken from existing nGMS or PMS funding and must be ring-fenced for out-of-hours care. To take further funding away from existing practice contracts would simply damage the quality of the current in-hours service provided by GPs. **The out-of-hours system must be designed with capacity adequate to respond to peaks in demand.**
- 7 **Out-of-hours providers need to be adequately quality controlled.** Successful providers currently use a range of skill-mix and models to deliver good care though it might nevertheless be sensible to consider minimum clinician to patient ratios, call-handler to nurse/doctor ratios, and acceptable minimum standards for nursing and medical staff. There are already National Quality Requirements but previously studies have found varying levels of challenge from commissioners regarding performance management of providers.²⁵ Most importantly, commissioners must commission with quality rather than price being the foremost requirement and they must continue to monitor provider quality over the duration of the contract. With CCGs now being the commissioners of out-of-hours, GPs themselves have a new role to play in these important commissioning functions.
- 8 **LMCs should have a central role in advising on investment in out-of-hours services and their strategic development at local level.** It became clear during the roll out of NHS 111 that LMCs were sometimes being sidelined in decision making. Yet LMCs are well positioned to coordinate input from all those involved in unscheduled care, including clinicians from local emergency departments.

24 Primary Care Foundation (2012) *Benchmark of out-of-hours: An overview across the services.*

25 Colin-Thome D & Field S (2010) *General practice out-of-hours services: Project to consider and assess current arrangements.*

Out-of-hours provision

- 9 **Out-of-hours services should be provided by experienced, preferably local, health professionals, led by GPs.** There are many good examples of GP-led out-of-hours organisations providing good care to the local population and the Government should build on those models. Greater investment in out-of-hours care would allow for the involvement of more of the best and most experienced local professionals. Ultimately, it may be worth allowing CCGs to become the providers as well as the commissioners of out-of-hours services. This is a matter for further debate, though David Nicholson, the Chief Executive of NHS England, has stated that the integration of commissioning and provision will be considered against particular sets of challenges.²⁶

We have every reason to believe **GPs may have more to offer out-of-hours care on a paid voluntary-participation basis along the lines of the most successful provider models** if the funding were made available to support the improvement.

- General practice is generally willing to provide more services to patients where resources and premises allow. GPs have a long history of responding quickly to changes, being resourceful, innovative and adaptable.
- Many existing out-of-hours organisations demonstrate the benefits to patient care of GP-led care.
- There is an ever-greater incentive for practices to behave collaboratively and entrepreneurially and to expand their services through tendering to survive. There is a general acceptance that practice survival may often lie in federation, cooperation and working in bigger teams or larger organisations. In *some* instances this may create new opportunities for out-of-hours provision on a voluntary-participation basis.
- Greater GP involvement in out-of-hours provision may help to limit creeping privatisation and vertically integrated, hospital-managed takeover.

- 10 If out-of-hours services are to be high quality and linked as closely as possible to the local health economy and in-hours services, **as a minimum there needs to be a level playing field for GP cooperatives, companies or federations to bid against large corporations to provide these services.** We are concerned that, as it stands, some providers are backed by large organisations so can sustain years of losses in order to secure long-term NHS business. Subsequent under-pricing of bids for out-of-hours work could push smaller organisations out of the market. The Public Accounts Committee recently stated that 'The large private providers coming on to the scene are better at negotiating contracts than delivering a good, value for money service'.²⁷ Creating a truly level playing field would require all bids to be internally financially sustainable (ie not relying on subsidy from a for-profit company). There may also need to be a realistic minimum contract length for GP-led organisations to be able to bid for these services.

26 *Health Service Journal* 7 June 2013 p4.

27 Rt. Hon Margaret Hodge, Public Accounts Committee, 11 July 2013.

- 11 Preferably, changes should go further by giving preferential treatment to local practices and GP-led organisations that want to be involved in out-of-hours care to be able to do this. **Practices should be given the right to opt back into out-of-hours provision individually or collectively where they express a desire to do so** (as recently in Hackney), **alongside the existing right to opt-out.**
- 12 **Models of out-of-hours provision must be GP-led but will not necessarily be exclusively GP provided.** There is a role for greater use of extended multi-professional and integrated teams led and or organised by GPs.

Supporting out-of-hours care

- 13 **To really relieve pressure on both secondary care and the out-of-hours system, the whole of in-hours primary care requires significant additional investment. In-hours capacity must be sufficient to avoid work spilling over to out-of-hours, urgent and emergency providers.** To demonstrate, there are over 300 million GP in-hours consultations a year (2008-09 figures) compared to approximately 8.6 million calls to out-of-hours services (2007-08 figures) and 21.7 million attendances at A&E departments, minor injury units and urgent care centres (2012-13 figures).²⁸ Even a small increase in in-hours capacity could potentially make an enormous difference to the pressure on these other services.
- 14 **Adequate ancillary services, such as pharmacy and social care, need to be commissioned** to support out-of-hours services. A full range of professional input is required for the best round the clock primary care. In some cases, such as community nursing, more professionals need to be trained and recruited to support the service.
- 15 **Doctors working primarily in out-of-hours settings face unique challenges and need proper training, induction and CPD support.** Exposure to out-of-hours and unscheduled care experience in general practice training remains crucial. **Those working in out-of-hours also need acceptable working conditions and hours.**
- 16 **Out-of-hours care may be improved by giving providers better access to electronic clinical records.** GPs have an overriding responsibility as the creator and protector of patient records but the profession needs to examine how information might be shared with out-of-hours providers in the future to improve the care that can be offered to patients.
- 17 **Pensions eligibility and steeply rising indemnity costs for GPs doing out-of-hours work are important issues that need to be reviewed to encourage GP involvement.**

Controlling demand

- 18 **Out-of-hours services should be designed for emergency and urgent care. Patient expectations must be managed to make this possible.** Even with the financial resource there is neither the workforce nor support resources to sustain 24/7 routine or on demand routine care. Any attempt to do so could have a major impact on the quality of care provided not only in out-of-hours settings but on in-hours care as well.

28 NHS England (2013) *High quality care for all, now and for future generations: Transforming urgent and emergency services in England. The evidence base from the urgent and emergency care review.*

- 19 **Demand management is key, including increasing the willingness and ability of people to self-care where appropriate.** NHS England's recent review of the evidence concludes that many people do not have the necessary confidence, or health literacy, to treat or manage their condition themselves leading them to depend too highly on support from formal healthcare services.²⁹ Face-to-face education from clinicians and better health education in schools might go some way to combating this problem. Standardisation of electronic and printed information on the treatment of common illnesses across the NHS might also help increase health literacy. Many of the highest users of out-of-hours and emergency care live in settings with professional carers. Appropriate care plans for vulnerable individuals within these settings, managed by responsible carers, can go some way to ensuring that out-of-hours calls are appropriate and correctly directed.

Summary

The UK is facing huge demographic change and urgently needs more community-based primary care. If properly managed and appropriately invested in, primary care can help provide the solutions to many of the challenges facing the health service. GPs will not however accept any compulsory personal or practice responsibility for out-of-hours provision. Changes to the GP contract are not required to secure improvements in out-of-hours care.

All over the country there are examples of local GPs working collaboratively to deliver excellent out-of-hours care to patients and new services to patients in the community. The best out-of-hours care is clinician-led and locally based. Sadly, we know there are also areas where poorly thought-out policy and short-sighted tendering, particularly of NHS 111, have resulted in ineffective and uneconomical services.

We believe GPs should have a central role in commissioning and designing out-of-hours care. We are willing to work with Government to consider what needs to be done to build on successful collaborative local models to allow GPs to deliver more GP-led extended care, including properly coordinated out-of-hours care, as well as a wider range of services for patients.

Government policy and in particular commissioner behaviour have damaged out-of-hours provision in recent years. GPs have more to offer out-of-hours both through CCG commissioning and as providers along the lines of the most successful (non-compulsory involvement) local models. Government should provide the tools GPs need to deliver the necessary improvements.

29 NHS England (2013) *High quality care for all, now and for future generations: transforming urgent and emergency services in England*.